

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
FORM APPROVED
OMB NO. 0938-0391

489

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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Park Shore Health Center on 10/22/13, 10/23/13, 10/24/13, 10/25/13 and 10/28/13. A sample of 18 residents was selected from a census of 22. The sample included 12 current residents, the records of six former and/or discharged residents and two supplemental residents.</p> <p>The survey was conducted by:</p> <p>██████████ MSW ██████████ RN, MN ██████████ RN, MN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Adult Services Administration Residential Care Facilities Region 2, Unit F 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p><i>[Signature]</i> Residential Care Services 11/5/13 Date</p>	F 000		

RECEIVED
NOV 19 2013
DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
██

TITLE
Administrative Director

(X6) DATE
11-18-2013

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure residents received care which upheld their right to dignity. Sensitive resident care information was posted for residents including #s 21, 13, 1, 14, 25, 27, 24 and 26 in areas visible to other residents and visitors. Additionally, an alarm was utilized for Resident #59 who felt it was undignified. These failures placed residents at risk for a diminished quality of life.</p> <p>Findings include:</p> <p>RESIDENT #59 When asked, in an interview on 10/22/13 at 2:15 p.m., if facility staff treated her with respect and dignity, Resident #59 stated they did not. She explained staff placed an alarm on her bed to alert them when she stood because "they had me on watch." She stated she was an adult making her own decisions and if she chose to get up, despite a recent [REDACTED], she felt she had the right to do so. She stated the staff told her she was "too independent". She further explained her goal was to recover from the [REDACTED] and discharge home as fast as possible. She felt the alarm was demoralizing and she was treated like a child. Resident #59 stated she had removed the alarm from the bed and placed it on the floor,</p>	F 241	<p><u>F 241 Dignity and Respect of Individuality</u></p> <p>Residents #59 and 13 have discharged from the facility</p> <p>Signs with care directives have been removed from all rooms.</p> <p>The facility will obtain written permission from residents and/or responsible parties prior to posting care directives or placing fall alert alarms.</p> <p>The facility will develop a policy and procedure about informing residents about care directives and obtaining permission from residents prior to posting care directives, placing fall alert alarms, or any other activity that would affect the dignity and respect of individuality. The nursing staff will be trained in how to implement the new policy and procedure.</p> <p>The medical records coordinator will periodically audit resident records to ensure written permission has been obtained.</p> <p>The quality assurance committee will monitor on a quarterly basis. The Director of Nursing Services will ensure that the tasks in the correction plan are completed by December 6, 2013.</p>	

RECEIVED

NOV 19 2013

DSHS/ADS/ARCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 241	<p>Continued From page 2</p> <p>where it was observed to remain, as she had no intention of using it, despite the facility's insistence.</p> <p>Review of the resident's record revealed a 10/18/13 Progress note that identified the resident was "noted to be attempting transfer from bed early this shift even though she was advised earlier not to attempt getting up without help and use call light for help for safety reasons. Res verbalized I have short term [REDACTED] problem hence bed alarm was placed."</p> <p>Further record review revealed the resident was alert and oriented with no identified cognitive loss. She received [REDACTED] pain medications due to a recent [REDACTED] replacement and worked with therapy who had released her to walk alone on 10/21/13.</p> <p>In an interview on 10/28/13 at 12:15 p.m., Staff A stated she did not know staff had placed an alarm on Resident #58. She stated staff should base the decision on whether to place an alarm on the individual and that an independent, alert and oriented resident should not have one used, especially if they did not want it.</p> <p>POSTINGS RESIDENT #21 Observation of Resident #21's room, which was shared with Resident #13, on 10/22/13 at 11:43 a.m. revealed two signs prominently posted that contained specific care instructions. The signs directed staff to "float [REDACTED] when in bed" and "place 2 [REDACTED] on charger before resident lay in bed". At that time Resident #21 stated the signs were posted because the facility frequently used "agency staff" who otherwise did not know</p>	F 241	

RECEIVED

NOV 19 2013

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	<p>Continued From page 3</p> <p>what care to provide. He stated in order to get the care he and his roommate required, the signs had to be posted. Resident #21 stated the facility had not asked prior to hanging the signs, they had simply informed him of the need for them to be posted.</p> <p>RESIDENT #13 Observation of Resident #13's room, which was shared with Resident #21, on 10/22/13 at 11:40 a.m. revealed two signs posted above his bed that contained specific care instructions. The signs directed staff to "float [REDACTED] while in bed" and "Do not leave alone in w/c (wheelchair)". Posted on the outside of the closet door was a care tracker on which staff documented when the resident had a bowel movement and when other care was provided.</p> <p>RESIDENT #1 Observation of Resident #1's room on 10/23/13 at 8:59 a.m. revealed five signs posted above her bed including but not limited to instructions to staff to "Keep (head of bed) elevated to 30 degrees at all times" and "Thin liquids only with one on one supervision. Use straight straw and chin tuck."</p> <p>RESIDENT #14 Observation of Resident #14's room on 10/22/13 at 1:52 p.m. revealed a sign posted above the resident's bed which listed instruction for "Safe Swallowing Strategies: up 90 degrees in wheelchair for all meals, chin tuck when drinking liquids, If wet voice, cue pt to clear throat/cough, small sips/bites, NO straws, if coughing/choking after eating, drinking please contact speech. - ST". In an interview on 10/23/13 at 8:40 a.m. when asked about the posting Resident #14 said</p>	F 241		

RECEIVED

NOV 19 2013

DSHS/ADS/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	<p>Continued From page 4</p> <p>"Usually its a matter of staff paying attention to that, I can't do much of it by myself."</p> <p>RESIDENT #25 Observation of Resident #25's room on 10/22/13 at 1:06 p.m. revealed five signs posted above her bed including but not limited to instructions that the resident was to "wear gray colored stockings during day and have them off at bed time, make sure (resident) wears shoes (no slippers), while in w/c. No footrests on w/c while (resident) on second floor, she can use footrests if going out of the unit" and "Float [REDACTED]."</p> <p>In an interview on 10/22/13 at 12:44 p.m. Resident #25's family member pointed to an additional posting "Please check pockets and wadded up tissue for hearing aids" and commented "We should eliminate that one notice there... I have the hearing aids at my home."</p> <p>RESIDENT #27, 24 & 26 Similar findings were identified for Resident #27, above whose bed hung two signs that informed staff to provide boots and an ADL functional status sign that noted the resident required maximum assistance of two staff to pivot transfer with the use of a gait belt to his wheelchair.</p> <p>Similar findings were identified for Resident #24 above whose bed was a sign that directed staff to "walk to all meals" and for Resident #26 above whose bed was direction to "float [REDACTED]."</p> <p>In an interview on 10/28/13 at 10:59 a.m. Staff A indicated the postings were for staff reference.</p> <p>In an interview on 10/28/13 at 12:40 p.m., Staff A further elaborated the signs were in resident's</p>	F 241			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	Continued From page 5 rooms to ensure all staff who provided care were aware of that resident's needs. She stated the facility utilized agency staff when necessary and in order to ensure they knew the resident's needs, the signs were posted. She acknowledged it was facility practice and resident's, or their family members, were not necessarily asked prior to the signs being hung.	F 241			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to allow one (# 21) of three residents reviewed for choices, of the 11 residents who were interviewed in Stage 1, the right to make choices regarding important daily routines, including accommodating preferences for the timing and frequency of bathing. The facility's failure to accommodate resident choice placed this resident at risk for poor hygiene and a diminished quality of life. Findings include: RESIDENT #21 In an interview on 10/23/13 at 9:02 a.m., Resident	F 242	<u>F 242 Self-Determination - Right to Make Choices</u> Resident #21 has been asked if he would like the shower schedule altered so that he can receive two showers at his preferred time of day. When developing initial care plans, the nursing staff will ask residents if they have a preference about time of day for bathing and will let the administrative assistant know so that accommodations can be made if necessary. The nursing staff will be trained in this procedure. Residents will be asked during care conferences about their bathing time preference and determine if their choice is being honored. Care plans will be updated to include resident's choice, and care plans will be reviewed on a quarterly basis. The quality assurance committee will monitor on a quarterly basis. The Director of Nursing Services will ensure that the tasks in the correction plan are completed by December 6, 2013.		

RECEIVED

NOV 19 2013

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 242	<p>Continued From page 6</p> <p>#21 stated he did not get to chose how many times a week he received a shower. He stated the facility scheduled each resident for two showers a week, one during the day and one at night. He stated it had never been his routine to take a shower in the morning or daytime. He stated he explained to the facility his lifelong routine had been to shower at night and so he refused the daytime shower. He stated he was now provided the one shower a week at night and the facility told him he could accept the daytime shower at any time. He stated staff cleaned him up each morning when they got him ready for the day but that it was not comparable to a shower. He further explained he exercised three times a week in "the gym" and experienced incontinence and so one shower a week did not always make him feel clean. He stated staff would occasionally provide a "spit bath", or bed bath, when they were able.</p> <p>Review of the resident's record revealed an Activities of Daily Living care plan, dated 08/07/13, that identified the approach "Whirlpool bath or shower" each week. A Care Area Assessment, dated 05/06/13, identified the resident was "showered weekly". Review of CareTracker documentation revealed staff noted providing a shower once a week.</p> <p>Review of the facility's Shower Schedule revealed the schedule was arranged by room and bed. Each resident was scheduled to receive a shower on day shift once a week and on evening shift once a week.</p> <p>In an interview on 10/28/13 at 11:07 a.m. Staff B stated she was aware the resident did not like showers on day shift, however skin assessments</p>	F 242			

RECEIVED

NOV 19 2013

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 7 were conducted on shower days and the facility needed to maintain that schedule. She explained the resident had a right to refuse the daytime shower, however he would then be provided just the one shower a week. Staff B stated while the facility tried to accommodate residents they were unable to change the shower schedule so the resident could have two showers on the evening shift. In an interview on 10/28/13 at 12:15 p.m., Staff A stated the facility tried to accommodate residents as much as possible. She stated while she knew Resident #21 did not want a shower on the day shift, he had not made a "big deal about it". She explained the resident never stated it mattered to him. She acknowledged the facility had not offered a change in the shower schedule to the resident once he made his preference for an evening shower known.	F 242		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	<u>F 279 Develop Comprehensive Care Plans</u> Residents # 49, 10 and 30 are no longer at the facility. The care plans for residents 31, 24 and 5 will be updated to have goals that can be objectively measured, to have identified reasons for medications, and to have appropriate interventions in place so that needs are met. The facility will train nursing and social services staff on how to write care plans with objective goals and appropriate interventions. Care plans will be reviewed in weekly care plan meetings to ensure that goals and interventions are appropriate. The quality assurance committee will monitor on a quarterly basis. The Director of Nursing Services will ensure that the tasks in the correction plan are completed by December 6, 2013.	

RECEIVED

NOV 19 2013

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013	
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	<p>Continued From page 8</p> <p>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to develop and/or revise comprehensive care plans for six (#s 49, 10, 30, 31, 24 & 5) sampled residents of the 16 residents whose care plans were reviewed in Stage 2. Failure to establish care plans that accurately reflected assessed care needs and provided direction to staff on the residents' care related to pain, mental health, diagnoses and medication use, and toileting assistance placed residents at risk to receive less than adequate care.</p> <p>Findings include:</p> <p>RESIDENT #49 Review of Resident #49's record revealed she admitted to the facility with care needs that included a [REDACTED] to her [REDACTED] that required dressing changes. She also received skilled therapy. Nursing progress notes indicated the resident complained of pain frequently with the dressing changes, movement and therapy.</p> <p>According to the 6/21/13 Minimum Data Set assessment, the resident had complaints of pain and indicators of pain on three to four of the previous five days.</p>	F 279		

RECEIVED

NOV 19 2013

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	<p>Continued From page 9</p> <p>In an interview on 10/25/13 at 9:25 a.m., Staff B stated if a dressing change was anticipated to be painful, staff should provide pain medication prior to the treatment. In an interview on 10/25/13 at 9:35 a.m., Staff A stated she expected residents with complaints of pain to be premedicated prior to therapy and dressing changes.</p> <p>Review of the resident's comprehensive care plan revealed an ADL care plan (CP) that identified a problem of "lower [REDACTED] issues". The goal did not pertain to pain and none of the listed interventions related to pain. The Elimination CP also identified a problem of "lower [REDACTED] issues", but again there were no interventions regarding pain. The "Pain Management" CP also identified the [REDACTED] and pain issues. While the identified goal was the "resident will be comfortable", the interventions did not specify for staff to premedicate the resident prior to therapy or dressing changes, both of which the resident identified as causing her pain.</p> <p>Failure to care plan specific interventions related to this resident's pain placed her at risk to experience increased and unrelieved pain.</p> <p>Similar findings were identified for Resident #10 whose Pain CP did not include specific direction to staff regarding the treatment of his pain.</p> <p>RESIDENT #30 Review of Resident #30's closed record revealed she admitted to the facility with care needs related to [REDACTED] and a surgically repaired [REDACTED]. Nursing progress notes revealed the resident exhibited indicators of pain, including verbal complaints, wincing and</p>	F 279	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">NOV 19 2013</p> <p style="text-align: center;">DSHS/ADSA/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	<p>Continued From page 10</p> <p>grimacing. She also was frequently noted to exhibit what the facility concluded was anxiety, which included frequent movement changes and restlessness.</p> <p>Review of the resident's comprehensive care plan revealed a Pain Management CP, dated 09/01/13, that identified the approach for staff to monitor the resident closely for signs or symptoms or complaints of pain or discomfort, however the CP did not specify how the resident's pain manifested itself. The CP also did not identify any non-drug interventions for staff to utilize to help manage the resident's pain.</p> <p>The Psychotropic Drug Use CP, dated 09/01/13, identified the use of an anti-psychotic medication for "agitation, anxiety, restlessness" and an approach for staff to monitor for effectiveness of the medication. However, the care plan did not include information regarding how the resident's anxiety manifested itself so staff could identify anxiety versus pain.</p> <p>Failure to identify how the resident's pain and anxiety differed or manifested themselves, as well as a failure to identify interventions to relieve pain, placed the resident at risk for continued or increased pain or anxiety.</p> <p>RESIDENT #31 Similar findings were identified for Resident #31, for whom the Mood CP and Psychosocial well-being CP, both dated 09/23/13, did not identify how the goal of "a positive improvement" in mood or psychosocial well-being would be objectively measured. In addition, the Psychotropic drug use CP, dated 09/23/13, failed to identify the initiation of the anti-depressant</p>	F 279		

RECEIVED

NOV 19 2013

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	<p>Continued From page 11 [REDACTED] or its reason for use.</p> <p>RESIDENT #24 Review of Resident #24's record revealed a Pharmacy Consultation Report, dated 06/07/13, that identified the physician ordered the medication [REDACTED] for [REDACTED] issues." A 10/04/13 Pharmacy Consultation Report identified the medication was prescribed for [REDACTED]"</p> <p>Review of the resident's Psychotropic Drug Use CP, updated 08/12/13, identified the resident received the medication [REDACTED] for [REDACTED]. The listed goal was that the resident would be on the lowest effective dosage of anti-anxiety medication as evidenced by her mood, behavior, anxiety level and ability to sleep. However this CP also noted the anti-anxiety medication was discontinued on [REDACTED]/13. Identified interventions included direction for staff to monitor for the effectiveness and/or adverse side effects of anti-anxiety medications (that the resident no longer received).</p> <p>Failure to ensure the care plan accurately identified the reason for a medication, as well as identified goals and interventions that were pertinent to the resident placed her at risk for unmet needs.</p> <p>RESIDENT #5 According to the 07/10/13 MDS, Resident #5 was on a toileting program and occasionally incontinent. According to the 10/05/13 MDS, the resident required extensive assistance of one staff for toileting, was still on a toileting program but had experienced a decline since admission as evidenced by frequent incontinence. In an interview on 10/25/13 at 11:32 a.m. Staff H</p>	F 279		

RECEIVED
NOV 19 2013
DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	<p>Continued From page 12</p> <p>indicated at the time of the second assessment, staff realized the resident was hiding episodes of incontinence and did not believe the resident's urinary status declined, but that the staff became more aware.</p> <p>The 10/08/13 Elimination CP listed one of the problems as "Occasional Urinary Incontinence" and had not been revised after the assessment to reflect the resident's actual urinary status of frequently incontinent.</p> <p>The 07/15/13 Urinary Care Area Assessment indicated the resident was very impulsive, did not ask for assistance (or forgot to) and then went to the bathroom by herself without using her walker which placed the resident at a very high risk for falls due to her poor balance. According to the Elimination CP, approaches included "Staff to offer to assist resident with toileting tasks at least 2-3 times per shift and prn (as needed)" but according to the 08/16/13 post fall incident report (IR) the resident was noted as "independent" with toileting. Similarly the 09/14, 19 and 30/13 post fall IRs identified the resident as "independent" with toileting.</p> <p>Review of the last two weeks of September 2013 Care Tracker documentation revealed staff did not document having toileted Resident #5 according to the toileting plan at all on 09/13, 14, 15, 23, 28 or 29/13 and documented having provided toileting to Resident #5 according to the toileting plan on only one occasion on 09/16, 18, 19, 20, 21, 24, 25, 26, 27 and 30/13.</p> <p>In an interview on 10/25/13 at 9:15 a.m. when asked about toileting Resident #5, the NAC, Staff F said "She'll let me know" and "I go in and check</p>	F 279			

RECEIVED
NOV 19 2013
DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 13 on her."	F 279		
F 309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to consistently recognize, assess and treat pain for four sampled residents of the 18 residents who were included in the Stage 2 review, including two (#s 49 and 10) of three residents reviewed for Rehabilitation and two (#s 30 and 59) supplemental residents reviewed for pain. Failure to identify causes and characteristics of pain and consider administration of pain medication prior to care and services that reasonably could be anticipated to cause pain placed the residents at risk to experience untreated pain and delayed rehabilitation.</p> <p>Findings include, but are not limited to:</p>	F 309	<p><u>F 309 Provide Care/Services for Highest Well Being</u></p> <p>Resident's #10, 30, 49, 59 have discharged from the facility.</p> <p>The facility will train nursing assistants and licensed nurses in pain management including recognizing signs of pain, the impact that pain can have on resident behavior and to notify the nurse if potential signs of pain are noted during care-giving or therapy. The facility will also train therapy staff and nursing staff about pre-medicating residents prior to therapy and other potentially painful treatments.</p> <p>The facility will ensure that care plans are reviewed and updated regularly to correctly identify appropriate interventions for pain. These will be reviewed in weekly care plan meetings.</p> <p>The quality assurance committee will monitor on a quarterly basis. The Director of Nursing Services will ensure that the tasks in the correction plan are completed by December 6, 2013.</p> <p style="text-align: center;">RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 309	<p>Continued From page 14</p> <p>FACILITY POLICY The facility's Pain Assessment and Management policy, dated 06/25/08, indicated "behaviors and/or non-verbal symptoms should be evaluated regarding the presence of pain in residents who are cognitively impaired or unable to communicate.</p> <p>RESIDENT #30 According to her record, Resident #30 admitted to the facility on [REDACTED]/13 following a [REDACTED] for a [REDACTED]. According to a Medicare A Conference sheet, dated [REDACTED]/13, the resident experienced "Significant [REDACTED], unable to follow most directions and unable to convey her needs".</p> <p>The Pain Management care plan (CP), dated 09/01/13, identified the resident with [REDACTED] [REDACTED], and a [REDACTED] with [REDACTED] repair. Approaches included medications as ordered, monitor closely for signs and symptoms or complaints of pain or discomfort and report to nurse and monitor for effectiveness of pain meds at relieving resident's discomfort.</p> <p>The Behavior problem CP, dated 08/30/13, identified the resident with severely impaired cognitive deficits; poor self-initiated safety precautions; spontaneous actions/movements and restlessness. Identified approaches included "respect resident's right to self determination within context of safety and well-being and utilize cues and supervision for safety and well-being". This CP did not identify the behaviors as a possible indicator of pain, nor did it include interventions for staff to treat pain as a possible</p>	F 309	

RECEIVED
NOV 19 2013
DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK SHORE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309	<p>Continued From page 15 cause of the behaviors.</p> <p>Review of Occupational Therapy (OT) notes revealed the resident was assessed to be in pain at times. For example, on 08/21/13, staff noted the resident "stated she felt some discomfort but could not quantify it." The 08/22/13 OT note identified staff assessed her pain to be a [REDACTED] on a scale of one to 10 (where 10 was the worst pain imaginable) that was "Gauged by facial expression and behavior. Pt was unable to quantify on pain scale." Similarly, on 08/28 the resident's pain was identified as a [REDACTED] and was "Assessed by behavior, pt is unable to quantify pain." On 08/29 the pain was rated a [REDACTED] and was again "Assessed by behavior, pt could not express pain."</p> <p>Physical Therapy (PT) notes also identified the resident experienced pain. For example, on 08/21 [REDACTED] pain was rated as a [REDACTED], on 08/23 the resident denied [REDACTED] or [REDACTED] pain but stated "that her butt hurts", "unable to point to location of symptoms upon multiple requests. Antalgic gait (a limp adopted so as to avoid pain on weight-bearing structures) with decreased [REDACTED] extension) noted throughout transfers and gait". This note indicated the pain limited the resident's functional activities. On 08/27 pain was assessed as [REDACTED] based on "facial expressions, guarding. Pt states she is not feeling [REDACTED] pain." On 08/28 the resident was noted to "reports no pain. Mild facial grimace with sit to stand transfers." On 08/30 the pain was a [REDACTED] and the resident reported a "headache, denies [REDACTED] pain. Nursing notified." On 08/31 the pain was assessed as a [REDACTED] based on "Facial grimacing/wincing noted during ambulation; pt asked if she had pain anywhere. She initially denied symptoms then</p>	F 309		
-------	---	-------	--	--

RECEIVED

NOV 19 2013

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013	
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 16</p> <p>indicated (both) [redacted] and (left) [redacted] hurt...". On 09/02 staff noted the pain at a [redacted] and that the resident "declines experiencing pain, however mild antalgic gait noted during gait training."</p> <p>Review of nursing progress notes revealed the resident frequently exhibited signs or symptoms of pain, which were often treated with pain medication. However, on 08/21/13, nursing wrote there were no signs or symptoms of "pain noted, worked with therapies this" morning. There was no indication nursing was notified of the resident's assessed pain during therapy or that it was treated. A nursing note, dated 08/23/13, identified the resident "ambulates with PT and continues to work with OT. No complaints of pain or discomfort noted or reported." There was no indication the PT notified nursing staff of the resident's verbal complaint of pain or her physical expressions of pain as described in their note. On 08/29/13 staff noted the resident worked with PT and OT with no complaints of breakthrough pain. There was again no indication OT staff reported their assessment that the resident was in pain so she could be treated.</p> <p>Additionally, staff administered as needed doses of the anti-psychotic medication [redacted] for restlessness, attempts to get out of bed or her wheelchair and increased agitation with no apparent assessment of whether or not those behaviors were indicative of pain.</p> <p>In an interview on 10/25/13 at 1:45 p.m., Staff A stated the facility needed a system in which therapy and nursing communicated regarding the premedication of residents who experienced pain during therapy, or the treatment of pain when a resident did experience pain during therapy. She</p>	F 309		

RECEIVED

NOV 19 2013

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 17</p> <p>stated staff should have assessed the resident's behaviors within the context of pain. Staff A stated Resident #30 was severely [REDACTED] and staff should not have fully relied on her to rate her pain or even be able to identify pain, but instead should have used her non-verbal behaviors as indicators of potential pain.</p> <p>RESIDENT #49 Review of Resident #49's record revealed she admitted to the facility on [REDACTED]/13 with care needs related to a [REDACTED] that required [REDACTED] changes, [REDACTED] and [REDACTED]</p> <p>According to record review, the resident received a dressing to a [REDACTED] which required changing twice a day. The wound required packing.</p> <p>According to the 6/21/13 Minimum Data Set assessment (MDS), the resident had vocal complaints of pain as well as indicators of pain observed on three to four of the previous five days. The Care Area Assessment, dated 07/02/13, identified the resident with "intermittent pain issues" related to the [REDACTED] wound for which she "occasionally" took as needed pain medication.</p> <p>The Pain Management CP identified the lower [REDACTED] as a cause of pain and included interventions for "medications as ordered" and monitor for pain and the effectiveness of pain medication. There was no direction to staff related to premedicating the resident for pain prior to dressing changes or therapy.</p> <p>Physician's orders directed staff to administer either [REDACTED] every six hours as needed for pain</p>	F 309		

RECEIVED

NOV 19 2013

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 309	<p>Continued From page 18</p> <p>or [REDACTED] every three hours as needed for pain. There was no direction to staff regarding when they were to administer one medication over another and the record indicated some staff gave [REDACTED] while others administered [REDACTED], often times for the same level of pain.</p> <p>Review of PT notes revealed the resident frequently complained of pain, however there was no indication nursing staff were notified nor that the resident received treatment for the pain. Additionally, despite the residents frequent complaints of pain related to therapy, there was no indication facility staff pre-medicated her to lessen the pain she experienced.</p> <p>For example, on 06/15/13 PT noted the resident with pain rated as an [REDACTED] on a scale of one to ten. The resident "described severe pain" when the PT aide attempted to reposition her leg. Review of the Medication Administration Record (MAR) revealed the resident did not receive pain medication on that day. A PT note dated 06/22/13 identified the resident with pain rated at a [REDACTED]. The resident was identified to "continues with loud outbursts whenever (left) [REDACTED] is touched deliberately (for positioning for deceased skin pressures) or inadvertent bumping by staff." Staff noted the pain limited the resident's functional activity. Review of the MAR revealed the resident did not receive pain medication until after 7:00 p.m. on that date, hours after the therapy session in which she complained of pain. Similarly, on 07/04/13 PT noted pain rated as a [REDACTED], while the MAR revealed the resident did not receive pain medication on that date.</p> <p>In an interview on 10/25/13 at 9:35 a.m., Staff A</p>	F 309	<p>RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK SHORE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 309	<p>Continued From page 19</p> <p>indicated she expected residents who complained of pain to be premedicated prior to therapy or dressing changes, both of which could reasonably be expected to cause pain. She was unable to explain why staff would administer a prn [REDACTED] for a pain rating which was higher than that for which a prn [REDACTED] was administered.</p> <p>In an interview on 10/25/13 at 9:25 a.m., Staff B stated the decision to premedicate prior to a dressing change or therapy depended on the resident. She explained "If it's (dressing change) gonna be painful we would premedicate... with the people with pain with movement, we would premedicate (prior to therapy)." She also explained for residents with two types of pain medications, staff would "start with the least one [REDACTED] first then use the other (if pain continued)...".</p> <p>Staff also failed to consistently premedicate the resident prior to dressing changes.</p> <p>On 06/28/13 at 11:00 am staff documented the resident complained of pain during and right after treatment by the wound nurse. There was no indication the resident was treated for pain either before or after the dressing change.</p> <p>The nursing progress note, dated 07/07/13, identified the treatment "to [REDACTED] done as ordered... Painful, but (tolerated treatment) well...". There was no indication staff premedicated prior to the dressing change which was identified to cause the resident pain.</p> <p>On 07/09/13, nursing staff noted the resident expressed pain during the dressing change and</p>	F 309	<p style="text-align: center;">RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>	
-------	--	-------	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 20</p> <p>██████ was then given with good effect. It was also noted the resident "appears agitated while working with PT/OT..." but there was no indication she was assessed or treated for pain.</p> <p>On several occasions (06/29, 30, 07/02, 07) staff documented they premedicated the resident for pain prior to a dressing change and she had no complaints of pain. Failure to consistently provide this care placed the resident at risk for pain that could have been avoided.</p> <p>RESIDENT #10 Similar findings were identified for Resident #10, whose closed record was reviewed. Therapy staff documented pain at varying levels that limited the resident's functional activities. According to the ██████/13 ██████ discharge summary, the resident did not perform a requested transfer due to "Patient declined due to ██████ pain", however there was no indication in the MAR he was treated for pain at that time. There was no indication nursing staff were made aware of, or provided treatment for, the pain therapy assessed the resident to experience.</p> <p>RESIDENT #59 Similar findings were identified for Resident #59 who stated in an interview on 10/22/13 at 2:15 p.m. she sometimes waited up to thirty minutes to receive pain medication without any explanation. In an interview on 10/24/13 at 1:01 p.m., she further stated she asked for pain medication prior to therapy, but staff were sometimes unable to provide it due to the time parameters in her Physician Orders (POs). She stated she would then experience pain during therapy, as neither the therapy staff nor the nurse were willing to alter the schedule to ensure her pain was treated.</p>	F 309	<p>RECEIVED</p> <p>NOV 19 2013</p> <p>DSHS/ADSA/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 21</p> <p>Resident #59 explained she had a [REDACTED] replacement that caused her pain and while the facility had obtained POs for pain medication and other treatments that better met her needs, she felt pain as it related to her therapy had not been adequately addressed.</p> <p>In an interview on 10/24/13 at 2:45 p.m., Staff B stated the resident received both routine and as needed pain medication, however she had asked for pain medication prior to therapy that morning and as it had not been enough time between doses Staff B was unable to administer the medication. Staff B then stated she observed the resident in therapy and she "seemed ok" so she did not offer her pain medication nor did she ask the resident or the therapist if pain was experienced. She stated the resident did request pain medication after therapy and it was provided.</p> <p>Failure to ensure residents were premedicated prior to services that could reasonably be expected to cause them pain placed residents at risk for increased or untreated pain.</p>	F 309	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">NOV 19 2013</p> <p style="text-align: center;">DSHS/ADSA/RCS</p> <p><u>F 323 Free from Accident Hazards/Supervision/Devices</u></p> <p>The care plan and NAC directives for resident # 5 has been reviewed and updated to increase the level of supervision and assistance for the resident. The facility had speech therapy do another [REDACTED] evaluation on resident #1, it was determined that she was no longer at risk for [REDACTED] and her diet could be safely upgraded, and the care plan has been updated.</p>	
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 323	<p>The facility will devise and implement a new post fall assessment to identify circumstances and causes of falls. The facility will train nursing staff in the use of the new assessment form, including reviewing medications that can cause falls and doing postural blood pressures. The nursing staff will be in-serviced on when and how to refer residents to speech therapy.</p> <p>The Director of Nursing Services will review unusual occurrence reports and post fall assessments to ensure compliance.</p> <p>The quality assurance committee will monitor on a quarterly basis. The Director of Nursing Services will ensure that the tasks in the correction plan are completed by December 6, 2013.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 323	<p>Continued From page 22</p> <p>by:</p> <p>Based on observation, interview and record review it was determined that the facility failed to ensure adequate supervision was provided to prevent accidents for two (#s 5 and 1) of three residents reviewed for accidents. Failure of the facility to conduct thorough post fall investigations to determine the circumstances of the incidents and ensure staff implemented care as planned left the facility unable to implement effective preventative measures and placed Resident #5 at risk of continued falls and injury. In addition, failure of the facility to provide supervision and assistance with eating Resident #1 was assessed to require placed the resident at risk of aspiration and [REDACTED]</p> <p>Findings include:</p> <p>RESIDENT #5 According to the 07/10/13 Minimum Data Set assessment (MDS), the resident was assessed to require extensive assistance of one staff for transfers and ambulation. The resident's balance was not steady, and although she had falls prior to admission, the resident had no falls since admission on [REDACTED]/13. The 07/15/13 Fall Care Area Assessment (CAA) indicated the resident had multiple falls over the past six to seven months while in her Assisted Living apartment. The falls were attributed to the resident's old [REDACTED] with mild [REDACTED] side [REDACTED] and a tendency to 'drag' her [REDACTED] foot, very poor balance, occasional [REDACTED] usage, impulsivity, resistance to asking for help with transfers and ambulation, refusing to or forgetting to use her walker, and very poor safety awareness and judgement. The resident also had a diagnosis of [REDACTED] with mild to moderate</p>	F 323	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">NOV 19 2013</p> <p style="text-align: center;">DSHS/ADS/RCS</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 323	<p>Continued From page 23</p> <p>██████ deficits, which also placed her at a high risk for falls. The CAA noted the resident "refuses to or forgets to ask for help or wait for help when she does use the call light and often either forgets to use or refuses to use her walker when ambulating. Resident is very strong-willed, stubborn and can be angry, resistive with care, at times. Will proceed with care plan." Additionally, the 07/15/13 Urinary CAA indicated the resident had a diagnosis of ██████ with occasional ██████ problems. The resident was identified as "very ██████, will not ask for assistance (or forgets to) and then go to bathroom by herself without using her walker which places resident at a very high risk for falls due to her poor ██████"</p> <p>According to the 10/05/13 MDS, the resident was assessed to require the same level of assistance with mobility, was on a toileting program and had sustained five falls since the prior assessment, three (08/24, 09/14 and 08/16) without ██████ and two (09/19 and 09/30) with ██████</p> <p>Review of Unusual Occurrence Reports revealed Resident #5 experienced additional falls on 10/22 and 10/23/13 with ██████</p> <p>In an interview on 10/23/13 at 8:53 a.m. Staff E said the resident fell frequently, "at least two to three times a month", as recently as "yesterday". Staff E said Resident #5 "just loses her balance and doesn't tell anybody, she hides it until we find the bruises or skin tears." When asked what Resident #5 was doing prior to falling, Staff E replied "She is fixing things, kneeling on the ground, cleaning things." Staff E indicated "She is on every two hour assistance to the toilet and supervision, but still (she falls)."</p>	F 323	<p style="text-align: center;">RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 24</p> <p>The post fall investigations were reviewed. The 08/24/13 11:05 a.m. Unusual Occurrence Report (UOR) indicated the resident was reaching up high to get a plastic box when she lost her balance, fell backwards and hit her [REDACTED] and [REDACTED] on the floor. According to the UOR the resident was last seen at the "time of fall."</p> <p>According to the 07/11/13 Fall care plan (CP), approaches included "Monitor resident frequently, does not always use her call light", "Check resident frequently" and "tends to not use call light or call for help first, and forgets to use her walker." The 08/24/13 UOR, and similarly the 09/19/13 and 09/30/13 UORs did not include investigations thorough enough to determine when the resident was last monitored, checked on or care provided prior to the fall to ensure staff implemented the plan of care designed to prevent continued falls. In an interview on 10/28/13 at 11:05 a.m. Staff A indicated the expectation of the intervention to monitor a resident "frequently" was "at least three times a shift." With the facility identified factors which placed the resident at risk of falls, and a lack of a thorough investigation, the facility was left unable to determine if the amount of supervision being provided was sufficient to prevent falls or if more was needed.</p> <p>On 10/25/13 at 9:18 a.m. Resident #5 was observed sitting on the side of her bed. Staff F was observed to enter the resident's room and ask "Did you use your call light?" to which the resident responded, "no why should I, I don't need anything". Prior to leaving the room, Staff F told Resident #5 to call before getting up to prevent falls. The 08/24/13 UOR indicated interventions to prevent reoccurrence included</p>	F 323		

RECEIVED

NOV 19 2013

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 25</p> <p>"Remind resident that she needs to call for assistance with transferring and ambulation" despite the prior assessments that indicated facility awareness that the intervention was not sufficient to prevent Resident #5 from falling.</p> <p>On 10/23/13 at 2:48 p.m. Resident #5 was observed standing in her room fiddling with objects on the overbed table. Although there was a caregiver in the room, the caregiver was assisting Resident #5's roommate and was not observed to intervene with Resident #5.</p> <p>According to the 09/14/13 8:00 p.m. UOR, an aide (NAC) reported that she heard a thump sound. She turned around and the resident was on the floor. The resident got up on her own and stated "I am fine." The resident statement was "I was looking for something, I just don't remember what" and "My leg got caught on carpet". Listed behavior issues prior to the fall included [REDACTED] keep getting up to talk to roommate without walker. Constantly reminded and encouraged to use walker." According to the UOR an agency NAC was in the room at the time helping the roommate.</p> <p>Review of the 07/11/13 Fall CP revealed approaches including "Monitor resident for unsafe acts or falls, report to LN" and "Remind resident to use her call light and to ask for assistance with transfers and ambulation prior to starting task." The investigation of the 09/14/13 fall indicated the resident was last seen "a minute prior to fall" but did not include a statement by the agency NAC in the room at the time to determine what the NAC observed the resident doing prior to the fall and if the NAC identified the act as unsafe, and what if anything was done, leaving the facility unable to</p>	F 323	<p style="text-align: right;">RECEIVED NOV 19 2013 DSHS/ADS/Bo</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013	
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 26</p> <p>implement an appropriate approach to prevent reoccurrence.</p> <p>Additionally, according to the 07/11/13 ADL CP the resident had a tendency to ' [redacted] her [redacted] foot. Review of the resident's record revealed an 08/08/13 Physical Therapy note indicating the resident had a [redacted] positioning device and "will need nursing assistance to secure appropriately each morning." The CP was not revised until 09/27/13 to include "Make sure resident is wearing adaptive device on [redacted] with shoe insert to decrease resident's tendency to [redacted] [redacted] (Helps to lift [redacted] "</p> <p>The 09/14/13 UOR indicated the resident reported catching her leg on the carpet prior to the fall, but an investigation was not conducted to determine with which foot or if the resident was wearing the adaptive device the resident was assessed to require to prevent falls.</p> <p>On 10/25/13 at 10:18 a.m. Resident #5 was observed lying on top of her bed reading a newspaper. The resident had tennis shoes on both feet, but was not observed wearing the adaptive device. When questioned, Resident #5 replied, "I've lost the inner part of it. It's in this room somewhere" and added "they took my shoes off here", pointing under the bedside table where the adaptive device was observed still attached to a shoe.</p> <p>Additional review of the 09/14/13 UOR revealed the facility was "Unable to determine if medications side effects are contributing to unsteadiness. Will discuss with ARNP at next visit." A 09/03/13 Pharmacist Consultation Report recommended the physician re-evaluate</p>	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013	
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 27</p> <p>continued concomitant use of two [REDACTED] as it "may increase the potential for adverse events." In an interview on 10/28/13 at 11:23 a.m. Staff A said she asked the physician to review the resident's medications and the physician did not think the [REDACTED] were contributing to the resident's [REDACTED]. Staff A indicated no changes had been made to the [REDACTED] medications because the physician felt the resident was stable on the medications as they were. Staff A acknowledged it was unknown if the resident was receiving the lowest effective dose of the medications, or how the physician had concluded the [REDACTED] the [REDACTED] of the [REDACTED].</p> <p>According to the 2011 Davis Drug Guide, located at the nurse's station, side effects of the antidepressant [REDACTED] which the resident received, included dizziness, confusion, weakness, and urinary frequency. Review of the UORs revealed for each of the falls experienced on 7/08, 08/24, 09/19 and 09/30/13 the resident said she lost her balance. Review of the Fall Risk Assessment form revealed staff failed to conduct post fall [REDACTED] pressure readings to determine if [REDACTED] contributed to the falls on 07/08, 09/19 and 09/30/13. In an interview on 10/28/13 at 11:05 a.m. Staff B said "On the fall assessment they are supposed to do the [REDACTED]."</p> <p>Review of the 08/16/13 UOR revealed at 5:00 a.m. Resident #5 had an unwitnessed fall in her bathroom. According to investigative documents the resident was not last toileted by staff as the resident was deemed "Independent". Similar findings were noted on the 09/14, 09/19 and 09/30/13 UORs.</p>	F 323	<p style="text-align: center;">RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 28</p> <p>According to the 07/11/13 Elimination CP, "Staff to offer to assist resident with toileting tasks at least 2-3 times per shift and prn (as needed)." In an interview on 10/25/13 at 11:32 a.m. Staff H indicated the resident was on a toileting program which included staff assistance to the toilet when the resident got up in the morning, before and after meals, and in between times when the resident needed to go. Staff H said "I toilet her frequently so she won't fall."</p> <p>In an interview on 10/25/13 at 9:15 a.m. when asked about toileting Resident #5, the NAC, Staff F said "She'll let me know" and "I go in and check on her."</p> <p>Review of the facility's computerized Care Tracker documentation revealed the resident was "Toileted per toileting plan" on 08/15/13 at 9:49 p.m. and not again until 08/17/13 at 10:31 a.m. The facility failed to ensure the resident was toileted according to the plan of care which may have contributed to the resident's fall in the bathroom. In an interview on 10/28/13 at 11:05 a.m. Staff A indicated the resident "seems so independent" and "the aids need to check on her more often". Staff A acknowledged staff should assist the resident in the bathroom.</p> <p>The facility identified preventative measure implemented after the 08/16/13 fall was "Will continue to monitor resident, reinforce safety awareness, will keep reinforcing resident to call for assistance when getting out of bed, assist with transfers to prevent falls." It did not include interventions to ensure the resident received the toileting assistance the resident was assessed to require.</p>	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013	
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 29</p> <p>On 10/25/13 at 10:18 a.m. Resident #5 was observed with a bruise to her [REDACTED] and three staples further back on the [REDACTED] of her [REDACTED]. Resident #5 said "That's from one of the falls" and described an incident as "My walker deserted me, I didn't have it latched so it fell over when I moved to grab the bar in the bathroom. I fell over it and hit my [REDACTED]"</p> <p>Review of the 10/22/13 UOR revealed the resident was noted to have a [REDACTED] to her [REDACTED], bruising on [REDACTED] and [REDACTED], and a [REDACTED] to her [REDACTED]. The resident statement at the time was "I must have fallen, my brakes on my walker weren't locked." The resident had last been seen at 4:15 a.m. with the skin tear. The plan to prevent reoccurrence listed was for the caregiver to check the resident several (three to four) times at night.</p> <p>Review of the 10/23/13 UOR revealed the resident sustained a [REDACTED] laceration when she had an unwitnessed fall in her room at 5:15 p.m. According to the UOR the "resident got out of bed without using call light or notifying staff. NAC was in the bathroom with her roommate and had seen resident moments prior to hearing the crash. Resident had not told NAC that she needed anything." According to the resident statement at the time, she tripped on her own feet. The investigation indicated the resident was wearing shoes, but not if the adaptive device was in place. In addition, the employee statement directed the NAC to answer "What was the last type of care that you provided to the resident? (For example... took to the bathroom?)" to which the NAC responded, "The resident is independent." To the question, "What level of</p>	F 323		

RECEIVED

NOV 19 2013

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013	
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 30</p> <p>assistance does the resident usually require with transfers?", the NAC replied "Independent." The facility failed to ensure staff provided the supervision, care and assistance the resident was assessed to require to prevent recurrent falls.</p> <p>RESIDENT #1 Observation of Resident #1's room on 10/23/13 at 8:59 a.m. revealed a sign posted above her bed which stated, "Thin liquids only with one on one supervision. Use straight straw and chin tuck." Resident #1 was observed in bed with a breakfast tray that contained unthickend orange juice and cranberry juice, without staff present. In addition, the resident had a water pitcher with a bent straw. An NAC was observed to enter the room, remove the tray, and bring in fresh ice water with a bent straw. In an interview on 10/24/13 at 1:33 p.m. Staff B said "I don't know who made this sign. I'll make a new one and put it up there. They always said she couldn't have a straw."</p> <p>Review of the resident's record revealed Physician's Orders, dated [REDACTED]/13, for a [REDACTED] and [REDACTED] "Patient may have [REDACTED] with 1:1 supervision for [REDACTED]"</p> <p>A [REDACTED]/13 SLP (speech therapy) treatment encounter note indicated the resident was "seen for 1:1 [REDACTED] (treatment). PT unable to follow 1 step directions today or accept PO (oral) trials of [REDACTED]. Pt to be placed on medical hold and to be reassessed for appropriateness of skilled intervention in one week". No further notes were found in the resident's record.</p> <p>According to the 08/10/13 MDS the resident received a therapeutic [REDACTED]. The MDS did not</p>	F 323	<p style="text-align: right;">RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK SHORE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 32</p> <p>present. The resident's lunch tray also contained glasses of unthickened water and juice. Staff B was summonsed to the room and said "she's been swallowing a lot better". When asked how Staff B determined that, Staff B replied "Because she hasn't been having chocking episodes." Staff B added, "we should probably have speech therapy in here and reevaluate her to upgrade her diet."</p> <p>Staff B was observed to raise the head of Resident #1's bed and told the resident "You need to be up to drink." She then offered the resident more to drink without a straw. When questioned, Staff B replied, "She's not supposed to have a straw." and left the room to review the resident's record with the thin liquids still within reach of the resident.</p> <p>At 1:04 a.m. the NAC, Staff D, entered the room, and removed the resident's lunch try. Staff B who had returned to the room informed Staff D "She's supposed to have _____ unless you're in here." Staff D responded, "I thought that (_____) was changed... because she was doing well by herself, she eats a little on her own."</p> <p>On 10/24/13 at 1:33 p.m. Staff B confirmed the last _____ received was in _____ 2013, and indicated staff failed to provide the level of supervision that was ordered.</p>	F 323		
F 325 SS=E	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p>	F 325	<p>RECEIVED NOV 19 2013 DSHS/ADS/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013	
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	<p>Continued From page 33</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to implement interventions to prevent weight loss or encourage weight gain when indicated for three (#s 28, 5 & 30) of three residents reviewed for Nutrition and two (#s 1 and 31) supplemental residents. The facility also failed to ensure weights and meal monitors were accurate in order to assess a resident's nutritional parameters.</p> <p>Findings include:</p> <p>RESIDENT #1 According to the 08/10/13 MDS Significant Change MDS, the resident's weight was [redacted] lbs and experienced a significant weight loss of [redacted] or more in the last month or [redacted] in the last six months. The 08/20/13 Nutrition Care Area Assessment (CAA) indicated that since 07/21/13 the resident had an ongoing overall decline in condition, refused to eat most of the time or ate very little, required staff assist with all intake and had a new significant [redacted] loss. The CAA noted "staff continue to encourage resident to eat more and supplements are being offered. Will update and continue with care plan."</p>	F 325	<p><u>F 325 Maintain Nutrition Status Unless Unavoidable</u></p> <p>The physician has changed the order for Resident #1 to indicate she should [redacted] per day and the medication administration record has been updated to reflect the change. Resident #31 has been reweighed and the [redacted] intake is being recorded accurately. The care plans for residents #28 and #5 have been revised to address [redacted] with appropriate interventions. Resident #30 has discharged from the facility.</p> <p>The nursing staff will be in-serviced on the importance of obtaining weights as ordered and re-weighing residents if there is a weight loss or gain of 5% or more. The nursing and NAC staff will be in-serviced on obtaining and recording meal monitors with accuracy. The nursing staff and the registered dietician will meet to discuss interventions that can be implemented to prevent weight loss.</p> <p>The medical records coordinator will audit weights once a week to ensure the weights have been obtained and recorded for each resident. If no re-weight has been obtained for a weight change of more than 5%, medical records will inform the Director of Nursing Services who will ensure that staff gets a new weight. The medical records coordinator will also audit meal monitors for completion on a bi-weekly basis and report errors to the Director of Nursing Services.</p> <p>The quality assurance committee will monitor on a quarterly basis. The Director of Nursing Services will ensure that the tasks in the correction plan are completed by December 6, 2013.</p> <p style="text-align: right;">RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK SHORE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 325	<p>Continued From page 34</p> <p>The 08/05/13 Quarterly Nutrition Review indicated the resident's IBW range [REDACTED] lbs. The analysis included "Wt [REDACTED] meals low currently." The plan was to "continue diet order, advancing as possible, encouraging meal completion, supplementation as necessary, monitor wt and meal %".</p> <p>Review of the POs revealed a 08/07/13 order to "Feed pt [REDACTED] small meals a day even if she says she is not hungry - try."</p> <p>The 08/13/13 Nutrition CP listed problems including significant weight [REDACTED] (prior admission) and recent weight [REDACTED] due to decline in condition (started 07/21/13) with very poor appetite. The listed goal was "Resident will consume adequate nutrition as evidenced by no further weight [REDACTED]" Approaches included tray monitor, RD eval PRN, diet as ordered and weight every week. The CP did not include the instructions to provide six meals a day, a plan to provide supplements, or instructions to encourage meal completion.</p> <p>The August Medication Administration Record (MAR) included instructions to staff to provide [REDACTED] small meals a day at 7:00 a.m., 10:00 a.m., 1:00 p.m., 4:00 p.m., 6:00 p.m. and 9:00 p.m. which were documented as offered from 08/08 through 08/31/13. The order was not carried over to September or October's MAR.</p> <p>Throughout the survey Resident #1 was observed to receive standard breakfast and lunch trays and not [REDACTED] small meals a day as ordered.</p> <p>In an interview on 10/24/13 at 1:33 p.m. Staff B said "They (the kitchen) were only sending three</p>	F 325		
-------	--	-------	--	--

RECEIVED

NOV 19 2013

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	<p>Continued From page 35</p> <p>meals a day and we would have to subsidize with snacks. They would give her bananas and orange juice." Staff B said Resident #1 was sick in August and September and now ate 100% of her lunch so she was not able to eat six small meals a day. The facility failed to provide the diet as ordered or reassess the resident to determine the need for the continued order.</p> <p>Review of the September Meal Monitor revealed the resident was offered breakfast, lunch and dinner. The AM snack, PM snack and bedtime snacks were not documented as offered or refused. The documented meal % intake was variable, with a range from 0% to 100%. The Resident's intake was less than █ on 38 occasions without supplements offered.</p> <p>Review of the Weight Flow Sheet revealed the weights were not completed on a weekly basis as planned and the resident sustained continued weight █. The weights were documented as: 08/02/13 █, 08/23/13 █, 08/31/13 █, 09/20/13 █, 09/27/13 █ lbs, 10/04/13 "Unable" and 10/18/13 was blank. In an interview on 10/24/13 at 1:33 p.m. Staff B said she would have the staff weigh the resident using the hoier lift and later reported the resident's current weight was █ lbs.</p> <p>In an interview on 10/28/13 at 11:34 a.m. Staff A indicated Licensed staff were expected to notify the RD of weight █ and the RD was expected to make recommendations. Following the weight █ on 09/27/13 the only dietary recommendation was to re-weigh the resident.</p> <p>RESIDENT #31 Review of Resident #31's weights revealed the</p>	F 325	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">OCT 19 2013</p> <p style="text-align: center;">DHS/ADSA/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	<p>Continued From page 36</p> <p>following: 09/10 [REDACTED], 09/20/13 [REDACTED], 09/27/13 [REDACTED], 10/04/13 [REDACTED], 10/19/13 [REDACTED] and 10/25/13 [REDACTED]. A PO, dated [REDACTED]/13, identified the anti-depressant [REDACTED] was added for [REDACTED] and low [REDACTED].</p> <p>In an interview on 10/28/13 at 8:56 a.m., Staff B stated the 10/04/13 weight was "probably inaccurate". She stated staff should have re-weighed the resident as the weight was over a [REDACTED] pound difference from the previous one. She stated there was no indication a re-weight was done.</p> <p>Review of meal monitors revealed staff frequently documented a resident's meal intake on a paper form. They would then input that data into the facility's computerized CareTracker system. However, data for the same meal did not always match. For example, on 09/27 staff noted on the paper monitor the resident consumed 50% of breakfast, but in the CareTracker they noted 100% consumed. On 09/29/13 they noted 50% intake on paper but 75% on the computer. On 10/05/13 they noted 25% intake for breakfast but 100% on the computer.</p> <p>Discrepancies in weights and meal intake monitoring prevented the facility from accurately determining the resident's nutritional status as well as impaired the facility's ability to monitor the use of [REDACTED], which was initiated for a poor [REDACTED].</p> <p>RESIDENT #28 Resident #28 was admitted to the facility on [REDACTED] 13. The 01/21/13 Nutrition Screen and Assessment listed the resident's IBW (Ideal Body Weight) at [REDACTED] pounds (lbs) and an actual</p>	F 325	<p style="text-align: right;">RECEIVED NOV 18 2013 DSHS/ADSS/RCJ</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 37</p> <p>admission weight of [REDACTED] lbs with a BMI (Body Mass Index) of [REDACTED]. The analysis included "Meals appear good to fair - perhaps enough to gain weight with encouragement." In an interview on 10/28/13 at 9:26 a.m., when asked about the BMI, Staff I said "I would be concerned at less than [REDACTED]" When asked what Resident #28's BMI was, Staff I said "Initially it was [REDACTED]"</p> <p>A 04/19/13 quarterly Nutrition Review indicated the resident's weight remained below the IBW range at [REDACTED] and meal intake was "fair". The plan included offering evening snacks and monitoring meal intake and weights. Review of the August and September Meal Monitors revealed no documentation staff offered evening snacks as planned. In an interview on 10/28/13 at 9:26 a.m. Staff I said "if a resident was to get snacks it would be ordered through a diet slip as a beginning, but I see nurses take it over and they will just offer. I don't know if that is recorded or not, it should be."</p> <p>The 07/16/13 quarterly Nutritional Assessment listed the resident's current weight at [REDACTED] with an average meal intake of 50-70%. The plan was the same, to continue diet as ordered, encourage meal consumption and monitor meal intake and weights.</p> <p>According to the 07/20/13 Minimum Data Set assessment (MDS) the resident required set up and supervision of one staff for eating, was [REDACTED] inches tall and weighted [REDACTED]. The resident had experienced no significant weight loss or gain and received a mechanically altered diet.</p> <p>The 07/22/13 second quarter Nutrition Care Plan (CP) Review indicated the appetite stimulant</p>	F 325			

RECEIVED
NOV 19 2013
DSHS/ADSARCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013	
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	<p>Continued From page 38</p> <p>██████ was discontinued on 05/16/13 due to ineffectiveness as the resident continued to eat 50-60% of meals and maintained a weight at around ██████. In an interview on 10/28/13 at 11:39 a.m. Staff A indicated the resident was on ██████ for a while, but it was discontinued on ██████/13 at the Pharmacist's request and "she did gain weight afterwards."</p> <p>According to the 07/23/13 Nutrition CP the resident had "poor appetite at times, potential for weight loss and below IBW". The listed goal was "Resident will continue to be able to feed self after set-up and consume adequate nutrition aeb (as evidenced by) no s/s (signs or symptoms) of weight loss." Interventions included Tray monitor, RD evaluation PRN (as needed), weekly weight, and set up food items each meal. The CP did not include the goal of weight gain or the interventions to offer evening snack or encourage intake.</p> <p>Review of the Weights Floor Sheet revealed the resident's weights were not monitored weekly as planned. The weights were as follows: 08/02/13 ██████, 08/16/13 ██████, 09/06/13 ██████, 09/13/13 ██████, 09/16/13 ██████, 10/04/13 ██████, 10/18/13 104 and 10/25/13 ██████</p> <p>In an interview on 10/28/13 at 9:26 a.m.. Staff I said "I have her at ██████ lbs on the 18th, that is on the bottom of the ideal range." In reviewing the weights, Staff I said "I think that weight of ██████ lbs was a mistake, at that point the scale was not very accurate"; "She has been as low as ██████ several times."</p> <p>A 10/16/13 quarterly Nutrition Review listed the resident's current weight at ██████, "weight</p>	F 325	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">NOV 19 2013</p> <p style="text-align: center;">DSHS/ADS/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK SHORE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 325	<p>Continued From page 39</p> <p>remains at low end of IBW range or slightly below her usual". The plan remained the same, "continue diet order, encouraging meals, extra as possible, continue to monitor wt and meal %."</p> <p>Review of October physician's orders (POs) revealed the resident's regular diet with [REDACTED] and [REDACTED] had been in place since [REDACTED]/13. In an interview on 10/28/13 at 9:26 a.m. Staff I said the resident admitted with a [REDACTED] mechanical diet with [REDACTED] but she refused so she was put on a general diet with [REDACTED]. "She went well with that, I was hoping she would come up and she did, then she went down again, we should have done something about it at that time, if we did it's not recorded."</p> <p>The 01/18/13 Nutrition Screen and Assessment indicated a plan of "supplements". Review of the October PO revealed the resident had no current orders for supplements. In an interview on 10/28/13 at 9:26 a.m. Staff I said "if (resident is) eating less than 50% they are offered alternatives, if refuse then we offer supplement, often is [REDACTED] some think too sweet, may be offered at end of meal or between meals. I always like to offer between meals for a start." In an interview on 10/28/13 at 12:21 p.m. Staff E said of Resident #28 "Sometimes when we feel she is not eating we offer her [REDACTED] supplement, but she doesn't always take it." Review of the September Meal Monitor revealed the resident ate 25% of her meal on four occasions and 50% of meal on 25 occasions without a supplement offered.</p> <p>On 10/28/13 when asked what interventions had been put in place to promote weight gain, or</p>	F 325	<p>RECEIVED</p> <p>NOV 19 2013</p> <p>DSHS/ADSA/RCS</p>	
-------	---	-------	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 325	<p>Continued From page 40</p> <p>prevent weight loss, Staff I said "I have talked to her about eating... I believe she was going to make some changes, like have milk with her meals. She's open to things, she doesn't follow through very well. She seems to want to help herself." When asked how the facility ensured the resident was offered milk at meals, Staff I said "I'm not sure how detailed we got with that, obviously it should have been written down... liquids are offered in the dining room, I was hoping she would take that up on her own."</p> <p>On 10/28/13 at 12:21 p.m. Resident #28 was observed in the dining room for lunch, drinking Fanta orange soda and water. The resident did not have milk and when asked why not, replied, "No, I didn't want any."</p> <p>RESIDENT #5 Similar findings were noted for Resident #5 who had a BMI of [REDACTED] with a wt of [REDACTED]. The Nutritional Assessment identified an IBW of [REDACTED]. The weights were not obtained on a weekly basis as care planned and no interventions were planned or implemented to promote weight gain and/or prevent further weight loss.</p> <p>RESIDENT #30 Review of Resident #30's record revealed she was not on a planned weight loss program. The resident's admission weight (wt) was recorded as [REDACTED] pounds on [REDACTED]/13. Her weight on 09/03/13 was recorded as [REDACTED] pounds (lbs) and then on 09/06/13 her wt was recorded as [REDACTED]</p> <p>The 09/03/13 MDS identified the resident experienced a a wt gain of [REDACTED] or more in the past month. There was no indication in the resident's</p>	F 325	<p>RECEIVED</p> <p>NOV 19 2013</p> <p>DSHS/ADSNRGS</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	Continued From page 41 record staff assessed the resident's weights as potentially being inaccurate or that they assessed the reported [REDACTED] pound weight gain and then [REDACTED] pound weight loss in 21 days. In an interview on 10/25/13 at 1:26 p.m. Staff B stated she did not believe the weights were accurate, as there was no indication the resident had the significant weight changes the weights indicated. She stated the [REDACTED] weight was likely a mistaken weight. She explained the facility's policy was staff were to reweigh the resident if a three pound difference was noted. She acknowledged that had not been done. Failure to accurately monitor the resident's weights prevented the facility from monitoring Resident #30's nutritional status. In an interview on 10/28/13 at 9:50 a.m., Staff I stated accurate weights were "very important to be able to monitor a resident's ongoing nutritional status".	F 325			
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329			

RECEIVED
NOV 9 2013
DSHS/ALSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 42</p> <p>resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure four of five residents (#s 11, 31, 27 & 5) reviewed for unnecessary medications and two of two residents (#5 & 24) reviewed for continence decline were free of unnecessary medications related to adequate indications for use, consistent monitoring of the medication, and gradual dose reductions when appropriate.</p> <p>In addition, medications were administered to Resident #11 in excess, outside of physician's orders, making them unnecessary medications.</p> <p>Findings include but are not limited to: Refer to: CFR 483.25, F-309, Provide Care/Services for Highest Well-Being CFR 483.25(h), F-323, Free of Accident Hazards / Supervision CFR 483.25(i), F-325, Maintain Nutrition Status</p>	F 329	<p><u>F 329 Drug Regimen is Free From Unnecessary Drugs</u></p> <p>The physician orders and MARs for resident #24 have been revised reflect an accurate diagnosis and to monitor the medication [REDACTED]. The physician will be approached again regarding discontinuing the [REDACTED], or monitoring for its effectiveness if the physician will not d/c it. The facility will contact the physician for resident #11 and request documentation of a failed GDR or an order for a GDR of the [REDACTED]. The facility will also request physician to reconsider pharmacy consultants' recommendations for the [REDACTED] and [REDACTED], and will monitor for the effectiveness of these medications. Resident #30 is no longer in the facility. The psychotropic monitoring sheets for resident #31 will be revised with more objective behaviors, and a correct diagnosis has been obtained for the [REDACTED]. For resident #21, facility will request further gradual dose reductions of [REDACTED]. For resident #5, the facility will re-approach the physician to request GDRs of the antidepressants and will ask the medical director to intervene if the primary physician refuses.</p> <p>The facility will train nursing and NAC staff about the facility's policy on unnecessary drugs including identifying and monitoring for objective behaviors and potential side effects. The staff will be in-serviced on the mood and behavior module in Care Tracker.</p> <p>Once per month, the Director of Nursing Services and the Behavior Management Team will review medication administration records to ensure that specific target behaviors are listed psychoactive medication administration sheets and that non-medication interventions are listed on the PRN medication sheets.</p> <p>The quality assurance committee will monitor on a quarterly basis. The Director of Nursing Services will ensure that the tasks in the correction plan are completed by December 6, 2013.</p>		

RECEIVED

NOV 19 2013

DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013	
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 43</p> <p>RESIDENT #24</p> <p>Review of Resident #24's record revealed a physician's order (PO) for ██████ "at bedtime and as needed for ██████. The 06/07/13 Pharmacy Consultation Report identified the ██████ was used for ██████ which was "not an approved use". It was requested the physician "re-evaluate continued ██████ use and consider discontinuation". The physician responded, on ██████/13, "the ██████ is being used for ██████ issues...". On 06/19/13 the as needed (prn) dose was discontinued, however the PO again stated the ██████ was for ██████.</p> <p>The 08/12/13 Psychotropic Drug Use care plan identified the ██████ was used "for ██████</p> <p>In an interview on 10/24/13 at 11:25 a.m., the resident's family member stated the resident was often sleeping when he visited. The resident was observed asleep at that time.</p> <p>Review of the resident's record revealed no monitoring of her sleep patterns.</p> <p>The 10/04/13 Pharmacy Consultation Report again notified the physician that ██████ "is not indicated for ██████. No sleep monitor found. No complaints of ██████ found... Please re-evaluate continued use of ██████ for i ██████. Suggest a day sleep monitor then re-eval." The physician responded on ██████/13, "The indication (for the ██████) is ██████ not... ██████ It appears to work well". The resident's record revealed no indication of a ██████ or that ██████ was monitored, nor was there any indication of why the physician altered the reason for which the medication was administered. Failure to monitor the reasons for</p>	F 329	<p>RECEIVED</p> <p>NOV 19 2013</p> <p>DSHS/ADSA/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK SHORE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 329	<p>Continued From page 44</p> <p>which a medication was used and failure to ensure medications were used only as indicated placed this resident at risk to receive an unnecessary medication.</p> <p>In addition, the resident received [REDACTED] since [REDACTED]/12, according to a [REDACTED]/13 physician's note. The [REDACTED]/13 Pharmacy Consultation Report indicated the manufacturer recommended re-evaluation of continued use of [REDACTED] in individuals with a creatinine clearance of less than [REDACTED]. The resident's estimated creatinine clearance was noted to be [REDACTED]. The pharmacist also identified there was no indication of fasting lipids in the resident's record, which could be used to determine the effectiveness and/or necessity of the medication.</p> <p>The physician responded on [REDACTED]/13 that the resident was "tolerating" the [REDACTED]. There was no monitoring of the medication nor did he provide any rationale to continue the medication despite the manufacture's recommendations. There was no indication how the resident's tolerance to the medication was measured, which put her at risk to receive an unnecessary medication.</p> <p>RESIDENT #11 Similar findings were identified for Resident #11 for whom a [REDACTED]/13 Pharmacy Consultation Report identified the resident received the anti-anxiety medication [REDACTED] every night for anxiety and recommended a trial Gradual Dose Reduction (GDR) of every other night dosing. The physician declined to implement the recommendations and noted the resident was "very stable on low dose medication for long term." Review of the facility's behavior monitors</p>	F 329	<p style="text-align: right;">RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>	
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK SHORE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 329	<p>Continued From page 45</p> <p>for August, September and October revealed no indication anxiety was exhibited. Failure to provide supporting documentation the resident was receiving the lowest effective dose of the medication, such as a failed GDR, in the absence of documented target behaviors and/or mood indicators, placed this resident at risk to receive an unnecessary medication.</p> <p>Additionally, a [REDACTED]/13 PO directed staff to administer [REDACTED] twice a day for "[REDACTED] and [REDACTED]" Side effects of [REDACTED] included nervousness and trouble sleeping. There was no indication the facility considered these side effects in light of the resident's continued use of the anti-anxiety medication.</p> <p>A 10/04/13 Pharmacy Consultation Report identified the resident received [REDACTED] daily since 07/26/13 for [REDACTED], which the pharmacist noted was not a supported diagnosis in the resident's record. The physician responded on [REDACTED]/13 that the medication was for "[REDACTED] and [REDACTED]."</p> <p>In an interview on 10/24/13 at 2:23 p.m., Staff G stated [REDACTED] was a medication that "should be short term and re-examined" as one's body can get hypersensitized and addicted. She stated [REDACTED] was considered "hazardous" and should be reduced. She further stated [REDACTED] was typically used short term and then a decrease should be attempted.</p> <p>The 2010 Drug Handbook identified the recommended usage of [REDACTED] was four to eight weeks, depending on the person's symptoms.</p>	F 329	<p style="text-align: center;">RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>	
-------	---	-------	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK SHORE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 329	<p>Continued From page 46</p> <p>Failure to ensure medications were used for appropriate durations, with consideration of side effects, and with supporting monitoring placed this resident at risk to receive unnecessary medications.</p> <p>According to the September 2013 MAR, Resident #11 received [REDACTED] on 09/28/13 at 1820 and the results were "effective". The resident received [REDACTED] again on 09/30/13 at 1800, however the PO directed staff to administer if no bowel movement in three days.</p> <p>Similar findings were identified for Resident #10 for whom staff noted the administration of [REDACTED] on 05/27/13 at [REDACTED] and 05/28/13 at [REDACTED], along with a [REDACTED] on 05/28/13 at [REDACTED]. Physician's orders directed staff to administer [REDACTED] if no [REDACTED] for three days and a [REDACTED] "if [REDACTED] not effective in 8 hours". Failure to follow POs resulted in this resident receiving an unnecessary dose of [REDACTED].</p> <p>RESIDENT #30 Review of Resident #30's closed record revealed she admitted to the facility on [REDACTED]/13 with [REDACTED] and a [REDACTED]. Nursing progress notes revealed the anti-psychotic medication [REDACTED] was ordered on [REDACTED]/13 due to the resident not sleeping at night and restlessness. A nursing progress note, dated 08/24/13, indicated the resident complained of [REDACTED] pain for which [REDACTED] was administered with little relief. The resident was noted to be "very restless, cannot sleep." The nurse contacted the physician who increased the dose of [REDACTED].</p>	F 329	<p style="text-align: center;">RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>	
-------	--	-------	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK SHORE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 329

Continued From page 47

A 08/30/13 progress note revealed the [REDACTED] was "not effective for behavior management" and so the physician discontinued the [REDACTED] and initiated the [REDACTED] medication [REDACTED] as needed for "anxiety / agitation." On 09/05/13 the [REDACTED] was increased to routinely at night in addition to the as needed doses.

On 09/03/13 the Pharmacy Consultation Report identified agitation was not an approved use for [REDACTED]. The physician responded the [REDACTED] was for "[REDACTED] disorder", despite a lack of indication in the resident's chart that she suffered from [REDACTED] disorder.

Behavior Tracking forms revealed staff monitored the resident for agitation, restlessness and anxiety. Nursing progress notes revealed the prn [REDACTED] was administered when the resident attempted to get out of bed or her wheelchair or was restless, on 08/31, 09/01, 04, 05, 06, 07 and 08/13. There was no indication staff considered the resident's restlessness and attempts to get up might be related to pain despite other times when the resident was treated with [REDACTED] for similar behaviors.

In addition, review of Progress Notes on 09/01/13 revealed staff noted the resident was "Settled and Calm", but family member "requested to give [REDACTED] and [REDACTED] for the night." Staff documented administration of as needed [REDACTED] and [REDACTED] concurrently, at the request of the resident's family member, despite lack of assessed pain or target behaviors. On 09/05/13 staff noted they administered as needed [REDACTED] and [REDACTED] together as the resident was "restless... would not stay in bed... holding [REDACTED] leg".

F 329

RECEIVED
NOV 19 2013
DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013	
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 48</p> <p>Failure to ensure the resident received an [REDACTED] medication for a diagnosis which was supported in her medical history, that she was monitored for the reasons the medication was administered and that the resident received an as needed [REDACTED] dose only when clearly indicated placed her at risk to receive an unnecessary medication and to have her pain untreated.</p> <p>RESIDENT #31 Review of the resident's record revealed she was admitted to the facility on [REDACTED]/13 with a PO for the anti-depressant [REDACTED]. On 10/08/13 the anti-depressant [REDACTED] was added to her regimen due to [REDACTED] and [REDACTED].</p> <p>The Behavior monitor, located in the MAR, identified the resident was monitored for irritability, persistent low mood and a disinterest in activities. Staff were directed to "monitor target behavior scale 0-3". In an interview on 10/25/13 at 9:19 a.m., Staff E explained the scale was designed so if the resident exhibited no behaviors staff documented a "0". If the resident exhibited a "severe" behavior, staff would document a "3". Any lesser manifestation staff would record as a "1" or "2" depending on how the staff subjectively measured the severity of the behavior. She also explained as all three behaviors were listed together, if staff noted a behavior occurred, there was no way to determine based on the behavior monitor which of the three behaviors it was. She stated typically if the behavior was new or extreme the nurse would write a progress note to identify the behavior.</p> <p>Staff documented a [REDACTED] on the day shift on 09/12</p>	F 329	<p style="text-align: right;">RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK SHORE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 329	<p>Continued From page 49</p> <p>and daily on 09/14 through 09/30/13. The evening shift documented a ● on 09/12, 13, 14, 15, 22, 25, 26, 27 and 28/13. Staff E stated she documented a ● on one occasion, however review of the progress note for that date referred to pain, not a mood or behavior. Staff E stated, "so she (the resident) was probably anxious". She acknowledged the progress note did not refer to the resident's mood or behavior and therefore there was no indication of why a severity level of ● was charted or for what mood/behavior it referred.</p> <p>Review of the mood and behavior monitor in the facility's computerized CareTracker system revealed staff documented the resident exhibited no mood or behaviors since her admission.</p> <p>In an interview on 10/28/13 at 8:35 a.m., Staff C reviewed the behavior monitor and stated the 0-3 scale was a subjective way in which to measure mood and behaviors. He acknowledged that if the CareTracker, progress notes and MAR did not include the information related to specific behaviors, there would be no way to monitor which behaviors the resident exhibited or their severity.</p> <p>In an interview on 10/28/13 at 11:10 a.m., Staff B stated the second anti-depressant, [REDACTED] was started because the resident was not [REDACTED] good when she first admitted to the facility. She stated it was also started due to negative statements such as [REDACTED]. She then acknowledged negative statements was not identified as a target behavior so staff did not monitor for them.</p> <p>Review of the meal monitors and the resident's weights revealed discrepancies and inaccuracies,</p>	F 329	<p>RECEIVED</p> <p>NOV 19 2013</p> <p>OSHS/ALISH/RCS</p>	
-------	--	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 50</p> <p>leaving the facility unable to accurately assess the effectiveness of the ██████████ as it related to the resident's decreased appetite.</p> <p>In an interview on 10/28/13 at 8:56 a.m., Staff B stated the weight obtained by the facility on 10/04/13 that showed an ██████ pound weight ██████ in one week was "probably inaccurate" and the resident should have been re-weighed. At 11:17 a.m., Staff B further stated the paper meal monitors and computerized CareTracker meal monitors should match. She acknowledged if there was a difference in what staff recorded without some indication of why, the facility would have no way to accurately monitor the resident's meal intake.</p> <p>Failure to ensure monitoring of the resident's mood, behaviors, weight and meal intake prevented the facility from determining the effectiveness and necessity of ██████ anti-depressants the resident received.</p> <p>Additionally, according to the September MAR, the resident received the medication ██████████ due to a diagnosis of ██████████. The 10/04/13 Pharmacy Consultation Report noted "please consider clarifying the indication for use of ██████████" On ██████/13 the MD wrote "Will have staff ask ██████████ to verify diagnosis of ██████████ followed by ██████████ said "██████████ is for ██████████" The facility failed to obtain the proper indicator for the medications use for a month, leaving them unable to monitor its effectiveness.</p> <p>RESIDENT #27 Record review revealed Resident #27 received the same dose of the anti-depressant ██████████ from ██████████/12 until a dose reduction on ██████████/13 and</p>	F 329	<p>RECEIVED</p> <p>NOV 5 2013</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK SHORE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 329	<p>Continued From page 51 remained on that dose since.</p> <p>The [REDACTED]/12 Quarterly Psychoactive Review indicated the resident's symptoms were "[REDACTED]". The [REDACTED]/13 QPR identified his symptoms were "[REDACTED]", he was eating and sleeping well, his weight was stable and a GDR was not clinically contraindicated. However, there was no indication a GDR was considered at that time.</p> <p>The 10/04/13 QPR identified the "successful GDR 6/12/13" and noted a further GDR was not contraindicated. The facility noted "Trial dose [REDACTED] was attempted in [REDACTED] 2013. Resident has not experienced any of the behavior symptoms and seems to be happy and stable" The plan was to "continue to monitor" the anti-depressant, however there was no indication a further GDR was considered based on the resident's continued lack of observed mood or behavior problems and a lack of indicators for its use.</p> <p>RESIDENT #5 According to the [REDACTED]/13 MDS the resident had diagnoses including [REDACTED] and was assessed with a mood score of [REDACTED] indicating minimal [REDACTED] related to little interest in doing things on several days, feeling [REDACTED] or [REDACTED] on several days, and feeling [REDACTED] or having little [REDACTED] on several days. According to the [REDACTED]/13 Psychotropic Drug Use Care Area Assessment (CAA) the resident received [REDACTED] and [REDACTED] to manage signs and symptoms of [REDACTED]. Both medications "had been working fairly well, however with recent nursing home placement, viewed as a permanent move due to increased</p>	F 329	<p style="text-align: center;">RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>	
-------	--	-------	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 52</p> <p>care needs and safety issues, resident has been exhibiting some [REDACTED] issues (resistance to [REDACTED], [REDACTED], etc). Hopefully as resident settles into HCC (Health Care Center) routine she will become more content with her surroundings. Will proceed with care plan."</p> <p>The 0 [REDACTED] /13 and [REDACTED] /13 Psychotropic Drug Use CP listed the goal of "Resident will be on the lowest effective dosage of [REDACTED] medication as evidenced by Resident's [REDACTED] and [REDACTED]." A listed approach was "Monitor for adverse effects of anti-depressant usage."</p> <p>A [REDACTED] /13 Pharmacist Consultation Report recommended the physician re-evaluate continued concomitant use of [REDACTED] as it "may increase the potential for adverse events." In addition, the pharmacist recommended that if the medication was to continue "the prescriber document an assessment of [REDACTED] versus [REDACTED], indicating that it continues to be a valid therapeutic intervention" and "the facility interdisciplinary team ensure ongoing monitoring for effectiveness and potential adverse consequences." On [REDACTED] /13 the ARNP responded no [REDACTED]s were to be made pending discussion with the resident's [REDACTED]. On [REDACTED] /13 it was documented that the [REDACTED] indicated the resident had "been very [REDACTED] by her [REDACTED] changes and this combination has worked best, [REDACTED] steady."</p> <p>According to the 10/05/13 MDS the resident's assessed [REDACTED] score had improved to [REDACTED] with no listed signs or symptoms of [REDACTED] for which the resident continued to receive daily [REDACTED] medications. The MDS indicated</p>	F 329			

RECEIVED
NOV 19 2013
DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK SHORE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 329	<p>Continued From page 53</p> <p>the resident had sustained [REDACTED] falls since the prior assessment, two of which caused injuries.</p> <p>Review of the investigation after the resident's fall on [REDACTED]/13 indicated the facility was aware of the [REDACTED] and noted "Unable to determine if medications side effects are contributing to [REDACTED]. Will discuss with ARNP at next visit."</p> <p>In an interview on [REDACTED]/13 at 11:23 a.m. Staff A said she asked the physician to review the resident's [REDACTED]s and the physician did not think the [REDACTED]s contributed to the resident's ongoing [REDACTED]. Staff A indicated no changes had been made to the [REDACTED] medications because the physician felt the resident was [REDACTED] on the medications as they were. Staff A acknowledged it was unknown if the resident received the lowest effective dose of the medications, or how the physician concluded that the [REDACTED] [REDACTED] the [REDACTED] of the medications.</p> <p>Further review of the resident's record revealed Resident #5 again fell on [REDACTED]/13 and sustained a [REDACTED] and fell on [REDACTED]/13 and sustained a [REDACTED] requiring [REDACTED]</p>	F 329		
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 332	<p>RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 332	<p>Continued From page 54</p> <p>by: Based on observation, interview and record review it was determined that the facility failed to ensure a medication error rate of less than 5%. One of two nurses (Staff E) failed to follow physician's orders for two of twenty-five medications which resulted in a medication error rate of 8% with one (#14) of seven residents reviewed experiencing medication errors. These failures placed residents at risk to experience adverse side effects or less than the intended therapeutic effects of medications.</p> <p>Findings include:</p> <p>RESIDENT #14 Observation of medication pass on 10/28/13 at 7:35 a.m. revealed Staff E prepare and administer multiple medications to Resident #14 including [REDACTED] and a [REDACTED] with [REDACTED] in the dining room where Resident #14 was actively eating breakfast.</p> <p>Record review revealed a Physician's Order (PO) which directed staff to administer the [REDACTED]. "According to the Nursing 2010 Drug Handbook located at the Nurse's Station, the [REDACTED] should be administered, "[REDACTED]." Failure to administer the medication according to the PO and manufacturer's recommendations placed the resident at risk for reduced effectiveness of the medication and constituted a medication error.</p> <p>In an interview on 10/28/13 at 8:39 a.m. Staff E acknowledged the [REDACTED] was not administered [REDACTED] as scheduled and said "it's not really possible. We</p>	F 332	<p><u>F 332 Free of Medication Error Rates of 5% or More</u></p> <p>The time for administering [REDACTED] to resident #14 will be changed to [REDACTED]. The [REDACTED] with [REDACTED] and the [REDACTED] for resident #14 will be separated for administration by at least [REDACTED] hours.</p> <p>The facility will review all physician orders and audit all MARs and will change ensure that all medications are given according to manufacturer's recommendations. The facility will in-service the nursing staff on the importance of giving medication within the parameters issued by the manufacturers.</p> <p>The facility will monitor this at least monthly during care plan reviews and at the end of the month.</p> <p>The quality assurance committee will monitor on a quarterly basis. The Director of Nursing Services will ensure that the tasks in the correction plan are completed by December 6, 2013.</p>		

RECEIVED
NOV 19 2013
DSHS/ADSV/11003

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	<p>Continued From page 55 (day shift nurse) get here at 6:30 a.m., get report, and start (passing medications) at 7:00 a.m. Breakfast comes at 7:30 a.m., but (the residents) get fruit (beforehand)."</p> <p>In an interview on 10/28/13 at 11:02 a.m. Staff A said "I didn't know that was an issue for them" and indicated in the future, the [REDACTED] would be scheduled to be given by the night shift.</p> <p>Additionally, record review revealed POs which instructed staff to administer the [REDACTED] hours apart from [REDACTED] and [REDACTED]"</p> <p>In an interview on 10/28/13 at 8:39 a.m. Staff E acknowledged the [REDACTED] was administered simultaneously with the [REDACTED] with [REDACTED]. At 10:22 a.m. Staff E said she had spoken to the pharmacy and the [REDACTED] given contained [REDACTED] of [REDACTED] and [REDACTED] of [REDACTED]. Failure to administer the medication according to POs constituted a medication error.</p> <p>In an interview on 10/28/13 at 11:02 a.m. Staff A indicated staff had recently completed a thorough audit and "must have missed that."</p>	F 332		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically</p>	F 431	<p>RECEIVED</p> <p>NOV 19 2013</p> <p>DSHS/ADS/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE			STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 56 reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to label, date and discard medications as indicated, in two of two medication carts and one of one medication rooms. This failure placed residents at risk to receive medications that lacked potency due to being expired.</p> <p>In addition, the facility failed to ensure medications at Resident #12's bedside were</p>	F 431	<p><u>F 431 Drug Records, Label/Store Drugs & Biologicals</u></p> <p>The medication carts and medication room will be inspected and any expired medications will be discarded. Any eye-drops or injectable medication that is not labeled with a date opened sticker will be discarded. The medications in the room of resident were immediately removed. The Director of Nursing Services spoke with the resident's [REDACTED] who confirmed that she had brought in those medications and left them at bedside. The Director of Nursing Services asked [REDACTED] to not bring in medications and leave them at bedside.</p> <p>The facility staff will be in-serviced about labeling medications when they are opened and about discarding expired medications. The Director of Nursing Services will assign a nurse to inspect each medication cart and the medication room once per month to identify medications that need to be discarded.</p> <p>The quality assurance committee will monitor on a quarterly basis. The Director of Nursing Services will ensure that the tasks in the correction plan are completed by December 6, 2013.</p>	

RECEIVED
NOV 19 2013
RECEIVED
DSHS/ADSA/RCS
DSH

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 57</p> <p>secured which placed residents at risk of medication errors.</p> <p>Findings include:</p> <p>FACILITY POLICY The Facility's Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy, dated May, 2010, identified the "Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines... are stored separate from other medications until destroyed or returned to the supplier." In addition, "Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."</p> <p>Observation of the "first medication cart" on 10/22/13 at 9:25 a.m. revealed [REDACTED] for Resident #33 that was open and not dated and a box of [REDACTED] with a manufacturer's expiration date of 09/13. Additionally, [REDACTED] were opened and not dated for a former resident and a medication with a manufacturer's expiration date of 1/12 for another former resident was observed. Staff B stated the medications should have been removed from the cart.</p> <p>Observation of the "second medication cart" revealed a bottle of [REDACTED] with a manufacturer's expiration date of 06/12, [REDACTED] that expired 05/13 and a bottle of [REDACTED] with an expiration date of 11/06.</p>	F 431	<p style="text-align: right;">RECEIVED NOV 19 2013 DSHS/ADSA/RCS</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
NAME OF PROVIDER OR SUPPLIER PARK SHORE		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 58</p> <p>Staff E confirmed the above medications were all past their manufacturer's expiration dates and should have been discarded.</p> <p>Observed in the medication room was a vial of [REDACTED] that was open and not dated and a vial of [REDACTED] that was open and not dated. At 9:31 a.m. Staff B confirmed the observations and stated "Those should be dated when opened."</p> <p>UNSECURED MEDICATIONS</p> <p>Observation on 10/22/13 at 11:44 a.m. revealed Resident #12 with the following medications at her bedside: [REDACTED] that was open and not dated with a manufacturer's expiration date of 03/13; [REDACTED] that were open and not dated, and a [REDACTED] that was folded in half but not dated or labeled in any manner.</p> <p>On 10/24/13 at 9:48 a.m. the [REDACTED] and [REDACTED] remained at the resident's bedside. The [REDACTED] was no longer present.</p> <p>Review of the resident's record revealed no physician's orders (PO) for either the [REDACTED] or the [REDACTED]. The 08/05/13 Visual Function care plan identified the resident with [REDACTED] and [REDACTED]. The 08/05/13 ADL care plan included an approach of "Resident has [REDACTED] and [REDACTED], monitor her for [REDACTED] as needed".</p> <p>An 0 [REDACTED]/13 PO directed staff to place a [REDACTED] a day for [REDACTED] then remove. Review of the 10/13 Medication Administration Record revealed the [REDACTED] was scheduled to be removed at [REDACTED]</p>	F 431		

RECEIVED
NOV 19 2013
DSHS/ADSA/RCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2013
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 10/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PARK SHORE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 43RD AVENUE EAST SEATTLE, WA 98112
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 431	Continued From page 59 In an interview on 10/24/13 at 2:27 p.m., Staff A stated the [REDACTED] [REDACTED] in the [REDACTED]. She acknowledged staff should have removed the medications as they were not properly stored.	F 431		
-------	--	-------	--	--

RECEIVED
NOV 19 2013
DSHS/ADSA/RCS