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) 58298 (Completion Date 04/22/2025) and 55053 (Completion Date 03/10/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/22/2025 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-2320-1-b, WAC 388-78A-2320-2-a, WAC 388-78A-2320-2-b, WAC 388-78A-2320-3-c, WAC 388-78A-2305-1, WAC 388-78A-2150-1, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2230-1-c-i, WAC 388-78A-2230-1-c-ii, WAC 388-78A-2230-1-c, WAC 388-78A-2230-2-a, WAC 388-78A-2230-2-b, WAC 388-78A-2230-2-c, WAC 388-78A-2230-2, WAC 388-78A-2240, WAC 388-78A-2482-1, WAC 388-78A-2482-2, WAC 388-78A-2482-3, WAC 388-78A-2482-3-a, WAC 388-78A-2482-3-b

The Department staff who did the on-site verification:
Alma Duran, Licensor
Keiko Kitano, Licensor

If you have any questions, please contact me at (253)312-1446.

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

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 on 02/19/2025 and 02/21/2025 of:

PARK SHORE
1630 43RD AVE E
SEATTLE, WA 98112

The following sample was selected for review during the unannounced on-site visit: 6 of 24 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Alma Duran, Licensor
Keiko Kitano, 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.

Jeanie Seigler
Residential Care Services

3/12/2025
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.

Gary Jacobs
Administrator (or Representative)

3-17-2025
Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(2) The assisted living facility providing nursing services, either directly or indirectly, must ensure that the nursing services systems include:

(a) Nursing services supervision;

(b) Nurse delegation, if provided;

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to follow the criteria for nurse delegation (ND) for 1 of 1 sampled resident (Resident 2). This resulted in non-licensed staff members administering medications without receiving ND training and placed Resident 2 at risk for compromised health conditions.

Findings included...

NOTE: Washington Administrative Code (WAC) 246-840-930 Criteria for delegation, In community-based and in-home care settings, before delegating a nursing task, the

registered nurse delegator shall decide if a task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE. PLAN (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; IMPLEMENT (15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s). EVALUATE (18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment.

Review of the ALF's undated Disclosure of Services, showed the ALF used Nursing Assistants (as Medication Technicians) under the delegation of a Registered Nurse (RN) to provide some authorized nursing services including administration of oral, topical medications, and eye/ear/nose drops.

Review of the ALF's policy titled RN (Registered Nurse) Delegation, dated 01/16/2018, showed, "Ensure the RN Delegation required forms were completed." "Review delegated tasks every 90 days or sooner and document required forms." "Maintain all RN Delegation documents on resident delegated tasks, 90-day reviews,.....and all forms in the RN Delegation binder."

Record review showed the ALF admitted Resident 2 on [redacted]/2024 with multiple disabling diagnoses including [redacted] ([redacted]). Review of an Assessment, dated 12/18/2024, showed that Resident 2 required staff to administer a topical medication.

Review of the December 2024, January 2025, and February 2025 electronic Medication Administration Records (eMARs) showed that Resident 2 had multiple prescribed medications, including an Aspercreme patch with lidocaine (used to relieve pain).

Observation and interview, on 02/20/2025 at 8:45 AM, showed Staff F (Certified Nursing Assistant/Medication Technician ((MT)) bringing morning medications to Resident 2's apartment. During the observation, Staff F applied two Aspercreme patches to Resident 2's lower back. When asked whether Resident 2 had been able to direct MTs where to put the patches on their lower back, Staff F said, "No, Resident 2 is unable to tell where the patch would be on," and stated that MTs had been applying them for back pain.

Review of the RN Delegation binder showed no documentation to indicate the ALF had ever delegated MTs to administer the pain patches for Resident 2 per the ALF's policy.

In an interview, on 02/20/2025 at 2:30 PM, Staff G (Assisted Living Director of Wellness) confirmed there were no required ND documents for administration of Resident 2's patches.

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) 4.10.2025.

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

Gary Jacobs — Administrator (or Representative)

3.17.2025 — Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to monitor and document food temperatures (FTs) prior to serving potentially hazardous food to residents and failed to ensure 2 of 2 kitchen staff servers (Staff J and K) followed proper hand sanitation guidelines. This placed 24 residents at risk for acquiring food borne illness.

Findings included....

FOOD TEMPERATURES

NOTE: Washington Administrative Code 246-215-03525 Temperature and time control—Time/temperature control for safety food, hot and cold holding (Food and Drug Administration Food Code 3-501.16).
(1) Except during active preparation for up to two hours, cooking, or cooling or when time is used as the public health control as specified under WAC 246-215-03530, and except as specified in subsections (2) and (3) of this section, time/temperature control for safety food must be maintained:
(b) At 41°Fahrenheit (F) (5°Celcius) or less.

Review of an undated Resident Characteristics Roster showed the facility provided care and services, including meals to 24 residents.

Observation, on 02/21/2025 at 11:55 AM, showed Staff J (Satellite Kitchen Attendant) preparing egg salad sandwiches at the satellite kitchen counter in the AL dining room on the third floor, followed by a caregiver serving the egg salad sandwiches to two residents.

Review of a FT log showed no FT record for the egg salad sandwiches prior to serving on 02/21/2025.

In an interview, on 02/21/2025 at 11:58 AM, Staff J stated that the food was transferred from the main kitchen on the first floor, and the FTs were supposed to be taken before serving each meal. When asked why the FTs for lunch were not recorded, Staff J replied, "I took FT only for the soup, but did not take FT for other food items."

Observation of the satellite kitchen in the AL dining room on the third floor, on 02/21/2025 at 12:05 PM, showed containers of food items for lunch, such as cut steaks and egg salad, in an ice bath on a food cart. When Staff J measured the FT, the egg salad FT measured 53.0 °F; the tuna salad FT measured 41.3 °F; the mixed green salad measured 51.8 °F; the cut steaks FT measured 54.4 °F.

Observation, on 02/21/2025 at 12:20 PM, showed a container of fruits salad sitting on the counter in the AL dining room on the third floor. The fruit salad FT measured 50.0 °F.

In an interview, on 02/21/2025 at 12:25 PM, Staff A (Administrator/Health Services Director) stated that the FT for cold food holding should be below 41.0 °F. Staff A stated that any food items which were measured to be above 41.0 °F should not be served to residents.

HAND WASHING

NOTE: Washington Administrative Code (WAC) 246-215-02310 Hands and arms—When to wash (Food and Drug Administration Food Code 2-301.14). Food employees shall clean their hands and exposed portions of their arms as specified under WAC 246-215-02305 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: (8) Before donning gloves for working with ready-to-eat-food unless a glove change is not the result of contamination; and

NOTE: WAC 246-215-02305 Hands and arms—Cleaning procedure (FDA Food Code 2-

301.12). (1) Except as specified in subsection (4) of this section, food employees shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a handwashing sink that is equipped as specified under WAC 246-215-05210 and Part 6, Subpart C of this chapter.

NOTE: According to Centers for Disease Control and Prevention guidelines on handwashing dated 02/16/2024: Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Lather your hands by rubbing them together with the soap, including the backs of your hands, between your fingers, and under your nails. Scrub your hands for at least 20 seconds. Rinse your hands well under running water. Dry your hands using a paper towel if possible

During lunch observation and interviews, on 02/21/2025 11:35 AM, showed Staff J (Satellite Kitchen Attendant) was serving residents on the 3rd floor kitchen. At 11:49 AM, Staff K (Dining Services Manager) entered the kitchen, turned the faucet on, washed her hands for less than 20 seconds. Then, Staff K then turned the contaminated faucet off with bare hands. When questioned, Staff K stated hand washing should be 10-15 seconds.

Observation and interview, on 02/21/2025 at 11:53 AM, Staff J turned the faucet on, washed her hands for less than 20 seconds. Staff J then turned the contaminated faucet off with bare hands. When questioned, Staff J stated hand washing should be 20 seconds, dry hands with paper towel, then turn the faucet off using the paper towel. Staff J acknowledged she failed to do proper hand washing.

In interview, on 02/21/2025 at 12:28 PM, Staff A, (Health Services Director / Administrator) stated that staff were expected to follow the facility policy for proper hand hygiene and must wash their hands prior to serving. Staff A acknowledged that kitchen staff required retraining.

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) 4·10·2025 .

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

Gary Jacobs — Administrator (or Representative)

3·17·2025 — Date

WAC 388-78A-2150 Signing negotiated service agreement. The assisted living facility must ensure that the negotiated service agreement is agreed to and signed at least annually by:

(1) The resident, or the resident's representative if the resident has one and is unable to sign or chooses not to sign;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure Negotiated Service Agreements (NSA) were signed at least annually for 6 of 6 sample residents (Residents 1, 2, 3, 4, 5, and 6). This failure placed Residents 1, 2, 3, 4, 5, and 6 at risk for receiving care and services that was not agreed upon.

Record review showed the ALF admitted Resident 1 on [redacted]/2024 with multiple diagnoses. Review of the Service Plan Report (equivalent an NSA), dated 12/19/2023 and 02/12/2025, showed no signature of Resident 1 or their representative.

Record review showed the ALF admitted Resident 2 on [redacted]/2024 with multiple diagnoses including [redacted] ([redacted]). Review of the NSA, dated 12/18/2024, showed no signature of Resident 2 or their representative.

Record review showed the ALF admitted Resident 3 on [redacted]/2023 with multiple diagnoses. Review of the NSA, dated 11/30/2023 and 01/31/2025, showed no signature of Resident 3 or their representative.

Record review showed the ALF admitted Resident 4 on [redacted]/2024 with multiple diagnoses. Review of the NSA, dated 12/18/2024, showed no signature of Resident 4 or their representative.

Record review showed the ALF admitted Resident 5 on [redacted]/2024 with multiple diagnoses. Review of the NSA, dated 12/17/2024, showed no signature of Resident 5 or their representative.

Record review showed the ALF admitted Resident 6 on [redacted]/2024 with multiple diagnoses. Review of the NSA, dated 01/11/2024 and 01/ 27/2025 , showed no signature of Resident 6 or their representative.

In interview, on 02/21/2025 at 11:00 AM, Staff G (Director of Wellness) acknowledged the lack of residents' or their representatives' signature on the NSAs for Residents 1, 2, 3, 4, 5, and 6.

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) 4·10·2025 .

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

Gary Jacobs — Administrator (or Representative)

3·17·2025 — Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement systems that support and promote safe medication services for 2 of 2 sampled resident (Resident 1 and 6). This resulted in Residents 1 and 6 not receiving their medications as prescribed and placed them at risk for health complications.

Findings included...

Review of the ALF's Medication Administration Policy, revised on 04/11/2024, showed medications were administered by a licensed nurse (LN), or other staff who are legally authorized to do so as ordered by the physician and in accordance with professional standards of practice. The policy stated to obtain and record vital signs, when applicable or per physician orders, and when applicable, hold medication for those vital signs outside the physician's prescribed parameters.

RESIDENT 1
Record review showed that the ALF admitted Resident 1 on [redacted]/2024 with multiple diagnoses including [redacted] ([redacted]). Review of a Service Plan Report (SPR - equivalent to a Negotiated Service Agreement ((NSA)), dated 02/12/2025, showed Resident 1 required staff to administer or assist with medication management.

Record review, dated 02/05/2024, showed a physician order for metoprolol (used to treat high blood pressure) to give every morning and to hold the medication for systolic BP (SBP) less than 90 or heart rate (HR) less than 50.

Review of December 2024 electronic Medication Administration Record (eMAR), showed Resident 1 had a HR of 46 on 12/24/2024. The eMAR showed Staff F (Caregiver/Medication Technician) had initialed the metoprolol to indicate the medication was given to Resident 1 and not held at 46 HR. There was no documentation that this was reported to a LN.

Review of the January 2025 eMAR, showed Resident 1's metoprolol was held on 01/08/2025, but there was no BP or HR reading documented. On 01/14/2025, Resident 1's BP reading was 91/60 with a HR of 82, and on 01/26/2025 BP was 90/58 and HR 80. The eMAR showed staff held the metoprolol on 01/14/2025 and 01/26/2025, when it should have been given per physician's parameters.

Review of the February 2025 eMAR, showed Resident 1's metoprolol was held on 02/03/2025 for a BP 90/64 with a HR 67, and on 02/06/2025 for a BP 99/33 and a HR 72 when it should have been given per physician's parameters. On 02/11/2025, Resident 1's metoprolol was held, and no BP or HR readings were documented.

In an interview, on 02/21/2025 at 12:45 PM, Staff G (Health Services Director) acknowledged that BP and HR medication parameters were not followed as prescribed.

RESIDENT 6
Record review showed the ALF admitted Resident 6 on [redacted]/2024 with multiple diagnoses including [redacted], [redacted] ([redacted]

[redacted]) and [redacted]). Review of the NSA, dated 01/27/2025, showed Resident 6 required staff assistance with medication management.

Record review showed a physician order, dated 01/09/2025, for Xarelto (used to prevent blood clots from forming due to a certain irregular heartbeat). Review of the February eMAR, showed Resident 6 did not receive their Xarelto on 02/06/2025 at 8:00 PM.

Review of the January 2025 eMAR, showed no staff signature indicating Resident 6 received zonisamide (used to treat encephalopathy) on 01/28/2025 at 8:00 PM.

Review of December 2024 eMAR, showed no staff signature indicating Resident 6 received losartan (used to treat high blood pressure) on 12/17/2024 at 8:00 PM.

In an interview, on 02/21/2025 at 12:45 PM, Staff G (Health Services Director) acknowledged medication orders were not followed as prescribed.

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) 4-10-2025.

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

Gary Jacobs — Administrator (or Representative)

3-17-2025 — Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

(2) The assisted living facility must comply with subsection (1) of this section, unless the prescriber or primary care practitioner has provided the assisted living facility with:

(a) Specific directions for addressing the refusal of the identified medication;

(b) The assisted living facility documents such directions; and

(c) The assisted living facility is able to fully comply with such directions.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to notify the physician and evaluate for any negative outcomes when 1 of 3 sampled residents (Resident 3) refused their prescribed medications. This placed Resident 3 at risk for compromised health.

Findings included...

Review of the ALF's Medication Administration Policy, revised 04/11/2024, showed to report to nurse supervisor when resident refused their medication. Make few attempts to administer medication and documents the reason for refusal.

Records review showed the ALF admitted Resident 3 on [redacted]/2023 with multiple diagnoses including [redacted] ([redacted]). Record review showed Resident 1 required Hospice Care (a special care focused on the comfort, care, and quality of life of individuals with terminal illness). Review of a Service Plan Report (SPR - equivalent to a Negotiated Service Agreement ((NSA)), dated 01/31/2025, showed Resident 3 required staff to administer or assist with medication management.

Review of the December 2024, January, and February 2025 electronic Medication Administration Record (eMAR) showed Resident 3 had refused fludrocortisone (a medication used to treat hypotension) on 12/05/2024, vitamin B12 (supplement) on 12/02/2024 and 12/05/2024, and refresh tears eye drops (used for dry eyes) on 12/05/2024. Resident 3 refused fludrocortisone on 01/17/2025, 01/23/2025, and 01/26/2025; metamucil (a fiber supplement) on 01/12/2024, 01/23/2025, 01/26/2025, and 01/30/2025, refresh tears eye drops on 01/23/2025, and vitamin B12 on 01/26/2025. Resident 3 refused fludrocortisone, vitamin B12, and metamucil on 02/03/2025 and 02/04/2025, and refresh tears eye drops on 02/04/2025, 02/06/2025 and 02/19/2025.

Record review showed no documentation the ALF notified the physician of Resident 3's medication refusals or evaluated for any outcome related to medication refusals.

In interview, on 2/21/2025 at 12:45 PM, Staff G (Director of Wellness) acknowledged the lack of evaluation when a resident refused their medications, and failure to notify physicians of their pattern of refusals.

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) 4·10·2025.

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

Gary Jacobs
Administrator (or Representative)

3·17·2025
Date

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to obtain a physician's prescribed medication in a timely manner for 1 of 3 sampled residents (Resident 1) who required staff assistance with medications. This placed Resident 1 at risk for a compromised health condition.

Findings included...

NOTE: Washington Administrative Code 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: (l) To manage residents' medications, consistent with WAC 388-78A-2210 through 388-78A-2290; sending medications with a resident when the resident leaves the premises;

Review of the ALF's Administration Policy, revised on 04/11/2024, did include a policy on non-availability of medication for staff direction.

Record review showed that the ALF admitted Resident 1 on [redacted]/2024 with multiple diagnoses. Review of a Service Plan Report (SPR - equivalent to a Negotiated Service Agreement ((NSA)), dated 02/12/2025, showed Resident 1 required staff to administer or assist with medication management.

Record review, dated 10/15/2024, showed a physician order for mounjaro (a medication used for weight loss) to inject weekly. Review of the January 2025 eMAR, showed mounjaro injection was not given on 01/05/2025 at 8:00 AM due to the drug being unavailable.

On 12/05/2024, Resident 1 missed a dose of amoxicillin (antibiotic given before dental work). On 12/23/2024, Resident 1 was not given chlorhexidine (an antibacterial mouthwash that kills bacteria in the mouth) due to medication was unavailable.

In interview, on 2/21/2025 at 12:45 PM, Staff G (Director of Wellness) acknowledged Resident 1's missed medications and were not following physician's order due to unavailability of medications.

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) 4.10.2025.

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

Gary Jacobs — Administrator (or Representative)

3.17.2025 — Date

WAC 388-78A-2482 Tuberculosis No testing. The assisted living facility is not required to have a staff person tested for tuberculosis if the staff person has:

(1) A documented history of a previous positive skin test, with ten or more millimeters induration;

(2) A documented history of a previous positive blood test; or

(3) Documented evidence of:

(a) Adequate therapy for active disease; or

(b) Completion of treatment for latent tuberculosis infection preventive therapy.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure documentation of history of previous positive tuberculin skin test (TST), blood test, or adequate therapy was in place for 2 of 2 sampled staff (Staff A and B) who did not have TST completed. This failure placed 24 residents of exposure to a communicable disease.

Findings included...

Record review showed the ALF hired Staff A (Health Services Director) on 8/17/2023. Staff A's record showed a history of negative chest x-ray (CXR) result on 01/04/2023. However, the ALF had no documented history of a previous positive TST, blood test or TB treatment.

Record review, showed the ALF hired Staff B (Caregiver) on 08/07/2024. Staff B's record showed a negative chest x-ray (CXR) result on 01/09/2024. However, the ALF had no documented history of a previous positive TST, blood test or TB treatment.

In interview, on 02/20/2025 at 10:30 AM, Staff A acknowledged the lack of documentation to show a history of a previous positive TST, blood test or TB treatment.

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) 4.10.2025.

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

Gary Jacobs
Administrator (or Representative)

3.17.2025
Date

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 # 183

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 03/10/2025 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 Return the Plan/Attestation Statement and report with signatures to:

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

eFax: (206) 971-6791
Email: rcsregion2email@dshs.wa.gov
Optional method:
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-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(d) Cardiopulmonary resuscitation and first aid; and

The Assisted Living Facility (ALF) failed to a care staff completed the required first aid training. This placed the residents at risk of compromised health status in the event of injury or medical emergency.

WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

(1) The caregiver or administrator is not disqualified based on the results of the Washington state name and date of birth background check; and

(2) The results of the national fingerprint background check are pending.

The Assisted Living Facility failed to a caregiver had completed a fingerprint background check within one hundred and twenty days of hire. This placed the residents at risk of exposure to care staff whose criminal background was unknown.

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:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

If You Have Any Questions:

• Please contact me at (253)312-1446.

Sincerely,

Jamie Singer

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

Enclosure