

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

PRINTED: 09/02/2014
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 08/22/2014
--	---	--	---

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 8/8/14 and 8/22/14. A sample of 18 residents was selected from a census of 150. The sample included 13 current residents and the records of 5 past or discharged residents.</p> <p>The following are complaints investigated as part of this survey: #3021030 #3022353 #3027920 #3021808</p> <p>The survey was conducted by: Marilyn Ferguson-Wolf, MA, RD, CD Mike Anbesse, MS, RN Tara Hawks, RN, BSN</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> 9/2/14 Residential Care Services Date</p>	F 000	<p>RECEIVED SEP 12 2014 DSHS - ADRA RCS - REGION 5</p>	
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Paul D. O'Connell / CEO	(X6) DATE 9/12/14
---	---	-----------------------------

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.

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 08/22/2014
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 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, interviews and record review it was determined the facility failed to ensure all measures to prevent accidents from occurring were implemented for four of four residents (Residents #1, #2, #3, and #4) reviewed for accidents. This failure resulted in falls for Residents #1 & 2, skin tears for Former Resident #3 and had the potential risk of injury for Resident #4.</p> <p>Findings Include:</p> <p>Resident #1 Resident #1 was admitted to the facility [REDACTED] 2014 with a Cerebral Vascular Accident, hemiplegia and dementia. The comprehensive assessment dated 6/27/14 showed she had severe cognitive impairment. Resident #1's care plan dated 5/23/14 documented a high risk for falls with a score of 39 out of 100. The resident required staff assistance and an assistive device when transferred from bed to wheelchair or back again.</p> <p>On 7/15/14 Resident #1 was transferred using a Hoyer Lift (a device used to move residents when</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> In the case of Resident #1, Staff B ensured that the Nursing Assistant who performed the transfer was provided training on how to safely use the Hoyer lift, and received written counseling related to selecting the appropriate size Hoyer sling for Resident # 1. The sling used for Resident # 1 was changed to a medium size Hoyer sling and her care directives were changed, requiring that Resident #1 be transferred with 2 person staff assistance.</p> <p>Each of the night shift Nursing Assistants who worked on 7/8/14 and placed Resident #2 into the shower chair in preparation for her morning shower received written counseling for leaving Resident #2 unattended which may have contributed to the non-injury fall. It was clarified for both Nursing Assistants that despite being across the hall, and the brief time that Resident #2 was alone, they should not have left this resident alone for any amount of time as they were instructed within the Resident's care directives.</p>	

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 08/22/2014
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 323	<p>Continued From page 2</p> <p>they cannot stand or transfer without assistance). Resident #1 fell during the transfer, slipping out of the sling that she was seated in. The Resident Incident report of 7/15/14 showed through investigation it was determined the sling was too large for her and that she was not positioned properly in the sling. The resident fell hitting her buttocks and then her head on the floor.</p> <p>On 8/22/13 at 10:30 a.m. Staff A, charge nurse for unit, reported, "We had a fall a couple months ago because the sling was too large. Before we had a gentleman that was around [redacted] pounds and his sling was placed on Resident #1. She doesn't weigh that much. It was the evening shift and she slide out of the bottom of the sling. At that time she needed just one person to assist with the transfer. Her husband was helping the aide, holding her feet while she was being transferred." When Staff A was asked about how staff knows which sling to use, she reported, "We removed the sling that was too big. Now all the slings are labeled." The Hoyer lift sling was observed in the hallway by Resident #1's room, there was no labeling as to the size on the observed sling on the Hoyer lift.</p> <p>The resident was observed in her wheelchair on 8/22/14 at 12:55 p.m., with her husband in the courtyard. When ask a question, Resident #1, did not respond. In an interview with Resident #1's spouse at this same time, he reported he was assisting with the transfer on 7/15/14. He also reported, he thought the sling was too big and was too high on her. "She fell out of it."</p> <p>In an interview on 8/22/14 at 1:00 p.m., with the staff who completed the Incident investigation, Staff B, she reported the sling "was discovered to</p>	F 323	<p>The Nursing Assistant who assisted Resident #3 without the help of another staff member received a written counseling for failure to follow the care directives that instructed her to not transfer Resident #3 alone for safety during transfers as her behaviors are unpredictable.</p> <p>In the case of Resident #4, the Nursing Assistant who left the resident unattended on the toilet was removed from resident care and following investigation of the incident the Nursing Assistant was terminated from employment.</p> <p><i>How the facility will act to protect residents in similar situations?</i></p> <p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i></p> <p>Resident #1 All Hoyer Slings on each hall were checked for visible labeling of its size, and remarked if needed. Nursing Staff were re-trained on the method used to select the appropriate size sling for residents. A Hoyer sling sizing chart has been posted in each Clean Linen Closet on each hall for staff reference.</p>	

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 08/22/2014
--	--	--	---

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 323	<p>Continued From page 3 be too large."</p> <p>Resident #2 Resident #2 was a long term care resident, living in the facility for a number of years. The comprehensive assessment dated 6/9/14 indicated she had complex medical conditions including dementia, [REDACTED] depression; that she was severely cognitively impaired; required extensive assistance of one staff member when she was transferred and was not steady during transitions or when walking. Resident #2 used a wheelchair for mobility. Resident #2's care directives dated 6/16/14 stated, "Do not leave alone in Bathroom or toilet or on commode for fall precautions:" The resident's fall risk assessment indicated a significant risk for falls.</p> <p>On observation on 8/22/14 at 11:10 a.m., Resident #2 was lying in bed. There was a pole next to her bed. Staff C reported the resident used the pole when she transferred from her bed to her wheelchair. During this observation the doorway from her room was observed with a raised rubber threshold going from the linoleum to the carpeted hallway.</p> <p>The Facility Resident Incident Report of 7/8/14 reveled the resident was placed in a shower chair and was left alone inside the doorway of her room. While staff was across the hall washing their hands the resident pulled herself forward to the bump of the threshold and the chair went backwards, causing the resident to fall.</p> <p>On 8/22/14 at 2:00 p.m., in an interview with the unit charge nurse, Staff D, she reported, "The</p>	F 323	<p>Resident #2 Resident #3 Resident #4 Nursing Staff will be re-in-serviced on the importance of reading, and following the resident care directives for the safety of all residents. No system changes are indicated.</p> <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i></p> <p>Resident #1 The Laundry Staff were instructed on how to measure each sling after cleaning, and to check for visible labeling of its size. They were also instructed to re-label the slings if the labeling has faded using an indelible laundry pen.</p> <p>Education, corrected practice, and initiation of monitoring process will be completed on or before 10/6/14.</p>	
-------	---	-------	--	--

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

PRINTED: 09/02/2014
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 08/22/2014
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 323	<p>Continued From page 4</p> <p>aide should have been with her and wasn't. The resident leaned forward and slide out of the chair."</p> <p>Former Resident #3 Resident #3 had lived in the facility for the past 5 months and most recently received Hospice Services(care needs when someone is not expected to live more than 6 months). The comprehensive assessment dated 6/17/14 reveled the resident had complex medical conditions including cancer, diabetes, cerebral vascular accident and osteoporosis. The assessment indicated the resident required total assistance of 2 staff members when she was transferred from bed to chair or vice versa and that the resident rarely/never understood. The resident recently expired at the facility.</p> <p>On 7/2/14, the resident was being transferred back to her bed by the use a sit-to-stand (a device in which the resident grabs unto grips and is assisted to stand and then transferred) device. One staff member was assisting the resident, rather than the care planned need for two staff members and the resident put her hands through the sling straps. After the transfer was completed, the staff member saw blood on the resident's hand. It was discovered the resident had 3 skin tears to her right hand. The Facility Resident Incident Report of 7/2/14 reported the aide did not follow the care directives to have 2 staff members assist with transfers.</p> <p>Resident #4 Resident #4 had lived at the facility for a number of years. The most recent comprehensive assessment of 5/15/14 indicated the resident had complex medical conditions including dementia,</p>	F 323			

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

PRINTED: 09/02/2014
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 08/22/2014
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 323	Continued From page 5 anxiety and psychotic disorder. The assessment noted the resident was severely cognitively impaired and was not steady on her feet during transitions from sitting to standing. The 5/22/14 care plan instructed one staff to use the sit to stand lift when transferring the resident. The resident's fall risk assessment indicated a significant risk for falls and stated "Do not leave unattended in bathroom." The Facility Resident Incident Report of 7/9/14 reported the resident was found yelling from her bathroom, sitting on the toilet and in the sit to stand lift. The aide reported he left the resident in the bathroom unattended.	F 323		