STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505239	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Rose Care Center	3919 South 19th Street Tacoma, WA 98405

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 46068 Based on interview and record review, the facility failed to provide a written decision for a grievance when requested for 1 of 3 residents (Resident 1) reviewed for grievances. This failure placed residents at risk for unmet care needs and resolution of voiced concerns. Findings included . Review of the facility's policy titled, Grievance Procedure, revised 08/2023, showed the resident/representative, has the right to obtain a written decision regarding their grievance. On 04/23/2024 at 12:22 PM, Collateral Contact 1, said they had not received a response to the grievances they had submitted to the facility. Review of Resident 1's progress notes, dated 02/06/2024, showed Resident 1's representative had requested a copy of the outcomes of all grievances filed on behalf of Resident 1 and requested the facility included the latest grievances related to staff's neglect to wear personal protective equipment, delay of informing them of quarantine protocol, inaccurate information in the resident's medical record and the outcome of missing medication patches. The progress notes further showed the facility responded that they had provided copies of past grievances, and they would meet with the representative to discuss the grievance procedure. On 04/29/2024 at 1:50 PM, Staff A, Administrator, said they believed the grievances that Resident 1's representative was requesting related to the staff use of personal protective equipment and quarantine protocol, had already been addressed and sent to the representative in September of 2023. When asked about the missing medication patches, Staff A said the facility had treated the issue as a medication error and therefore had not provided the resident representative with the written decision upon request. Staff A said they were aware that residents and resident's representatives had the right to obtain a written decision of a grievance. Reference WAC 388-97-0460

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on observation, interview and record review, the facility failed to ensure services provided met professional standards of practice for 1 of 3 residents (Resident 1). Facility nurses' failure to follow physician orders and only sign for tasks that were completed, placed residents at risk for medication errors, unmet care needs and potential negative outcomes. Findings included . Resident 1 was admitted to the facility on [DATE] with a diagnosis of chronic pain. On 04/23/2024 at 12:22 PM, Collateral Contact 1, said they were concerned that Resident 1's medication was not being administered per the physician's order and specifically that medication patches were not applied as documented. Resident 1's physician orders showed the resident had an order, dated 06/23/2024, for a Lidoderm Patch (medication to relieve pain) to be applied to the lower back in the morning and removed per schedule for chronic pain. Review of the schedule in the physician order showed the patch was to be applied daily at 8:00 AM and removed twelve hours later. On 04/29/2024 at 8:43 AM, Resident 1 was observed with a Lidoderm Patch on their lower back with a date on the patch of 04/27/2024. Staff C, Licensed Practical Nurse, observed the patch and said the patch was placed daily and a new patch should have been placed on 04/28/2024 and removed in the evening of 04/28/2024. Resident 1's Medication Administration Record, dated 04/01/2024 through 04/30/2024, showed documentation the Lidoderm Patch was removed on 04/27/2024 at 7:59 PM, applied on 04/28/2024 at 8:00 AM and removed on 04/28/2024 at 7:59 PM. On 04/29/2024 at 2:52 PM, Staff B, Director of Nursing, said they expected the licensed nurse would have removed the Lidoderm Patch on the evening of 04/27/2024, placed a new patch on 04/28/2024 and removed it on the evening of 04/28/2024. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46068 Based on observation, interview and record review, the facility failed to ensure infection control standards were followed related to use of required Personal Protective Equipment (PPE) with residents on Transmission Based Precautions (TBP) for 2 of 6 residents (Resident 2 and 6), cleaning resident equipment and performing hand hygiene between residents for 5 of 6 residents (Resident 2, 3 4, 5 and 7) reviewed for infection control. These failures placed residents at risk for facility acquired or healthcare-associated infections and related complications. Findings included . Review of the facility's policy titled, Transmission-Based Precautions, revised 03/2024, showed for residents placed on Enhanced Barrier Precautions (EBP), staff were required to wear gloves and gown during resident care activities: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs and device care. Review of the facility's policy titled, Hand Hygiene, revised 10/2017, showed staff were to perform hand hygiene before and after direct resident contact and upon and after coming in contact with a resident's skin (vitals). Review of the facility's policy titled, Resident Equipment Sanitation, revised 10/2017, showed non-critical items including blood pressure cuffs are devices that come into contact with intact skin and require disinfection between residents. On 04/23/2024 at 11:33 AM, Staff D, Certified Nursing Assistant (CNA), was observed entering Resident 2's room. A sign on the door showed EBP were to be utilized by staff. Staff D donned gloves and proceeded to change the pillowcase, replaced the pads on the bed and leaned against the bed while making it. Staff D bagged the used linens prior to exiting the room. On 04/29/2024 at 7:03 AM, Staff E, CNA, was observed entering Resident 1's room. Staff E was observed taking Resident 1's vital signs utilizing an electronic vital sign machine. Staff E proceeded to exit Resident 1's room without performing hand hygiene and/or cleaning the vital sign machine. Staff E immediately entered Resident 3's room without performing hand hygiene, took Resident 3's vital signs and then proceeded to exit the room without performing hand hygiene and/or cleaning the vital sign machine. Upon exiting Resident 3's room, Staff E entered Resident 4's room without performing hand hygiene and was observed taking Resident 4's vital signs and their roommate Resident 5's vital signs without performing hand hygiene between residents. Staff E proceeded to exit the room, performed hand hygiene, and placed the vital sign machine in the hallway without cleaning it. On 04/29/2024 at 7:25 AM, a sign was observed on Resident 6's door that showed the resident was on EBP and required all staff to perform hand hygiene prior to entering the room and to wear a gown and gloves for changing linens and direct resident care. Staff F, Nursing Assistant Registered (NAR), was observed entering Resident 6's room without performing hand hygiene and donned gloves. Staff F was observed leaning on the resident's bed, adjusting the linen and moving the resident up in the bed with the assistance of another staff member. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/29/2024 at 7:32 AM, Staff D, CNA, was observed entering Resident 2's room and taking the resident's vital signs with an electronic vital sign machine. A sign on the door showed EBP were to be utilized by staff. Staff D exited Resident 2's room and proceeded directly into Resident 7's room and was observed taking the resident's vital signs without cleaning the machine. On 04/29/2024 at 2:03 PM, Staff G, Infection Preventionist, said they expected staff to perform hand hygiene prior to caring for residents, including taking vital signs and the vital sign machine should be cleaned between residents, they need to clean the equipment every single time. Staff G said when residents are on EBP, they expected staff to wear a gown and gloves when they made beds, replaced pillowcases, and adjusted residents in bed. Staff G said they had just completed education with staff on EBP and hand hygiene and they expected staff to follow the facility's policies. Reference WAC 388-97-1320 (1)(c)(2)(c)