

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

2062683275

1231

PRINTED: 08/13/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/07/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COVENANT SHORES HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9107 FORTUNA DRIVE MERCER ISLAND, WA 98040
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000 INITIAL COMMENTS

F 000

This report is the result of an unannounced Abbreviated Survey conducted at Covenant Shores Health Center on 08/05/13 and 08/07/13. A sample of 9 residents was selected from a census of 41. The sample included 4 current residents and 5 former residents.

The survey was conducted by:

 MSW

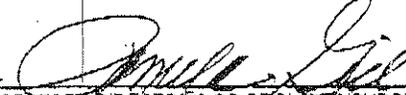
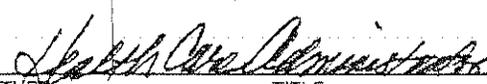
Complaints Investigated included:  
#27844176

The surveyor is from:

Department of Social and Health Services  
Aging and Long Term Services Administration  
Residential Care Services, Region 2, Unit B  
20425 72nd Avenue South, Suite 400  
Kent, WA 98032-2388

Telephone: (253)234-6003  
Fax: (253) 395- 5071

 8/13/13  
Residential Care Services Date

		8/27/13
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X5) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received Time Aug. 28. 2013 5:08PM No. 0494

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2013  
FORM APPROVED  
OMB NO. 0938-0391

1231

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/07/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  COVENANT SHORES HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9107 FORTUNA DRIVE MERCER ISLAND, WA 98040
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	Continued From page 1	F 000	<b>F164</b>	
F 164 SS=E	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain confidentiality</p>	F 164	<p><u>How deficiency corrected:</u></p> <ul style="list-style-type: none"> <li>The binder was reviewed in its entirety and any item with reference to staff/resident names was immediately removed.</li> </ul> <p><u>Action to protect residents and measures to ensure correction:</u></p> <ul style="list-style-type: none"> <li>Staff were instructed by the Director of Nurses/Administrator regarding the regulation and further instructed regarding procedure that information/documents added to the binder will be at the discretion of the DON and administrator. No documents may be added to the binder without the approval of the DON and/or administrator</li> </ul> <p><u>Quality assurance monitoring:</u></p> <ul style="list-style-type: none"> <li>Director of Nursing/designee to conduct random checks of the binder to ensure compliance.</li> </ul>	

RECEIVED  
AUG 28 2013  
DSHS/ADSA/RCS Kern

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/07/2013
NAME OF PROVIDER OR SUPPLIER  COVENANT SHORES HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9107 FORTUNA DRIVE MERCER ISLAND, WA 98040	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
F 164	<p>Continued From page 2</p> <p>of resident names and records. For Residents #1, 2, 3, 4, 5 and 6, who were named in a previous citation, the facility posted the names of the residents involved in complaint investigation sample, even though all names are required to remain confidential. By posting resident names with the survey report, the facility did not uphold the right of these residents to have all personal and medical information maintained in a confidential manner.</p> <p>Findings include:</p> <p>Each nursing home is required to maintain records of all recent complaint citations and the most recent annual survey citations. This information is to be kept in the facility, in a location that is readily accessible to residents, families and the public.</p> <p>On 08/05/13 at 12:25 pm , review of a binder labeled "State Survey" at the nursing home's second floor reception desk found a citation from a recent complaint investigation survey, dated 03/05/13. The citation included a page titles "Resident &amp; Staff List" which identified the names of six sample residents reviewed during that complaint investigation survey. This list, dated 03/05/13 , included a specific directive ("DO NOT POST") to remind staff this information was to be maintained in a confidential manner.</p> <p>At 12:27 pm, the presence of this information in the binder that was accessible to residents, families and the public was observed with the Director of Nursing Services (DNS, Staff A). Staff A acknowledged the Resident Identifier List, which identified the names of Residents 1, 2, 3, 4, 5 and 6, was not to be posted in the binder,</p>	F 164	

RECEIVED

AUG 20 2013

DSHS/ADSA/RCS Kent

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/07/2013
NAME OF PROVIDER OR SUPPLIER  COVENANT SHORES HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9107 FORTUNA DRIVE MERCER ISLAND, WA 98040	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 164  F 225 SS=D	<p>Continued From page 3</p> <p>where any member of the public could review it. On 08/07/13 at 2:50 p.m., the Administrator also acknowledged this information was to be confidential and should not to be posted with the survey reports.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance</p>	F 164  F 225	

RECEIVED  
AUG 28 2013  
DSHS/ADSA/RCS Kent

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/07/2013
NAME OF PROVIDER OR SUPPLIER  COVENANT SHORES HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9107 FORTUNA DRIVE MERCER ISLAND, WA 98040	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 225	<p>Continued From page 4</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify and report a significant injury of unknown origin for Resident #7, one of three sample residents reviewed for injuries. For this resident, the facility did not complete a thorough investigation of the resident's injury to rule out abuse as a potential cause of bruising, or reported it to the State as required by CFR 483.13(c)(1)(3)(4).</p> <p>Findings include:</p> <p>Resident #7 was admitted on [REDACTED]/11 with care needs related to [REDACTED] and limited ability to communicate. Her most recent Minimum Data Set (MDS) assessment, dated 5/16/13, stated Resident #7 required extensive assistance from two staff with all transfers and toileting. She required extensive assistance from one staff person with dressing and hygiene. Her care plan, dated 12/7/13, also stated the resident was dependent on staff for this care.</p> <p>A nursing progress note, dated 6/1/13, stated Resident #7 was complaining of "pain in her [REDACTED] groin area", which was not relieved by use of [REDACTED]. Her physician was notified and ordered additional pain medication. On the morning of 6/4/13, a licensed nurse documented Resident #7 had a "bruise on her [REDACTED] inner thigh and [REDACTED]"</p>	F 225	<p><b>F225</b></p> <p><u>How deficiency corrected:</u></p> <ul style="list-style-type: none"> <li>Review of State Law regarding parameters for recording and reporting injuries or unknown origin. Incident Book complete with "Purple Book" as reference tool.</li> </ul> <p><u>Action to protect residents and measures to ensure correction:</u></p> <ul style="list-style-type: none"> <li>Facility will identify, investigate, and report injury of unknown origin according to State law.</li> </ul> <p><u>Quality assurance monitoring:</u></p> <ul style="list-style-type: none"> <li>Incident Committee will review occurrences weekly to ensure appropriate reporting of incidents to log according to state law.</li> <li>Report from Incident Committee will be compiled and submitted to the Quarterly Quality Assurance team by the Director of Nursing/designee.</li> </ul>

RECEIVED

AUG 28 2013

DSHS/ADSA/RCS Kent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/07/2013
NAME OF PROVIDER OR SUPPLIER  COVENANT SHORES HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9107 FORTUNA DRIVE MERCER ISLAND, WA 98040		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	<p>Continued From page 5.</p> <p>groin area". On 6/4/13, her physician documented the bruise was present on the resident's [redacted] groin, medial thigh and lateral hip. From 6/5/13 through 6/10/13, staff continued to document the presence of the bruise (without specifying its size).</p> <p>On 8/7/13, review of the facility's Accident/Incident reporting Log found no information recorded by staff regarding this bruise, which, according to State Abuse reporting guidelines, would be considered to be a "substantial injury" in an area not generally vulnerable to trauma (the definition includes "groin and inner thigh"). Review of the facility's investigation of this bruise, completed by Staff A on 6/4/13, included information the resident's hip had been x-rayed on 5/31/13 after her initial report of pain, and revealed no fracture.</p> <p>Review of the investigation found a brief statement by the DNS stating abuse had been ruled out as a cause of Resident #7's bruise, with little factual information to support this conclusion. The resident could not recall how she sustained the bruise. Review of her 5/16/13 MDS and her current medications found Resident #7 was prescribed no anti-coagulant medications, which might contribute to bruising more easily.</p> <p>In describing the "Root cause" of the resident's bruised groin/ inner thigh, Staff A concluded the bruise was caused by staff "pulling underwear up firmly". During an interview on 8/7/13, Staff A was asked about this conclusion, including how much force would be required to cause a bruise in someone's groin. She replied the resident tended to "bruise easily", but could not explain how a bruise, which she stated was approximately 3</p>	F 225		

RECEIVED  
AUG 21 2013  
DHS/MSA/RCS Kent

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505504	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/07/2013
NAME OF PROVIDER OR SUPPLIER  COVENANT SHORES HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9107 FORTUNA DRIVE MERCER ISLAND, WA 98040		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 6 inches (7 cm ) long when observed on 6/3/13, could be caused by dressing a resident. Staff A was unable to identify other circumstances which could cause a bruise in this area.  After reviewing current regulations for reporting significant injuries in areas not generally vulnerable to trauma, Staff A was asked if she had reported this bruising to the State's Complaint Reporting Unit (CRU) or recorded the incident in the facility's Accident/ Incidents Log. She acknowledged she had not. When asked for further evidence of her investigation which supported her conclusion that abuse had been ruled out, she stated she had interviewed staff, but had not documented the interviews. When asked about additional training for staff to prevent further injury of residents by forceful dressing, she stated this had been done, but was not documented as part of the investigation.	F 225		

RECEIVED  
AUG 23 2013  
DSHS/ADSA/RCS Kent