STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505140	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Health and Rehabilitation of Cascadia	2400 Samish Way Bellingham, WA 98229

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to conduct a complete and thorough investigation of mistreatment for 1 of 1 resident (Resident 20) who was sent to the emergency department due to a Registered Nurse (RN) accidentally cutting a residents peripherally inserted central catheter (PICC) line during a PICC line dressing change. This failed practice prevented the facility from identifying why the incident occurred, identifying the nursing staff's competency improvement needs which placed residents at risk. Findings included .Review of the facility's policy titled, Abuse, Prevention, Identification, & Reporting, revised 10/31/2017, stated the facility will investigate patterns, trends, and events that suggest the possible presence of abuse, or neglect . if the allegation is verified, the report includes appropriate corrective action taken. Review of the facility's January and February 2026 incident logs showed no incidents related to Resident 20's incident of Staff F, Registered Nurse (RN) inadvertently cutting the resident's PICC line when attempted to change the dressing. Review of Resident 20's progress note dated 01/20/2026 showed the resident's PICC line was accidentally cut while changing the dressing. The resident was sent to the emergency department. In an interview and record review on 02/11/2026 at 3:02 PM, Staff L, Interim Chief Nursing Officer, brought an in-service sheet to the surveyor which showed Staff F was educated to not use scissors on a PICC line dressing and stated the resident did not return to the facility. Staff L stated no incident report was completed as the resident was discharged home from the hospital. In an interview on 02/11/2026 at 4:43 PM, Staff L stated they were going to do an incident report today. Staff L stated they had looked at the Purple Book and discussed it with the intradisciplinary team and had determined the incident did not meet the definition to complete an incident report. In an interview on 02/11/2026 at 4:23 PM, Staff O, Licensed Practical Nurse/Resident Care Manager, stated incident reports were usually started by the cart nurse, but the Nursing Managers could start them. [NAME] O stated they would discuss incidents in their stand-up meeting, I do not know if we intended to it to be a risk management or not. Staff O stated they were never directed to do an incident report. Staff O stated the incident was more like a mistake and the nurse was educated, then the resident went to the hospital and did not return. In an interview on 02/13/2026 at 5:23 PM, Staff K, Interim Administrator, stated they thought the incident report was in the facility's risk management electronic software system or they reviewed it in the facility's stand-up meeting regarding the PICC line event on 01/20/2026. Staff K stated they remembered the day Staff F made a mistake. Staff K stated they would expect an investigation to see what happened. In the facility's exit on 02/13/2026 at 5:52 PM, the facility's company Lead Chief Nursing Officer, Staff M, stated that they were told at the time of the incident involving the PICC line that an investigation was being conducted. Staff P stated they would expect an investigation to be done as there was room for improvement. Reference WAC 388-97-0640(6)(a)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the nursing staff used professional standards of care and aseptic (to prevent healthcare associated infections, surgical site infections and laboratory contamination) technique when changing Resident 20's PICC line [a peripherally inserted central catheter (PICC) is a long, soft, flexible tube inserted into a vein in the upper arm and advanced to a large vein above the heart] dressing. Resident 20 experienced harm when they required an emergency transfer to the emergency department (ED) to have their PICC line replaced, and additional diagnostic procedures (ultrasound and Xray) performed when their PICC line was cut with unclean and unsterile scissors. Additionally, this failed practice placed the resident at serious risk for central line associated blood stream infection. Findings included .Review of the 2025 Facility Assessment showed the facility had specific types of care and practices that required nursing care for the facility's specific population which included intravenous (IV) peripheral or central lines. Monitoring of competencies would be accomplished through Senior Leader rounding, mentoring, return demonstration during monthly skills check and staff competencies would be completed annually. Review of the facility's policy titled, Dressing Change for Vascular Access Devices, dated [DATE], showed Central Venous Access Device Dressing Change Procedure, in the following order * using first pair of sterile gloves, *remove old dressing, use care to prevent skin tear, shearing, or bruising, *press skin away from dressing vs pulling up on dressing, *stretch TSM (transparent semi-permeable membrane) dressing to side, *work from the edge of the dressing toward the insertion site while stabilizing the catheter to minimize catheter movement, *use alcohol to help loosen adhesive. Resident 20 was admitted to the facility on [DATE] with diagnoses to include osteomyelitis (serious infection of the bone marrow and bone tissue) of vertebra, thoracic and lumbar region, type 2 diabetes, and resistance to vancomycin. Review of Resident 20's care plan showed the following focused problems: The resident had enhanced barrier precautions to reduce the risk of multi drug resistant organism transmission related to having a PICC line to their left upper arm dated [DATE]. The interventions included to use enhanced barrier precautions to prevent infection. The resident had a PICC line on their left upper arm dated [DATE]. Interventions included site change/treatment, and dressing changes as indicated to maintain site patency and infection free. Review of Resident 20's progress note dated [DATE] documented the resident's PICC line was accidentally cut while staff were changing the resident's dressing. A pressure dressing was applied and the resident left via stretcher to the ED. Review of Resident 20's progress notes with an effective date of [DATE] which was created on [DATE], documented the facility was notified the resident was discharged home to continue intravenous (IV) antibiotic therapy, with an in-home infusion agency who would be in contact with infection disease. Review of a grievance complaint dated [DATE], showed Resident 20's Collateral Contact 1 (CC1- resident 20s family member) wrote a letter to the facility's home office regarding Resident 20's PICC line being cut while at the facility. The facility's resolution and/or additional corrective actions documented an in-service would be provided to nursing staff related to PICC lines. Review of a letter dated [DATE], attached to the grievance complaint, showed CC 1 wanted to bring attention to the events and issues that occurred during Resident 20's stay at the facility. The serious issue on [DATE] when Resident 20's PICC line was cut was most troubling. They were concerned about the residents' care and the training of the facility's staff during the residents' stay, which CC1 stated was insufficient and should be addressed to prevent further repeated actions for other residents. **Nurse Competencies***Review of the facility's licensed nurses' competencies showed the last dates the following LN competencies were completed: Staff O, Licensed (continued on next page)

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F 0694 Level of Harm - Actual harm Residents Affected - Few	Practical Nurse (LPN) [DATE], Licensed Nurse Clinical Competencies including Central/PICC/CVAD Care Staff N, RN [DATE], Licensed Nurse Clinical Competencies including Central/PICC/CVAD Care Staff F, Registered Nurse (RN) [DATE], General Competencies including Central line/midline dressing changeAll past due as of the date reviewed on [DATE]. Review of an undated form titled, Staff Education Needed, included, All Nurses, PICC line dressing/protocols for dressing changes. In an interview on [DATE] at 1:16 PM, Staff N, Registered Nurse (RN), stated they were unaware of any facility in-services provided that instructed them not to use scissors during a PICC line dressing change but, I know we are not supposed to use sharps. In an interview on [DATE] at 1:43 PM, Staff F, RN, stated they were comfortable working with IV lines. Staff F stated they were taking off Resident 20's old PICC line dressing and tried to cut the tape and snipped the line. Staff F stated they called 911 directly afterwards, told their nurse manager when it happened and applied pressure as we did not have a clamp until emergency medical service arrived which took about 10 minutes after the line had been cut. Staff F stated the facility had them sign something and they said they were going to do general education on PICC line dressing changes. Staff F stated they signed an in-service sheet, but they only told them not to use scissors when changing a PICC line dressing. Staff F stated they thought if they could cut the tape on the dressing, it was not 100% they had cut the line as it did not feel like they cut the line. Staff F stated they felt it cut the dressing unless the line snapped. Staff F stated they have not had a lot of training but were certified to insert IVs while employed at another facility and graduated nursing school back in 2014. Staff F stated it was hard to do their job sometimes when they did not feel supported due to not receiving education. In an interview and record review on [DATE] at 3:02 PM, Staff L, Interim Chief Nursing Officer (CNO), brought the surveyor an in-service education summary form dated [DATE] that showed the topic was PICC line dressings, the content of the in-service was for prevention to not use scissors but to assist with removing a dressing use adhesive remover, with Staff F's signature. Staff L stated they were going to go over PICC line dressing and protocols for dressing changes in their monthly nursing in-service. Staff L stated they had not provided the in-service it was scheduled for upcoming Friday. In an interview on [DATE] at 12:42 PM, Staff F stated they had used a pair of general wound care scissors (unsterile) to snip a piece of tape which was on Resident 20's weekly PICC line dressing change. Staff F stated they did not notice blood but 911 was called to get the line replaced. Staff F stated they noticed the line was cut after they got the PICC line dressing removed. Staff F stated they were unsure if the line broke from pulling the dressing tape or from the cut. In an interview on [DATE] at 1:06 PM, Staff D, Licensed Practical Nurse/Resident Care Manager, stated Staff F had come into the morning meeting and they went into Resident 20's room to assess the situation. Staff D stated Staff F reported the PICC line had come apart but it looked cut and Staff F did not know what to do. Staff D stated the Director of Nurses at the time flipped out criticizing our nurses. Staff D stated it was pretty simple, Staff F knew they should have removed the dressing with adhesive remover. Staff D stated it seemed cut and dry and was an awful mistake. In a phone interview on [DATE] at 3:10 PM, CC1 stated the facility seemed to have only one nurse who knew how to work with a PICC line. CC 1 stated they seemed to waste the resident's IV antibiotic when they were trying to get air bubbles out of the IV line. CC 1 stated the worst day Resident 20 had at the facility was the day the nurse cut the resident's PICC line. CC 1 stated one of the nurses dropped a vial of medication and broke it. CC 1 stated it was unsettling. CC 1 stated Resident 20 had to have a new PICC line placed, an X-ray and an ultrasound to confirm placement. CC 1 stated the PICC line was like what broke the camel's back. CC 1 stated they were not going to bring Resident 20 back to that facility. CC 1 stated the facility should not have accepted (continued on next page)

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F 0694 Level of Harm - Actual harm Residents Affected - Few	Resident 20 if the nursing staff did not have the training to work with a PICC line. CC 1 stated if you made a mistake like that you would think you would know what to do. CC 1 stated it was a huge deal for Resident 20, and the hospital staff were all concerned that anyone would be using scissors like that near a PICC line. In an interview on [DATE] at 5:23 PM, Staff K, Interim Administrator, stated the licensed nursing competencies should be done annually and was not aware they were not up to date. In a phone interview on [DATE] at 3:36 PM, Resident 20 stated it did not seem like anyone at the facility knew how to care for my PICC line or my IV antibiotics. The resident stated the staff had a lot of problems administering my IV antibiotics, they had a lot of issues with the IV pump jamming, excessive air bubbles in the line and how the antibiotics were to be infused. Resident 20 stated that when they asked the staff how many residents had IVs like mine, they said theirs was the only one. The resident stated on the day my PICC line was cut, the nurse came in to change my dressing, and they were trying to get this gummy stuff off my dressing. The resident stated the nurse got a pair of what looked like gauze scissors out of the front pocket of their scrub top and they cut my line. Resident 20 stated the nurse just looked at me and stated, Oh it broke, it snapped, and I stated, No, you cut it. Resident 20 stated they began to freak out, and the nurse was freaking out too. The resident stated the nurse had removed most of the old dressing and then placed the new dressing over the insertion site, then told me to hold pressure on it and then they left the room. The resident stated if they knew that scissors were not supposed to be used around a PICC line they would have told them. The resident stated the nurse returned with an administration staff person and they were discussing whether to call 911, I was bleeding, I could feel the blood under my arm pit. Resident 20 stated the nurse came back in again asking if, I wanted to be revived, they did not seem like they knew what they were doing, which further freaked me out. The resident stated they were freaking out too because they were told repeatedly the PICC line was supposed to be clean, the PICC line was a serious thing as it went into their heart. Resident 20 stated when it happened, they looked at the nurse, thinking okay what do we do now but the nurse just looked at me in a panic. Resident 20 stated, I was telling myself not to freak out cause the nurse was freaking out but I did not know what to do and they did not know what to do. Resident 20 stated in the ED they had to remove the PICC line and then they had to have ultrasounds to both of their arms to check for blood clots before they could insert a new line which was uncomfortable. Resident 20 stated, I has already having anxiety from everything going on and now I had to learn to do everything on my own, as I was not going to discharge back to that facility. Reference WAC 388-97-1060 (1)(3)(ii)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on interview and record review the facility failed to ensure the daily nurse staffing posting was completed daily with the total number of actual nursing hours worked along with the resident census from 01/07/2026 to 02/13/2026 for a total of 37 days. This failed practice prevented the residents and visitors' ability to readily view the nurse staffing information. Findings included. In an observation on 02/11/2026 at 12:22 PM, the daily nurse staffing posting was dated 01/07/2026. In an observation on 02/12/2026 at 12:40 PM, the daily nurse staffing posting continued to be dated 01/07/2026. In an observation and interview on 02/13/2026 at 3:10 PM, Staff L, Interim Chief Nursing Officer, confirmed the nurse daily staffing was dated 01/07/2026, and stated it should be posted daily reflecting the actual nurse staffing hours along with the facility's current census number.No reference WAC

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were provided all physician ordered medications on 13 of 14 days reviewed for 20 residents. This failed practice disrupted the residents' continuity of care and placed residents at risk of not having their medical needs met.Findings included. Review of the facility's Medication Not Available, report ran for the scheduled dates of 01/30/2026 through 02/12/2026, listed the following physician ordered medications were not administered due to not available along with correlating dispensing reference from the facility's contracted pharmacy:01/30/2026 Resident 1 - gabapentin (anticonvulsant medication), albuterol sulfate inhalation (respiratory medication) [available in pyxis (machine dispenser], metronidazole topical cream (antiprotozoal and antibiotic medication), fluticasone-salmeterol inhaler (respiratory medication) [no stat request], ranitidine (stomach acid medication) [Over the Counter (OTC), facility supplied stock] Resident 2 -clopidogrel bisulfate [an antiplatelet medication], [14-day supply delivered on 01/20/2026], biotin (vitamin supplement) [OTC] Resident 3 -slow-magnesium (mineral supplement) [OTC] 01/31/2026 Resident 1 - albuterol sulfate inhalation, metronidazole topical cream, fluticasone-salmeterol inhalation [no stat request], Excedrin Extra Strength (pain medication) [OTC] Resident 4 - duloxetine (antidepressant medication) [14-day supply delivered on 01/16/2026 refill request on 02/02/2026] Resident 3 - slow-magnesium [OTC] 02/01/2026 Resident 1- fluticasone-salmeterol inhalation, metronidazole topical cream, [no stat request, available in pyxis], ranitidine [OTC] Resident 5 - ipratropium-albuterol (respiratory medication) [7-day supply delivered on 01/29/2026] Resident 2 - biotin [OTC] 02/02/2026 Resident 1 -metronidazole topical cream, [no stat request] Resident 6 - levothyroxine sodium (thyroid medication) [30-day supply delivered on 01/03/2026 refill requested on 02/03/2026] Resident 7 - levothyroxine [14-day supply delivered on 01/17/2026 refill request on 02/04/2026] Resident 8 - semaglutide (diabetic hormone medication) [28-day supply delivered on 01/12/2026 -supply on hand] 02/03/2026 Resident 1- ranitidine [OTC] Resident 6 - levothyroxine sodium [30-day supply delivered on 01/03/2026 refill requested on 02/03/2026] Resident 4 - montelukast sodium (respiratory medication) [14-day supply delivered on 01/16/2026 refill request on 02/04/2026] Resident 9 - estradiol (hormone medication) [14-day supply delivered on 01/27/2026] Resident 19 - calcium carbonate - vitamin D (mineral/vitamin supplement) [OTC] 02/04/2026 Resident 1 - ranitidine [OTC] Resident 4 - montelukast sodium [14-day supply delivered on 01/16/2026 refill request on 02/04/2026] 02/06/2026 Resident 10 - Prolensa ophthalmic solution (anti-inflammatory medication) [dispensed 28-day supply on 12/24/2025 for start date of 01/24/2026, date of surgery] 02/07/2026 Resident 11 - diclofenac sodium (anti-inflammatory medication) [OTC] 02/08/2026 Resident 1 - esomeprazole magnesium oral packet (gastroesophageal reflux disease medication) [14-day supply delivered on 01/31/2026], calcium magnesium zinc tablet (multivitamin with minerals), [OTC] Resident 12 - duloxetine (antidepressant medication), clopidogrel bisulfate (antiplatelet medication), oxybutynin chloride (bladder medication), diltiazem (heart medication) [14-day supply delivered on 01/22/2026, refills requested on 02/10/2026] Resident 2 - escitalopram oxalate (antidepressant medication) [100-day supply delivered on 12/09/2025], isosorbide mononitrate (heart medication) [14-day supply delivered on 01/08/2026 refill request on 02/14/2026] 02/09/2026 Resident 1 - esomeprazole magnesium oral packet [14-day supply delivered on 01/31/2026], Excedrin Extra Strength, calcium magnesium zinc tablet [OTC] Resident 12 - oxybutynin chloride, diltiazem [14-day supply delivered on 01/22/2026, refills requested on 02/10/2026] Resident 3 - potassium chloride (electrolyte mineral supplement) [14-day supply delivered on 01/31/2026] Resident 13 - pantoprazole sodium potassium (gastroesophageal medication) and sodium phosphates (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	packet (bowel medication) [OTC] Resident 11 - diclofenac sodium (non-steroidal anti-inflammatory medication) and lidocaine external gel (pain relief medication) [OTC] Resident 6 - cranberry vaccinium macrocarpon (herbal drug) [OTC] 02/10/2026 Resident 1- esomeprazole magnesium oral packet [14-day supply delivered on 01/31/2026] Resident 13 - potassium and sodium phosphates packet [OTC] Resident 14 - Liquacel amino acid (protein supplement) [OTC] Resident 15 - Liquacel amino acid [OTC] Resident 16 - Liquacel amino acid [OTC] 02/11/2026 Resident 17 - calcium citrate (mineral supplement) [OTC] Resident 13 - potassium and sodium phosphates packet [OTC] 02/12/2026 Resident 18 - alendronate sodium (osteoporosis medication) [14-day supply delivered on 02/05/2026] In an interview on 02/11/2026 at 1:20 PM, Staff J, Licensed Practical Nurse (LPN) stated the facility was not on track with ensuring resident continuity of care related to nursing following up on thing that should be taken care of by the nurse managers. Staff J stated there were issues with obtaining medications from both the pharmacy and OTC medications. Staff J stated there were times when medications were not ordered at all or the medication needed a renewed prescription refill order but unsure the issue with the problem. In an interview on 02/11/2026 at 1:43 PM, Staff F, Registered Nurse (RN), stated the OTC medications were not always available, and the management staff does not want us to document the medications that are unavailable. Staff F stated they told management they would not document something they did not do. Staff F stated they are told to talk to the Administrator about the unavailable medications, and the Administrator says to talk to Staff G, Human Resources (HR). Staff F stated then when they talked to Staff G about a needed medication that is not available, Staff G tells them, they do not have a card to purchase the needed medication. In an interview on 02/11/2026 at 3:12 PM, Staff N, LPN, stated they worked at the facility as an agency staff member. Staff N stated they sometimes notice a lack of OTC medications available at the facility. Staff N stated as an agency staff they are not allowed to use the pyxis machine, a regular staff nurse would have to pull the medication out of the pyxis machine. Staff N stated they had a resident who had a medication that was not available and they alerted the Resident Care Manager (RCM). Staff N stated they thought the RCM would have called the pharmacy, but the medication did not get ordered and the oncoming nurse was upset. In an interview on 02/11/2026 at 4:04 PM, Staff H, RN, stated the facility sometimes does not have OTC medications like lidocaine patches. Staff H stated the facility runs out of random items and they tell Staff G. Staff H stated if medication is not available for a day or two, we try to notify the residents' provider. In an interview on 02/12/2026 at 3:01 PM, Staff D, LPN/Resident Care Manager (RCM), stated they have continuous issues with the pharmacy and they have escalated it with the pharmacy in that they reordered items that are not delivered in a timely manner like high cost medications that have to get the administration's okay and a signature from the administrator. Staff D stated they might have to wait on medications till a Monday that were ordered on a Friday. In an interview on 02/12/2026 at 3:45 PM, Staff L, Interim Chief Nursing Officer, stated they did not know where the disconnect was with having medications available. In an interview on 02/13/2026 at 3:21 PM, Staff C, RN, stated there have been medications not available to administer and had to check with the pharmacy. Staff C stated they would check with the pharmacy, and they would be sent on the midnight round. Staff C stated there was a medication they had to sign for it to come in as soon as possible, it probably was for payment reasons. Staff C stated the medications not available are usually OTC medications. In an interview on 02/13/2026 at 4:00 PM, Staff D stated the Medication Not Available report is straight forward, those medications listed were just not available whether they were medications delivered from the pharmacy or OTC medications supplied from the facility. In an interview on 02/13/2026 at 3:46 PM, Staff B, LPN, stated the facility had to order medications before 3:00 PM, for the medications (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to be delivered on the first delivery rounds delivered around 7:00 PM, and the second delivery comes around midnight. In a phone interview on 02/13/2026 at 4:38 PM, Staff I, Contracted Pharmacist in Charge, stated they were not aware of any difficulties with medication delivery to the facility. Staff I stated lidocaine 5% (percent) had been back ordered and the lidocaine 4% is a facility house supplied medication. Staff I stated the pharmacy sent a 14-day supply of Resident 12's oxybutynin on 01/21/2026 and there was not a refill request until 02/10/2026 which was delivered on 02/11/2026, the resident should have been out on 02/04/2026. Staff I stated the pharmacy's refill turnaround time is five to seven days. Resident 1's respiratory medication was sent to the facility on [DATE] at midnight which should have been available for the next day's morning dose. Staff I stated the facility's cut off time to order medication for the early delivery is 1:00 PM, which will arrive at the facility at midnight. In an interview on 02/13/2026 at 3:55 PM, Staff A, RN, stated the unavailable medications are an issue with the pharmacy. Staff A stated they have to call the pharmacy as the pharmacy never sends the resident medications on time even though they called for medications for the prior day to be administrated for the next morning, the medication is never delivered. Staff A stated when they have a new order, for example, thyroid medication to be given the next morning. Staff A stated they called the pharmacy and requested the medication to be delivered on the first pharmacy delivery run but they do not know why there is a barrier or a problem, but the medication never makes it to the facility to be administered on time the following morning. In an interview on 02/13/2026 at 4:13 PM, Staff D, stated the medications listed on the Medication Not Available, report was not administered due to waiting on the pharmacy to deliver the medications. Staff D stated nursing would call the pharmacy for medication orders and the medication would not arrive and we would call again only to have the pharmacy it was not ordered when indeed it was ordered. Staff D stated the availability of medications has been an issue since before they went on leave, it has been an ongoing issue. In an interview on 02/13/2026 at 5:23 PM, Staff K, Interim Administrator, stated the issue with unavailable OTC medications had been brought to their attention in the daily morning meetings. Staff K stated they directed the staff to use petty cash to obtain the medications locally if they were going to take too long to arrive from the vendors. In a follow-up email on 02/19/2026, Staff I, Pharmacy Consulted, noted several medications on the Medication Not Available report should have been available as OTC facility stock. Staff I noted, Many medications should have been on hand based on previous delivery dates, and there were multiple cases where the refill requests were submitted well after the existing supply should have been exhausted. Staff I noted there was one admission where medication doses were missing on the evening of the residents' arrival. Staff I noted the facility submitted the resident's orders to the pharmacy at 5:00 PM on 01/30/2026 and were delivered at the standard delivery time at approximately 2:00 AM on 01/31/2026. Staff I noted there were three of five medications on the medication order that were available in the pyxis, and there was no facility rush request submitted to the pharmacy for the remaining two medications. Reference WAC 387-97-1300(1)(b)(i)(ii)