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	06/12/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46827 Based on observation, interview, and record review the facility failed to protect resident's rights to be free from abuse when facility policies and procedures were not implemented for 1 of 8 sampled residents (Resident 1) reviewed for abuse. Resident 1 was assessed for bilateral shoulder subluxation (dislocation) with no investigation conducted to rule out abuse/neglect. This failure placed all residents at risk of abuse, and a diminished quality of life. Findings included . Review of the facility policy Abuse/Neglect/Misappropriation/Exploitation with an original date of 10/2017 and a revised date of 10/2022 states All alleged incidents of abuse, neglect, misappropriation of resident property and injuries of unknown source are thoroughly investigated in order to determine what occurred and make necessary changes to the provision of care and services to prevent reoccurrences. Resident 1 was admitted to the facility on [DATE] with diagnsis of anoxic brain damage, not elsewhere classified. The Admission Minimum Data Set, an assessment tool, dated 05/17/2024, documented Resident 1 was dependent on staff via 2-person assist for transfers, bed mobility, and dressing. Resident 1 was assessed as severely cognitively impaired. A progress note, dated 05/15/2024, written by the facility provider, Staff C, Nurse Practitioner (NP), documented Patient is being seen today at request of OT (Occupational Therapy) for concerns of bilateral subluxed shoulders. On exam, patient has pillows under bilateral arms supporting her shoulders. Once pillow is removed, both shoulders appear to be subluxed. Right is able to be easily realigned but left shoulder triggers pain response and does not appear to be able to realign. No records in hospital documents of any injury or trauma that could results, but patient has a history of cardiac arrest requiring compressions. Record review of the facility incident log dated May 2024 had no entry or subsequent investigation for Resident 1's suspected injury of bilateral shoulder subluxation. Review of the electronic health record showed Resident 1 was not placed on alert status to monitor the suspected subluxed shoulders. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review showed Resident 1's care plan was not updated to include suspected bilateral shoulder subluxation. On 06/03/2024 at 1:49 PM, Staff D, Resident Care Manger (RCM)/Licensed Practical Nurse (LPN), said she was not aware of any injury to the resident until 05/17/2024 when Staff C, NP, asked for x-rays to be ordered to rule out bilateral shoulder subluxation. Staff D said X-ray services did not arrive to obtain the x-rays until 05/18/2024 as Resident 1 was being sent out to the hospital per the daughter's request. On 06/11/2024 at 1:50 PM, Staff B, Director of Nursing Services (DNS)/Registered Nurse (RN), said if there was a report of an injury of unknown origin the resident representative and the provider should be notified, and risk management should be completed. There should be notification made on the state hotline. Staff B said an investigation should be completed to rule out abuse/neglect and the care plan should be updated. Staff B said there was no risk management for this resident due to not having been informed of the injury prior to state informing her. REFERENCE WAC 388-97-0640(1).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46827 Based on interview and record review, the facility failed to provide written notification of the reason for transfer/discharge to the hospital, reason why resident cannot be readmitted to the facility, and appeal contact information to the resident or responsible party for 1 of 8 sampled residents (Resident 3) reviewed for facility-initiated discharge. This failure placed residents at risk for diminished protection from being inappropriately discharged . Findings included . Review of the facility policy, Admission/Transfer/Discharge with an original date of ,d+[DATE] and a revised date of ,d+[DATE] states 3. Prior to a facility-initiated discharge or transfer; the facility must provide notice of transfer or discharge and reasons to the resident, resident representative, and State Long-Term Care Ombudsman. Copies of these notifications will be retained in the resident recordand 7. The facility must notify resident in writing when the facility determines that the resident cannot be readmitted to the facility, the reason the resident cannot be readmitted to the facility, and the appeal and contact information specified. Resident 3 was admitted to the facility on [DATE] with diagnosis of malignant neoplasm of brain, unspecified (tissue growth exhibiting cancer cells). The Discharge Minimum Data Set (MDS), an assessment tool, dated [DATE], documented Resident 3 was dependent on staff via 2-person assist for transfers, bed mobility, and dressing. Resident 3 was assessed as severely cognitively impaired. Review of Resident 3's MDS tracking record showed Resident 3 discharged to the hospital on [DATE] with return anticipated. Review of Resident 3's electronic health record (EHR) showed no documentation that a written notice of transfer/discharge was provided to Resident 3 and/or a responsible party for the transfer to the hospital on [DATE]. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:05 AM, Collateral Contact 1 (CC1), said she spoke with the Admissions Director, at Park [NAME] Care Center, related to Resident 3 being ready to be readmitted back to the facility on [DATE]. CC1 said the Admissions Director said the facility would not accept resident back related to Resident 3 having a code status of Cardiopulmonary resuscitation (CPR, a lifesaving technique that's useful in many emergencies in which someone's breathing or heartbeat has stopped). CC1 said after this conversation Resident 3 was noted to have developed a fever and the resident was kept an extra day for monitoring at the hospital. On [DATE] CC1 spoke with the Executive Director related to Resident 3 being medically cleared for discharge back to[the facility]. CC1 said the Executive Director said they would not be accepting the resident back related to the resident's code status not having been changed to 'do-not-resuscitate' (DNR, when a person has decided not to have CPR attempted on them if their heart or breathing stops). CC1 said, on [DATE], she also received a message from the Admission Director at [the facility]. The message was a letter from the Director of Nursing Services stating the facility was unable to meet the complex needs of this resident, the resident was hemodynamically unstable, and they were unable to provide the medical equipment needed to care for the resident. CC1 said the only medical equipment needed to care for Resident 3 was a vent (ventilator is a machine that helps you breathe or breathes for you) and a hoyer lift (a device that holds the patient in a hammock-type sling to lift them completely up and transfer them) and that [the facility] was a vent unit and had multiple hoyer lifts. CC1 said it was the resident/resident representatives right to be CPR or DNR and not up to the facility. On [DATE] at 1:50 PM, Staff B, Director of Nursing Services (DNS)/Registered Nurse (RN), said Resident 3 was denied readmission related to the facility not being able to meet his needs. Staff B said that the resident was having issues with fluid volume overload (too much fluid in your body) that required daily labs and provider notification to make changes to his flushes (increase or decrease in flushes) which is not something that is sustainable in the facility 7 days a week. Staff B said Resident 3 required frequent hospitalization s due to his unstable health conditions. On [DATE] at 1:06 PM, Staff G, Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN), said that Trident lab comes in and draws all labs Monday thru Friday and then takes them to the lab to be processed. Only labs classified as STAT will be drawn on Saturdays and Sundays. If a STAT lab, then Trident will come in and draw the lab and transport the sample to the lab. Staff G said there is a provider on call 24 hours a day/7 days a week for the facility. At 2:12 PM, Staff A, Executive Director (ED), said if a resident declines a bed hold and the facility feels the resident's needs cannot be met then the facility would talk to the family and the hospital and let them know the reasoning. Staff A said Resident 3's code status was a concern as the resident remained CPR. And also, the concern related to the number of re-admissions to the hospital Resident 3 had related to fluid volume overload. Staff A was unable to locate documentation of the hospital and/or family being notified about declining readmission to facility. Staff A was unable to locate bed hold notice for [DATE] discharge to hospital. Reference WAC [DATE](2)(a-d), -0140 (1)(a)(b)(c)(i-iii)

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(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** 46827 Based on observation, interview, and record review, the facility failed to implement post-op (post-operation) recommendations/orders and to coordinate visits with outside specialty providers, per the health care provider's orders in a timely manner for 1 of 8 sampled residents (Resident 2) reviewed for quality of care. This failure placed residents at risk for delayed healing, health complications, and a diminished quality of life. Finding included . Resident 2 was admitted to the facility on [DATE] with diagnosis of malignant neoplasm of larynx, unspecified with laryngectomy (throat cancer with removal of the voice box). The Medicare 5-day Minimum Data Set (MDS), an assessment tool, dated 05/05/2024, documented Resident 2 required minimal assistance of 1-person for transfers, bed mobility, and dressing. Resident 2 was assessed as moderately cognitively impaired. <Recommendations/Orders> Record review of Resident 2's electronic health record (EHR) documented Resident 2 went to a follow up post-op laryngectomy appointment on 05/09/2024. The After Visit Summary documented an order for DIET - clear liquids x 1-2 days and full liquids x 2 weeks. Will follow up in clinic in 2 weeks to see if we can advance diet further at that time. This order was processed and shows on the physician orders, dated 05/24/2024, with no directions specified such as Referral to SLP (Speech Language Pathologist) per ENT (Ear Nose Throat) recommendations-Diet clear liquid x 1-2 days and then advance to full liquid x 2 weeks). This order was placed without communication to SLP or a diet slip forwarded to the kitchen. On 06/03/2024, the Speech therapist was notified of the diet order via the ENT liason and then wrote and delivered a diet slip communication to the kitchen. Without the diet slip the kitchen would not know there had been a change in diet status. During an interview on 06/03/2024 at 11:30 AM, Resident 2 said at breakfast that morning was the first time receiving any liquids to drink. Resident 2 said at the last 2 post-op appointments, on 05/09/2024 and 05/24/2024, he was told by the specialty doctor he was supposed to have been receiving liquids. <Appointments> Record review of Resident 2's EHR showed documentation of the following appointments: -05/28/2024-PET/CT scan (Positron Emission Tomography-imaging test that produces images of organs and tissues/Computed Tomography-shows details of each organ for a clear and precise view). Resident was a no call no show. Appointment rescheduled for 06/11/2024. -05/29/2024-Urology (medical field focusing on the urinary system) appointment related to foley catheter (flexible tubing inserted into bladder for urine drainage) use. Resident was a no call no show. Appointment rescheduled for 07/29/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-06/04/2024-ENT (Ear Nose Throat specialty) post-op appointment. Resident was a no call no show. Appointment rescheduled for 06/10/2024. -06/07/2024-Oncology/Hematology (medical field that deals with cancer and blood disorder/diseases) appointment. Resident was a no call no show. At time of investigation this appointment had not been rescheduled. On 06/03/2024 at 1:49 PM, Staff D, Resident Care Manager (RCM)/Licensed Practical Nurse (LPN), said that the process for residents with appointments was as follows: A packet gets sent with the resident. Upon the resident's return the packet should be given to the floor nurse. The floor nurse will then place the packet on the RCMs desk or in the RCM box. The RCM will then go through the packet and note any orders or scheduled appointments. If there are orders or appointments, then these will be processed. Staff D said that in this case the RCM was not working when the resident returned from the appointment. Staff D said she thought the packet got placed in the medical records box instead of the RCM box. Staff D said it wasn't until 05/24/2024 when Resident 2 went to his 2nd post-op appointment that she was notified by the office nurse that orders had not been implemented from the 1st post-op appointment (05/09/2024). Staff D said this prompted her to look through the miscellaneous section of Resident 2s chart to read the 1st post-op appointment paperwork. Staff D said she read orders to start a clear liquid diet. Staff D said she processed these orders on 05/24/2024. Staff D said she wouldn't have known about the orders dated 05/09/2024 if the doctor's office hadn't called her on 05/24/2024. At 2:03 PM, Staff E, Director of Rehab Services (DOR), said that the Speech Therapist (ST) assigned to Resident 2 was unaware of any orders involving clear liquid consumption until 06/03/2024. The ST became aware of these orders on 06/03/2024 and turned in an updated diet order to the kitchen. On 06/11/2024 at 1:24 PM, Staff D said she was unaware that Resident 2 did not go to the urology appointment set up for 05/29/2024 nor the oncology/hematology appointment set up for 06/07/2024. Staff D said the reason why Resident 2 did not make the post-op appointment at the ENT on 06/04/2024 is because a licensed nurse is required to go with Resident 2 related to his trach (tracheostomy-surgical hole in windpipe to assist in breathing) and due to callouts, there was not a licensed nurse to be spared. Staff D said the liaison from the specialty doctor office would also call with future appointments. Staff D said she would then input the appointments as orders and let medical records know so that transportation can be set up. Staff D said she made 4 copies of the appointment transportation slip. She gave one to the resident, one to staffing, one to medical records and kept one until after the appointment then she got rid of them. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 1:41 PM, Staff F, Medical Records Director said she sets up the transportation for all appointments. Staff F said the residents with trachs need to have a licensed nurse accompany them in case there is an issue with the trach. Staff F said she kept a spreadsheet for all appointments made. Staff F said there was no record on her spreadsheet or in her file containing all the transportation sheets for Resident 2's 05/28/2024 PET/CT, 05/29/2024 urology appointment, or 06/07/2024 oncology/hematology appointment. Staff F was able to locate the 06/04/2024 ENT appointment but due to lack of a licensed nurse to accompany Resident 2 the appointment was rescheduled for 06/10/2024. At 1:50 PM, Staff B, Director of Nursing Services (DNS)/Registered Nurse (RN), said the RCMs would review packets for orders and appointments. Appointments would be communicated to medical records who is responsible for setting up transportation. Staff B said the facility has revised this system recently to include reviewing appointment packets returning with residents at the daily clinical meeting to ensure orders have been reviewed by the in-house provider and implemented. REFERENCE WAC 388-97-1060 (1) .