STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on interview and record review, the facility failed to accurately assess 1 of 10 residents (Resident 11), reviewed for Minimum Data Set (MDS - an assessment tool). The failure to ensure accurate assessments regarding active diagnosis placed the resident at risk for unidentified and/or unmet care needs, and a diminished quality of life. Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.18.11, dated October 2023, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable . Active Diagnoses-Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/ problem list, and other resources as available. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). Resident 11 admitted to the facility on [DATE]. Review of the physician orders printed on 10/11/2024, showed Resident 11 was receiving a medication [for depression (or mood disorder)] for diagnosis of anxiety and pain that started on 08/03/2024. Review of Resident 11's quarterly MDS dated [DATE], showed that anxiety was not marked on the diagnoses section (Section I) of the MDS. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Joint record review and interview on 10/16/2024 at 10:35 AM with Staff D, Resident Care Manager/MDS Coordinator, showed Resident 11's physician's order had an antidepressant order for anxiety and pain. Staff D stated that anxiety was the diagnosis for Resident 11's antidepressant medication. Joint record review of the quarterly MDS dated [DATE], showed anxiety was not marked on Section I. Staff D stated that Resident 11's MDS should have had anxiety marked in Section I and that the MDS was inaccurate. On 10/16/2024 at 11:45 AM, Staff C, Assistant Director of Nursing, stated that they expected MDS assessments to be accurate and that Resident 11's MDS was not accurate. On 10/16/2024 at 11:53 AM, Staff B, Director of Nursing, stated they expected the MDS assessment to be accurate and have accurate diagnoses. Reference: (WAC) 388-97-1000(1)(b)(j)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASARR - a federally required screening of all individuals who has both an Intellectual Disability [ID] or Related Condition [RC] and a Serious Mental Illness [SMI] prior to admission to a Medicaid-certified nursing facility or a significant change of condition) form was completed prior to admission and according to the guidelines specified for 3 of 5 residents (Residents 11, 14 & 68), reviewed for unnecessary medications. This failure placed the residents at risk for inappropriate placement and/or lack of access to specialized services for residents with identified mental health diagnosis or disability. Findings included . Review of the facility's policy titled, PASARR, revised on 04/01/2023, showed that the facility would ensure all residents had a PASARR level I completed on admission and would ensure PASARR Level II referrals were made in accordance with State requirements. The document further showed that the facility's social services team would review the Level I PASARR for accuracy within 72 hours on all admissions. If the PASARR level I was inaccurate, a new accurate Level I PASARR would be immediately completed. If the PASARR Level I screening identified possible SMI or ID or RC, the social services team member would notify the DDA (Developmental Disability Administration) and/or mental health PASARR evaluator so a Level II evaluation can be conducted. RESIDENT 11 Review of the face sheet printed on 10/11/2024, showed Resident 11 admitted to the facility on [DATE]. Review of the physician orders printed on 10/11/2024, showed Resident 11 was receiving an antidepressant medication for diagnosis of anxiety and pain that started on 08/03/2024. Review of Resident 11's Level I PASARR dated 08/27/2024, showed the diagnosis of anxiety was not marked in Section I (SMI/ID/RC). Joint record review and interview on 10/16/2024 at 10:02 AM with Staff E, Social Services Coordinator, showed Resident 11's physician order had an order for an antidepressant medication for diagnosis of anxiety and pain since 08/03/2024. Staff E stated that anxiety was the diagnosis for Resident 11's antidepressant medication. Another joint record review and interview on 10/16/2024 at 10:02 AM with Staff E, showed no diagnosis of anxiety was listed under Section IA [SMI] of Resident 11's Level I PASARR dated 08/27/2024. Staff E stated that the diagnosis of anxiety should have been listed in Resident 11's Level I PASARR. Staff E further stated that Resident 11's Level I PASARR was not referred to the PASARR evaluator for a PASARR level II evaluation and it should have been. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/2024 at 1:17 PM, Staff A, Health Services Administrator, stated they expected the PASARR forms to be accurate. Staff A further stated that Resident 11's most current Level I PASARR form should have had a diagnosis of anxiety marked in the SMI section and that it should had been sent to the PASARR evaluator for a PASARR level II evaluation upon completion. 48899 RESIDENT 14 Review of a face sheet showed Resident 14 admitted to the facility on [DATE]. Review of Resident 14's Level I PASARR form dated 09/18/2024, showed the name of the resident and the hospital staff member who completed the form. Further review of the Level I PASARR form did not show the required four sections (Sections I to IV) were completed or filled out. In an interview and joint record review on 10/15/2024 at 3:17 PM, Staff E stated that they ensured the Level I PASARR be completed upon admission. A joint record review with Staff E showed Resident 14's Level I PASARR form did not have the four sections completed. Staff E stated that Resident 14's Level I PASARR form was incomplete and that it needed to be redone properly. In an interview on 10/16/2024 at 2:33 PM, Staff A stated that Resident 14's Level I PASARR was not reviewed properly, and it should have been. :33 PM, Staff A stated that Resident 14's PASARR Level I was not reviewed properly, and it should have been. 50891 RESIDENT 68 A review of Resident 68's face sheet showed they admitted to the facility on [DATE] with multiple diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder. A review of Resident 68's Level 1 PASARR form dated 10/07/2024 showed that mental mood disorders and anxiety disorders were marked in the SMI section. Further review of the document showed the SMI Indicators section was marked yes [has SMI] and no [does not have SMI]. In an interview and joint record review on 10/16/2024 at 10:19 AM, Staff E stated that they reviewed the Level I PASARR either on the day the resident arrives to the facility or the day before. Staff E stated that they had reviewed Resident 68's Level I PASARR form multiple times and did not know how they missed that Section IA and that it was mismarked. In an interview on 10/16/2024 at 1:56 PM, Staff A stated that their expectations included the PASARR forms to be reviewed prior to a new resident's admittance. Staff A further stated that any new admit with a mental health diagnosis, they would review and update the PASARR activity according to standard. Reference: (WAC) 388-97-1915 (1)(2) (a-c) (4), 1975(1)(4)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to develop and implement care plans for 3 of 8 residents (Residents 14, 2 & 6), reviewed for comprehensive care plan. The failure to implement care plans for Activities of Daily Living (ADL), use of medication to reduce swelling, and use of psychoactive [mind-altering] medication to include target behaviors and non-pharmacological interventions placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Comprehensive Resident Centered Care Plans, revised on 02/09/2024, showed the facility must develop and implement a comprehensive person-centered care plan for each resident . that includes measurable objections and periods to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Review of the facility's policy titled, Policy and Procedure - Psychoactive Drug use, revised on 07/01/2024, showed, Care plan documentation will include measures to monitor, avoid and prevent decline in function and a plan to attempt other alternatives . Each resident's behavior monitoring record will be identifying the specific symptoms for which the drug is being used . Documentation of the behaviors will be quantitative and objective. ACTIVITIES OF DAILY LIVING RESIDENT 2 Review of the face sheet showed that Resident 2 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS - an assessment tool) dated 08/09/2024 showed Resident 2 had severe cognitive impairment and required total assist with showering/bathing. Review of the ADL care plan printed on 10/10/2024, showed Resident 2's showers were scheduled for twice a week on Tuesdays and Fridays. The care plan further showed that hospice [a type of end -of-life care that provides comfort, dignity, and peace for people who are dying] services would provide Resident 2 a shower/bath every Monday morning. Review of the facility provided undated and untitled document, showed that room [ROOM NUMBER] (Resident 2's room) was scheduled for a shower on Mondays and Fridays. Further review of the undated document showed that the hospice bath aide would come every Monday to provide shower to Resident 2. Review of the July 2024 to September 2024 Documentation Survey Report [documentation for shower/bath], showed Resident 2 received showers on 07/03/2024 (Wednesday) and 07/12/2024 (Friday). The document further showed that Resident 2 did not receive any showers in August 2024 and received one shower on 09/27/2024. Further review of the document showed no documentation to show Resident 2's refusals for shower. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/2024 at 10:55 AM, Collateral Contact 1 (CC1) stated that Resident 2 received one shower a week for 10 consecutive weeks. CC1 mentioned that when they reported their concern to the nurse manager [Staff C, Assistant Director of Nursing], the manager responded that they had instructed the aides to offer one shower a week. In an interview on 10/14/2024 at 1:12 PM, Staff K, Certified Nurse Assistant (CNA), stated that Resident 2 required total assist with showering/bathing. In an interview and joint record review on 10/15/2024 at 3:01 PM, Staff D stated that Resident 2 was scheduled for two showers a week. A joint record review with Staff D showed Resident 2 received showers on 07/03/2024 and 07/12/2024 for the month of July 2024, did not receive any showers in August 2024, and received one shower on 09/27/2024 for the month of September 2024. Staff D stated that Resident 2 should have received two showers a week and that the care plan should have been followed. In an interview and joint record review on 10/15/2024 at 10:21 AM, Staff C, stated that Resident 2's shower schedule was initially for Tuesdays and Fridays but was recently changed to Mondays and Fridays. Staff C stated, It seems that while the resident had been receiving showers, the NACs [CNAs] have not documented it properly. Staff C further stated that there was no documentation that showers were provided twice a week. A joint record review and interview on 10/16/2024 at 12:01 PM with Staff B, Director of Nursing, showed that Resident 2 received two showers in July 2024, no showers in August 2024, and one shower in September 2024. When asked if the care plan was followed, Staff B stated it was not and it should have been followed. USE OF MEDICATIONS RESIDENT 14 Review of the face sheet showed Resident 14 admitted to the facility on [DATE]. Review of Resident 14's September 2024 Medication Administration Record showed an order for a diuretic (helps to reduce fluid buildup [edema or swelling] in the body) medication 1 milligram (unit of measurement) take three tablets by mouth twice a day for edema that started on 09/19/2024. Review of Resident 14's comprehensive care plan printed on 10/14/2024, did not show a care plan for diuretic use. Observations on 10/11/2024 at 9:23 AM and on 10/14/2024 at 10:17 AM, showed Resident 14 had swelling to both legs. In an interview on 10/15/2024 at 3:01 PM, Staff D, Resident Care Manager/Minimum Data Set [Assessment] Coordinator, stated that Resident 14 had been on diuretic medication for edema since 09/19/2024. Staff D stated that a diuretic care plan was just added on 10/15/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 10/15/2024 at 10:21 AM, Staff C stated that residents on diuretic medication needed a care plan when they started using it. A joint record review with Staff C showed that Resident 14's care plan for diuretic use was developed on 10/15/2024. Staff C stated that the care plan should have been developed immediately after the medication was started [09/19/2024]. On 10/16/2024 at 12:01 PM, Staff B stated that they were aware Resident 14 was on a diuretic medication. Staff B stated that they expected a care plan was developed as soon as Resident 14 started using diuretics. 51090 RESIDENT 6 Resident 6 admitted to the facility on [DATE]. Review of Resident 6's physician orders printed on 10/15/2024, showed an order for a medication for depression [persistent feeling of sadness, loss, anger, or frustration that interferes with everyday life]) 50 milligram (mg-unit of measurement) tablet by mouth in the morning dated 08/15/2024. Review of Resident 6's antidepressant medication care plan, revised on 08/27/2024 did not show there were target behaviors and non-pharmacological interventions identified and/or listed in the care plan. In an interview on 10/16/2024 at 10:18 AM, Staff B stated they expected target behaviors and non-pharmacological interventions for Resident 6 to be in place and that they should have been included in Resident 6's antidepressant medication care plan when the antidepressant medication was started. Reference: (WAC) 388-97-1020 (1) (2)(a)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on interview and record review, the facility failed to revise a comprehensive care plan for 1 of 10 residents (Resident 11), reviewed for care plan revision. The failure to revise the care plan for use of a diuretic (reduce swelling/fluid buildup in the body) and psychoactive [mind-altering] medications placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Comprehensive Resident Centered Care Plans, revised on 02/09/2024, showed that care plans should be reviewed and revised after each assessment comprehensive and quarterly. The policy further showed that the facility was to update care plans upon change in planned interventions, new diagnosis, and new medications. Review of the facility's policy titled, Psychoactive [chemicals that change the brain and can alter mood, perception, or behavior] Drug Use, revised on 07/01/2024, showed that each resident with a potential need for a psychoactive drug and/or currently receiving a psychoactive drug will be assessed upon admission and according to resident condition. Care plan documentation will include measures to monitor, avoid and prevent decline in function and a plan to attempt other alternatives as the team deems appropriate. Resident 11 admitted to the facility on [DATE]. Review of the physician orders printed on 10/11/2024, showed Resident 11 had an order for a diuretic medication that started on 08/06/2024 and an order for antipsychotic [min-altering] medication that started on 08/03/2024. Review of the care plan printed on 10/11/2024, showed Resident 11 had no care plan for use of diuretic medication. Further review of the care plan did not show non-pharmacological interventions were in place for antipsychotic medication use. A joint record review and interview on 10/16/2024 at 10:29 AM with Staff D, Resident Care Manager/Minimum Data Set [Assessment] Coordinator showed Resident 11's had no care plan for diuretic medication. Staff D stated that Resident 11 should have had a care plan for diuretic use. On 10/16/2024 at 11:31 AM, Staff C, Assistant Director of Nursing, stated Resident 11 should have had a care plan for use diuretic medication. Staff C further stated that Resident 11 should have had non-pharmacological interventions for their targeted behaviors in their physician orders for staff to monitor and document in the medication administration record, and that it should have been care planned. On 10/16/2024 at 11:53 AM, Staff B, Director of Nursing, stated they expected diuretic medication and non-pharmacological interventions for Resident 11's targeted behaviors be care planned. Reference: (WAC) 388-97-1020 (2)(a)(5)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to provide necessary assistance with showering/bathing for 1 of 2 residents (Resident 2), reviewed for Activities of Daily Living (ADL). This failure placed the resident at risk for unmet care needs, and a diminished quality of life. Findings included . Review of the face sheet printed on 10/10/2024 showed Resident 2 admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS - an assessment tool) dated 08/09/2024 showed Resident 2 had severe cognitive impairment and required total assist with showering/bathing. Review of the ADL care plan printed on 10/10/2024, showed Resident 2's showers were scheduled twice a week on Tuesdays and Fridays. The care plan further showed that hospice [a type of end -of-life care that provides comfort, dignity, and peace for people who are dying] services would provide Resident 2 a shower/bath every Monday morning. Review of the facility provided undated and untitled document, showed that room [ROOM NUMBER] (Resident 2's room) was scheduled for a shower on Mondays and Fridays. Further review of the undated document showed that the hospice bath aide would come every Monday to provide shower to Resident 2. Review of the July 2024 to September 2024 Documentation Survey Report [documentation for shower/bath], showed Resident 2 received showers on 07/03/2024 (Wednesday) and 07/12/2024 (Friday). The document further showed that Resident 2 did not receive any showers in August 2024 and received one shower on 09/27/2024. Further review of the document showed no documentation to show Resident 2's refusal for shower. On 10/10/2024 at 10:55 AM, Collateral Contact 1 (CC1) stated that Resident 2 received one shower a week for 10 consecutive weeks. CC1 mentioned that when they reported their concern to the nurse manager [Staff C, Assistant Director of Nursing/Infection Preventionist], the manager responded that they had instructed the aides to offer one shower a week. On 10/14/2024 at 1:12 PM, Staff K, Certified Nurse Assistant (CNA), stated that Resident 2 required total assist with bathing. In an interview and joint record review on 10/15/2024 at 3:01 PM, Staff D, Resident Care Manager/MDS Coordinator, stated that Resident 2 was scheduled for two showers a week. A joint record review with Staff D showed Resident 2 received showers on 07/03/2024 and on 07/12/2024 for the month of July 2024, did not receive any showers in August 2024, and received one shower on 09/27/2024 for the month of September 2024. Staff D stated that Resident 2 should have received two showers a week. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 10/15/2024 at 10:21 AM, Staff C, stated that Resident 2's shower schedule was initially for Tuesdays and Fridays but was recently changed to Mondays and Fridays. Staff C stated, It seems that while the resident had been receiving showers, the NACs [CNAs] have not documented it properly. Staff C further stated that they believed Resident 2 had received more showers than what it was documented but was not able to provide documentation. A joint record review and interview on 10/16/2024 at 12:01 PM with Staff B Director of Nursing, showed that Resident 2 received two showers in July 2024, no showers in August 2024, and one shower in September 2024. Staff B stated, that cannot be true because Resident 2 was receiving more showers than that. Staff B further added, It seems there is an issue with documentation. [If there was] no documentation, we have lost the battle. Reference: (WAC) 388-97-1060 (2)(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to ensure consistent communication and collaboration of care occurred between the facility and hospice care for 1 of 1 resident (Resident 2), reviewed for hospice services. In addition, the facility failed to ensure adverse side effects for diuretic medication (that helps with edema [swelling] to reduce fluid buildup in the body) use and monitoring of edema were conducted for 1 of 1 resident (Resident 11), reviewed for unnecessary medications. These failures placed the residents at risk for not receiving necessary comfort care services, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's policy titled, Nursing Services - Hospice, revised on 02/13/2024, showed that the facility would ensure all documentation of hospice visits were completed according to the state and federal regulations. Review of the face sheet printed on 10/10/2024 showed Resident 2 admitted to the facility on [DATE]. Review of the nursing progress notes dated 08/15/2024, showed that the Resident 2's hospice referral was made on 08/15/2024. Review of Resident 2's Electronic Health Records (EHR and paper charting) did not show documentation of hospice care referral order and/or hospice visit notes. In an interview and joint record review on 10/15/2024 at 3:01 PM with Staff D, Resident Care Manager/Minimum Data Set [Assessment] Coordinator, stated that Resident 2 was receiving hospice services. A joint record review of the EHR showed there was no documentation of hospice care referral order and/or hospice visit notes. Staff D stated that the hospice referral order and/or the hospice notes should have been in Resident 2's EHR. In an interview and joint record review on 10/15/2024 at 3:38 PM with Staff F, Medical Records Coordinator, stated that the order for hospice service and visit notes should have been in Resident 2's EHR. A joint record review showed no documentation of the hospice care referral order and/or hospice visit notes. Staff F stated that if the records were not in Resident 2's EHR, it meant that the hospice agency did not send them to the facility. In an interview and joint record review on 10/15/2024 at 10:21 AM with Staff C, Assistant Director of Nursing, stated that Resident 2 received hospice services since 08/19/2024. A joint record review of Resident 2's EHR showed no documentation of hospice care referral order and/or hospice visit notes. Staff C stated that they expected the order for hospice care and visit notes documented in Resident 2's EHR. In an interview on 10/15/2024 at 3:17 PM, Staff E, Social Services Coordinator, stated that they coordinated communication between the hospice agency and the facility. Staff E further stated that the hospice care order and/or visit notes should have been in Resident 2's EHR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/16/2024 at 12:01 PM with Staff B, Director of Nursing, stated that there was verbal communication between the facility and hospice agency staff. Staff B further stated that there should have been both verbal and written communication to coordinate care between the facility and hospice. 47218 USE OF DIURETIC MEDICATION/EDEMA MONITORING Review of the facility's policy titled, Medication Administration, revised on 04/11/2024, showed that medications were administered by licensed nurses in accordance with professional standards of practice. Review of the face sheet printed on 10/11/2024, showed Resident 11 admitted to the facility on [DATE]. Review of the physician orders printed on 10/11/2024, showed Resident 11 had an order for a diuretic medication that started on 08/06/2024. Further review of the physician order did not show Resident 11 was being monitored for adverse side effects related to the use of diuretic medication and/or monitoring of edema. A joint record review and interview on 10/16/2024 at 10:29 AM with Staff D showed Resident 11's physician orders had a diuretic medication order that started on 08/06/2024. Staff D stated that there should have been an order to monitor the adverse side effects for use of diuretic medication and monitoring of edema. Staff D further stated that the order should have had a documentation of the specific location of the edema. On 10/16/2024 at 11:31 AM, Staff C stated that Resident 11 should have had an order for monitoring the side effects of the diuretic medication and edema for staff to monitor and document in the medication administration record. On 10/16/2024 at 11:53 AM, Staff B stated that they expected diuretic medication side effects and edema were monitored. Reference: (WAC) 388-97-1060 (1)(3)(k)(4)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on interview and record review, the facility failed to ensure target behaviors and non-pharmacological interventions were identified and monitored for residents receiving psychotropic medications (drugs that affects how the brain works, and causes changes in mood, awareness, thoughts, feelings or behavior) for 2 of 5 residents (Residents 6 & 11), reviewed for unnecessary medications. This failure placed the residents at risk for receiving unnecessary medications, adverse side effects, and a diminished quality of life. Findings included . Review of the facility's policy titled, Policy and Procedure - Psychoactive (chemicals that change the brain and can alter mood, perception, or behavior) Drug use, revised on 07/01/2024, showed, Assessment will include the medical symptoms and specific conditions necessitating need for the drug, results of behavior monitoring and interventions .Each resident's behavior monitoring record will be identifying the specific symptoms for which the drug is being used .Documentation of the behaviors will be quantitative and objective. RESIDENT 6 Resident 6 admitted to the facility on [DATE]. Review of Resident 6's physician orders printed on 10/15/2024, showed an order for an antidepressant medication 50 milligrams (mg-unit of measurement) tablet by mouth in the morning for depression [persistent feeling of sadness, loss, anger, or frustration that interferes with everyday life]). Further review of the physician orders showed Resident 6 started on the antidepressant medication on 08/15/2024. Review of Resident 6's October 2024 Medication Administration Record (MAR) printed on 10/15/2024, did not show target behaviors were identified and/or monitored. Further review of the MAR did now show non-pharmacological interventions and monitoring were in place. Joint record review and interview on 10/15/2024 at 9:19 AM with Staff C, Assistant Director of Nursing, showed Resident 6's physician orders did not have non -pharmacological interventions identified and/or monitored. Staff C stated, I don't see it, it's supposed to be in the [Physician] orders. Further review of the physician orders showed Resident 6 had an order written to monitor target behaviors on 10/15/2024. Staff C stated Resident 6 did not have target behaviors identified and/or monitored and that they updated Resident's 6's physician orders to include target behaviors related to the antidepressant medication, starting on 10/15/2024. Staff C then stated their expectation was for the facility to monitor target behaviors and non-pharmacological interventions for residents on psychotropic medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/16/2024 at 10:18 AM, Staff B, Director of Nursing, stated they expected target behaviors and non-pharmacological interventions for Resident 6 to be in place and that they should have been monitored in the MAR when the antidepressant medication was started. 47218 RESIDENT 11 Review of the face sheet printed on 10/11/2024, showed Resident 11 admitted to the facility on [DATE]. Review of the physician orders printed on 10/11/2024 showed Resident 11 had an order for an antipsychotic [mind altering] medication for dementia (memory loss) with combative behaviors that started on 08/03/2024. A joint record review and interview on 10/16/2024 at 10:32 AM with Staff D, Resident Care Manager/ Minimum Data Set [Assessment] Coordinator, did not show Resident 11 had non-pharmacological interventions for their targeted behaviors identified and/or monitored in the physician order. Staff D stated Resident 11's non-pharmacological interventions should have been identified in the care plan and/or monitored in the MAR. Joint record review and interview on 10/16/2024 at 11:45 AM with Staff C showed Resident 11's physician orders did not have non-pharmacological interventions or monitoring in place. Staff C stated they expected non-pharmacological interventions specific to targeted behaviors were in Resident 11's MAR from when the antipsychotic medication was started. On 10/16/2024 at 11:53 AM, Staff B stated they expected non-pharmacological interventions for Resident 11 to be in place and that they should have been monitored in the MAR when the antipsychotic medication was started. Reference: (WAC) 388-97-1060 (3)(k)(i)(4)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51090 Based on observation, interview, and record review, the facility failed to appropriately label and store drugs and/or biologicals for 1 of 1 medication refrigerator, reviewed for medication storage. This failure placed the residents at risk for receiving compromised and/or ineffective medications. Findings included . Review of the facility's policy titled, Controlled Substance Storage, dated [DATE], showed that the facility's pharmacy recommended the best practice for storage for schedule II-V medications and other medications subject to abuse or diversion was in a permanently affixed, double-locked compartment separate from all other medications. Review of the facility's policy titled, Medication Storage in the Facility: Storage of Medications, revised on [DATE], showed that the facility should verify the refrigerator or freezer in which vaccines were stored was maintained at the outlined temperature range, at least two times a day, per the Centers of Disease Control and Prevention guidelines. Review of the facility's policy titled, Specimen [biological material taken for testing] Collection and Storage, revised on [DATE], showed that the staff will be educated on the proper storage of specimens, ensuring proper infection control practices are used. It further showed that storage of collected specimens were preferably kept in a separate area away from medications, that a separately marked refrigerator may be used for specimens that may be held until picked up by or transported to a lab for testing. NARCOTIC BOX IN THE MEDICATION REFRIGERATOR In a joint observation and interview on [DATE] at 9:37 AM with Staff H, Licensed Practical Nurse, showed an unlocked medication refrigerator was in the medication room. Further observation showed there was a locked narcotic box that was not permanently affixed to the medication refrigerator. Staff H stated the narcotic box was not permanently affixed to the medication refrigerator and that there were controlled substances stored inside it. A joint observation and interview on [DATE] at 10:30 AM with Staff C, Assistant Director of Nursing, showed liquid Ativan (or Lorazepam - a medication used to manage anxiety disorders [a mental health condition that causes people to experience excessive and persistent worry that interferes with their daily lives]) prescribed to Resident 3 was stored inside the narcotic box within the unlocked medication refrigerator. Staff C stated their pharmacy delivered the narcotic box as a separate locked box and that it was not permanently affixed to the inside of the medication refrigerator. On [DATE] at 9:51 AM with Staff B, Director of Nursing, stated that the narcotic box was not permanently affixed to their medication refrigerator and that the medication refrigerator was not locked. Staff B further stated they expected controlled substances to be stored safely in a storage unit in accordance with requirements. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SPECIMEN STORAGE IN MEDICATION REFRIGERATOR Joint observation and interview on [DATE] at 9:37 AM with Staff H, showed there was a specimen tube of plasma (the liquid part of blood) stored in the medication refrigerator's freezer. Staff H stated specimens should not be stored in the medication refrigerator because it was unsanitary. Joint observation and interview on [DATE] at 10:00 AM with Staff C, showed the plasma specimen found in the medication refrigerator was moved to the specimen refrigerator located inside the soiled utility room by staff H. Staff H stated that the plasma specimen should not have been there [in the medication refrigerator]. On [DATE] at 9:51 AM, Staff B stated the facility's procedure for specimen collection and storage was that collected specimens were placed in the specimen refrigerator located in the soiled utility room. Staff B further stated they would not expect any specimen collected to be stored in the medication refrigerator including the freezer and that they [staff] should not be mixing [medications and specimens]. VACCINE STORAGE A joint observation on [DATE] at 9:37 AM with Staff H, showed there was an [unexpired] pneumococcal vaccine (protects against bacterial infections that can cause serious illness) that was dispensed (prepared and distributed by the facility's pharmacy) on [DATE], stored in the medication fridge. Review of the facility's [DATE] refrigerator temperature log for the medication refrigerator, showed Refrigerator temperature should be monitored twice a day if vaccines are present. A Joint record review and interview on [DATE] at 10:58AM with Staff C, showed the [DATE] medication refrigerator log was not checked a second time on [DATE] through [DATE] and on [DATE]. Staff C stated they expected that staff followed the facility's policies and procedures to check the temperature log for the medication refrigerator twice daily. On [DATE] at 9:51 AM, Staff B stated they expected that staff followed the facility's policy and procedures for the proper storage of vaccines. Reference: (WAC) [DATE] (2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on observation, interview, and record review, the facility failed to ensure foods stored were labeled/dated and discarded after the expiration date or use by date in accordance with professional standards for food safety for 2 of 2 refrigerators (Dairy Refrigerator and Main Walk-In Refrigerator) and 1 of 1 freezer (Walk-In Freezer), reviewed for food services. This failure placed the residents at risk for food borne illness [caused by the ingestion of contaminated food or beverages] and a diminished quality of life. Findings included . Review of the facility's policy titled, Date Marking for Food Safety, revised on [DATE], showed that the food items would be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The policy further showed, the individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. DAIRY REFRIGERATOR Joint observation and interview on [DATE] at 8:13 AM with Staff M, Lead Cook, showed an unopened coleslaw dressing with a manufacturer expiration date of [DATE]. Follow up observation on [DATE] at 9:05 AM with Staff M, showed butter for bread prepared on [DATE] with a use by date of [DATE]. Further observation showed four jugs of hollandaise sauce with no dates. Staff M stated that both the coleslaw and butter should have been discarded. Staff M stated that the hollandaise sauce came in a box with a manufacturer date on it, but they were unsure where the box was. Staff M further stated that they would need to put dates on the hollandaise sauce when they unbox and place them on the shelf. MAIN WALK-IN REFRIGERATOR Joint observation and interview on [DATE] at 8:27 AM with Staff M, showed one opened and undated container of heavy whipping cream, and a half can of cheese with a preparation date of [DATE] and a use by date of [DATE]. Staff M stated that the heavy whipping cream should have been dated when it was first opened, and the expired cheese should have been discarded. WALK-IN FREEZER Joint observation and interview on [DATE] at 8:45 AM with Staff M, showed seven bags of diced carrots with use by date of [DATE] and with shelf life of [DATE]. Staff M stated that the dates did not seem accurate, but the diced carrots were still considered good to use. In an interview on [DATE] at 2:33 PM, Staff A, Health Services Administrator, stated that it was their expectation for the kitchen staff to maintain food safety according to State and Federal guidelines. Staff A further stated that the kitchen staff should have followed the facility's food safety and storage policies. Reference: (WAC) [DATE] (3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50891 Based on observation, interview, and record review, the facility failed to ensure glucometers (portable device used to measure blood sugar) were disinfected properly for 2 of 2 residents (Residents 168 & 14), clean insulin [medication that works by lowering levels of sugar in the blood] pen rubber seal prior to attaching a needle for 2 of 2 residents (Residents 168 & 14), and ensure Enhanced Barrier Precautions (EBP- gown and glove use to protect residents from multidrug-resistant organism [germ that is resistant to medications that treat infections]) practices were followed for 2 of 5 residents (Residents 12 & 68), reviewed for infection control. In addition, the facility failed to ensure hand hygiene practices and/or proper use of gloves were followed for 3 of 7 residents (Residents 168, 15 & 7), reviewed for medication administration, and for 2 of 2 staff (Staff J and I), reviewed for dining observations. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included . Review of the facility's policy titled, Glucometer Disinfection, revised on 04/01/2024, showed that the purpose for the disinfection of glucometers was to prevent transmission of blood borne diseases to residents and employees. The policy showed that the glucometers would be disinfected with a wipe pre-saturated with an EPA (Environment Protection Agency) registered healthcare disinfectant that is effective against HIV (Human Immunodeficiency Virus- a virus [a tiny infectious agents that requires a host cell to replicate and survive] that attacks the body's immune system), Hepatitis [inflammation of the liver] C and Hepatitis B Virus. Review of the facility's policy titled, Handwashing-Hand hygiene, revised on 02/07/2024, showed hand hygiene should be performed before and after entering a resident's room, before performing invasive procedures, before and after manipulation of an IV [Intravenous - a flexible tube is inserted into a vein, to deliver medicine or fluids into the bloodstream] device before and after handling indwelling catheters [a medical device used to drain urine from the bladder], to include handling the catheter drainage bags and/or tubing. The policy further showed that the use of gloves did not replace handwashing. Review of the facility's policy, Insulin Injection, revised 01/02/2024, showed that when attaching the pen needle, the insulin pen rubber seal must be wiped with an alcohol pad first before screwing on the pen needle onto the insulin pen. The policy further showed that gloves must be worn when administering insulin. Review of the facility's policy titled, Enhanced Barrier Precaution, revised on 04/11/2024, showed EBP referred to a set of infection control practices that involve wearing gowns and gloves during high-contact care of residents in nursing homes. High contact resident care activities included dressing, transferring, providing hygiene, and device care or use (such as central lines, urinary catheters). DISINFECTING GLUCOMETERS (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint observation and interview on 10/14/2024 at 10:44 AM, showed Staff H, Licensed Practical Nurse, was cleaning the glucometer for Resident 168 with alcohol pads. At 10:48 AM, Staff H was observed cleaning the glucometer with alcohol wipes after checking Resident 14's blood sugar. Staff H stated that they were out of Clorox [brand, disinfectant] wipes and had to use alcohol wipes to clean the glucometer. In an interview on 10/16/2024 at 2:06 PM, Staff B, Director of Nursing, stated that the facility cleaned the glucometers with alcohol wipes and not with disinfectant wipes. INSULIN ADMINISTRATION RESIDENT 168 Review of the October 2024 Medication Administration Record (MAR) showed Resident 168 had an order for Insulin Lispro injection 100 units per milliliter (mL-unit of measurement) inject 8 units subcutaneously (in fatty tissue under the skin) with meals. An observation on 10/14/2024 at 11:38 AM, showed Staff H placed a needle onto the insulin pen rubber seal without cleaning the rubber seal first. Staff H entered Resident 168's room and injected the insulin into their arm. Staff H did not perform hand hygiene and did not wear gloves when giving the insulin injection. Staff H stated they did not wear gloves when giving insulin to Resident 168. RESIDENT 14 Review of the October 2024 MAR showed Resident 14 had an order for Insulin Lispro Injection 100 units per mL inject 6 units subcutaneously with meals. An observation and interview on 10/14/2024 at 11:42 AM, showed Staff H placed a needle to the insulin pen without cleaning the insulin pen rubber seal. Staff H stated they did not wipe the insulin pen rubber seal because it belonged to Resident 14 and that they cleaned the surface of the pen. Staff H entered the room and administered the insulin to Resident 14. Staff H did not perform hand hygiene before and/or after entering the room and did not wear gloves to administer the insulin to Resident 14. An interview on 10/16/2024 at 2:06 PM, Staff B stated that they [staff] should be hand sanitizing [in between tasks] and wear gloves when giving insulin injection. ENHANCED BARRIER PRECAUTIONS RESIDENT 12 Review of the October 2024 MAR showed Resident 12 had an order for Cefazolin [treats infections] 2 grams [unit of measure] intravenously [through a vein] every 8 hours for bacteremia [infection in the bloodstream]. The MAR further showed that the resident had a Peripherally Inserted Central Catheter (PICC-a thin flexible tube inserted into a vein) line. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 10/14/2024 at 1:48 PM, showed an EBP signage outside of Resident 12's door that directed staff to use gloves and gowns when handling a PICC line. Staff H did not put on a gown when handling Resident 12's PICC line. On 10/16/2024 at 2:06 PM, Staff B stated that when there was an EBP precaution sign at the door and that staff were expected to wear gloves and gown. RESIDENT 68 Observations on 10/15/2024 at 8:05 AM of Staff H and Staff L did not show they wore gowns when they provided high contact resident care activities that included repositioning, emptying the catheter bag, handling a condom (urine collection device) catheter and changing soiled reusable incontinent pad for Resident 68. On 10/15/2024 at 8:24 AM, Staff H stated that Staff A, Health Services Administrator, had just informed them that they should be wearing a gown when care was being provided. Staff H stated that they have to improvise and that they knew they should be wearing a gown. Staff H then told Staff L they needed to wear a gown. On 10/15/2024 at 8:30 AM, Staff H was observed connecting the IV antibiotics to Resident 68's PICC line without wearing a gown. In an interview on 10/16/2024 at 2:06 PM, Staff B stated that they [staff] should be gowning before providing resident care [on EBP precautions]. MEDICATION PASS RESIDENT 168 Observation on 10/14/2024 at 10:41 AM, showed Staff H was entering Resident 168's room, donned gloves, checked the resident's blood sugar level, removed the soiled gloves, and then left the room. Staff H did not do hand hygiene before entering/after leaving the room and before and after glove use. RESIDENT 15 Another observation on 10/14/2024 10:46 AM, showed Staff H entered Resident 15's room without performing hand hygiene. Staff H was observed donning a pair of clean of gloves and then walked over to the medication cart (outside of the room) to retrieve a lancet [small needle used to make a tiny prick on the skin] from the medication cart. Staff H then removed their soiled gloves and donned a new pair. No hand hygiene was observed between glove change. RESIDENT 7 Observation on 10/14/2024 at 10:46 AM, showed Staff H was adjusting the magnetic door holder before they entered Resident 7's room. Staff H gave Resident 7 their oral medications, picked up their breakfast tray, and carried it out of their room. Staff H closed Resident 7's door with their hand and left the room. Staff H did not perform hand hygiene before entering or after leaving the resident's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/14/2024 at 2:20 PM, Staff H stated that they were to use gloves during resident care, when checking blood sugars, and administering injections. Staff H stated that the appropriate times to sanitize their hands was when they remove their gloves and when they exit the resident's room. In an interview on 10/16/2024 at 2:06 PM, Staff B stated that they [staff] should be hand sanitizing, then gloving and gowning before providing resident care. An interview on 10/16/2024 at 1:56 PM, Staff A stated that hand hygiene should have been done before and after resident's care and between gloving. An interview on 10/16/2024 at 2:06 PM, Staff B stated that they [staff] should be hand sanitizing [do hand hygiene in between tasks (and between glove change) for Residents 168, 15 & 7]. 47218 DINING ROOM OBSERVATION STAFF J Observations on 10/10/2024 at 12:16 PM and on 10/14/2024 at 11:51 AM, showed Staff J, CNA, was holding a sandwich with their bare hands and brought it up to Resident 11's mouth. On 10/16/2024 at 8:43 AM, Staff J stated they used their bare hands to hold Resident 11's sandwich when assisting them with eating and that their hands were clean. Staff J further stated they did not know they needed to wear gloves prior to touching Resident 11's food. MEAL TRAY PASS OBSERVATION STAFF I On 10/11/2024 at 11:34 AM, Staff I, CNA, was observed delivering meal trays to residents' room from a meal rolling cart. Staff I delivered Resident 10's lunch to their side table, moved the side table closer to the resident, and left their room without performing hand hygiene. Staff I then delivered Resident 5's lunch to their side table, Staff I moved Resident 5's trash can to their left side, uncovered the plate and pushed it closer to the resident, touched Resident 5's shoulder, then donned gloves to cut resident's quesadilla with utensils, and left the room. Staff I, then went to the dining room, took a meal tray, delivered it to Resident 7's side table, and left the room. Staff I did not perform hand hygiene before entering and/or after leaving the room for Residents 10, 5 and 7. On 10/11/2024 at 11:49 AM, Staff I stated that hand hygiene should have been performed before entering and after leaving Residents 10, 5, and 7's room. Staff I further stated that hand hygiene should be performed before serving lunch, after providing resident care, and when they touched the resident or their environment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/2024 at 8:53 AM, Staff H stated that it was not okay for staff to touch the resident's food with their bare hands and that gloves should have been worn. Staff H further stated that staff [Staff I] should have performed hand hygiene before entering and after leaving residents' room, after touching the resident and their environment, and after removing their [used/soiled] gloves. On 10/16/2024 at 9:24 AM, Staff C stated that Staff J should not have touched Resident 11's food with their bare hands. Staff C further stated they expected staff to perform hand hygiene before entering and after leaving the residents' room, after providing care, after removing soiled gloves, and after touching the residents' and their environment. On 10/16/2024 at 11:25 AM, Staff B stated that Staff J should not have touched Resident 11's food with their bare hands and that they should have used a fork or gloves when assisting the resident with their meals. Staff B further stated that Staff I should have performed hand hygiene prior to entering/after leaving the rooms for Residents 10, 5 and 7, and after touching the residents' and their environment. Reference: (WAC) 388-97-1320 (1)(a)(c)(5)(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505493	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Shore	1630 43rd Avenue East Seattle, WA 98112

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)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 48899 Based on observation, interview, and record review, the facility failed to ensure an effective pest control program was maintained to keep the facility free of fruit flies (small insects that are attracted to ripe, rotting, or fermenting fruits and vegetables) in the kitchen area of the facility. This failure placed residents at risk for infection, maggot infestation (small, worm like bugs that hatch from fly eggs) and a diminished quality of life. Findings included . Review of the facility's policy titled, Policy and Procedure - Pest Control, revised on 01/02/2024, showed, It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. Observation on 10/15/2024 at 10:30 AM, and at 10:43 AM showed fruit flies in the dish washing and hand wash areas of the kitchen. Another observation on 10/15/2024 at 11:04 AM showed flies in the kitchen fridge area (where ready to eat cold food were stored). During a joint observation and interview on 10/15/2024 at 11:07 AM with Staff N, Executive Chef, showed that one trash can was full and overflowing, while another trash can was unclean and had dark stains on the lid. Further joint observation showed flies on the wall near the trash can and landed on unwashed utensils that were returned from breakfast. Staff N stated that they would ensure the area was cleaned immediately and that there should have been no flies in the kitchen. On 10/16/2024 at 11:56 AM, Staff C, Assistant Director of Nursing/Infection Preventionist, stated that there should be no insects in the kitchen as that was unacceptable. On 10/16/2024 at 2:33 PM, Staff A, Health Services Administrator, stated that having flies in the kitchen is unacceptable and that they would arrange for the pest control team to come and inspect. Reference: (WAC) 388-97-3360 (1)