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	09/12/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a thorough investigation for 3 of 4 residents (Resident 1, 2 & 3), reviewed for incident investigations. This failure placed the residents at risk for repeated incidents, unidentified abuse and/or neglect, and a diminished quality of life.Findings included .Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2015, showed, A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abuse, neglect, abandonment personal and/or financial exploitation or misappropriation of resident property occurred, and how to prevent further occurrences . All incidents require thorough investigation and reporting, as necessary, according to state and federal regulations.If the suspected perpetrator is staff, interview the other residents the staff person was assigned to.Review of the facility's policy titled, Policy and Procedure Abuse/Neglect, revised on 03/31/2025, showed, It is this facility's policy that all suspected, alleged, or actual cases of resident abuse including injuries of unknown origin, shall be thoroughly investigated, and reported according to State and Federal regulations. The policy further showed that it is the facility's investigation procedure that conducts interviews of all the people involved, including the residents. RESIDENT 1Resident 1 was admitted to the facility on [DATE] with diagnosis that included dementia (conditions that cause a decline in cognitive abilities, such as memory, thinking, and reasoning). Review of the quarterly Minimum Data Set (MDS - an assessment tool) dated 08/01/2025, showed Resident 1 had severe cognitive impairment and was dependent on staff with all aspects of care. It further showed that Resident 1 had a chronic disease that may result in a life expectancy of less than six months and was on hospice (comfort-focused care for people who are terminally ill and can no longer be cured by treatment).Review of the July 2025 Medication Administration Record (MAR) showed Resident 1 had an order for Morphine sulfate (a pain medication) every six hours for pain and shortness of breath. Further review of the MAR showed that Resident 1's routine morphine was signed as received on the evening of 07/29/2025 at 8:00 PM but the medication was not taken out from the controlled drug box or signed out in the controlled drugs logbook. Review of the facility investigation document titled, Medication Error, dated 07/30/2025 showed Resident 1 did not receive their routine morphine on the evening of 07/29/2025 at 8:00 PM. The investigation showed Staff D, Registered Nurse (RN), was interviewed and the staff stated they were unaware that they missed giving the scheduled morphine to Resident 1. Further review of the investigation did not show if interviews of other residents Staff D was assigned to was conducted or abuse or neglect was ruled out. RESIDENT 2Resident 2 admitted to the facility on [DATE] with diagnoses that included dementia and pain. Review of the quarterly MDS dated [DATE], showed Resident 2 had severe cognitive impairment and was dependent on staff with all aspects of care. It further showed that Resident 2 had a chronic disease that may result in a life expectancy of less than six months and was on hospice care. Review of the July 2025 MAR showed Resident 2 had an order for Pregabalin (a pain medication for nerve pain) at bedtime for pain. Further review of the MAR showed Resident 2's routine Pregabalin was signed as received on 07/19/2025, 07/21/2025, 07/23/2025, 07/28/2025, 07/29/2025 at 8:00 PM but the medication was not taken out from the controlled drug box or signed out in the controlled drugs logbook for these five days. Review of the facility investigation document titled, Medication Error, dated 07/30/2025 showed Resident 2 had several missed doses of routine Pregabalin. The investigation showed Resident 2 did not receive their routine Pregabalin scheduled at 8:00 PM from the following contract staff assigned to the resident:-On 07/19/2025 and 07/21/2025 Staff E, RN-On 07/23/2025 and on 07/28/2025 Staff F, RN-On 07/29/2025 Staff DThe investigation showed Staff D, Staff E, and Staff F were interviewed but the investigation did not show if interviews with other residents assigned to these staff were conducted.In an interview on 08/20/2025 at 10:29 AM, Collateral Contact 1 (CC1), stated that they witnessed an unknown contract license nurse attempting to administer wrong medication to Resident 2. CC1 further stated they stopped the staff and reported the incident to the facility. RESIDENT 3Resident 3 was admitted to the facility on [DATE] with diagnosis that included gout (sudden, severe attack of pain, swelling, and redness in a joint). Review of the admission MDS dated [DATE], showed Resident 3 had intact cognition and had occasional pain that was treated with scheduled and as needed pain medication. Review of the July 2025 MAR showed Resident 3 had an order for oxycodone (a pain medication) 5 milligram (mg - unit measurement) as needed daily for pain. Further review of the MAR showed Resident 3's oxycodone 5 mg was signed as received on

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide routine and as needed medications as prescribed by the physician to meet the needs of 3 of 3 residents (Residents 1, 2 & 3), failed to ensure controlled drugs were accurately accounted for and timely discarded for 2 of 2 residents (Residents 1 and 4), reviewed for medication management and controlled drugs. In addition, the facility failed to document medication administration in accordance with professional standards for 1 of 1 resident (Resident 5), reviewed for medication administration. These failures placed residents at risk for uncontrolled pain, medication errors, negative outcomes, and placed the facility at risk for potential loss and/or drug diversion of the controlled medications.Findings included.Review of the facility's document titled, Medication Administration-General Guidelines, revised on [DATE], showed, Medications are administered in accordance with written orders of the prescriber. The individual who administers the medication dose records the administration on the resident's MAR [Medication Administration Record] directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented.Review of the facility's policy titled, Medication Destruction (Narcotic [or controlled medications]) Policy, revised on [DATE], showed, It is the policy of this Skilled Nursing Facility to ensure the safe, timely, and compliant destruction of all unused, discontinued, or expired controlled medications in accordance with [NAME] Administrative Code (WAC 246-865-060) and federal regulations. All other discontinued/unused controlled substances: Destroyed within 90 days. MEDICATION MANAGEMENTRESIDENT 1Resident 1 was admitted to the facility on [DATE] with diagnosis that included dementia (conditions that cause a decline in cognitive abilities, such as memory, thinking, and reasoning).Review of the quarterly Minimum Data Set (MDS - an assessment tool) dated [DATE], showed Resident 1 had severe cognitive impairment and was dependent on staff with all aspects of care. It further showed that Resident 1 had a chronic disease that may result in a life expectancy of less than six months and was on hospice (comfort-focused care for people who are terminally ill and can no longer be cured by treatment).Review of the [DATE] MAR showed Resident 1 had an order for Morphine sulfate (a controlled pain medication) every six hours for pain and shortness of breath. Further review of the MAR showed that Resident 1 received their routine morphine on the evening of [DATE] at 8:00 PM but the medication was not taken out from the controlled drug box or signed out in the controlled drugs logbook.Review of the [DATE] MAR showed Resident 1 had an order for Morphine sulfate every four hours for pain and shortness of breath. Further review of the MAR showed that Resident 1 received their routine morphine on the evening of [DATE] at 8:00 AM but the medication did not show it was taken out from the controlled drug box or signed out in the controlled drugs logbook in page #007.RESIDENT 2Resident 2 admitted to the facility on [DATE] with diagnoses that included dementia and pain.Review of the quarterly MDS dated [DATE], showed Resident 2 had severe cognitive impairment and was dependent on staff with all aspects of care. It further showed that Resident 2 had a chronic disease that may result in a life expectancy of less than six months and was on hospice.Review of the [DATE] MAR showed Resident 2 had an order for Pregabalin (a pain medication for nerve pain) at bedtime for pain. Further review of the MAR showed Resident 2 received their routine Pregabalin on [DATE], [DATE], [DATE], [DATE], [DATE] at 8:00 PM but the medication did not show it was taken out from the controlled drug box or signed out in the controlled drugs logbook for the above dates.RESIDENT 3Resident 3 was admitted to the facility on [DATE] with diagnosis that included gout (sudden, severe attack of pain, swelling, and redness in a joint).Review of the admission MDS dated [DATE], showed Resident 3 had intact cognition and had occasional pain that was treated with scheduled and as needed pain medication.Review of the [DATE] MAR showed Resident 3 had an order for oxycodone (a controlled pain medication) 5 milligram (mg - unit measurement) as needed daily for pain. Further review of the MAR showed that Resident 3 received 5 mg of oxycodone on [DATE] at 6:00 PM but the medication did not show it was taken out from Resident 3's oxycodone stored in the controlled drug box or signed out in the controlled drugs logbook in page #109.Review of the facility investigation document titled, Medication Error, dated [DATE] showed Resident 3 did receive a wrong dose of oxycodone 2.5 mg from Resident 4's medication on [DATE].In an interview on [DATE] at 10:29 AM, Resident 3 stated that they were not aware that they had received a wrong dose of oxycodone on [DATE].CONTROLLED DRUGS MANAGEMENTRESIDENT 1During a joint observation and interview on [DATE] at 1:41 PM with Staff C