

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2024
NAME OF PROVIDER OR SUPPLIER Park Rose Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46827</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services by transcribing orders with stop dates for medications that should be on-going for 1 of 5 sampled residents (Residents 1) reviewed for pharmacy services and the facility failed to consistently reconcile controlled medications correctly for 1 of 5 sampled residents (Resident 2) reviewed for medication storage. These failures placed residents at risk for inadequate and/or ineffective treatment of underlying medical conditions, risk for misappropriation/diversion of controlled medications, and other negative health outcomes.</p> <p>Findings included .</p> <p><Pharmaceutical Services></p> <p>Review of the policy titled 4.4 New Orders for Non-Controlled Substances, last revised on 01/01/2013, states 1. Facility should provide information regarding a new admission order to Pharmacy using a completed and reconciled physicians order sheet, telephone order sheet, or an electronically transmitted medication order.</p> <p>Resident 1 was admitted to the facility on [DATE] with multiple diagnoses including Diabetes Mellitus II (a disease of the pancreas that produces a hormone to assist in regulating blood sugar levels), Epilepsy unspecified (a disease involving unprovoked seizures), and Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis or weakness of right side of body following a stroke (blood flow to brain is reduced or blocked)). The Admission Minimum Data Set (MDS-an assessment tool), dated 10/05/2024, documented Resident 1 was severely cognitively impaired.</p> <p>Review of the October 2024 electronic Medication Administration Record (eMAR) documents the following orders as started on 10/01/2024 and ended on 10/31/2024:</p> <p>-Cyclobenzaprine HCL tablet 5 milligram (MG) Give 1 tablet via PEG-Tube (a feeding tube that is inserted through the abdomen and into the stomach) every 8 hours as needed for muscle spasms (involuntary contractions of a muscle) for 30 days.</p> <p>-Insulin Glargine- subcutaneous solution 100 units/milliliter (ML) inject 5 units subcutaneously one time a day for Diabetes Mellitus II for 30 days.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Isosorbide Dinitrate oral tablet 20 MG give one tablet via PEG-Tube two times a day for Hypertension (HTN-high blood pressure a condition in which the force of the blood against the artery walls is too high) for 30 days. Hold for systolic blood pressure (SBP) less than 100 or Heart rate (HR) less than 60.</p> <p>-Keppra Oral Solution 100 MG/ML (Levetiracetam) Give 7.5 ML via PEG-Tube every 12 hours for Epilepsy for 30 days.</p> <p>-Prevacid Solutab dispersible 30 MG (Lansoprazole) Give one tablet via PEG-Tube one time a day for Gastroesophageal reflux disease (GERD-a digestive condition that occurs when stomach contents flow back up into the esophagus) for 30 days.</p> <p>Review of the November 2024 eMAR showed these medications were restarted on 11/19/2024.</p> <p>During an interview on 12/09/2024 at 12:50 PM, Staff D, Licensed Practical Nurse (LPN)/ Resident Care Manager (RCM), said she input orders into the que from the discharge orders received from the hospital and if there was a stop date included on that order she would add the stop date to the queued orders. Staff D said after the orders were in the que she and the floor nurse for the resident usually verified the orders then confirmed them. Staff D said she now knows not to include the stop dates from the hospital because the hospital orders are usually set up as if the resident is going home and following up with their Primary Care Physician (PCP) instead of admitting to a facility.</p> <p>At 1:23 PM, Staff C, LPN/ Assistant Director of Nursing (ADON), said orders should not be transcribed into Point Click Care (PCC) from the hospital discharge orders without a stop date unless it's for an antibiotic or some other medication that should not be administered on an ongoing basis. ADON said if the admitting nurse had a question about a medication, the provider should be notified and the orders reviewed for any changes prior to the orders being sent to the pharmacy for filling.</p> <p><Medication Storage></p> <p>Review of the policy titled Shift Verification of Controlled Substances, revised 2013, states 2 licensed nurses shall reconcile all doses of controlled substances stored in the assigned medication cart at the change of each shift. The oncoming nurse shall inspect each package of controlled medication and read the remaining quantity in each package. The off-going nurse shall read the remaining quantity documented on each resident Controlled Substance Declining Inventory Record and record their findings .If the quantities do not match, notify the Nursing Supervisor immediately to initiate an investigation.</p> <p>Resident 2 was admitted to the facility on [DATE] with multiple diagnoses including Chronic pain syndrome (persistent pain lasting weeks to years). The Quarterly MDS, dated [DATE], documented Resident 02 was severely cognitively impaired.</p> <p>Review of Resident 2's eMAR shows an active order dated 07/29/2024 for Lorazepam 1 mg by mouth every 6 hours for Anxiety (feelings of unease, worry, or fear often in response to imminent or perceived threats) and every 2 hours as needed times 14 days. The as needed portion of the Lorazepam order discontinued on 08/13/2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of the narcotic book, page 32, for the 300 hall second cart, documented a blister pack with 7 remaining tablets of Lorazepam for Resident 2 last administered on 11/17/2024 at 5:15 AM. The same narcotic book, page 33, documents a new full blister pack of Lorazepam tablets for Resident 2 with the first administration dated 11/16/2024 at 0000 AM. The next entries for page 33 are 11/17/2024 at 12:10 PM, 11/17/2024 at 5:30 PM with on-going entries.</p> <p>Review of facility investigation, dated 11/20/2024, showed the unaccounted for 7 tablets of Lorazepam were not discovered as missing until 11/20/2024 during the narcotic count between the day shift nurse and the evening shift nurse.</p> <p>During an interview on 12/09/2024 at 1:23 PM, Staff C, LPN/ADON, said an investigation was completed and it was determined the off-going nurse was not going through the narcotic books page by page instead the on-coming nurse was calling out the blister pack numbers with the off-going nurse flipping to that page in the narcotic book.</p> <p>Reference WAC 388-97-1300 (1) (a) (2)</p>		