

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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505435	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/12/2013
NAME OF PROVIDER OR SUPPLIER  TACOMA LUTHERAN HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Tacoma Lutheran Home on 9/12/13. The sample included 4 current residents and 1 former resident. Facility census was 149.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#2850391 #2847414 #2863861</p> <p>The survey was conducted by:</p> <p>██████████ RN, BSN</p> <p>The surveyor is from:</p> <p>Department of Social and Health Services Aging and Long-Term Support Administration Division of Residential Care Services District 3, Unit B P.O. box 45819 MS: N27-24 Olympia, WA 98504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>[Signature]</i> Residential Care Services</p> <p>9/24/13 Date</p>	F 000	<p style="text-align: center;">RECEIVED SEP 30 REC'D DHHS - ADSA RCS - REGION 5</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

*[Signature]* Admin. Staff 9/30/13

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.

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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure an adequate assessment of an assistive device was completed to avoid accidents and failed to follow physician's orders to prevent accidents for 2 of 3 Sampled Residents (#'s 1 &amp; 2) reviewed for accidents. These failures placed the residents at potential risk for falls and/or injury during care.</p> <p>Findings include:</p> <p><b>RESIDENT #1</b> Resident #1 admitted to the facility on [REDACTED] 13 after undergoing surgery to repair a [REDACTED].</p> <p>Observations of Resident #1 interacting with others in the facility on 9/12/13 at 10:30 a.m. revealed he/she was alert and relied on assistance from staff for locomotion.</p> <p>Review of Resident #1's medical records revealed a physician's order dated 7/4/13 that directed staff to ensure the resident did not bear weight on [REDACTED] for 8 weeks.</p>	F 323	<p>F-323, SS=D, FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p><i>How will the facility correct the deficiency as it relates to the resident?</i> On 7/5/13, the care directives for Resident #1 were clarified due to conflicting report received from hospital to be non-weight bearing, and care directives were corrected. Evaluation was conducted on 9/16/13, and it was determined that Resident #2 was safe to continue with use of the transfer pole. A written diagram on how the furniture should be positioned in the room as it relates to the transfer pole were provided and added to the care directives.</p> <p><i>How the facility will act to protect residents in similar situations?</i> Staff E, will receive written reminder to verify weight bearing status orders to ensure that he/she is communicating clear and appropriate instructions on the resident care directives as part of the initial plan of care. Staff C will receive a written reminder to notify the therapy department in a timely manner when an assessment is requested.</p>	

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F 323	<p>Continued From page 2</p> <p>Review of Resident #1's care plan dated 7/4/13 revealed care directives that directed staff to transfer the resident using 2 people assist with a gait belt.</p> <p>During an interview on 9/12/13 at 2:20 p.m. Staff E reported Resident #1 was not able to transfer and not put weight on her [REDACTED] therefore she would have to transfer using a mechanical lift device. Staff E further reported any resident who is not able to bear weight would have to be a mechanical lift for transfers.</p> <p>On 9/12/13 at 2:25 p.m. Staff E reviewed Resident #1's care directive and confirmed the care directive for 2 person assist for transfer and not a mechanical lift was an error and would cause Resident #1 to bear weight on her [REDACTED] against physician's orders.</p> <p>Further review of Resident #1's medical record revealed a progress note dated 7/5/13 indicating that the resident had been evaluated by the therapy department and was determined to be a 2 person assist with transfers. This note indicated the therapy staff had stood the resident to transfer even though she was not able to stand without putting weight on her [REDACTED] against physician's orders.</p> <p>Review of the incident log indicated on two occasions 7/29/13 and 7/30/13 Resident #1's daughter reported to the charge nurse that nursing assistants had stood her mother allowing her to bearing weight during care.</p> <p>Both the 7/29/13 and the 7/30/13 incidents were investigated and both determined the staff members had not reviewed the resident's care</p>	F 323	<p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i></p> <p>Although the facility maintains that these occurrences represent a very limited number of residents affected and a limited number of staff involved, staff in-services will be conducted on the process of interdisciplinary communication and care planning as they relate to patient safety precautions and the use of assistive devices to ensure that this does not recur.</p> <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i></p> <p>Nursing administration will monitor Staff C &amp; E's performance and provide 1:1 counseling/training as needed to ensure retention of corrective action. Education, corrected practice, and initiation of monitoring process will be completed on or before 10/27/13.</p>	

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F 323	<p>Continued From page 3</p> <p>directives and were unaware of the physician's order for non-weight bearing. The investigations indicated staff had stood Resident #1 and even allowed her to ambulate short distances such as to the bathroom. Through further investigation the facility identified 7 staff members who had transferred the resident in a way that allowed her to bear weight on her [REDACTED] against physician's orders.</p> <p>During an interview on 9/12/13 at 1:30 p.m. Staff B confirmed multiple staff had been transferring the resident against physician's orders on multiple occasions.</p> <p><b>Failure to follow the physician's orders for not bearing weight on the resident's [REDACTED] following surgical repair of a broken bone placed the resident at risk for further injury, delayed healing, and possible additional surgical repair.</b></p> <p><b>RESIDENT #2</b> Observations on 9/12/13 at 9:55 a.m. revealed Resident #2 was sitting in a recliner in her room. Further observations revealed throughout 20 minutes of observations Resident #2 continually had both of her hands on her transfer pole using it to pull herself to the edge of her seat.</p> <p>Review of the incident log revealed Resident #2 sustained a fall on 8/9/13. Review of the facility's fall investigation revealed Resident #2 was found on the floor between her bed and the transfer pole. A staff witness statement indicated the resident's right leg was "trapped tightly" against the pole. Resident #2 had sustained a "long" abrasion to her [REDACTED] from a bolt in the pole during the fall. Further review of the investigation revealed staff identified there were no</p>	F 323		

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F 323	<p>Continued From page 4</p> <p>environmental factors (the pole) that contributed to the fall and the check off blank labeled Refer to therapy for screening was left blank.</p> <p>During an interview on 9/12/13 at 1:45 p.m. Staff D reported the physical therapy department had not received a request from nursing for an assessment of Resident #2 related to use of a transfer pole. Staff D further reported when residents have an accident using an assistive device physical therapy will typically assess the resident to ensure safe use of the device.</p> <p>During an interview on 9/12/13 at 2:35 p.m., Staff C reported the nursing assistants change the positioning of the furniture in Resident #2's room depending on what she is doing at the time. Staff C reported when Resident #2 is in bed or her wheelchair staff will push her recliner against the wall. However, if Resident #2 wants to sit in her recliner then staff will pull it away from the wall so the resident is able to recline the chair back. Staff C confirmed there are no markings in the room or directives to indicate what the distance between to bed, the pole and the chair has been assessed by therapy as being safe for that resident.</p> <p>During an interview on 9/12/13 at 2:45 p.m. Staff C confirmed she knew to make a therapy assessment request following Resident #2's fall on 8/9/12, however, she did not make the referral.</p> <p>Failure to have Resident #2 re-assessed following a fall while using an assistive device placed Resident #2 at potential risk for further accidents and potential injury.</p>	F 323			