DEPARTMENT OF HEALTH AND HU..AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

601

PRINTED: 05/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505435		05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TACOMA LUTHERAN HOME	1301 N HIGHLANDS PARKWAY TACOMA, WA 98406

(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 Quality Indicator Survey conducted at Tacoma Lutheran Home on 4/23/13; 4/24/13; 4/25/13; 4/26/13; 4/29/13; 4/30/13; 5/1/13; 5/2/13 and 5/3/13. The survey included data collection on 4/26/13 between the hours of 4:45 a.m. to 8:00 a.m. A sample of 33 residents was selected from a census of 153. The sample included 27 current residents and the records of 6 former and/or discharged residents.

The survey was conducted by:

[redacted], RN, BSN, MBA
[redacted]RN, BSN, MSN
[redacted] RN, BSN, MN
[redacted]N, BSN, MSN

The survey team is from:

Department of Social and Health Services
Aging and Long Term Support Administration
Residential Care Services, District 3, Unit A
1949 South State Street, MS: N27-24
Tacoma, Washington, 98405-2850

Telephone: (253) 983-3800
Fax: (253) 589-7240

5/14/13
Signature Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE President — (X6) DATE 5/21/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505435		05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TACOMA LUTHERAN HOME	1301 N HIGHLANDS PARKWAY TACOMA, WA 98406

(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 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to timely distribute resident mail delivered by the post office on Saturdays. This failure potentially placed residents at risk for diminished quality of life. Findings include: On 4/26/13 at 8:00 a.m. Resident #80 reported he/she was not sure if mail was being delivered by the post office to the facility on Saturdays. On 4/26/13 at 9:16 a.m. Staff J reported the post office delivered resident mail on Saturdays but social service personnel were not on duty on Saturdays so resident mail was held until Monday for distribution. On 5/2/13 at 1:10 p.m. when asked if the facility distributed resident mail within 24 hours after the post office delivered mail on Saturdays, Staff A reported the issue with Saturday mail had been corrected.	F 170	**F-170-Right to privacy-Send and Receive unopened mail** ***How will the nursing home correct the deficiency as it relates to the resident?*** No residents were identified to have been negatively affected by this deficiency. Saturday mail is now delivered to the residents on Saturdays. ***How the nursing home will act to protect residents in similar situations?*** No residents were identified to have been negatively affected by this deficiency and mail is now delivered on Saturdays. ***Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur.*** A scheduled overlap of receptionist shifts is now planned on Saturdays to specifically accommodate completion of mail delivery to residents receiving mail. The lead receptionist has reviewed schedule changes and the intent of the shift overlap for required mail delivery to receptionists whose schedules are affected. ***How the nursing home plans to monitor its performance to make sure that solutions are sustained.*** The lead receptionist or designee will report any failure to deliver mail to residents to the Department Director or Administrator when identified. The Department Director will review monthly schedules to ensure shift overlaps to accommodate mail delivery	
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before	F 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505435		05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TACOMA LUTHERAN HOME	1301 N HIGHLANDS PARKWAY TACOMA, WA 98406

(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 247	Continued From page 2 the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to give advance notice to 2 of 3 Sampled Residents (#'s 39 & 330) of a roommate change of the 33 residents who were included in the Stage 2 review. This failure placed both residents at potential risk for diminished quality of life. Findings include: RESIDENT #39 On 4/24/13 at 11:23 a.m. Resident #39 reported she/he was not given notice prior to admission of a roommate to his/her room. On 5/1/13 at 1:45 p.m. Staff K could not find documentation that Resident #39 was given advance notice of an admission of a roommate. Review of Resident #39's record noted no information the resident was given notice before receiving a new roommate. On 5/2/13 at 7:55 a.m. Staff L confirmed Resident #39 had a new roommate admitted to his/her room on 11/21/12. On 5/2/13 at 8:00 a.m. Resident #39 confirmed she/he did not receive any notice before receiving a new roommate on 11/21/12. RESIDENT #330	F 247	are continually scheduled on Saturdays. This deficiency has been corrected and mail is being delivered on Saturdays. **F-247 Right to Notice before room/roommate change** **How will the facility correct the deficiency as it relates to the resident?** Resident # 39 voiced no concerns regarding her current roommate and is well adjusted to her roommate at this time. No action necessary. Resident #330 has discharged back to her home per her original plan at time of admission. No action necessary. **How the nursing home will act to protect residents in similar situations?** All residents will be informed in advance of any plan for a new roommate by the Social Worker or designee. This communication will be documented in the resident's electronic health record. **Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur?** All Social Workers, Social Service interns and Licensed Nursing Staff will be educated of the requirement to inform residents of the potential for a new roommate and the need to document these encounters in the electronic health record. **How does the nursing home plan to monitor its performance to make sure that the solutions are sustained?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	505435		05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TACOMA LUTHERAN HOME	1301 N HIGHLANDS PARKWAY TACOMA, WA 98406

(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 247	Continued From page 3 On 4/25/13 at 9:03 a.m. Resident #330 reported being admitted to his/her room on [redacted]13. Resident #330 reported about a week later he/she received a new roommate without being given advance notice. Review of Resident 330's record noted the resident received a new roommate on [redacted]13. There was no documentation Resident #330 was given advance notice that a new roommate would be admitted to his/her room. On 5/2/13 at 8:33 a.m. Staff M, who was responsible for giving Resident #330 advance notice of roommate change, reported he/she did not give Resident #330 notice he/she would receive a new roommate.	F 247	The Director of Social Services is responsible to conduct random audits of resident's electronic health records who have received a new roommate to ensure that new roommate notifications are occurring and are being documented in the resident's electronic health record. The Director of Social Services will report any deficiencies to the Director of Nursing or facility Administrator as indicated. Education, corrected practice and initiation of monitoring process will be completed by June 21, 2013.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined dietary staff failed to ensure dishwashing procedures were conducted to consistently maintain adequate sanitization and/or prevention of cross contamination. This	F 371	**F-371 Food Procure/ Store/ Prepare/Serve-sanitary** **How will the facility correct the deficiency as it relates to the resident?** No residents were identified having been affected by the deficiencies noted. **How the nursing home will act to protect residents in similar situations?** No residents were identified having been affected by the deficiencies noted. **Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur?** **Inadequate Dishwashing temperatures-** The dishwasher was evaluated by the contracted dishwasher maintenance firm and discovered to not heat adequately under heavy use. The Tacoma Lutheran Maintenance Department Director evaluated the electrical connections and identified that only one of two electrical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	505435		05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TACOMA LUTHERAN HOME	1301 N HIGHLANDS PARKWAY TACOMA, WA 98406

(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 371	Continued From page 4 had the potential to expose residents to food borne illness and/or contaminants from dishware. Findings include: Observations of dishwashing procedures were conducted on 5/2/13 beginning 9:45 a.m. through 10:30 a.m. INADEQUATE WATER TEMPERATURE Staff C reported in order to sanitize dishes water temperatures during the dishwashing cycle needed to reach 160 degrees Fahrenheit (F) and rinse temperatures needed to reach 180 degrees F. Staff C and the surveyor reviewed recent dishwashing temperatures staff conducted and logged each shift which showed adequate temperature levels. The top of the temperature log identified the minimum temperatures needed for washing (160 F) and rinsing (180 F)dishes. The front of the dishwasher contained two small visible temperature gauges. The right gauge registered wash temperatures and the left gauge identified rinse temperatures. At 9:49 a.m., the dishwashing temperature gauge measured approximately 140 degrees F and did not reach the minimum 160 degrees. Following the rinse cycle, a tray that contained several pink resident water pitchers and cups exited from the dishwasher. When asked how staff monitored dishwasher temperatures, Staff F reported he/she did "sometimes." When asked what staff did if they noticed minimum temperatures were not reached during wash or rinse cycles, Staff F reported "I	F 371	power lines was providing power to the dishwasher heating element. The power lines were repaired and the heating elements are now sufficiently functioning. Additionally, the contracted dishwasher maintenance firm has adjusted the temperature gauge to exceed the required minimum temperatures to allow for any potential reduction of temperature under heavy use. The dishwashing staff have been educated to monitor the dishwashing & rinsing gauges with each cycle to insure the temperatures reach the required 160 degrees for washing and 180 degrees for rinsing and have been instructed to immediately report any deficiencies to the Department Director or designee. Any items that were not washed/rinsed under adequate temperatures will not be distributed for use until adequately sanitized. **Uncovered Hair-** Dishwashing staff have been educated about the required use of hairnets while in the kitchen/dishwashing areas. **Dust covered fans-** The first and second fans identified have been removed from the area. The ceiling fan has been cleaned and will be cleaned as needed . **How does the nursing home plan to monitor its performance to make sure that the solutions are sustained?** **Inadequate Dishwashing temperatures-** The Director of Dining Services or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	505435		05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TACOMA LUTHERAN HOME	1301 N HIGHLANDS PARKWAY TACOMA, WA 98406

(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 371	Continued From page 5 wait" and that temperatures would go up again. Staff F did not know what to do if dishes finished washing and the wash cycle did not reach 160 degrees. Staff E reported he/she would rewash the dishes if they looked dirty. Neither Staff E or Staff F identified the need to place the rack of dishes through the dishwasher for a repeat wash if minimum temperatures were not reached. The surveyor informed Staff C, Staff E and Staff F the temperature of the wash cycle did not reach 160 degrees F. Staff did not rewash the pink pitchers after they were informed dishwashing temperatures did not reach minimum levels to ensure sanitization of dishes. Staff E removed the pink pitchers from the rack and stored them on a shelf. At 10:15 a.m., when asked what staff should do if minimum temperatures were not reached, Staff C reported "under normal circumstances" staff would take dishes and rewash them. Staff C reported he/she expected staff to "eyeball" the temperature gauge continually when dishwashing. UNCOVERED HAIR Staff E wore a hat while standing in front of a work space that contained racks of cleaned dishes that exited the dishwasher and waited for them to air dry and then moved them to storage shelves when dried. The hat did not fully contain the ends of Staff E's hair. Approximately two inches of the bottom of hair remained exposed beneath the lower rim of the hat.	F 371	designee will perform random daily checks of temperature gauges for wash and rinse cycles to ensure continued proper function of equipment. Any deficiencies will be reported to the Tacoma Lutheran Retirement Community Maintenance Director and the contracted dishwasher firm. **Uncovered Hair-** Department Director or designee will randomly monitor staff for proper hair coverings while on duty in kitchen/dishwashing area. **Dust covered fans-** Director of Dining Services will randomly check the vent identified to ensure it is clean. If cleaning is needed, the Tacoma Lutheran Retirement Community Maintenance Director will be notified and cleaning will be done. Education, corrected practice and initiation of monitoring process will be completed by June 21, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	505435		05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TACOMA LUTHERAN HOME	1301 N HIGHLANDS PARKWAY TACOMA, WA 98406

(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 371	Continued From page 6 Following observations, Staff C reported Staff E usually tucked the ends of hair beneath the hat. DUST COVERED FAN and VENT A black circular fan that measured approximately 15 inches wide was positioned at the end of a counter on the clean side of the dishwasher. The fan blades and spokes were coated with visible dust. Racks of cleaned dishware that exited the dishwasher were placed directly in front of the fan. The fan blew across clean dishes contained in large plastic racks that included food trays, burgundy soup bowls, small plastic glasses, china plates, stainless steel food prep bowls and baking pans. A stack of rimmed plates were placed within a very short distance (approximately 12 inches) from the fan. A second fan approximately three feet high placed beneath the counter on the clean side of the dishwasher also actively blew air. Vents on the sides of the fan were coated with dust that did not remove when swiped with a finger. A square ceiling vent that measured approximately one foot square was coated with a visible thick layer of dust. Staff C reported housekeeping and maintenance was responsible for cleaning them. When asked why staff blew fans in the dishwashing area, Staff E reported Staff F put them on. Staff C reported staff wanted additional cross ventilation. Staff C removed both fans at this time.	F 371		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441	**F 441 Infection Control, Prevent, Spread, Linens** **How will the nursing home correct the deficiency as it relates to the resident?** No residents were identified as having been affected by this deficiency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505435		05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TACOMA LUTHERAN HOME	1301 N HIGHLANDS PARKWAY TACOMA, WA 98406

(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 441 SS=F	Continued From page 7 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**How the nursing home will act to protect residents in similar situations?** No residents were identified as having been affected by this deficiency. **Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur.** Proper sanitization of the washing machine, procedure for removing & donning Personal Protective Equipment (PPE) and proper hand washing technique has been reviewed with laundry staff and return demonstrations of understanding of practice were presented. The laundry policy and procedure manual has been reviewed and updated to reflect proper infection control procedures. Signs reflecting the need for proper hand washing have also been posted as reminders for proper technique. **How the nursing home plans to monitor its performance to make sure that solutions are sustained.** Annual inservices on hand washing and proper use of PPE for all housekeeping/laundry staff will continue. Infection control nurse & Department Director or designee will randomly monitor staff for compliance with proper procedures. Education, corrected practice & initiation of monitoring process will be completed on or before June 21, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505435		05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TACOMA LUTHERAN HOME	1301 N HIGHLANDS PARKWAY TACOMA, WA 98406

(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 441	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure staff washed hands when required during handling and processing of laundry. This had the potential to expose residents to infectious agents. Findings include: On 5/2/13 at 10:10 a.m., during a tour of the laundry area, when demonstrating the steps of the laundry sort and wash process, Staff G did not wash hands before putting on Personal Protective Equipment (PPE) that included gloves, gown, and mask. Staff G explained that she/he puts on two pair of gloves, removing the first pair of gloves after sorting the dirty laundry to have the "clean" pair for completing the laundry process. Without first washing hands, Staff G put on PPE to include two pairs of clean gloves and pushed a covered laundry barrel of soiled linen through the soiled laundry entrance into the soiled sorting area. Staff G sorted the linen into different sorting containers. After sorting, Staff G pushed a cart that contained soiled towels to the washer and placed them inside. The soiled towels touched the rim of the opening of the washing machine as they were placed inside. Staff G then removed his/her outer layer of gloves worn. Without removing both pairs of gloves and washing hands, Staff G walked over to the hand washing sink and removed a towel from the bucket in the sink, sprayed it with cleanser, wiped	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505435		05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TACOMA LUTHERAN HOME	1301 N HIGHLANDS PARKWAY TACOMA, WA 98406

(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 441	Continued From page 9 down the inside of the door to the washing machine and the front of the washer then closed the door and started the wash cycle. Staff G did not disinfect the rim of the opening contaminated by contact with soiled towels. Without washing his/her hands or gloving, Staff D entered the laundry area on 5/2/13 at 10:30 a.m. through the soiled linen entrance and removed clean laundry from the washer and placed it into a clean laundry cart and rolled the cart around the corner to the dryer area. On 5/3/13 at 12:30 p.m. Staff D stated staff should wash hands each time upon entering the laundry area from another area in the facility. Staff D confirmed he/she did not wash hands before handling the clean laundry. On 5/3/13 a review of the Laundry Policy and Procedure Manual, identified by Staff D as the current policy, listed hand washing practices for all employees to include: before starting work, after handling soiled linen and before and after wearing or removing gloves. Although the facility had a policy and procedure in place to address infection control to include hand washing, the laundry staff failed to follow hand washing practices to prevent potential infectious agents from contaminating clean linen.	F 441		