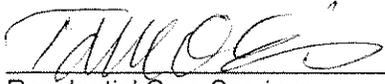


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/21/2014
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 04/16/2014
NAME OF PROVIDER OR SUPPLIER TACOMA LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N HIGHLANDS PARKWAY TACOMA, WA 98406	
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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 4/16/14. The sample included 7 current residents. Facility census was 153.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#2992450 #2989701</p> <p>The survey was conducted by:</p> <p>Tara Hawks, 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> Residential Care Services</p> <p>4/21/14 Date</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE **Pres/CEO** (X6) DATE **4/29/14**

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.

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F 323 SS=E	<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 all measures to reduce the risk of falls were implemented for 5 of 7 Sample Residents (#s 1,2,3,4 & 5) reviewed for falls. This failure placed residents at potential risk for falls and injuries related to falls.</p> <p>Findings include:</p> <p>Resident #1 Observations on 4/16/14 at 11:30 a.m. revealed Resident #1 sleeping near the edge of her bed.</p> <p>Review of Resident #1's current fall assessment indicated she was scored 45/100, meaning significant risk for falls.</p> <p>Review of Resident #1's medical record revealed a care plan dated 12/9/13 that identified her as being at high risk for falls related to weakness of lower extremities, [REDACTED] cognitive loss, and poor safety awareness. Interventions listed on the care plan to reduce falls included use of a bed alarm (a pad placed under the mattress that has a cord</p>	F 323	<p>F-323 SS=E, FREE OF ACCIDENTS HAZARDS/SUPERVISION/DEVICES</p> <p><i>How will the facility correct the deficiency as it relates to the resident?</i> Residents #1, 2, 3, 4, & 5 have each had their bed alarms cords zip-tied to the frames of their beds to prevent them from coiling onto the floor.</p> <p><i>How the facility will act to protect residents in similar situations/</i> Each resident with a bed alarm sensor pad has had the cords of the alarm boxes zip-tied to the frame of the beds to prevent the coiling of the cords on at the bedside. Staff C, D, & E were informed of the new directives to zip-tie the cords to the bed frames of any resident requiring a bed alarm.</p> <p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i> Nursing staff has been educated on the correct technique of securing the bed alarm cords. A review of corrected practice will be provided during the upcoming Licensed Nurse & Nursing Assistant Meetings to ensure understanding of its importance for any resident with a bed alarm to ensure resident safety.</p>	

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F 323	<p>Continued From page 2</p> <p>approximately 3 feet long leading to an alarm box. The alarm sounds when the resident gets off the mattress alerting staff the resident is attempting to ambulate independently).</p> <p>Review of the facility's incident log revealed Resident #1 had fallen four times in the past three weeks while attempting to transfer herself between her bed and her wheelchair.</p> <p>Review of the investigation for a fall on 4/1/14 revealed a staff member had witnessed the resident falling in her room. A written statement from the staff member indicated she had seen the resident standing at her bedside with her feet entangled in the cord from the pad to the alarm box. The resident attempted to ambulate and fell in front of her bed. The investigation indicated following the fall the staff determined new interventions to prevent falls would include medication changes and frequent visual checks on the resident. The interventions listed to reduce the risk of falls did not include placement of the cord to prevent tripping.</p> <p>Observations on 4/16/14 at 11:30 a.m. and again at 1:30 p.m. revealed Resident #1 lying in bed which was in a low position near the floor. The alarm box was attached to the bed frame mid-way down the length of the bed. The alarm cord reached from the bottom to the floor where it coiled and then led back up the bed to the pad under the mattress.</p> <p>During an interview on 4/16/14 at 11:40 a.m. Staff C reported she has never been directed where to place the alarm box for bed alarms. Observations with Staff C in room 810 revealed an alarm box placed at the head of the bed with</p>	F 323	<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 monitor compliance with the new technique of zip-tying the bed alarm cords to the bed frames for the next 4 weeks to determine that the corrected practice is well instituted. The results of this audit will be provided to the facility Quality Assurance Committee for further direction if necessary. Education, corrected practice, and initiation of monitoring process will be completed on or before 5/31/2014.</p>	

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F 323	<p>Continued From page 3</p> <p>the cord tucked under the mattress. Staff C confirmed the alarm box can be moved to the head or the foot of the bed so the cord is off the floor.</p> <p>During an interview and observations on 4/16/14 at 1:30 p.m. Staff E confirmed Resident #1 had previously gotten her feet entangled in the alarm cord and fell. Staff E confirmed the cord remained on the floor in front of the bed where it could be a potential tripping hazard. Staff E confirmed the alarm box could be placed in a different place which would raise the cord off of the floor. Staff E then moved the alarm box.</p> <p>Resident #2 Resident #2 admitted to the facility from a local hospital on [REDACTED] 14. Review of Resident #2's admission assessment dated 2/25/14 indicated she had a fall which resulted in a fracture prior to being hospitalized.</p> <p>Review of the facility's incident log indicated Resident #2 had fallen since being admitted to the facility. Review of a fall investigation dated 4/2/14 indicated staff had noticed a 10 cm x 5 cm bruise on Resident #2's head. Resident #2 reported to the staff she had fallen in her room. Staffs were not aware of the fall and it was not witnessed by anybody.</p> <p>During an interview on 4/16/14 at 11:25 a.m. a family member reported Resident #2 gets out of bed on her own without seeking assistance from staff. Observations at that time revealed Resident #2 had a bed alarm. The bed alarm was attached to a side rail which was in the lowest position, half way down the length of the bed. The cord between the alarm box and pad</p>	F 323			

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F 323	<p>Continued From page 4 extended to, and coiled on the floor.</p> <p>During an interview on 4/16/14 at 11:30 Staff D reported nursing staff place the alarms on the beds of any resident who may have the potentials to fall. Staff D reported she had not been given any specific directives related to placement of the alarm box. Staff D confirmed Resident #2's alarm box was placed where the cord was on the floor in front of the bed. Staff D confirmed the cord could be a potential tripping hazard if the resident were to get out of bed unassisted.</p> <p>Resident #3 Resident #3 admitted to the facility on [REDACTED] 14. Review of Resident #3's Minimum Data Set (MDS) assessment dated 3/6/14 revealed he had fallen prior to being admitted to the facility.</p> <p>Review of Resident #3's care plan revealed his fall assessment score was 35/100 indicating moderate risk for falls. The care plan identified factors contributing to Resident #3's fall risk included generalized weakness, hypotension, and poor balance.</p> <p>Observations on 4/16/14 at 11:35 a.m. revealed Resident #3 sitting in a wheelchair next to his bed. The bed had an alarm. The alarm box was attached to the bed frame approximately half way down the length of the bed. The cord from the box hung down touching the floor, looped on the floor and then extended back up to the bed frame.</p> <p>Resident #4 Resident #4 admitted to the facility [REDACTED] 3 from a local hospital.</p>	F 323		

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F 323	<p>Continued From page 5</p> <p>Review of Resident #4's care plan dated 12/2/13 revealed her fall assessment score was 36/100, indicating she was at significant risk for falls. The care identified contributing factors to Resident #4's risks were weakness, deconditioning, vision problems, hearing problems, gait, and balance problems.</p> <p>Observations on 4/16/14 at 11:45 a.m. revealed Resident #4 lying in bed. Resident #4 had a bed alarm with the alarm box attached to the frame of her bed, mid-way down the length of the bed. The cord from the box hung down touching the floor, looped on the floor and then extended back up to the bed frame.</p> <p>During an interview and observations on 4/16/14 at 1:30 p.m. Staff D confirmed the cord lying on the floor in front of the bed could potentially be a tripping hazard. Staff D then moved the alarm box to the end of the bed which brought the cord up off of the floor, and it was tucked along the frame of the bed.</p> <p>Resident #5 Resident #5 admitted to the facility on [REDACTED] 14.</p> <p>Review of Resident #5's admission MDS assessment dated 12/16/13 indicated Resident #5 had fallen prior to admission, and had fallen in the facility since being admitted.</p> <p>Review of Resident #5's care plan dated 12/5/14 revealed a fall assessment score of 35/100 indicating moderate risk of falling. The care plan identified Resident #5 had balance and gait problems putting him at risk for falls.</p> <p>Observations on 4/16/14 revealed Resident #5</p>	F 323		

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F 323	<p>Continued From page 6</p> <p>had a bed alarm with the alarm box attached to the bed frame mid-way down the length of the bed. The cord from the box hung down touching the floor, looped on the floor and then extended back up to the bed frame.</p> <p>Failure to ensure the rooms of residents with known fall risks are free of debris on the floor placed residents at risk for potentially tripping over the cords on the floor which may have led to a fall and/or injury.</p>	F 323		