STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

PRESBYTERIAN RETIREMENT COMMUNITIE
PARK SHORE
1630 43RD AVE E
SEATTLE, WA 98112

RE: PARK SHORE License # 183

Dear Administrator:

This letter addresses Compliance Determination(s) 29045 (Completion Date 09/05/2023) and 27589 (Completion Date 08/10/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/05/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2450-2-c, WAC 388-78A-2450-2-e

The Department staff who did the off-site verification:
Alma Duran, Licensor

If you have any questions, please contact me at (425)670-6070.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 183	Compliance Determination #:27589
Plan of Correction	PARK SHORE	Completion Date
Page 1 of 3	Licensee: PRESBYTERIAN RETIREMENT COMMUNITIE	08/10/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site follow-up on 08/03/2023 and 08/03/2023 of:
PARK SHORE
1630 43RD AVE E
SEATTLE, WA 98112

This document references the following SCD dated: 08/10/2023

The following sample was selected for review during the unannounced on-site visit: 0 of 25 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Jamie Singer
Residential Care Services

08/17/2023
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Statement of Deficiencies	License #: 183	Compliance Determination #:27589
Plan of Correction	PARK SHORE	Completion Date
Page 2 of 3	Licensee: PRESBYTERIAN RETIREMENT COMMUNITIE	08/10/2023

Administrator (or Representative) 08/28/2023 Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(c) Verify prior to hiring that staff persons have the required licenses, certification, registrations, or other credentials for the position, and that such licenses, certifications, registrations, and credentials are current and in good standing;

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 2 sampled staff (Staff E) had the required specialized training for dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and mental health to fulfill their expected responsibilities. This failure placed 24 residents at risk for not having their care needs met.

Findings included...

NOTE: Washington Administrative Code (WAC) 388-78A-2510 - Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090(7).

NOTE: WAC 388-78A-2500 - Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.

Review of a Resident Characteristic Roster, undated, showed the ALF provided care and services to 24 residents. Seven of the 24 residents were identified with a diagnosis of dementia and four residents were identified with behavior/psychosocial issues and or

Statement of Deficiencies	License #: 163	Compliance Determination #:27589
Plan of Correction	PARK SHORE	Completion Date
Page 3 of 3	Licensee: PRESBYTERIAN RETIREMENT COMMUNITIE	08/10/2023

mental health diagnosis.

Review of staff records showed the ALF hired Staff E (Registered Nurse) on 05/06/2019. Review of staff records showed Staff E did not have the required specialized dementia and mental health training.

During an interview, on 08/03/2023 at 9:30 AM, Staff F (Director of Wellness) stated Staff E worked the night shift in the facility's Skilled Nursing (SNF). Staff F stated that when there were residents' needs in the ALF such as falls, any incidents, abnormal blood sugar, and blood pressure readings, Staff E would work in the ALF as needed.

In an interview, on 08/03/2023 at 11:15 AM, Staff G (Human Resources) confirmed he did not have dementia or mental health specialty training on file for Staff E.

This is an uncorrected deficiency previously cited on 07/17/2023.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PARK SHORE is or will be in compliance with this law and / or regulation on (Date) 09|05|2023

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Randi Sater — 08|28|2023

Administrator (or Representative) — Date

Residential Care Services
Investigation Summary Report

Provider/Facility: PARK SHORE
Provider Type: Assisted Living Facility
License/Cert.#: 183
Compliance Determination #: 25897
Intake ID: 87620
Investigator: Alma Duran
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 06/27/2023 through 07/17/2023
Complainant Contact Date(s):

Allegation(s):

Allegation of abuse by (a non-employee agency) staff toward a Named Resident (NR) and 5 other residents.

Investigation Methods:

Sample:	Total residents: 25 Resident sample size: 7 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Residents
Record Reviews:	Medical records Incident investigation Facility policies Personnel files

Investigation Summary:

Based on observation, interviews and record review, the NR had multiple medical diagnoses, including [redacted] was unable to recall the incident of the alleged mistreatment. The ALF failed to follow their policies and procedures to immediately report to their Administrator an allegation of abuse, and failed to protect the NR and 24 other residents by allowing the the alleged staff to continure to work for 7 hours unaccompanied. The ALF also failed to report the allegation of abuse to local law enforcement.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

07/18/2023

PRESBYTERIAN RETIREMENT COMMUNITIE
PARK SHORE
1630 43RD AVE E
SEATTLE, WA 98112

RE: PARK SHORE # 183

Dear Administrator:

This document references the following complaint numbers 87620.

The Department completed a full inspection of your Assisted Living Facility on 07/17/2023 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Mail the Plan/Attestation Statement and report with original signatures to:

Jamie Singer, Field Manager
Residential Care Services

Region 2, Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

The Assisted Living Facility (ALF) failed to notify the Department of a change in the ALF's Administrator. This failure prevented the Department from reviewing the Administrator's qualifications.

WAC 388-78A-2880 Changing use of rooms. Prior to using a room for a purpose other than what was approved by construction review services, the assisted living facility must:

(1) Notify construction review services:

(a) In writing;

(b) Thirty days or more before the intended change in use;

(c) Describe the current and proposed use of the room; and

(2) Obtain the written approval of construction review services for the new use of the room; and

The Assisted Living Facility (ALF) failed to notify and obtain a written approval from the State of Washington, Department of Health Facilities and Services Licensing Construction Review Services prior to using a room for a purpose other than what was approved. This failure placed residents at risk for negative impact from an unauthorized change to the ALF.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

- o What specific deficiency or deficiencies you disagree with;
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o Send your request to:

IDR Program Manager
Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

If You Have Any Questions:

• Please contact me at (425)670-6070.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Enclosure

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 183	Compliance Determination # 25897
Plan of Correction	PARK SHORE	Completion Date
Page 4 of 14	Licensee: PRESBYTERIAN RETIREMENT	07/17/2023

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for the unannounced on-site full inspection and complaint investigation on 06/27/2023 and 06/28/2023 of:
PARK SHORE
1630 43RD AVE E
SEATTLE, WA 98112

This document references the following complaint numbers: 87620.

The following sample was selected for review during the unannounced on-site visit: 7 of 25 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor
Erin Steinbrenner, Nursing Consultant Institutional

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Jamie Singer
Residential Care Services

7/18/2023
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Statement of Deficiencies	License #: 183	Compliance Determination # 25897
Plan of Correction	PARK SHORE	Completion Date
Page 5 of 14	Licensee: PRESBYTERIAN RETIREMENT	07/17/2023

Administrator (or Representative) 7/20/2023 Date

WAC 388-78A-2484 Tuberculosis Two step skin testing. Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 5 of 6 staff members (Staff A, C, D, E and F) completed the required two-step tuberculin skin test (TST). This placed 25 residents at risk of exposure to a communicable disease.

Findings included...

Review of records showed the ALF hired Staff A (Health Services Director) on 03/10/2023. Record review showed Staff A did not have the two-step TST completed.

Review of records showed the ALF hired Staff C (Nursing Assistant) on 05/03/2023. Record review showed Staff C did not have the two-step TST completed.

Review of records showed the ALF hired Staff D (Certified Nursing Assistant) on 05/30/2023. Record review showed Staff D did not have the two-step TST completed.

Review of records showed the ALF hired Staff E (Certified Nursing Assistant) on 02/13/2017. Record review showed Staff E did not have the two-step TST completed.

Review of records showed the ALF hired Staff F (Registered Nurse) on 05/06/2019. Record review showed Staff F did not have the two-step TST completed.

In an interview, on 06/28/2023 at 11:22 AM, Staff H (Director of Human Resources) confirmed he did not have TB test results for any of the selected staff.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PARK SHORE is or will be in compliance with this law and / or regulation on (Date) 7/20/2023.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) — Date: 7/20/2023

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(c) Verify prior to hiring that staff persons have the required licenses, certification, registrations, or other credentials for the position, and that such licenses, certifications, registrations, and credentials are current and in good standing;

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 3 of 6 sampled staff (Staff A, E and F) completed the required cardiopulmonary resuscitation (CPR) training and 2 of 6 sampled staff (Staff E and F) had the necessary specialized training to fulfill their expected responsibilities. This failure placed 25 residents at risk of harm and injury from improper CPR technique in the event of an emergency and untrained and unqualified staff.

Findings included...

CPR

NOTE: WAC 388-112A-0700 - What is CPR training? Cardiopulmonary resuscitation (CPR) training is training provided by an authorized CPR instructor. Trainees must successfully complete the written and skills demonstration tests.

Review of staff records showed the ALF hired Staff A (Health Care Director) on 03/10/2023. Record review showed Staff A did not complete the required CPR training.

Review of staff records showed the ALF hired Staff E (Certified Nursing Assistant) on 02/13/2017. Record review showed Staff E did not complete the required CPR training.

Review of staff records showed the ALF hired Staff F (Certified Nursing Assistant) on 05/06/2019. Record review showed Staff F did not complete the required CPR training. Additional record review after department inspection showed Staff F obtained CPR and first aid certification on 06/29/2023.

Specialized Training

NOTE: WAC 388-78A-2500 - Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.

NOTE: WAC 388-78A-2510 - Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090(7).

Review of a Resident Characteristic Roster, undated, showed the ALF provided care and services to 25 residents of which had a diagnosis of [redacted] and four residents had a [redacted] diagnosis.

Review of staff records showed the ALF hired Staff E (Certified Nurse Assistant) on 02/13/2017. Review of staff records showed Staff E did not have the required specialized dementia and mental health training.

Review of staff records showed the ALF hired Staff F (Registered Nurse) on 05/06/2019. Review of staff records showed Staff F did not have the required specialized dementia and mental health training.

During an interview, on 06/28/2023 at 11:22 AM, Staff H (Human Resource Director) stated there had been a miscommunication regarding who keeps track of CPR and First Aid certification and confirmed he did not have CPR certification for Staff A, E and F. Staff H stated he was certain Staff E and F had the specialized training but did not have it on file. Staff H stated he was new to the industry and still learning about the required certification and training required for staff.

Statement of Deficiencies	License #: 183	Compliance Determination # 25897
Plan of Correction	PARK SHORE	Completion Date
Page 8 of 14	Licensee: PRESBYTERIAN RETIREMENT	07/17/2023

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PARK SHORE is or will be in compliance with this law and / or regulation on (Date) 7/20/2023.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) — Date: 7/20/2023

WAC 388-78A-2600 Policies and procedures.

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(a) Related to suspected abandonment, abuse, neglect, exploitation, or financial exploitation of any resident;

This requirement was not met as evidenced by:

Based on observation, interviews, and record, the Assisted Living Facility (ALF) failed to implement **their policies and procedure to protect 1 of 7 sampled residents (Resident 7) when there was an allegation of resident abuse. This failure placed Resident 7 and 24 other vulnerable residents at risk for further abuse.**

Findings included...

NOTE: WAC 388-78A-2371 Investigations. The assisted living facility must: (4) Protect residents during the course of the investigation.

Review of the ALF's "Overall Policy and Procedure", dated 12/08/2022, showed "Abuse" meant the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish..." The ALF's "Procedure for Protection stated, "It is the responsibility of the nurse to ensure protection to any resident who has been involved in any suspected or alleged abuse/neglect incidents. This may include immediate suspension by the supervisor. The supervisor will notify the Director of Nursing and/or the Administrator of the incident. If the person involved is not a team member, the alleged person shall be removed from the immediate area and any contact with the abused party shall not continue until outcome of the investigation is determined." Procedure for Reporting/Response showed, "Team members are to immediately report to their onsite supervisor any alleged incidents of abuse/neglect... The Director of Nursing and/or the Administrator shall be notified immediately of all allegations of abuse and neglect."

The building's structure showed the ALF was located on the 3rd and 4th floor and the Skilled Nursing Facility (SNF) was located on the 2nd floor.

In interview regarding staffing, on 06/27/2023 at 10:30 AM, Staff G (Director of Wellness ((DW)) stated staff worked 8-hour shifts. Staff G stated there were two staff scheduled to work in the ALF at night. However, if there was only one staff working, the SNF staff would assist as needed. Staff G stated that the SNF had a 24-hour Licensed Nurse (LN) coverage and able to respond should a resident issue occur in the ALF.

Review of Move-in Record, showed the ALF admitted Resident 7 on [redacted]/2015 with care need related to multiple diagnoses including [redacted].

Review of an ALF investigation document, dated 06/27/2023, showed Staff K (a non-employee Agency Nursing Assistant) allegedly abused Resident 7 and five other residents. The ALF's investigation showed the following:

- Staff I (Nursing Assistant Certified) and Staff K worked night shift from 10:30 PM (06/26/2023) through 6:00 AM on 06/27/2023. Staff K requested to switch assignment from SNF to the ALF section.
- Staff I and Staff K went to the ALF's 4th floor section, entered 6 residents' rooms (400, 403, 405, 406, 408, and [redacted]). Staff I noted that as they entered residents' room, Staff K "Turned the lights on, spoke very rude and loudly, and woke every resident."
- Staff I and Staff K proceeded to Resident 7's apartment in [redacted]. Staff I and Staff K observed Resident 7 had locked himself in the bathroom. Staff K got a butter knife and forced open the bathroom door. Resident 7 was observed still seated on the toilet. Without speaking to Resident 7, Staff K yanked the resident's pants and brief, and demanded Resident 7 go change. Staff K "Got very aggressive toward [Resident 7], started pulling the resident to go back to bed, even if the resident said he was not done yet." Staff I attempted to stop Staff K but they continued to get Resident 7 up. Resident 7 started kicking and trying to grab Staff K who sustained a scratch mark on his cheek. Staff K repeatedly told Resident 7 he would "smack" him. Resident 7 got very agitated. Staff I noted that Resident 7 seemed scared of Staff K and said, "I want to be friends with you, but Staff K kept on yelling at him."
- When Resident 7 finally sat on the bed, Staff K grabbed his legs aggressively and tried lifted them off the floor. Resident 7 started kicking Staff K who then tried pushing Resident 7. Staff I and Staff K eventually left Resident 7's apartment. After 10 minutes, Staff I and Staff K went back to Resident 7's apartment and found him walking back to his bed. Staff K then, "Started yelling at him [Resident 7] and told him to hurry." According to the report, Staff I tried to stop Staff K twice, but Staff K would not listen and continued to "fight" with Resident 7.

In interview, on 06/29/2023 at 10:15 AM, Staff J (Registered Nurse on-duty) stated she was the nurse on-duty the night of the incident with Staff K and Resident 7. Staff J stated that Staff I reported the incident to her within an hour. Staff J stated she did not send Staff K home because the ALF needed help. Staff J stated Staff K continued to work unobserved with residents until 6:00 AM. Staff K stated she had not reported the incident to the SNF's Director of Nursing (DNS) until 6:00 AM.

Statement of Deficiencies	License #: 183	Compliance Determination # 25897
Plan of Correction	PARK SHORE	Completion Date
Page 10 of 14	Licensee: PRESBYTERIAN RETIREMENT	07/17/2023

In a telephone interview, with Staff G and Staff N (DNS) and Staff A (Health Services Director/Administrator), on 07/11/2023 at 2:10 PM, Staff A confirmed Staff K was not sent home until 5:57 AM. Staff A stated the facility's policy and procedure for immediate reporting and removal of an individual suspected of abuse was not followed. When questioned on how to ensure the safety of the residents in the ALF, Staff A stated immediate reporting and removal of the individual suspected of abuse would occur moving forward.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PARK SHORE is or will be in compliance with this law and / or regulation on (Date) 7/20/2023.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) 7/20/2023 Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to report to local law enforcement (LLE) an incident of abuse regarding 1 of 7 sampled residents (Resident 7). This failure placed Resident 7 and the ALF's other 24 residents at risk for further abuse and harm.

Findings included...

NOTE: Review of the Department's "Assisted Living Guidebook-Partners in Protection" dated February 2018, showed in Chapter 3 on Individual Mandated Reporting Requirements included, reporting to Law Enforcement: Individual mandated reporters and covered individuals must report to law enforcement: • When there is a reason to suspect that any crime, including sexual assault or physical assault, has been committed against a resident; or: When there is reasonable cause to believe that an act has caused fear of imminent harm..."

Review of the ALF's "Overall Policy and Procedure," dated 12/08/2022, under the section,

"Procedure for Protection" stated, "It is the responsibility of the nurse to ensure protection to any resident who has been involved in any suspected or alleged abuse/neglect incidents....All team members are mandatory reporters and any incident regarding abuse/neglect must be reported to the State Hotline and law enforcement when appropriate."

Review of an ALF's investigation documentation, dated 06/27/2023, the ALF documented a witnessed incident of Staff K (a non-employee Agency Nursing Assistant) verbally and physically abusing Resident 7 and five other non-sampled residents.

In interview, on 06/30/2023 at 12:20 PM, Staff G (Director of Wellness) stated the ALF did not contact LLE to report the incident involving Staff K. Staff G stated that she was aware that they need to call the incident to LE but failed to do so.

For further details see Washington Administrative Code 388-78A-2600 in this statement of deficiencies.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PARK SHORE is or will be in compliance with this law and / or regulation on (Date) 7/20/2023 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) 7/20/2023 Date

WAC 388-78A-2700 Emergency and disaster preparedness.

(1) The assisted living facility must:

(g) Develop and maintain a current disaster plan describing measures to take in the event of internal or external disasters, including, but not limited to:

(i) On-duty staff persons' responsibilities;

(ii) Provisions for summoning emergency assistance;

(iii) Coordination with first responders regarding plans for evacuating residents from area or building;

(iv) Alternative resident accommodations;

(v) Provisions for essential resident needs, supplies and equipment including water, food, and medications; and

(vi) Emergency communication plan.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure the Emergency and Disaster Preparedness Manual included names of on-duty staff person's responsibilities, alternate resident accommodations, and provision of residents' medications in the event of an emergency evacuation. This failure placed 25 residents at risk of compromised health due to lack of life sustaining provisions and displacement in the event of an emergency or disaster.

Findings included...

Review of the ALF's Resident Characteristic Roster, undated, showed the facility provided 24-hour care and services to 25 current AL residents.

Observation of the building structure, on 06/27/2023 at 10:30 AM the ALF was located on the 3rd and 4th floor, and the Skilled Nursing Facility (also known as nursing homes or healthcare centers, are residential facilities where individuals receive a high level of care and assistance following an injury, surgery, illness or to help manage chronic conditions) was on the 2nd floor, providing care and services to 13 residents.

In an interview regarding the ALF's Disaster Manual, on 06/28/2023 at 10:30 AM, Staff G (Assisted Living Director of Wellness) stated, "I know they are in the process of updating the Disaster Manual."

Review of the ALF's "Disaster Manual", on 06/28/2023 at 1:30 PM, showed it did not include names of on-duty staff person's responsibilities, alternate locations, or clear provision of essential resident needs including medications.

During the exit interview, on 06/29/2023 at 3:15 PM, Staff K (Executive Director) stated, "The alternate location would be across the street from here." When questioned the name of the alternate locations in the event of an evacuation, Staff K stated, "I will email the updated names of alternate locations."

As of 07/11/2023, no further information about the ALF's Disaster Manual was provided to the Department.

Plan/Attestation Statement

Statement of Deficiencies	License #: 183	Compliance Determination # 25897
Plan of Correction	PARK SHORE	Completion Date
Page 13 of 14	Licensee: PRESBYTERIAN RETIREMENT	07/17/2023

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PARK SHORE is or will be in compliance with this law and / or regulation on (Date) 7/20/2023.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) 7/20/2023 Date

WAC 388-78A-3100 Safe storage of supplies and equipment. The assisted living facility must secure potentially hazardous supplies and equipment commensurate with the assessed needs of residents and their functional and cognitive abilities. In determining what supplies and equipment may be accessible to residents, the assisted living facility must consider at a minimum:

(1) The residents' characteristics and needs;

(2) The degree of hazardousness or toxicity posed by the supplies or equipment;

(3) Whether or not the supplies and equipment are commonly found in a private home, such as hand soap or laundry detergent; and

(4) How residents with special needs are individually protected without unnecessary restrictions on the general population.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the Assisted Living Facility (ALF) failed to secure potentially hazardous supplies to ambulatory and cognitively impaired residents. This failure placed 25 residents at risk for exposure and inadvertent ingestion of hazardous materials causing harm.

Findings included...

Review of the Resident Characteristic Roster, undated, showed the ALF provided care and services to eight residents identified with cognitive impairment, four residents with behavior/psychosocial issues.

On 06/27/2023 at 11:15 AM, an ALF walkthrough was conducted with Staff G (Director of Wellness).

Observation, on 06/27/2023 at 11:45 AM, showed an unlocked cabinet under the sink on the 4th floor. The following hazardous supplies with precautionary warning labels to keep out of reach of children, eye/skin irritant, harmful if swallowed, or contact poison control

center were observed: two one-quart size spray bottles of Bacteria/Enzyme D Culture; 2 32 fluid ounce (Fl. Oz) spray bottles of ASAP all surface/all-purpose Handi spray cleaner; 32 Fl. Oz NABC non-acid disinfectant bathroom cleaner, a 500 milliliters of hand soap and hand sanitizer.

Observation, on 06/27/2023 at 12:08 PM, showed an unattended housekeeping cart in front of Room 325. The following hazardous supplies with precautionary warning labels : hazards to human and animals, avoid breathing vapor, keep out of reach of children, eye/skin irritant, harmful if swallowed, or contact poison control center were observed: spray bottles of Contempo Spotting Solution; Peroxy II antibacterial foaming bath and surface cleaner (flammable); and two spray cans of Renown stainless steel cleaner with Danger label: extremely flammable aerosol, contain gas under pressure.

In interview, on 06/27/2023 at 12:30 PM, Staff M (Housekeeper) stated she was aware she should not leave the chemicals unattended, "I know, I know."

Observation, on 06/28/2023 at 1:15 PM, the [lockable] kitchen gate was left ajar on the 3rd floor. Under the unlocked sink cabinet was a 38 fluid dish detergent and jar of chemical sanitizer with precautionary warning labels to keep out of reach of children, eye/skin irritant, harmful if swallowed, or contact poison control center.

In interview, on 06/28/2023 at 1:30 PM, Staff G on stated she always reminded staff to keep the kitchen door completely latched.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, PARK SHORE is or will be in compliance with this law and / or regulation on (Date) 7/20/2023

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Administrator (or Representative) 7/20/2023 Date