

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505493	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Park Shore		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure handrail/support bars in resident bathrooms were maintained and were safe to use for 3 of 4 residents (Residents 23, 24 & 25) and failed to ensure plastic bags were not used as light switch pullcords for 2 of 4 residents (Residents 24 & 11), reviewed for environment. Additionally, the facility failed to ensure a homelike environment when medications were administered in the dining room for 1 of 11 residents (Resident 2), reviewed for medication administration. These failures placed the residents at risk for injury, a less than homelike environment, and a diminished quality of life. Findings included. Review of the facility's undated policy titled, Physical Environment, Maintenance, and Housekeeping Policy and Procedure, showed that the facility shall maintain a clean, well-maintained, hazard-free environment that supports resident health, safety, infection prevention, and quality of life. Review of the facility's policy titled, Homelike Environment Policy, revised on 01/01/2025, showed that the facility will ensure that the physical environment is safe, clean, orderly, and as homelike as possible. It further showed that the facility will promote a person-centered care environment that minimizes institutional characteristics while maintaining compliance with life safety, infection prevention, and resident safety standards. RESIDENT 23 Observations on 12/02/2025 at 11:00 AM and on 12/03/2025 at 11:06 AM showed that the handrail/support bar in Resident 23's bathroom was not secured and was coming away from the wall. RESIDENT 24 & 25 (room [ROOM NUMBER]) Observation on 12/02/2025 at 1:48 PM and on 12/03/2025 at 11:50 AM showed the light switch pullcord above Resident 24's bed had a plastic bag tied to it. It further showed that the handrail/support bar in Resident 24 and Resident 25's bathroom was loose/wobbly. RESIDENT 11 Observation on 12/02/2025 at 11:28 AM and on 12/03/2025 at 12:00 PM showed the light switch pullcord above Resident 11's bed had a plastic bag tied to it. In an interview and joint observation on 12/03/2025 at 2:09 PM, Staff S, Certified Nursing Assistant (CNA), stated that if the handrails in a resident's bathroom were loose/wobbly they would notify the nurse and put in a maintenance request. Staff S stated that the plastic bags were being used to extend the light switch pullcord so residents could reach it. Joint observation of Resident 24's room showed a short light switch pullcord attached to a plastic bag. It further showed the handrail/support bar in Resident 24 and Resident 25's bathroom was loose/wobbly. Staff S stated, it's [it is] a little wobbly, could be tighter. Joint observation of Resident 11's room, showed Staff S pointed at the light (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	switch pullcord and stated that it has the plastic bag attached. Joint observation of Resident 23's bathroom handrail/support bar showed that it was not secure, and Staff S stated, it looks like it's coming off [from the wall] a little. In an interview and joint observation on 12/03/2025 at 11:53 AM, Staff T, Director of Facilities, stated that they checked resident rooms weekly. Staff T stated that they expected staff to put in a work order if they noticed anything in disrepair. Joint observation at 3:15 PM with Staff U, Maintenance Supervisor, showed that the bathroom handrail/support bar in Resident 23's bathroom was not secured and was coming away from the wall. Staff U stated, looks like the dry wall is cracking, definitely not safe, need to replace the wall. Joint observation of Resident 24 and Resident 25's bathroom showed that the handrail/support bar was loose/wobbly. Staff U stated that the handrail was for sure loose, needs to be tightened. It might need to be replaced. It further showed that there was a plastic bag attached to the light switch pull cord above the beds of Resident 24 and Resident 11. Staff U stated that the plastic bags were added by CNAs to make the light switch easier to pull. Staff U further stated that they had connectors that could be used instead and the plastic bags shouldn't [should not] be used. In an interview on 12/08/2025 at 8:16 AM, Staff A, Administrator, stated they expected maintenance to do some walkthroughs [of resident rooms] and as needed. Staff A stated they expected loose/wobbly handrails in resident bathrooms to be reported to maintenance if they need to be tightened. When asked about the plastic bags tied to the light switch pull cords in some of the resident rooms, Staff A stated, I never heard of that. Joint observation of Resident 24's room showed a short light switch pullcord attached to a plastic bag. Staff A stated, it's not ideal. RESIDENT 2 Observation on 12/02/2025 at 12:20 PM, Staff F, Registered Nurse, administered Morphine Sulfate (medication to treat pain) to Resident 2 who was sitting upright in their wheelchair at the dining room table with food in front of them and one other unknown resident at the dining room table. In an interview on 12/02/2025 at 12:22 PM, Staff F stated Resident 2 did not take their medications in the dining room and that they should not have administered their medications in the dining room. Review of Resident 2's comprehensive care plan and physician orders printed on 12/03/2025 showed no documentation that Resident 2 received their medications in the dining room. In an interview and joint record review on 12/03/2025 at 2:05 PM, Staff B, Director of Nursing Services, stated that a resident could take their medications in the dining room if they agreed and if it was care planned. Joint record review of Resident 2's physician orders, care plan, and nursing tasks did not show Resident 2 could take their medications in the dining room. Staff B stated they did not see it in the physician orders, care plan, or nursing tasks to give Resident 2's medications in the dining room and that it should have been care planned that they agreed to take it in the dining room. Reference: (WAC) 388-97-0880 (1) .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were secured for 2 of 2 medication carts (Medication Cart 1 and Medication Cart 2), reviewed for medication storage. This failure placed the residents at risk to have unintended access to medications and biologicals that should have been locked and/or compromised medications. Findings included. Review of the facility's policy titled, Medication Administration-General Guidelines, revised in January 2023, showed that the medication cart is kept closed and locked when out of sight of the medication nurse or aide. Observation on 12/02/2025 at 11:21 AM, showed Medication Cart 1 and Medication Cart 2 were unlocked, parked, and unattended at the nurse's station. In an interview and joint observation on 12/02/2025 at 11:26 AM, Staff F, Registered Nurse, stated that the medication cart should have been locked when they were not near them. Joint observation showed Medication Cart 1 and Medication Cart 2 were unlocked. Staff F stated they should have been locked. In an interview on 12/03/2025 at 2:05 PM, Staff B, Director of Nursing Services, stated that when the nurse leaves the medication cart, it should be locked. Staff B stated they expected Medication Cart 1 and Medication Cart 2 to have been locked as any resident or someone could get into the medication cart and access it if it was unlocked. Reference: (WAC) 388-97-1300 (2).		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure foods were handled appropriately in accordance with professional standards of food safety for 5 of 5 refrigerators (PM [Evening] Production Floor Refrigerator, Walk-in Main 2 Refrigerator, Dairy Healthcare (HC)/Assisted Living (AL)] Dressing 3 Refrigerator, Second Floor Kitchen Refrigerator & Second Floor Resident Supplement Refrigerator), reviewed for food services. The failure to label and discard food items past the use by/best by date, placed the residents at risk for foodborne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life. Findings included. Review of the facility's policy titled, Date Marking for Food Safety, revised on 08/01/2025, showed, The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The policy showed, The individual opening and preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. The policy further showed, The Head [NAME] or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. PM PRODUCTION FLOOR REFRIGERATOR In an interview and joint observation on 12/02/2025 at 9:11 AM, Staff M, Cook, stated that any food items that have been opened needed to be labeled with an open date and expiration date. Staff M stated that if food items were past the use by or expiration date, it should be discarded. Joint observation showed one uncovered container of green peas with no label or use by date. Staff M stated that it should have been covered and labeled. WALK-IN MAIN 2 REFRIGERATOR Joint observation and interview on 12/02/2025 at 9:15 AM with Staff M, showed the following: -One plastic container of celery with use by date of 12-1 [12/01/2025]. -One large plastic container labeled Casserole Sauce with use by date of 11-28-25 [11/28/2025]. -One plastic container labeled Limon [Lemon] with use by date of 12/01/2025. -One plastic container labeled Pepperoncini with use by date of 11/30/2025. -One plastic container of Pico de Gallo [salsa] with use by date of 11/30/2025. Staff M stated that food items that were past the use by date should have been thrown out as soon as it was noticed. Staff M further stated that everyone was responsible for checking. DAIRY HC/AL DRESSING 3 REFRIGERATOR Joint observation and interview on 12/04/2025 at 10:48 AM with Staff L, Executive Chef, showed the following items: -One plastic container labeled Romaine lettuce with use by date of 12/02/2025. -One plastic container labeled Mandarin Oranges with use by date of 11/30/2025. -One opened container of Dannon (brand name) Vanilla low fat yogurt labeled with preparation date of 11/11 [11/11/2025] with no use by date. Further observation showed that the container had a best if used by date of 11/28/2025. -Four unopened containers of Dannon Vanilla low fat yogurt with best if used by date of 11/28/2025. -Three unopened Yoplait [brand name] original yogurt with best by date of 12/02/2025. Staff L stated that if food items were past the use by or best by date, they would be discarded. Staff L further stated that the above items should have been discarded and that the opened container of Dannon Vanilla low fat yogurt should have been labeled with the use by date. SECOND FLOOR KITCHEN REFRIGERATOR Joint observation and interview on 12/05/2025 at 2:24 PM with Staff N, Dietary Manager, showed one red raspberry Yoplait yogurt with best by date of 12/03/2025. Staff N stated that it should have been discarded. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/05/2025 at 3:23 PM, Staff A, Administrator, stated that they expected food items to be labeled and those that were past the used by/best by date should be discarded. SECOND FLOOR RESIDENT SUPPLEMENT REFRIGERATORJoint observation and interview on 12/03/2025 at 8:35 AM with Staff C, Assistant Director of Nursing, showed that the Second Floor Resident Supplement Refrigerator in the medication room had four unopened Swiss Miss (brand name) butterscotch puddings with a use by date of 10/07/2025 on the bottom shelf. Staff C stated that the four puddings with the use by date of 10/07/2025 should have been discarded.In an interview on 12/03/2025 at 2:00 PM, Staff A stated they expected the four puddings to have been discarded. Staff A stated food items expired or past the use by date should have been discarded.Reference: (WAC) 388-97-1100 (3)		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precaution (EBP-precaution to protect residents from multidrug-resistant organism [a germ that is resistant to medications that treat infections]) practices were followed for 2 of 9 residents (Residents 5 & 2), and failed to ensure Transmission Based Precautions (TBP- measures put in place to prevent spread of infection by staff wearing Personal Protective Equipment [PPE-use of gown, gloves, mask and/or face shield] before entering a resident's room or environment) practices were followed for 1 of 1 resident (Resident 1), reviewed for infection control. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included. EBPReview of the facility's policy titled, Enhanced Barrier Precaution, revised on 08/01/2025, showed that EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact care activities. It further showed that an order for EBP will be obtained for residents that have indwelling medical devices such as central lines (a long, flexible tube that provides access to a person's blood supply for various purposes). Review of the facility's policy titled, Handwashing-Hand Hygiene, revised on 08/01/2025, showed that hand washing/hand hygiene was regarded as the single most important means of preventing the spread of infections. The policy showed hand washing/hand hygiene should be performed after incontinence care, after contact with blood, urine, feces, oral secretions, mucous membranes, or broken skin. The policy further showed the use of gloves did not replace handwashing. RESIDENT 5Review of Resident 5's comprehensive care plan initiated on 12/03/2025 showed that Resident 5 was on enhanced barrier protection related to IV [intravenous-in a vein] antibiotic [a medication that treats infections]. It further showed the intervention to use gown and gloves during high-contact resident activities. Observation on 12/03/2025 at 1:31 PM, showed Staff Q, Occupational Therapist, working with Resident 5 in the resident's room (EBP room). Staff Q provided range of motion exercises to Resident 5, which included touching the resident's arms, wrists, and hands. Staff Q touched a gauze bandage on the resident's left arm. Staff Q was not wearing a gown or gloves while working with Resident 5. Staff Q left Resident 5's room, did not perform hand hygiene and went to the nurse's station, where they touched the counter with their hands. In an interview on 12/03/2025 at 1:31 PM, Staff Q stated that they go by the chart or sign, to know if a resident was on any precautions. Staff Q stated that Resident 5 has a line [central line] and that they had been doing range of motion exercises and extensions with the resident. Staff Q stated they had had close contact with Resident 5 and that yes, they should have worn gloves and gown when working with the resident. Staff Q further stated that they should have performed hand hygiene after leaving Resident 5's room. In an interview on 12/08/2025 at 9:00 AM, Staff C, Infection Preventionist, stated that EBP was used for anybody who has a wound, catheter [a semi-flexible tube inserted into the bladder to drain urine], or IV. Staff C stated that they expected staff to use appropriate PPE if having high contact with a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident [on EBP]. Staff C stated that touching a resident while doing range of motion exercises with them was considered high contact. Staff C stated they expected Staff Q to wear PPE while working with Resident 5. Staff C further stated that they expected staff to practice hand hygiene when leaving an EBP room and that any healthcare worker should be doing proper hand hygiene. In an interview on 12/08/2025 at 11:16 AM, Staff B, Director of Nursing Services, stated that if a resident was on EBP, they expected staff to wear appropriate PPE if providing care including doing range of motion exercises with a resident. Staff B further stated that they expected staff to perform hand hygiene after leaving an EBP room. RESIDENT 2Review of Resident 2's physician orders printed on 12/08/2025, showed an order for EBP due to a left outer ankle and coccyx (tailbone) pressure ulcer (bedsore). Review of Resident 2's EBP care plan revised on 11/03/2025, showed Resident 2 was on EBP for left outer ankle and coccyx pressure ulcer. The care plan further showed interventions for proper hand washing or use of alcohol base hand rub before and after caring for resident and use of gown and gloves during high-contact activities such as transferring, changing briefs, and providing wound care. Observation on 12/04/2025 at 1:27 PM, showed Staff I, Certified Nursing Assistant (CNA), and Staff J, CNA, wearing a gown and gloves to transfer Resident 2 from their chair into bed using a mechanical lift. After transferring Resident 2 into bed, Staff I took the trash bin, placed it next to them and removed a wet wipe and placed it on top of its package while they removed Resident 2's foam boots. Staff I then removed Resident 2's soiled brief and took the wet wipe and began to clean Resident 2's peri-area (private area) in a downward motion, using a different wipe each time and then cleaned Resident 2's bottom. Staff I removed their gloves, applied new gloves, and then applied a barrier cream to Resident 2's bottom. Staff I then removed their soiled gloves and applied new gloves and put on a clean brief on Resident 2. Staff I did not remove their gloves when they touched and moved the trash bin, before providing peri-care to Resident 2, and did not perform hand hygiene between glove use. On 12/04/2025 at 2:03 PM, Staff I stated they should do hand hygiene before and after taking care of a resident. Staff I stated that they thought it was necessary to have their gloves removed after they touched the trash bin and performed hand hygiene. Staff I further stated it was important to perform hand hygiene to kill any bacteria or germs on their hands. Observation on 12/05/2025 at 2:12 PM, Staff E, Licensed Practical Nurse, performed hand hygiene prior to applying PPE to provide wound care for Resident 2. Staff E uncovered Resident 2's feet, removed their foam boot, and placed a trash bag in the trash bin. Staff E removed their gloves and applied new gloves. Staff E prepared the wound care supplies on a barrier on Resident 2's bed and changed their gloves. Staff E removed Resident 2's sock and used an adhesive remover to remove the old dressing. Staff E cleaned Resident 2's wound and waited for it to dry and applied the new dressing. Staff E changed their gloves and finished putting supplies away and repositioned Resident 2. Staff E did not perform hand hygiene between glove use. On 12/05/2025 at 2:22 PM, Staff E stated that they would change gloves and use hand sanitizer between different tasks. Staff E stated that they did not perform hand hygiene between glove use for Resident 2's wound care because the wound was closed and the dressing was more of a preventative measure. Staff E stated they would have performed hand hygiene between glove use if the wound had been open. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure resident dignity was maintained related to indwelling urinary catheter (a semi-flexible tube inserted into the bladder to drain urine) use for 1 of 2 residents (Resident 8), reviewed for dignity. This failure placed the resident at risk for decreased self-worth and a diminished quality of life. Findings included. Review of the facility's policy titled, Resident Rights Policy, revised on 08/01/2025, showed that the resident has the right to a dignified existence. It further showed the resident has a right to be treated with respect and dignity. Review of the admission Minimum Data Set (an assessment tool), dated 11/21/2025, showed that Resident 8 had an indwelling urinary catheter. Observations on 12/02/2025 at 9:57 AM and at 1:36 PM showed Resident 8 with an uncovered catheter drainage bag with yellow colored urine visible from the hallway. There was no privacy bag covering the drainage bag. In an interview and joint observation on 12/02/2025 at 3:30 PM, Staff R, Certified Nursing Assistant, stated that if a resident had a urinary catheter, we put [it] in a [privacy] bag, cover it and try to hide it. Staff R stated that it should not be visible from the hallway. Joint observation showed that Resident 8's catheter drainage bag was uncovered and visible from the hallway. Staff R stated that it should be in a [privacy] bag, it's [it is] not covered. I will cover it and went to get a privacy bag to cover it. In an interview on 12/08/2025 at 11:18 AM, Staff B, Director of Nursing Services, stated that they expected the catheter drainage bag to be covered and that a resident's urine should not be visible from the hallway. Reference: (WAC) 388-97-0180 (1)(2).		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written transfer/discharge notice with the required information for 2 of 3 residents (Residents 5 & 3), reviewed for discharge process. This failure placed the residents at risk for not having an opportunity to make informed decisions about their transfer/discharge rights and a diminished quality of life. Findings included. Review of the facility's policy titled, Transfer and Discharge (Including AMA [Against Medical Advice] Policy, revised on 08/01/2025, showed, The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided . d. an explanation of the right to appeal the transfer or discharge to the State. e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests. f. Information on how to obtain an appeal form. g. Information on obtaining assistance in completing and submitting the appeal hearing request. h. The name, address (mailing and email) and phone number of the representative of the Office of the State Long-Term Care Ombudsman [an advocate for residents of nursing homes who protect and promote resident rights under federal and state law and regulations]. The policy further showed, Generally, the notice must be provided at least 30 days prior to a transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because. b. The resident's health improves sufficiently to allow a more immediate transfer or discharge, c. An immediate transfer or discharge is required by the resident's urgent medical needs . RESIDENT 5 Review of a progress notes dated 10/13/2025 showed that Resident 5 had a change of condition and was transferred to the hospital. Review of the discharge Minimum Data Set (MDS- an assessment tool) dated 10/13/2025 showed that Resident 5 was discharged to a short term general hospital. Review of Resident 5's Electronic Health Record (EHR) did not show documentation that a written notice of transfer/discharge was provided to Resident 5 and/or their representative. Review of Resident 5's facility provided document titled, Transfer/Discharge Report printed on 12/08/2025, did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required. RESIDENT 3 Review of the progress note dated 11/25/2025 showed that Resident 3 was discharged to the community. Review of the discharge MDS dated [DATE] showed that Resident 3 was discharged to Home/Community. Review of Resident 3's EHR did not show documentation that a written notice of transfer/discharge was provided to Resident 3 and/or their representative. Review of the facility's document titled, Recapitulation [summary] of Stay with an effective date of 11/20/2025, did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required. In an interview on 12/08/2025 at 8:43 AM, Staff G, Social Services Coordinator, stated that it was their understanding that they would provide the State Nursing Home Transfer or Discharge Notice [a form that included a statement of the resident's appeal rights and Ombudsman contact information] form to residents who were being evicted from the facility, if they could not meet the needs of the resident, or if the resident was transferred to another facility. Staff G stated that on a resident/representative-initiated discharge, they would review the Recapitulation of Stay with the resident and/or representative. Staff G stated that when a resident transferred to the hospital, they did not complete the State Nursing Home Transfer or Discharge form, and that nursing staff would complete another form and would place it in the discharge packet that was given to the resident and/or their representative. When asked if Resident 5 and Resident 3 were provided a transfer/discharge notice with the required information, Staff G stated that Resident 5 was provided with the facility's Transfer/Discharge Report and Resident 3 was provided with the facility's Recapitulation of Stay. In a joint record review and interview on 12/08/2025 at 9:25 AM with Staff G and Staff A, Administrator, showed Resident 5's Transfer/Discharge Report printed on 12/08/2025 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required. Staff A stated that their Transfer/Discharge Report did not have information regarding the resident's appeal rights. Staff G stated that they would do the Recapitulation of Stay for Resident 3 and that it did not include the resident's appeal rights and Ombudsman contact information. In a follow up interview at 11:17 AM, Staff A stated that they agreed that Resident 3's Recapitulation of Stay that was provided to Resident 3 at discharge did not include the resident's appeal rights and Ombudsman contact information. Staff A further stated that they would start including it with their transfer/discharge paperwork. Reference: (WAC) 388-97-0120 (2)(a-d).		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess 1 of 8 residents (Resident 10), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding medications placed the resident at risk for unidentified and/or unmet care needs, and a diminished quality of life. Findings included. Review of the facility's policy titled, MDS - 3.0 - Completion, revised on 08/01/2025, showed, According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI [Resident Assessment Instrument- a guide directing staff on how to accurately assess the status of residents] specified by the State. The policy further showed all disciplines would follow guidelines in Chapter 3 of the current RAI Manual for coding each assessment. According to the Long-Term Care RAI 3.0 User's Manual, Version 1.20.1, dated October 2025, showed coding instructions to code all high-risk drug class medications according to their pharmacological (drug's uses, effects, and modes of actions) classification and not how they are being used. Review of Resident 10's face sheet printed on 12/08/2025, showed they admitted to the facility on [DATE] with a diagnosis of insomnia (a common sleep disorder that makes it hard to fall asleep or stay asleep). Review of Resident 10's physician orders printed on 12/05/2025, showed an order started on 10/31/2025 for Trazadone (an antidepressant that can help with low mood, insomnia, or problems concentrating) at bedtime for insomnia. Review of Resident 10's admission MDS Section N0415 (High-Risk Drug Classes: Use and Indication) dated 11/07/2025, showed antidepressant was not coded. In a phone interview and joint record review on 12/05/2025 at 9:39 AM, Staff D, MDS Nurse, stated they followed the RAI manual and that the medication Trazadone was an antidepressant that should be coded as an antidepressant. Joint record review of Resident 10's admission MDS Section N0415 dated 11/07/2025, showed antidepressant was not coded. Staff D stated Resident 10 started Trazadone upon admission on [DATE] and should have been coded as a yes. On 12/08/2025 at 9:53 AM, Staff B, Director of Nursing Services, stated they would expect staff to follow the RAI manual and that Trazadone should be coded as an antidepressant in the MDS. Reference: (WAC) 388-97-1000 (1)(b).		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a care plan for 2 of 8 residents (Residents 5 & 16), reviewed for comprehensive care plans. The failure to develop a care plan for antibiotic (medication to treat infections) use and discharge plan placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Comprehensive Resident Centered Care Plans, revised on 08/01/2025, showed, The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights.that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial [interaction between social and mental factors] needs that are identified in the comprehensive assessment. The policy showed that the facility must develop and implement a comprehensive person-centered care plan for each resident and describe in consultation with the resident and the resident's representative their goals for admission, desired outcomes, preferences and potential for discharge. The facility must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and discharge plans in the comprehensive care plan. The policy further showed that the care plan will be updated and/or revised when there are new diagnosis, new medications or abnormal labs [laboratory results]. RESIDENT 5Review of a face sheet printed on 12/04/2025 showed that Resident 5 was readmitted to the facility on [DATE] with diagnoses that included bacteremia (bacteria in the bloodstream). Review of Resident 5's November 2025 and December 2025 Medication Administration Record (MAR) showed an order for the following:-Ceftriaxone (antibiotic medication) two grams (unit of measurement) intravenously (administered through the vein) once a day for bacteremia for 28 days with a start date of 11/07/2025.-Metronidazole (antibiotic medication) 500 milligrams (unit of measurement) give one tablet by mouth two times a day for purulent (thick yellow liquid that comes from an infection) skin and soft tissue infection for 28 days with a start date of 11/06/2025. Further review of November 2025 and December 2025 MAR showed that Resident 5 received Ceftriaxone and Metronidazole from 11/07/2025 through 12/04/2025. Review of Resident 5's comprehensive care plan printed on 12/04/2025 did not show a care plan for antibiotic use. In an interview on 12/05/2025 at 3:37 PM, Staff P, Registered Nurse, stated that Resident 5 received antibiotics when they returned from the hospital. In an interview and joint record review on 12/05/2025 at 3:50 PM, Staff C, Assistant Director of Nursing, stated that antibiotic use would be care planned. Joint record review of Resident 5's comprehensive care plan did not show a care plan for antibiotic use. Staff C stated that they did not see one and that it should have been part of Resident 5's care plan for its use and adverse side effect monitoring. In an interview on 12/08/2025 at 11:03 AM, Staff B, Director of Nursing Services, stated that they expected a care plan for residents who were on antibiotics to monitor for adverse side effects. Staff (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B further stated that Resident 5 should have had a care plan for antibiotic use. RESIDENT 16Review of Resident 16's comprehensive care plan printed on 12/02/2025 did not show whether Resident 16 and/or their representative wished for them to stay long-term in the facility or any discharge care plan. In an interview and joint record review on 12/08/2025 at 9:08 AM, Staff G, Social Services Coordinator, stated they would document the resident's discharge goals in their care conference notes and in the resident's care plan. Staff G stated that Resident 16's representative wished for them to stay in the facility long term. Joint record review of Resident 16's comprehensive care plan did not show a discharge care plan to reflect this. Staff G stated that they had just updated the care plan and were not sure why it was not there. On 12/08/2025 at 12:25 PM, Staff B stated Resident 16 was a long-term care resident. Staff B further stated they expected staff to follow their comprehensive care plan policy. Reference: (WAC) 388-97-1020 (1)(2)(a)		

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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** Based on observation, interview, and record review, the facility failed to monitor residents taking diuretic (used to treat fluid retention or swelling) medications and/or failed to notify the provider of weight loss/gain for 3 of 4 residents (Residents 4, 10 & 11), reviewed for weight monitoring. The failure to obtain/monitor weights and measure abdominal girth (measurement around the abdomen) placed the residents at risk for unrecognized weight loss/gain, medical complications, and a diminished quality of life. Findings included. Review of the facility's policy titled, Weight Assessments, revised on 07/16/2025, showed Each resident will be weighed on a regular basis to monitor for weight gain or loss. The policy showed residents would be weighted when they are admitted to the facility and once per week and recorded in their medical record. The policy showed the nurse will compare the current weight to the previous weights to determine if significant weight loss or gain was occurring. The policy further showed that if a weight was four or more pounds more or less than the previous weight the nurse would reweigh, and if a true weight loss or gain had occurred, the nurse would notify the physician, registered dietitian, and responsible party and document it in the progress notes. Review of the facility's policy titled, Medication Administration-General Guidelines, revised on 01/01/2023, showed that Monitoring of side effects or medication-related problems occurs continually, but particularly after medication administration and especially after the first few doses of a new medication. The risk for adverse consequences increases with both the number of medications being taken and with the medication from specific pharmacological classes including diuretics. RESIDENT 4 Review of Resident 4's physician order's printed on 12/05/2025, showed an order for furosemide (diuretic) 20 milligrams (mg-unit of measurement) in the morning for Congestive Heart Failure (CHF- a chronic condition where the heart muscle weakens, failing to efficiently pump blood to meet the body's needs causing blood and fluid to back up leading to shortness of breath, swelling, and fatigue). Review of Resident 4's weights printed on 12/04/2025 showed the following:-On 08/28/2025, they weighed 186.3 pounds (lbs-unit of measurement).-On 09/05/2025, they weighed 166.4 lbs.-On 09/15/2025 at 1:53 PM, they weighed 184 lbs and at 3:57 PM, they weighed 196.2 lbs.-On 09/18/2025, they weighed 166 lbs.-On 09/25/2025, they weighed 164 lbs (12 percent [%] weight loss or 22.3 lbs less from 08/28/2025 weight). In a joint record review and interview on 12/05/2025 at 1:31 PM with Staff C, Assistant Director of Nursing, showed Resident 4's weights:-On 08/28/2025, they weighed 186.3 lbs.-On 09/05/2025, they weighed 166.4 lbs.-On 09/15/2025 at 1:53 PM, they weighed 184 lbs and at 3:57 PM, they weighed 196.2 lbs.-On 09/18/2025, they weighed 166 lbs.-On 09/25/2025, they weighed 164 lbs (12% weight loss or 22.3 lbs less from 08/28/2025 weight). Staff C stated that Resident 4 was taking a diuretic for CHF and that they had an order for weekly weights on Thursdays. Staff C stated that there were a lot of inconsistencies, in Resident 4's weights and that they had both significant weight gain and weight loss. Staff C further stated they would expect more weight monitoring if Resident 4's weights were not stable and that they would have expected the nurse to notify the provider of the weight gain/loss. In an interview and joint record review on 12/08/2025 at 9:57 AM, Staff B, Director of Nursing Services, stated they expected nursing staff to monitor the residents' weights. Joint record review of (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 4's weights from 08/28/2025 to 11/23/2025, showed consistent warnings for weight loss/gain in their electronic health record. Staff B stated that there was a lot of weight gain and weight loss and that it was a red flag. Staff B further stated they would have expected the nursing staff to reweigh Resident 4, notify the doctor, and to ensure accurate weights. RESIDENT 10Review of Resident 10's face sheet printed on 12/08/2025, showed they were admitted to the facility on [DATE]. Review of Resident 10's physician orders printed on 12/05/2025, showed an order for bumetanide (diuretic) 0.5 mg to be given twice a day for hypertension (high blood pressure)/chronic venous stasis (a condition where leg veins struggle to send blood back to the heart, causing blood to pool in the lower legs)/autonomic dysreflexia (a sudden, dangerous increase in blood pressure caused by a stimulus below the level of a spinal cord injury). Further review of the physician orders did not show an order to obtain weights. Review of Resident 10's weights printed on 12/04/2025, showed the following:-On 11/03/2025, they weighed 139.4 lbs.-On 11/06/2025, they weighed 139.2 lbs.-On 11/14/2025, they weighed 146.8 lbs (5.3% weight gain or 7.4 lbs more from 11/03/2025 weight).-On 11/23/2025, they weighed 152 lbs (9% weight gain or 12.6 lbs more from 11/03/2025 weight). Review of Resident 10's potential for dehydration (occurs when the body uses or loses more fluid than it takes in) or potential fluid deficit related to diuretic use care plan initiated on 10/31/2025, showed an intervention for Weight per facility protocol. Review of Resident 10's nursing progress note dated 11/17/2025, showed an SBAR (Situation, Background, Assessment, and Recommendation- a communication tool used primarily in healthcare) was left to the provider for review regarding Resident 10's representative's concerns of increased confusion, lower extremity (legs) edema (swelling) and blisters, and request for treatment and cause of Resident 10's increased confusion. Review of Resident 10's provider progress note dated 11/18/2025, showed Resident 10's bilateral (both) lower extremities had worsened gradually over the last one to two weeks, and ordered to increase bumetanide to twice a day. In an interview and joint record review on 12/05/2025 at 10:39 AM, Staff E, Licensed Practical Nurse, stated that if a resident was a new admission they would be weighed for the first three days and if the residents refused, they would document why. Staff E stated that there would also be an order to weigh the residents after admission. Staff E stated they were expected to follow the resident's care plan and that everyone was responsible for monitoring a resident's weight. Staff E stated that they would expect to notify the provider if there were any discrepancies. Joint record review of Resident 10's weights from 11/03/2025 through 11/23/2025, showed a weight gain of 12.6 lbs or 9% gain. Staff E stated that they did not believe that was accurate and that the scale was not always accurate if a resident was not standing in the middle. In an interview and joint record review on 12/05/2025 at 1:07 PM, Staff C stated, weight per protocol, meant to obtain weight upon admission for three days and then on a weekly basis unless specified in the order. Staff C stated they expected staff to follow the care plan, and that nurses would record the resident's weight and if the resident refused, they would reattempt and/or document why the resident refused and notify the provider. Joint record review of Resident 10's weights from 11/03/2025 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through 11/23/2025, showed a weight gain of 12.6 lbs or 9% gain. Staff C stated that Resident 10 was not weighed per protocol the first three days of upon admission. Staff C stated they had a nutrition meeting on 11/21/2025 with a recommendation for a reweight and had not obtained it prior to the next weight on 11/23/2025. Staff C stated that they did not see that the provider was notified of the weight gain in the progress notes, just of Resident 10's edema. Staff C further stated that the nurse should be notifying the provider of significant weight gain/loss. On 12/08/2025 at 9:57 AM, Staff B stated residents should be weighed for the first three days upon admission and then there should be an order for weekly weights. Staff B stated they would expect staff to document why Resident 10 did not get weighed for the first three days upon admission. Staff B stated they expected staff to follow the residents' care plan and obtain a reweight if there was a discrepancy. Staff B further stated that staff should have notified the doctor that Resident 10 was gaining weight. RESIDENT 11Review of Resident 11's diagnosis list printed on 12/08/2025, showed a diagnosis of ascites (the buildup of excess fluid in the abdomen). Review of Resident 11's physician orders, printed on 12/03/2025, showed the following orders:- Daily weights for three days upon admission, then weekly, and must be taken by a licensed nurse every Thursday.- Furosemide oral tablet 20 mg. Give 1 tablet by mouth one time a day.- Spironolactone (a diuretic medication) oral tablet 25 mg. Give 1 tablet by mouth one time a day. Review of Resident 11's ascites care plan, revised on 10/02/2025, showed a goal that Resident 11 would remain free of signs/symptoms of fluid overload (too much fluid in the body) as evidenced by the decrease in or absence of edema/ascites. It further showed an intervention to weigh Resident 11 per orders/facility protocol. Review of the facility's document titled, Weights and Vitals Summary, printed on 12/05/2025, showed that Resident 11 was last weighed on 11/20/2025 (15 days prior). Review of the November 2025 Medication Administration Record (MAR) showed that a R [Resident Refused] was documented on 11/27/2025. Review of the December 2025 MAR showed a 9 [nine-indicating other/see progress notes] was documented on 12/04/2025. Review of the progress notes from 11/27/2025 through 12/05/2025 showed no documentation that Resident 11 had refused their weight or that any follow-up had been done. Review of a physician note dated 11/18/2025, showed the plan to monitor weight, abdominal girth for Resident 11. Review of a physician note dated 12/04/2025, showed the plan to monitor weight, abdominal girth and reminded nursing for weekly weight for Resident 11. Observation on 12/04/2025 at 8:59 AM, showed Resident 11 had a distended [swollen or enlarged] abdomen and stated, no one has measured it. Another observation on 12/05/2025 at 9:58 AM, showed Resident 11 had a distended abdomen and (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that nursing did not measure their abdomen. When asked how often they had weights done, Resident 11 stated, I think the doctor put in an order to do weekly but was not necessarily being done weekly. In an interview on 12/05/2025 at 10:40 AM, Staff E stated if a resident refused getting weighed, they would follow up, try three times and write a progress note. Staff E stated they would care for a resident who was on a diuretic by monitoring if a resident was gaining or losing weight. Staff E stated that they would care for a resident with ascites by measuring the abdomen, if [the measurement] was going up or down and there should be an order to put in [document] the measurement. When asked if they should follow an order for weekly weights, Staff E stated that yes would expect that to be done. Staff E further stated that resident care plans should be followed. In an interview and joint record review on 12/05/2025 at 11:45 AM, Staff C stated that they expected staff to follow orders and resident care plans. Staff C stated that they expected weights to be done as written on the MAR. Staff C stated that weight per protocol meant that weights should be done upon admission for three days and then weekly. Staff C stated that if a resident refused to get their weight done the staff should document the refusal. Staff C stated that if a resident had ascites they would expect staff to measure abdominal girth and would expect them to document it. Joint record review of Resident 11's diagnosis list showed that Resident 11 had ascites. Joint record review of Resident 11's physician orders showed that they were on two diuretics, Furosemide and Spironolactone and showed an order for weekly weights. Joint record review of the weights and vitals summary showed that the last weight was done on 11/20/2025 (15 days prior). Joint record review of the November 2025 MAR showed an R documented on 11/27/2025. Staff C stated that it indicated resident refused. Joint record review of the December 2025 MAR showed a 9 documented on 12/04/2025. Staff C stated that it indicated other, see progress note. Joint record review of the progress notes from 11/27/2025 through 12/05/2025 showed no documentation that Resident 11 had refused their weight or that any follow-up had been done. Staff C stated, there's [there is] nothing about refusals documented in the progress notes. Joint record review of Resident 11's ascites care plan, revised on 10/02/2025, showed an intervention to weigh Resident 11 per orders/facility protocol. When asked if the care plan had been followed, Staff C stated, no, it wasn't [was not]. Joint record review of a physician note dated 12/04/2025, showed the plan to monitor weight, abdominal girth and reminded nursing for weekly weight for Resident 11. Staff C stated, I would expect the weights to be done and we should monitor abdominal girth by measuring the abdomen. Staff C stated that measuring Resident 11's abdominal girth had not been done. In an interview and joint record review on 12/08/2025 at 11:16 AM, Staff B stated that they expected staff to follow care plans and to follow orders [physician orders]. Staff B stated that if there was an order for weekly weights then they would expect staff to weigh the resident. Staff B stated that if a resident refused to be weighed, they would expect staff to attempt again at another time and to document it in the progress notes. Staff B stated that if a resident was on a diuretic it's very important to check weights. Staff B stated that if a resident had ascites, they would check abdominal girth. Joint record review of Resident 11's diagnosis list showed a diagnosis of ascites. Joint record review of Resident 11's physician orders showed orders for Furosemide and Spironolactone. Staff B stated, it's very important [to weigh residents] if they have ascites and [were] on diuretics, [they] could be retaining fluid. Reference: (WAC) 388-97-1060 (1) .		

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NAME OF PROVIDER OR SUPPLIER Park Shore		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43rd Avenue East Seattle, WA 98112	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide respiratory care in accordance with accepted professional standards of practice for 1 of 2 residents (Resident 22), reviewed for respiratory care. The failure to properly store oxygen and nebulizer (medical device that turns liquid medication into a fine mist that can be inhaled through a mouthpiece or mask) equipment placed the resident at risk for respiratory infections, and related complications. Findings included .Review of the facility's policy titled, Oxygen Administration, revised on 07/08/2025, showed, Place cannula (prongs) or mask in place with date written on label attached to tubing. O2 [Oxygen] tubing should be changed every week with new cannula or mask. Review of the facility's policy titled, Nebulizer policy, revised on 01/01/2025 showed, Nebulizer equipment will be maintained in a clean, functional condition. The policy further showed, Rinse nebulizer components with sterile or distilled water after each use, disinfect daily, replace tubing weekly, dedicate equipment to each resident, and comply with infection-control standards. Review of a face sheet printed on 12/03/2025 showed that Resident 22 was admitted to the facility on [DATE] with diagnoses that included idiopathic pulmonary fibrosis (scarring of the lungs which leads to difficulty breathing), lung transplant (surgical procedure to replace a diseased or failing lung with a healthy lung) status and acute nasopharyngitis (common cold). Review of Resident 22's physician orders printed on 12/03/2025 showed an order for the following:- HyperSal Inhalation Nebulization Solution [medication used to help thin mucus in the lungs, making it easier to cough up and clear from the airways] four milliliters (unit of measurement) inhale orally via nebulizer once a day for idiopathic pulmonary fibrosis and acute nasopharyngitis with a start date of 11/26/2025.- Oxygen one to two liters (unit of measurement) per minute via nasal cannula (flexible tubing that sits inside the nostrils and delivers oxygen) every shift with a start date of 11/25/2025. Observations on 12/02/2025 at 9:50 AM, on 12/03/2025 at 8:19 AM and at 12:06 PM, showed Resident 22 was lying in bed receiving oxygen via undated nasal cannula. Further observation showed an undated and uncovered nebulizer tubing/mouthpiece was laying on top of a hamper. In an interview and joint observation on 12/03/2025 at 2:01 PM, Staff F, Registered Nurse, stated that they would change the nasal cannula when they were soiled and that they would clean the nebulizer mouthpiece/mask and leave them to dry on a table. When asked if they would store it in a bag when not in use, Staff F stated, no. Staff F stated that residents did not have a physician's order to regularly change the tubing/nasal cannula and nebulizer equipment. Joint observation showed Resident 22's undated and uncovered nasal cannula was laying on the bed. Further observation showed Resident 22's undated and uncovered nebulizer tubing/mouthpiece was laying on top of a hamper. Staff F stated that the nebulizer tubing/mouthpiece should be stored in a clean area. Staff F further stated that Resident 22's nasal cannula should have been stored in a bag when not in use for infection control. In an interview on 12/05/2025 at 11:25 AM, Staff C, Assistant Director of Nursing, stated that they expected the nebulizer tubing/mouthpiece to be changed weekly. Staff C stated that the mouthpiece/mask should be cleaned after each use, airdried on a clean paper towel and placed it in a bag when not in use. Staff C stated they expected the nasal cannula to be dated, changed weekly and stored in a bag when not in use. Staff C further stated that Resident 22's nasal cannula and nebulizer tubing/mouthpiece should have been dated and stored in a bag when not in use. In an interview on 12/05/2025 at 2:35 PM, Staff B, Director of Nursing Services, stated that they expected the nebulizer mouthpiece/mask to be cleaned after each use, placed on a clean towel to airdry and stored in a clean bag when not in use. Staff B further stated that the nasal cannula should be stored in a bag when not in use. Reference: (WAC) 388-97-1060 (3)(j)(vi).		

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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. Based on interview and record review, the facility failed to ensure 2 of 5 residents (Resident 4 & 16) were free from significant medication errors. The failure to document and/or provide medications placed the residents at risk for complications, decline in medical condition, and a diminished quality of life. Findings included. Review of the facility's policy titled, Medication Administration-General Guidelines, revised on 01/01/2023, showed Medications are administered in accordance with written orders of the prescriber. The policy showed the individual who administers the medication dose records the administration on the resident's Medication Administration Record (MAR) directly after the medication is given. The policy further showed if a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, nursing would document an explanatory note and notify the physician and their response. RESIDENT 4 Review of the facility's document titled, Pharmacist's Report to Nursing, recommendation for Resident 4 dated 10/24/2025, showed the MAR had missing documentation for medication administration on 10/08/2025 for the following:-Furosemide (diuretic-primarily used to treat fluid retention and swelling and Congestive Heart Failure [CHF- a chronic condition where the heart muscle weakens, failing to efficiently pump blood to meet the body's needs causing blood and fluid to back up leading to shortness of breath, swelling, and fatigue]).-Losartan (used to treat high blood pressure).-Metamucil (fiber supplement).-Vitamin D3 (vitamin for bone health).-Quetiapine (an antipsychotic medication that helps balance chemicals in the brain that regulate mood, thoughts, and behaviors). The recommendation further showed each medication should be documented at the time of administration, indicating that each medication had been administered, refused, or unavailable. Review of Resident 4's October 2025 MAR printed on 12/04/2025, showed missing/blank documentation for day shift on 10/08/2025 for furosemide, losartan, Metamucil, vitamin D3, and quetiapine. The October 2025 MAR further showed Resident 4 had behaviors on 10/08/2025 evening shift including use of foul language. Review of Resident 4's nursing progress notes dated 10/08/2025 did not show why furosemide, losartan, Metamucil, vitamin D3, or quetiapine were not administered or that the physician was notified. On 12/05/2025 at 10:28 AM, Staff E, Licensed Practical Nurse, stated that after medication they would document in the MAR. Staff E further stated that it was important to document to show whether a resident took their medication or if they refused. In a joint record review and interview on 12/05/2025 at 2:57 PM with Staff C, Assistant Director of Nursing, showed Resident 4's October 2025 MAR, had missing/blank documentation for day shift on 10/08/2025 for furosemide, losartan, Metamucil, vitamin D3, and quetiapine. Staff C stated that the day shift nurse did not sign for those administrations and that meant if they were not signed, they were not given. Staff C stated that Resident 4 was placed at risk for behaviors, constipation, and effects on their blood pressure. Staff C stated that Resident 4 had behaviors documented on 10/08/2025 evening shift. Staff C further stated that they would expect the staff to document a reason why each medication was not given. RESIDENT 16 Review of the facility's document titled, Pharmacist's Report to Nursing, recommendation for Resident 16 dated 09/22/2025, showed hydroxychloroquine (medication used for rheumatoid arthritis [an autoimmune disease that causes pain, stiffness, and swelling in the joints]) was documented as unavailable in the electronic MAR. The recommendation showed the orders should be promptly reordered, pulled from the Medbank (an automated medication dispensing system used to manage and secure on-site medications), house supply, or requested from the family to prevent missed doses and to document any delays. The recommendation further showed to notify the provider of missed doses. Review of Resident 16's September 2025 MAR, showed an order for hydroxychloroquine sulfate tablet was documented as code 11 (Medication not available) on 09/05/2025, 09/07/2025, 09/08/2025, 09/09/2025 and code 5 (Hold/See progress notes) on 09/06/2025. Review of Resident 16's nursing progress notes showed the following documentation for hydroxychloroquine:-On 09/05/2025, showed staff documented medication was on order from (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy- placed a call- waiting for call back.-On 09/06/2025, showed medication was on order pharmacy aware.-On 09/07/2025, showed medication was on order.-No documentation for 09/08/2025 and 09/09/2025.Further review of the progress notes did not show Resident 16's representative or provider were notified the medication was unavailable.On 12/05/2025 at 9:56 AM, Staff E stated nurses on the floor were responsible for reordering medication. Staff E stated that if medication was unavailable, they would call the pharmacy to have it delivered and notify the resident and provider the medication was not available. Staff E stated they did not document the follow-up they did regarding Resident 16's unavailable medication.In a phone interview on 12/05/2025 at 11:18 AM, Staff H, Consultant Pharmacist, stated that hydroxychloroquine was long acting and that missing five doses in a row would be significant with possible return of rheumatoid arthritis symptoms such as stiffness, pain, and inflammation.In a joint record review and interview on 12/05/2025 at 3:11 PM with Staff C, showed Resident 16's September 2025 MAR order for hydroxychloroquine sulfate tablet. Staff C stated that Resident 16 missed five doses of their hydroxychloroquine sulfate medication because the medication was not available. Staff C stated missing five doses of the medication could be significant because it could put the resident at risk for pain from arthritis. An additional joint record review of Resident 16's nursing progress notes from 09/05/2025 through 09/09/2025, did not show that the provider was notified that the medication was not available. Staff C stated staff should have notified the provider. Staff C further stated it was the staff's responsibility to reorder medication and follow up with the pharmacy to ensure residents had their medication. On 12/08/2025 at 10:07 AM, Staff B stated that staff should use the emergency supply medication or call the pharmacy when medication was unavailable. Staff B stated that staff should have notified the doctor and Resident 16's representative when they did not receive their medication. Staff B further stated that missing five doses in a row of Resident 16's hydroxychloroquine medication was significant and would be considered a medication error.Reference: (WAC) 388-97-1060(3)(k)(iii).		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the posted daily nurse staffing information included the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift for 30 of 30 days (11/08/2025 to 12/08/2025), reviewed for posted nurse staffing information. The failure to post a complete and accurate form daily prevented the residents, family members, and visitors from exercising their rights to know the actual nursing staff hours worked in the facility. Findings included. Review of the facility's policy titled, Nurse Staffing Posting Information, revised on 03/28/2025, showed the nurse staffing sheet would be posted daily and include the following: facility name, current date, current resident census, actual hours worked by categories of licensed and unlicensed staff per shift. Observations on 12/02/2025 at 9:08 AM, on 12/03/2025 at 10:54 AM, on 12/04/2025 at 9:10 AM, on 12/05/2025 at 9:27 AM, and on 12/08/2025 at 8:32 AM showed the daily nurse staff posting was posted outside the facility's therapy gym without the total number and actual hours worked by licensed Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants. In an interview and joint record review on 12/08/2025 at 8:39 AM, Staff K, Medical Records Coordinator, stated they were responsible for the daily nurse staff posting. Joint record review of the 12/08/2025 posting showed no total number or actual hours worked by staff. Staff K stated they would not expect the schedule to have actual hours posted, and that they expected to have scheduled hours posted because the actual hours would not show until after the shift had occurred. Record review of the facility provided nurse staff posting documents dated from 11/08/2025 through 12/08/2025, did not show the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. In a joint record review and interview on 12/08/2025 at 11:19 AM with Staff A, Administrator, showed the facility's nurse staff posting documents dated from 11/08/2025 through 12/08/2025, did not show the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. Staff A stated they would expect the daily nurse staff posting to reflect the total number and actual hours staff worked and to make changes in real time to reflect the staff on duty accurately. Reference: (WAC) 388-97-1620(2)(b)(i).		