

601

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

PRINTED: 01/02/2014
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 12/23/2013
--	--	--	---

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 12/09/13, 12/16/13 and 12/23/13. The sample included 9 current residents and 10 former and or discharged residents out of a census of 154.</p> <p>The following are complaints investigated as part of this survey:</p>	F 000		
-------	--	-------	--	--

	<p>#2898906 #2903552 #2903593 #2903595 #2920926 #2921271</p> <p>The survey was conducted by: _____, RN, MN</p> <p>The surveyor is from: Department of Social and Health Services Aging and Long-Term Support Administration Division of Residential Care Services District 3, Unit A 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> 1/2/14 Residential Care Services Date</p>			
--	--	--	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE President/CEO	(X6) DATE 1/9/14
---	------------------------	---------------------

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.

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

PRINTED: 01/02/2014
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 12/23/2013
--	--	--	---

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 157 SS=G	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §463.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to timely consult with the physician and failed to provide accurate</p>	F 157	<p>F-157, SS=G, Notification of Changes, (Injury/Decline/Room, ETC)</p> <p><i>How will the facility correct the deficiency as it relates to the resident?</i> There is no opportunity to correct this deficiency for Resident # 1.</p> <p><i>How the facility will act to protect residents in similar situations?</i> As part of the facility's Safety Plan requested on 12/19/13, Staff C was removed from the work schedule on 12/19/13 and required to complete additional training on the care and management of residents during a change of condition before being able to return. Learning and competency were assessed by a written post-test on the material covered on 12/23/13.</p> <p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i> In-service training will be provided to nursing staff on properly identifying and timely reporting of significant changes in residents' physical, mental, or psychological status in either life-threatening conditions or clinical complications.</p>	
---------------	--	-------	--	--

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

 PRINTED: 01/02/2014
 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 12/23/2013
NAME OF PROVIDER OR SUPPLIER TAGOMA 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 157	<p>Continued From page 2</p> <p>assessment findings to the physician when 1 of 5 residents (Resident #1) reviewed had a deteriorated condition. This failure prevented the physician from being fully aware of the deteriorating condition and the opportunity to alter treatment in a timely manner. This failure caused harm to Resident #1 who went to the hospital in active [REDACTED]</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility on [REDACTED]/13 from the hospital with multiple diagnoses to include [REDACTED], and acute [REDACTED] with [REDACTED]. The resident was a [REDACTED] meaning he desired [REDACTED] efforts.</p> <p>Hospital discharge instructions included the following:</p> <p>Patient advised to return to the emergency department immediately if chest pain, shortness of breath, lightheadedness, passing out, weakness, fatigue, or any problems develop at all.</p> <p>Nursing progress note dated 12/4/13 at 3:30 a.m., documented, in part, "sleeping now, had back pain "no" relieved by [REDACTED], respirations regular and even, oxygen saturation 94% on room air, skin color gray, feet white, fleeting pedal pulses."</p> <p>At 3:45 a.m., "Resident #1 was found on the floor and while sitting up, the resident's breathing became striderous (a physical sign which is produced by narrowed or obstructed airway path) and the resident then became unresponsive. The resident did not have a pulse and did not have an</p>	F 157	<p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i></p> <p>To ensure ongoing monitoring and retention of education and corrected practice, Staff C was removed from the night shift and placed on evening shift under the supervision of the evening shift Unit Coordinator. The DNS or designee will continue to observe staff performance and audit compliance with timely reporting of pertinent changes of condition to residents' health care providers, using the INTERACT Quality Improvement Tool. Education, corrected practice, and initiation of monitoring process will be completed on or before 2/6/14.</p>		

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

 PRINTED: 01/02/2014
 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 12/23/2013
NAME OF PROVIDER OR SUPPLIER TACOMA LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N HIGHLANDS PARKWAY TACOMA, WA 98405		
(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 157	<p>Continued From page 3</p> <p>apical heart rate. The licensed nurse (Staff C) performed 3 chest compressions and the resident became responsive."</p> <p>At 6:08 a.m., approximately 2 1/2 hours after being unresponsive and becoming responsive after chest compressions, the resident stated, "It seems like it's harder to get air," Staff C administered 2 puffs of an [REDACTED] inhaler.</p>	F 157			
	<p>Review of the record did not identify that the physician had been notified the resident was administered an [REDACTED] inhaler treatment due to stating "It seems like it's harder to get air" after receiving chest compressions for an unresponsive episode.</p> <p>On 12/18/13 at 6:20 a.m., during a phone interview, Staff C stated prior to the chest compressions, 911 was called, and when the resident became responsive she told a co-worker to cancel the 911 call. Staff C stated she cancelled the 911 call because the resident was talking, alert and oriented. According to Staff C she called the doctor at approximately 7 a.m. (more than three hours later) to inform him of the above events. Staff C stated she should have called the physician earlier.</p> <p>On 12/4/13 at 8:41 a.m., nursing note documented, in part, "resident refused his breakfast did drink shake. Resident color is off from yesterday. Resident breathing is labored. Resident is on 4 liters of oxygen via nasal cannula placed on the previous shift. Heart rate irregular, has chest discomfort over the sternum. MD expected in, will leave resident in bed till he arrives."</p>				

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

 PRINTED: 01/02/2014
 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 12/23/2013
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 157	<p>Continued From page 4</p> <p>Six hours after the resident being unresponsive and requiring chest compressions, review of the documentation did not reveal the physician had been notified of the labored breathing, skin color being off from the day before and irregular heart rate.</p> <p>On 12/16/13 at 10:51 a.m., during an interview, licensed nurse Staff E stated she received in report from Staff C that Resident #1 became unresponsive and required 3 chest compressions and the 911 call was cancelled because he became responsive.</p> <p>Staff E reported when the resident was assessed at 8:41 a.m. and noted to have labored breathing and an irregular heart rate with the color that was off from the day before, she did not call the doctor because the resident was on the nebulizer at the time and was not different from the time she arrived on day shift. Staff E stated the night shift nurse had already informed the doctor of her findings, and received an order for an EKG, and she knew the doctor would be in that day. Staff E stated she checked on the resident every 15 minutes because he had coded and was worried he would code again.</p> <p>On [REDACTED]/13 at approximately 11:00 a.m., during a phone interview, the physician stated he received a phone call at approximately 6 or so in the morning, and was told of an unresponsive event the resident had approximately 3 hours earlier. According to the physician, he was told the resident required some shaking and pushing before becoming responsive, not that the resident received chest compressions. The physician stated he was told the resident was currently in bed on oxygen talking and responsive. This</p>	F 157			

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

PRINTED: 01/02/2014
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 12/23/2013
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 157	Continued From page 5 information gave him the impression that the resident was stable, so he ordered an EKG. The physician stated that was the only call he received until later about 10 a.m., when the resident became unresponsive, and was sent to the hospital. The physician stated he was never told that 911 had been called and cancelled or of the resident's labored breathing, and stated as a whole the resident should have been out and at the hospital.	F 157			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the	F 225	F-225 SS=D, INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS <i>How will the facility correct the deficiency as it relates to the resident?</i> Staff interviews with each staff member that was pertinent to this investigation have been conducted and included in the investigation. <i>How the facility will act to protect residents in similar situations/ Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i> Each facility investigation summary will be completed with a new template that includes staff interviews as a visual cue to conduct them under each circumstance that is appropriate during the investigative process. Nursing administration will educate each investigative nurse on the use of this new form prior to implementation.		

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

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 12/23/2013
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 225	Continued From page 6 Investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to conduct a thorough investigation to include staff interviews and witness statements for 1 of 5 residents (Resident #1) when a nurse (Staff C) neglected to ensure that 911 assessment and assistance was obtained when Resident #1 was found pulseless. Findings include: Resident #1 was admitted to the facility on 12/2/13 from the hospital with multiple diagnoses to include [REDACTED], and acute [REDACTED] with resuscitation. The resident was a [REDACTED] meaning he desired [REDACTED]. On 12/4/13 at 3:45 a.m., Resident #1 was found on the floor and while sitting up, the resident's breathing became stridorous (a physical sign which is produced by narrowed or obstructed airway path) and the resident then became unresponsive. Review of the facility's investigation revealed a	F 225	<i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i> The DNS or designee will require two administrative nurses to review each investigation to ensure that the summations are completed using the new template. This review will also be done to ensure that the written summations are thoroughly and more objectively investigated. Education, corrected practice, and initiation of monitoring process will be completed on or before 2/6/14.		

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

 PRINTED: 01/02/2014
 FORM APPROVED
 OMB NO. 0938-0301

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 12/23/2013
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 225	<p>Continued From page 7</p> <p>licensed nurse (Staff C) had 911 called when Resident #1 became unresponsive and was determined pulseless. Staff C gave 3 chest compressions as part of resuscitation, the resident roused and Staff C asked that 911 be cancelled.</p> <p>On 12/23/13 at 10:50 p.m., during and interview, a nursing assistant (Staff F) stated on 12/4/13 she was asked to get the lift and sling because Resident #1 was on the floor. Staff F stated she left the room while Staff C and the other licensed nurse (Staff G) worked on the Resident. According to Staff F, Staff G left out of the room to call 911. While staff G was on the phone, Staff C called out for Staff G to cancel the call.</p> <p>According to the facility's investigation, Staff C was given a decision making day to reflect on her actions. She was asked to read her written statement regarding her understanding of errors and assurance that nothing like the above would happen again.</p> <p>Although, the resident became responsive after 3 chest compressions, he had significant shortness of breath and complained of chest pain over the sternum. His color was poor even when Staff C applied oxygen. He was fatigued. No EKG was obtained at that time to determine if the resident was having another [REDACTED] ([REDACTED]) 911 had the capability to do an EKG strip and identify if the resident was having an [REDACTED]. However, despite, these signs of acute [REDACTED] distress and with the history of [REDACTED] issues, 911 was cancelled by the nursing staff. The resident continued to deteriorate and became unresponsive again approximately 6 hours later. 911 was called again and arrived and determined</p>	F 225			

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

PRINTED: 01/02/2014
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 12/23/2013
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 225	Continued From page 8 the resident to be in active [REDACTED] Failure of the facility to thoroughly investigate the circumstances of why 911 was cancelled when there was a nursing assessment of no pulse and nursing staff starting CPR, prevented the facility from determining what actions to take to prevent the recurrence for other residents who may need urgent assessment and treatment that 911 could provide.	F 225		
F 281 SS-G	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined 2 licensed staff (Staff C and Staff G) failed to obtain emergent help and assessment of Resident #1's cardiac condition when the nurses called 911 then cancelled the call. This failure caused harm to Resident #1 whose urgent treatment was delayed approximately 6 hours when he experienced a 2nd unresponsive episode and went to the hospital in [REDACTED] arrest. Findings include: According to "Lippincott Manual of Nursing Practice," ninth edition, the nursing process is a "deliberate, problem-solving approach to meeting the health care and nursing needs of patients." The process "involves assessment (data collection), nursing diagnosis, planning, and	F 281	F-281 SS-G, SERVICES PROVIDED MEET PROFESSIONAL STANDARDS <i>How will the facility correct the deficiency as it relates to the resident?</i> The DNS and ADNS provided personnel counseling with Staff C and Staff G related to the care and services they provided to Resident #1. <i>How the facility will act to protect residents in similar situations?</i> The DNS required Staff C to complete additional training with the ADNS on the emergent care and management of residents during a change of condition. Staff C was required to demonstrate learning and competency by successful completion of a written posttest. Lastly, to ensure on-going monitoring of retention of education and corrected practice, Staff C was offered an evening shift position under the supervision of a Registered Nurse. As an on-call nurse Staff G will be required to work while there is another Registered Nurse on duty.	

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

PRINTED: 01/02/2014
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 12/23/2013
NAME OF PROVIDER OR SUPPLIER TACOMA LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N HIGHLANDS PARKWAY TACOMA, WA 98408		
(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 281	<p>Continued From page 9</p> <p>evaluation, with subsequent modifications used as feedback mechanisms to promote the resolution of the nursing diagnoses. The process as a whole is cyclical, with the steps being interrelated, interdependent, and recurrent." Implementation includes coordinating care with other health team members.</p> <p>Resident #1 admitted to the facility on [REDACTED]/13 with multiple diagnoses to include [REDACTED], and acute [REDACTED] with resuscitation. The resident was a [REDACTED].</p> <p>At 3:45 a.m., Resident #1 was found on the floor and while sitting up, the residents breathing became striderous and the resident then became unresponsive. The resident did not have a pulse and did not have an apical heart rate. Licensed nurse Staff C and staff G were with the resident, and Staff G left to call 911 while Staff C stayed with the resident and performed 3 chest compressions. The resident became responsive. While Staff G was on the phone with 911, Staff C called out for Staff G to cancel the call.</p> <p>Although the nursing staff assessed the resident to be pulseless, 911 who could have run an EKG strip and further assessed resident #1's cardiac status was called off. The resident who had a history of [REDACTED] was prevented from having emergent assessment by emergency personnel.</p> <p>At 4:52 a.m., Staff C administered [REDACTED] for poor color perfusion.</p> <p>At 6:08 a.m., approximately 2 1/2 hours after being unresponsive and becoming responsive after chest compressions, the resident stated, "It seems like it's harder to get air," Staff C</p>	F 281	<p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i></p> <p>In-service training will be provided to nursing staff on properly identifying and timely reporting of significant changes in residents' physical, mental, or psychological status in either life-threatening conditions or clinical complications.</p> <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i></p> <p>The DNS or designee will continue to observe staff performance and audit compliance with timely reporting of pertinent changes of condition to residents' health care providers, using the INTERACT Quality Improvement Tool. Education, corrected practice, and initiation of monitoring process will be completed on or before 2/6/14.</p>		

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

 PRINTED: 01/02/2014
 FORM APPROVED
 OMB NO. 0938-0301

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 12/23/2013
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)	(X6) COMPLETION DATE	
F 281	Continued From page 10 administered 2 puffs of an [REDACTED] inhaler. At 9:41 a.m., nursing note documented "resident oxygen saturation of 80% on 4 liters of oxygen. Resident lethargic and not responding to verbal stimuli. Called 911, obtained large tank oxygen and placed on 10 liters of oxygen. Unable to get oxygen saturation. 911 arrived at 9:45 a.m., and worked on resident. Resident transferred to the stretcher at 10:05 a.m., left with paramedics to the hospital."	F 281			
F 309 SS-G	According to the hospital records the resident arrived to the emergency department in active [REDACTED] with compressions started at 10:15 a.m., in route to the emergency department, and pronounced dead at 10:48 a.m. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to provide the necessary timely care and services in response to deteriorated condition for 1 of 5 residents (Resident #1) reviewed. The resident had an unresponsive episode, which required chest compressions. 911 was called and cancelled	F 309	F-309, SS=G, PROVIDE CARE/SERVICES FOR HIGHEST WELL-BEING <i>How will the facility correct the deficiency as it relates to the resident?</i> There is no opportunity to correct this deficiency for Resident #1. <i>How the facility will act to protect residents in similar situations?</i> Staff C received personnel counseling related to the proper administration of medication based on indications and the overall management of residents experiencing a change in condition or residents in need of emergent care.		

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

 PRINTED: 01/02/2014
 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 12/23/2013
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 309	<p>Continued From page 11</p> <p>when the resident became responsive. Failure to provide adequate care and treatment caused harm to Resident #1 who was later sent to the hospital in active cardiac arrest.</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility on 2/13 from the hospital with multiple diagnoses to include [REDACTED], and acute [REDACTED] with [REDACTED]. The resident was a [REDACTED] meaning he desired [REDACTED].</p> <p>Hospital discharge instructions included the following:</p> <p>Discharge to Tacoma Lutheran Home for further rehabilitation Patient advised to return to the emergency department immediately if chest pain, shortness of breath, lightheadedness, passing out, weakness, fatigue, or any problems develop at all.</p> <p>The facility's "Notification of Resident change of Condition" policy and procedure dated 3/98 and 2/12 directed staff to notify the physician as soon as possible to participate in the decision-making process.</p> <p>Examples of change in condition included:</p> <p>New onset of abnormal vital signs Respiratory distress or cardiovascular changes including chest pain not relieved by nitroglycerin when ordered Changes in mental status and/or behavior changes</p>	F 309	<p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i></p> <p>To ensure that the highest professional standards of care and services for residents with this diagnosis; in-service training will be provided by the Medical Director or designee to nursing staff on proper nursing assessment and reporting of changes in condition for residents with cardiomyopathies.</p> <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i></p> <p>The DNS or designee will continue to observe staff performance and audit compliance with timely reporting of pertinent changes of condition to residents' health care providers, using the INTERACT Quality Improvement Tool. Education, corrected practice, and initiation of monitoring process will be completed on or before 2/6/14.</p>	

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

 PRINTED: 01/02/2014
 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 12/23/2013
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 309	Continued From page 12 Nursing progress noted dated 12/4/13 at 3:30 a.m., documented, in part, "sleeping now, had back pain "no" relieved by [REDACTED], respirations regular and even, oxygen saturation 94% on room air, skin color gray, feet white, fleeting pedal pulses."	F 309			
	<p>At 3:45 a.m., Resident #1 was found on the floor and while sitting up, the resident's breathing became stridorous (a physical sign which is produced by narrowed or obstructed airway path) and the resident then became unresponsive. The resident did not have a pulse and did not have an apical heart rate. The licensed nurse (Staff C) performed 3 chest compressions and the resident became responsive.</p> <p>At 4:52 a.m., Staff C administered [REDACTED] [REDACTED] for poor color perfusion.</p> <p>At 6:08 a.m., approximately 2 1/2 hours after being unresponsive and becoming responsive after chest compressions, the resident stated, "It seems like it's harder to get air," Staff C administered 2 puffs of an albuterol inhaler.</p> <p>Staff C administered [REDACTED] for poor color perfusion although the medication was ordered to give as needed for chest pain.</p> <p>Staff C documented in a written statement, "I did give [REDACTED] as a preventative measure and should have only given it as ordered."</p> <p>On 12/18/13 at 6:20 a.m., during a phone interview, Staff C stated prior to the chest compressions, 911 was called, and when the</p>				

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

PRINTED: 01/02/2014
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 12/23/2013
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 309	Continued From page 13 resident became responsive she called and cancelled the 911 call. Staff C stated she cancelled the 911 call because the resident was talking, alert and oriented. According to Staff C she called the doctor at approximately 7 a.m. (three hours later) to inform him of the above events, when asked, Staff C stated she should have called the physician earlier.	F 309			
	<p>On 12/23/13 at 10:50 p.m., during an interview, a nursing assistant (Staff F) stated on 12/4/13 she was asked to get the lift and sling because Resident #1 was on the floor. Staff F stated she left the room while Staff C and the other licensed nurse (Staff G) worked on the Resident. According to Staff F, Staff G left out of the room to call 911. While staff G was on the phone, Staff C called out for Staff G to cancel the call.</p> <p>On 12/4/13 at 8:22 a.m., social service note documented, in part, resident is engaging and pleasant, though tired and has labored breathing. Resident indicates that he is very tired and has no energy, but does not feel depressed.</p> <p>On 12/16/13 at 11:00 a.m., during an interview, Social Services Staff (D) stated the resident called him in and asked if he needed to ask him questions. Staff D stated he noticed the resident was having difficulty breathing, but was not gasping for air and was no different from what he noticed before, and therefore did not notify the nurse.</p> <p>On [redacted]/13 at 8:41 a.m., nursing note documented, in part, resident refused his breakfast did drink shake. Resident color is off from yesterday. Resident breathing is labored. Resident is on 4 liters of oxygen via nasal</p>				

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

PRINTED: 01/02/2014
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 12/23/2013
--	--	--	---

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 309	<p>Continued From page 14</p> <p>cannula placed on the previous shift. Heart rate irregular, has chest discomfort over the sternum. MD expected in, will leave resident in bed till he arrives.</p> <p>At 9:41 a.m., nursing note documented resident oxygen saturation of 80% on 4 liters of oxygen. Resident lethargic and not responding to verbal stimuli. Called 911, obtained large tank oxygen and placed on 10 liters of oxygen. Unable to get oxygen saturation. 911 arrived at 9:45 a.m., and worked on resident. Resident transferred to the stretcher at 10:05 a.m., left with paramedics to the hospital.</p> <p>According to the hospital records the resident arrived to the emergency department in active cardiac arrest with compressions started at 10:15 a.m., in route to the emergency department, and pronounced dead at 10:48 a.m.</p> <p>On 12/16/13 at 10:51 a.m., during an interview, licensed nurse Staff E stated she received in report from Staff C that Resident #1 became unresponsive and required 3 chest compressions and the 911 call was cancelled because he became responsive.</p> <p>Staff E reported when the resident was assessed at 8:41 a.m. and noted to have labored breathing and an irregular heart rate with color that was off from the day before, she did not notify the doctor because he was on the nebulizer at the time and was not different from the time she arrived on day shift. Staff E stated the night shift nurse had already informed the doctor of her findings, and received an order for an EKG, and she knew the doctor would be in that day. Staff E stated she checked on the resident every 15 minutes</p>	F 309		
-------	--	-------	--	--

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

PRINTED: 01/02/2014
FORM APPROVED
OMB NO. 0938-0301

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 12/23/2013
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 309	Continued From page 15 because he had coded and was worried he would code again.	F 309			