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	10/24/2024

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on interview and record review, the facility failed to inform the resident's representative in advance of physician visits and changes to the plan of care for 1 of 3 residents (Resident 1) reviewed for resident rights. This failure placed residents and/or resident representatives at risk of not being fully informed of the risks and benefits before making decisions about care, lack of advocacy, and a diminished quality of life. Findings included . Resident 1 was admitted on [DATE] with diagnoses including heart disease, stroke and dementia. The Minimum Data Set Assessment, an assessment tool, dated 10/04/2024, showed the resident was severely cognitively impaired. Resident 1's care plan, revised on 01/24/2024, showed the resident had impaired cognitive function and staff were to anticipate and meet all needs resident is non-verbal. Resident 1's Power of Attorney for Health Care, dated 01/09/2018, showed the resident designated a power of attorney for healthcare (POA) to make health care decisions for them if they cannot and instruct doctors and other professionals how they would like to be treated if they were unable to tell them their wishes. Resident 1's Pharmacist Consultation Report, dated 06/13/2024, showed the pharmacist recommended a fasting lipid panel if consent was given and if the POA does not agree, please note here and scan this consult into PCC [electronic medical record]. Written on the report was a note that said please follow up w/ [with] POA regarding labs and signed by the medical provider. Resident 1's progress note, dated 07/02/2024, showed the POA had stipulated they did not want Resident 1 seen by any provider unless they were present. The note showed the facility staff agreed with the POA that email would be used as a form of communication if the facility was unable to contact the POA via the telephone. Resident 1's medical provider notes, dated 07/09/2024, showed the resident was seen for a routine MD follow-up visit. The note showed the resident was unable to participate in the evaluation. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's medical provider notes, dated 07/16/2024, showed the resident was seen for a comprehensive exam by the physician. The notes showed the resident was unable to report and their judgement and insight appear to be impaired. The note showed the physician's plan was to start baclofen (medication for muscle spasms). Resident 1's physician order, dated 07/16/2024, showed baclofen was ordered. Resident 1's lab result, dated 07/22/2024, showed the resident's ferritin (lab test that checks iron levels in the blood) level was high. Resident 1's progress note, dated 08/04/2024, showed the RD (dietician) adjusted the resident's TF (tube feeding) from 55 ml [milliliters] to 50 ml/hr [hour] to maintain current weight and decrease weight gain. Resident 1's medical provider notes, dated 08/09/2024, showed the resident was seen for a routine, scheduled MD follow-up visit. The notes showed the resident does not participate in the evaluation and the plan was to DC [discontinue] the iron and reassess the patient's ferritin levels within the next 2 weeks. Resident 1's physician order, dated 08/10/2024, showed the iron was discontinued. Resident 1's Pharmacist Consultation Report, dated 08/15/2024, showed the pharmacist recommended to reduce the famotidine (a medication that prevents heartburn) from BID (twice per day) to HS (at night). The report showed the medical provider accepted the recommendations from the pharmacist and wrote with the consent from the granddaughter. Resident 1's physician order, dated 09/16/2024, showed an order for a dermatology consult for blisters. Resident 1's provider notes, dated 09/18/2024, showed the resident was seen for a routine scheduled MD visit. The notes showed the resident still maintains in usual state and habit of no participation in evaluation, offering up no insight on exam. The note showed ferritin levels were pending. Review of Resident 1's electronic medical record on 10/15/2024, showed no documentation the resident's representative/POA was contacted before and/or after the physician visits, medication changes and/or treatment decisions outlined above. On 10/23/2024 at 4:23 PM, Collateral Contact (CC1), POA, said they had not been contacted before and/or after the physician visits on 07/09/2024, 07/16/2024, 08/09/2024 and 09/18/2024. CC1 said they had not been included in the discussion regarding iron and baclofen, TF changes, ferritin levels or the pharmacist recommendations. CC1 said they were not consulted on the dermatology consult and were unaware if it had occurred. CC1 said they had made it clear on numerous occasions to facility staff that they must be present at any medical provider visits to speak and advocate for Resident 1 because they were unable to advocate for themselves and/or communicate their concerns and wishes. CC1 said they deserved the opportunity to know the risks and benefits of any proposed medication and/or changes to the plan of care. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/2024 at 1:02 PM, Staff A, Director of Nursing, said they had reviewed Resident 1's medical record and discussed with facility staff and they could not find documentation CC1 had been contacted before and/or after the physician visits on 07/09/2024, 07/16/2024, 08/09/2024, 09/18/2024, and/or included in the discussion regarding iron and baclofen, TF changes, ferritin levels, pharmacist recommendations or the dermatology consult. Staff A said the facility should have notified CC1 prior to the physician visits and correlate a time for CC1 to be present. Staff A said the staff should have contacted CC1 prior to new medications, labs, TF changes, and pharmacist recommendations and obtained their permission and if they were not in agreement, notified the provider. WAC Reference 388-97-0300(3)(a),0260,1020(4)(a-b)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on interview and record review, the facility failed to ensure residents consistently received restorative care (movement of joints to maintain range of motion) to maintain or prevent declines in mobility for 2 of 3 residents (Residents 1 and 5) reviewed for range of motion (ROM)/mobility. This failure placed residents at risk for decreased mobility, pain and a diminished quality of life. Findings included . Resident 1 Resident 1 was admitted on [DATE] with diagnoses including stroke and dementia. The Minimum Data Set Assessment (MDS), an assessment tool, dated 10/04/2024, showed the resident was severely cognitively impaired, required substantial assistance for activities of daily living, had limitation in ROM on her upper extremities, lower extremities and participated in a restorative program. Resident 1's restorative care plan, initiated on 02/01/2024 and revised on 08/08/2024, showed the resident was on a restorative program to decrease risks of contractures. The care plan showed the following interventions: - Apply resting hand splint to left hand for 2 hours daily 5x wkly [weekly] - Apply splint to ankle on in AM and off in PM for 2 hours daily 5x wkly - Passive ROM to BUE [bilateral upper extremities] all joints prior to splint application 5x wkly - PROM [passive ROM] to BLE [bilateral lower extremities] 5x wkly On 10/08/2024 at 11:38 AM, Collateral Contact 1 (CC1), said that they visited the resident frequently and were concerned they were not receiving their restorative program consistently. CC1 said the program was sporadic and they saw the resident with a hand splint occasionally but had never seen an ankle splint on the resident. Resident 1's Documentation Survey Report, dated 06/01/2024 through 10/15/2024, showed the resident received their restorative program for their ankle splint four times. Resident 1's Documentation Survey Report, dated September 2024, showed the resident received their restorative program for their left-hand splint, ROM to BUE and BLE, 4 times the week of 09/15/2024 through 09/21/2024 and 3 times the week of 09/22/2024 through 09/30/2024. Resident 1's Documentation Survey Report, dated 10/01/2024 through 10/14/2024, showed the resident had not received their restorative program for their left-hand splint, and received ROM to BUE and BLE, 3 times the week of 10/01/2024 through 10/07/2024. Resident 5 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 5 was admitted on [DATE] with medically complex diagnoses. The MDS, dated [DATE], showed the resident required substantial assistance with their activities of daily living. Resident 5's restorative care plan, revised on 03/14/2023, showed the resident had a restorative program for a hand/wrist splint to be applied after ROM four hours daily and a strengthening program for their RUE [right upper extremity] three times a week. Resident 5's Documentation Survey Report, dated September 2024, showed the resident received their restorative program for their hand/wrist splint, 14 of 30 days and did not receive their strengthening program the week of 09/22/2024 through 09/30/2024. Resident 5's Documentation Survey Report, dated 10/01/2024 through 10/14/2024, showed the resident received their restorative program for their hand/wrist splint, three of 14 days and had received their strengthening program three days during the two-week period. On 10/24/2024 at 12:34 PM, Staff G, Restorative Program Oversight Registered Nurse, said they reviewed Resident 1 and Resident 5's restorative program. Staff G said the restorative programs for the residents were not completed consistently. Staff G said they were currently evaluating the restorative program at the facility and implementing corrective actions. WAC Reference 388-97-1060(3)(d)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on interview and record review, the facility failed to act on the consultant pharmacist's drug regimen review recommendations for 1 of 3 residents (Resident 1) reviewed for pharmacy services. This failure placed residents at risk for experiencing adverse side effects, medical complications, and a decreased quality of life. Findings included . Resident 1 was admitted on [DATE] with diagnoses including heart disease, stroke and dementia. The Minimum Data Set Assessment, an assessment tool, dated 10/04/2024, showed the resident was severely cognitively impaired. Resident 1's Pharmacist Consultation Report, dated 05/14/2024, showed the pharmacist recommended a fasting lipid panel (lab that monitors levels of fats in blood) to evaluate the effectiveness and to assist in adjusting medication therapy. The report showed the medical provider accepted the recommendation from the pharmacist and wrote consent was needed from the POA (power of attorney). Resident 1's Pharmacist Consultation Report, dated 06/13/2024, showed the pharmacist recommended a fasting lipid panel if consent was given and if the POA does not agree, please note here and scan this consult into PCC [electronic medical record]. Written on the report was a note that said please follow up w/ [with] POA regarding labs and signed by the medical provider. Review of Resident 1's electronic medical record on 10/15/2024, showed no documentation of a fasting lipid panel and no documentation the POA was contacted. Resident 1's Pharmacist Consultation Report, dated 08/15/2024, showed the pharmacist recommended to reduce the famotidine (a medication that prevents heartburn) from BID (twice per day) to HS (at night). The report showed the medical provider accepted the recommendations from the pharmacist and wrote with the consent from the granddaughter. Review of Resident 1's Medication Administration Record (MAR), dated October 2024, showed famotidine BID on the MAR and the licensed nurses were administering it twice per day. Review of Resident 1's electronic medical record on 10/15/2024, showed no documentation the granddaughter was contacted regarding the famotidine. On 10/24/2024 at 1:02 PM, Staff A, Director of Nursing, said the staff should have contacted the POA with the pharmacist's recommendations and if the POA consented, carried out the recommendations and if the POA did not consent, notify the provider. Staff A said they found no documentation in the medical record that this occurred. WAC Reference 388-97-1300 (4)(c).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46068 Based on interview and record review, the facility failed to administer a medication in accordance with provider orders for 1 of 3 residents (Resident 1) reviewed for medications. This failure placed residents at risk for medical complications, adverse side effects and a diminished quality of life. Findings included . Resident 1 was admitted on [DATE] with diagnoses including stroke and dementia. The Minimum Data Set Assessment, an assessment tool, dated 10/04/2024, showed the resident was severely cognitively impaired and on a pain medication regimen. On 10/08/2024 at 12:36 PM, Collateral Contact 1, said they were concerned about Resident 1's pain patches and thought the nurses were not administering them correctly. Resident 1's physician order, dated 08/14/2024, showed an order for a Fentanyl (medication to treat severe pain) patch to be applied transdermal (application of a drug through the skin) every 72 hours for pain. Resident 1's physician order, dated 01/25/2024, showed an order for 2 nurses to be present with application of the Fentanyl patch. Resident 1's Medication Administration Record (MAR), dated 08/01/2024 through 08/31/2024, showed on 08/16/2024 at 8:00AM, the MAR was signed off that 2 nurses were present for the application of the patch. On 08/17/2024 at 10:00 AM (27 hours later), the Fentanyl patch was signed off as administered. Resident 1's Narcotic Administration Record showed a Fentanyl patch was removed from the supply on 08/16/2024 and on 08/17/2024. Resident 1's Medication Administration Record (MAR), dated 09/01/2024 through 09/30/2024, showed on 09/19/2024 at 10:00AM, the Fentanyl patch was signed off as administered. On 09/21/2024 at 8:00 AM (50 hours later) the MAR was signed off that 2 nurses were present for the application of the patch. Resident 1's Narcotic Administration Record showed a Fentanyl patch was removed from the supply on 09/19/2024 and 09/21/2024. On 10/24/2024 at 1:02 PM, Staff A, Director of Nursing, said the licensed nurses had not followed the physician order for administration of the Fentanyl patch. Staff A said it was a medication error and an incident report should have been completed, the resident placed on alert monitoring and the medical provider and resident's representative should have been notified. WAC Reference 388-97-1060 (3)(k)(iii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46068 Based on observation, interview and record review, the facility failed to ensure 3 of 3 staff members (Staff B, C and D) used personal protective equipment (PPE) in accordance with the Centers for Disease Control (CDC) guidelines when caring for residents with known COVID 19 (an infectious virus causing respiratory illness) infections and failed to ensure 1 of 3 staff (Staff E) performed hand hygiene during care. This failure placed residents at risk of infection and contracting and spreading COVID 19. Findings included . A 06/24/2024 CDC update titled, Recommended routine infection prevention and control practices during the COVID-19 pandemic, showed when health care personnel enter the room of a patient with suspected or confirmed COVID 19, they should use a N95 respirator (a mask that filters 95% of airborne particles), gown, gloves, and eye protection. When a N95 respirator was used during the care of a resident with a COVID 19 infection, they should be removed and discarded after the resident care encounter. A 02/27/2024, CDC guidance titled, Clinical Safety: Hand Hygiene for Healthcare Workers, showed if a task requires gloves, perform hand hygiene before donning gloves and immediately after glove removal. The guidance showed gloves were to be changed when moving from work on a soiled body site to a clean body site on the same patient. Staff B Review of Resident 2's progress note, dated 10/14/2024, showed on 10/13/2024, the resident tested positive for COVID 19 and was placed on aerosol contact precautions (guidelines that indicate staff to wear gown, N95, gloves, and eye protection when entering room). An observation on 10/15/2024 at 11:34 AM showed Staff B, Certified Nursing Assistant (CNA), entered Resident 2's room wearing a N95 respirator, gown, gloves and face shield. Prior to exiting Resident 2's room, Staff B removed their gown and gloves and performed hand hygiene. Staff B exited the room and removed their face shield and laid it on a cart outside the room. Staff B had not removed or discarded their N95 respirator. Staff B continued to wear the N95 respirator and entered a resident's room with no aerosol contact precautions. Staff B assisted the resident with a task and proceeded down the hallway and off the unit. On 10/15/2024, at 12:25 PM, Staff B, said when they entered the room of a resident that is positive for COVID 19 and on aerosol contact precautions, they wore a gown, gloves, and face shield. Staff B said when they exited the room, they removed their gown and gloves. Staff B said they kept their N95 on and changed it every now and then. Staff C Review of Resident 3's progress note, dated 10/14/2024, showed the resident tested positive for COVID 19 and was placed on aerosol contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 10/15/2024 at 11:54 AM showed Staff C, CNA, entered Resident 3's room wearing a N95 respirator, no gown, no gloves and no face shield. Staff C exited the room, and without changing the N95 respirator, proceeded to the lunch tray cart, obtained a lunch tray and took the tray into a resident's room that was not on aerosol precautions and was not positive for COVID 19. At 11:57 AM, Staff C went back into Resident's 3 room, with a N95 respirator on, no gown, gloves and/or face shield. Staff C exited the room with the same N95 respirator on and proceeded to interact and engage with a resident in the hallway that was not wearing a mask. On 10/15/2024 at 12:28 PM, Staff C, CNA, said after exiting a resident's room that was positive for COVID 19 they had to remove their gown and gloves but did not have to remove the N95 mask and/or the face shield, not that I have been told. Staff D Review of Resident 4's progress note, dated 10/14/2024, showed on 10/13/2024, the resident tested positive for COVID 19 and was placed on aerosol contact precautions. An observation on 10/15/2024 at 12:07 PM showed Staff D, Licensed Practical Nurse (LPN), entered Resident 4's room wearing a N95 respirator, gown, gloves and face shield. Prior to exiting Resident 4's room, Staff D removed their gown and gloves. Staff D exited the room and had not removed or discarded their N95 respirator and/or the face shield. Staff D, with the same N95 respirator and face shield on, stopped in the hallway and engaged in conversation with another resident, then proceeded down the hallway and off the unit. On 10/15/2024 at 12:22 PM, Staff D, LPN, said that staff wore the same N95 respirator and face shield during their shift and changed it on breaks and at end of their shift. Staff D said they did not have to change their N95 respirator after they cared for a resident with a COVID 19 infection. Staff E On 10/08/2024 at 11:48 AM, Staff E, CNA, was observed providing care to Resident 1 in bed. Staff E had a gown and gloves on. Staff E turned Resident 1 over on their side and proceeded to clean the resident's buttocks with a wet wipe. There was bowel movement observed between the resident's buttocks. Staff E removed the bowel movement with the wipe, threw the wipe into a plastic bag and without changing their gloves and/or performing hand hygiene, obtained a clean brief from the closet. Staff E placed the clean brief on the resident, pulled the resident's dress down and covered the resident with blankets. Staff E then removed their gown, gloves and performed hand hygiene. On 10/15/2024 at 1:46 PM, Staff F, Infection Preventionist, said the facility follows the CDC guidelines for infection control. Staff F said when residents test positive for COVID 19 they are placed on aerosol contact precautions and the staff must wear a gown, gloves, N95 respirator and a face shield when they entered the room. Staff F said when staff exited the room they must remove the gown, gloves, N95 respirator and the face shield. Staff F said they expected staff to remove their gloves and perform hand hygiene after providing incontinent care to a resident and reapply clean gloves to finish the care. WAC Reference 388-97-1320(1)(c)(2)(b)