

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 10/25/2024
NAME OF PROVIDER OR SUPPLIER Eliseo		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N Highlands Parkway Tacoma, WA 98406	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29644</p> <p>Based on observation, interview and record review, the facility failed to evaluate the effectiveness of fall prevention interventions, need for additional action, and/or attempt to mitigate environmental modifications preferred by the resident that presented a risk to safety for 1 of 3 sampled residents (Resident 1) reviewed for accidents and hazards. Resident 1 experienced harm when they fell out of bed and sustained a neck fracture. This failure placed residents at risk for falls, injury and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility Fall Prevention Program policy and procedure dated 03/2023 showed the facility used a standardized risk assessment for determining a resident's fall risk. The risk assessment categorizes residents according to low, moderate, or high risk. According to the policy, each resident's risk factors, and environmental hazards are evaluated when developing the resident's comprehensive plan of care.</p> <p><Resident 1></p> <p>Review of the 08/21/2024 Quarterly Minimum Data Set (MDS - an assessment tool) showed Resident 1 was assessed as cognitively intact, with no behaviors, required substantial assistance with bed mobility, transfers, toileting, was frequently incontinent and a toileting program of scheduled toileting had not been attempted. According to this MDS, Resident 1 had two non-injury falls and two falls with injury since the last Quarter's MDS.</p> <p>Review of Resident 1's Fall Risk Assessment showed they were assessed at High Risk with a score of 20 on 08/26/2024, a High Risk with a score of 21 on 09/19/2024, and 10/01/2024.</p> <p>Review of the 12/01/2021 Fall Care Plan (CP) showed Resident 1 fell on [DATE], 06/21/2024, 08/13/2024, 08/25/2024, 08/26/2024, 09/19/2024 and 10/01/2024. Staff were directed to maintain a clear pathway, free of obstacles.</p> <p>Review of the 06/04/2024 Incident Report showed Resident 1 was found on their bedroom floor, on their left side, between the table and bed. One hour before the fall, Resident 1 was observed in bed sleeping. Resident 1 sustained skin tears and bruising to their arms.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The Fall CP was revised on 06/05/2024 to place bed in a diagonal position to create space for the resident.</p> <p>Review of the 06/21/2024 3:00 AM Fall Investigation showed Resident 1 woke up, sat at the bedside and slipped off the bed landing in the sitting position. The resident sustained no injuries.</p> <p>During an interview on 10/21/2024 at 3:00 PM, Staff E, MDS Nurse, stated at that time Resident 1's bed was in room [ROOM NUMBER], diagonal to the door and accessible from either side of the bed.</p> <p>Review of the census showed Resident 1 changed rooms on 08/08/2024.</p> <p>During an interview on 10/25/2024 at 11:40 PM Staff G, Social Services, stated that they believed Nursing staff did a deviation of care (care that does not follow the standard) regarding the diagonal bed when Resident 1 moved from the 900 to the 800 hall.</p> <p>During an interview on 10/25/2024 at 11:33 AM, Staff F, Resident Care Manager (RCM), stated that when Resident 1 moved to the 800 Hall they told the staff how they wanted their bed and where to put their stuff. Staff F said the Resident was their own decision maker. Staff F stated they did not review risks and benefits and did not do a deviation of care. Staff F could not find that either had been completed and placed in the resident's record.</p> <p>Review of 08/13/2024 11:30 PM Fall Investigation showed Resident 1 attempted to self-transfer from the edge of the bed, slid and fell . Resident 1 was found on their left side. Resident 1 sustained skin tears and bruising to their arms.</p> <p>Review of the 08/26/2024 3:55 AM Fall Investigation showed Resident 1 was found on the floor next to their bed. The resident reported they were trying to get out of bed. Review of the undated Incident Summary showed Resident 1's fall risk score was 19 indicating they were at high risk for falls. The fall risk was related to diagnoses, medications, cognition, deconditioning, poor awareness of personal safety, and a strong desire to remain independent. Fall interventions in place included lock wheelchair at bedside when not in use, encourage resident to use call light when needing assistance, encourage to wait for staff when attempting to transfer. The resident was independent with bed mobility and reminded to turn every two hours.</p> <p>Review of the 10/01/2024 4:20 AM Fall Investigation showed Staff H, Licensed Practical Nurse (LPN), documented they responded to the alarm from Resident 1's room, I did not find the resident on the bed, but the wheelchair was besides the bed. I started looking for her in the bathroom, but she was not there. Then I looked on the other side of the bed and found her laying on her neck with all her weight, lower body up .</p> <p>Review of the 10/01/2024 5:12 AM Fall Note written by Staff H showed the resident was found in a cumbersome position, the bed was also restricting the space.</p> <p>Review of the undated Incident Summary showed the nurse and nursing assistant repositioned the resident to relieve pressure off their head and neck and ensure they could breathe. The nurse called 911 and the resident was transported and admitted to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/25/2024 at 10:24 AM, Staff C, Assistant Director of Nursing, stated Resident 1 was found with their head down and feet up. The staff moved the resident so the resident could breathe and called 911. Staff C stated the bed was at an angle because that was how Resident 1 wanted it.</p> <p>During an interview on 10/21/2024 at 10:10 AM Resident 1's representative stated they felt the facility was negligent in Resident 1's safety as the resident was a high fall risk and the facility left the bed diagonal from the wall, with no fall mats, and Resident 1 fell in that area. Resident 1's representative stated the way the dresser was placed left only a triangle of floor space and would not have allowed Resident 1 to get out if they fell in there. Resident 1's representative stated they were told Resident 1 had rights and wanted the bed placed at a triangle from the wall, but it was an entrapment risk and should not have been allowed.</p> <p>On 10/21/2024 at 3:54 PM, Staff I, Certified Nursing Assistant (CNA), stated the bed was angled because that was what the resident preferred. Staff I explained the space between the dresser, the mattress and the wall, was a tiny bit of space, not much space. Staff I stated they suggested placing the bed against the wall, but was told it would be a restraint.</p> <p>On 10/21/2024 at 3:54 PM, Staff J, CNA, stated the resident wanted the bed angled to have more room. Staff J showed where the dresser was placed. When asked if the resident could get around the dresser from the side of the bed, Staff J stated no.</p> <p>A 10/03/2024 Social Services Note showed Staff G called Resident 1's family member to see if it was okay for staff to pack up some of Resident 1's belongings to create more space in the room and make things more accessible for resident when they returned from the hospital.</p> <p>Review of the undated Incident Summary showed upon return to the facility on [DATE] the resident was placed in a low bed with a mat to the left side of the bed.</p> <p>During an interview on 10/25/2024 at 11:33 AM, Staff F said when Resident 1 returned from the hospital the bed was placed against the wall with a floor mat for safety. When asked why the bed had not been placed against the wall sooner, Staff F said because Resident 1 did not want it that way.</p> <p>Review of hospital records showed Resident 1 was hospitalized from 10/01/2024 to 10/04/2024, diagnosed with a Cervical (neck) Fracture, a Nondisplaced superior sternal body (breast bone) fracture, and left-sided rib fractures.</p> <p>REFERENCE: WAC 388-97-1060(3)(g).</p>		