STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505226	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Healthcare Center	721 Otis Avenue Sunnyside, WA 98944

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30528 Based on observation, interview and record review, the facility failed to provide goods and services that met professional standards of care for 2 of 3 residents (Resident 3 and Resident 7) reviewed for documentation before and after receiving an opioid (a powerful class of medications meant to be used for a short time after an injury or surgery to manage acute pain and enable activity) pain medication. The failure to assess and document resident's symptoms before and after receiving pain medication put the residents at risk for unmet care needs. Findings included . Record review of the facility's policy titled, Pain Assessment and Management, dated 10/2022, showed that when opioids were used for pain management, the resident was monitored for medication effectiveness. Record review of the facility's policy titled, Charting and Documentation, dated 04/2008, showed that all medications administered must be documented in the resident's clinical record that included date and time medication given, assessment data obtained at the time medication was administered, how the resident tolerated the medication and signature and title of the individual documenting in the record. <Resident 3> Record review showed the resident was admitted to the facility with diagnoses to include stroke (when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen and nutrients) and dementia (a loss of mental ability severe enough to interfere with normal activities of daily living.) Review of a 09/17/2024 comprehensive assessment showed the resident had severe cognitive impairment and was dependent on staff for their activities of daily living. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505226	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Healthcare Center	721 Otis Avenue Sunnyside, WA 98944

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an 11/12/2024 at 11:34 AM progress note showed the resident's medical provider and family opted for end-of-life care (support and medical care given during the time surrounding death) due to a rapid, notable decline in the resident's health. At that time lorazepam (a medication commonly used in end-of-life care to treat anxiety, seizures, and nausea) was ordered to be given as needed for restlessness and morphine sulfate (MS, a controlled opioid medication that interacts with the opioid receptor cells that provides short term relief for significant pain) was ordered to be given as needed for pain. During a telephone interview on 12/11/2024 at 2:30 PM, Resident 3's representative (RR), stated they were concerned Resident 3 received MS on 11/18/2024 12 hours prior to their passing and they did not think Resident 3 appeared in pain. Review of Resident 3's November 2024 medication administration record (MAR) showed no documentation that MS was administered to Resident 3 on 11/18/2024. Record review of the facility Narcotic (opioid) Book- (a tamper-proof record system used to track every drug administered to individual resident) showed that MS was signed out on 11/18/2024 at 12:00 PM, by Staff D, Licensed Practical Nurse (LPN). Review of Resident 3's nursing progress notes for 11/18/2024 showed no documentation from Staff D on the resident's signs of pain or restlessness. During a telephone interview on 12/11/2024 at 2:45 PM, Staff D stated they recalled Resident 3 was having a difficult time swallowing on 11/18/2024 and they had family in the room. Staff D stated they could not recall why they thought Resident 3 was in pain but did remember giving the resident MS and told the resident and family what the medication was, and it was for pain. Staff D stated they were not aware they did not chart the medication on the MAR or make a progress note, I should have. <Resident 7> Record review showed the resident was admitted to the facility on [DATE] with diagnoses to include aftercare following surgery for abdominal aortic aneurysm (an enlarged area in the lower part of the body's main artery), care for wound vac (negative pressure wound therapy to assist with wound healing) to bilateral inguinal area (known as the groin and serves as passage way for structures such as blood vessels and nerves to and from the abdomen) and a cervical disc herniation (when the cushion-like discs between the neck vertebrae rupture or bulge). Review of the 12/01/2024 comprehensive assessment showed the resident had intact cognition, was dependent on staff for activities of daily living and was frequently in moderate pain that effected sleeping and mobility. During a concurrent interview and observation on 12/12/2024 at 1:45 PM, Resident 7 was observed lying flat on their back in bed. The resident stated they were in too much pain to sit up and pointed to the wound vac tubes coming from each inguinal area. The resident stated they were having trouble staying on top of the pain. Record review of the facility Narcotic Book showed that Resident 7 had an order for oxycodone as needed for pain and on 12/10/2024 the medication was signed out at 8:27 PM; on 12/11/2024 at 4:08 PM and again on 12/11/2024 at 8:45 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505226	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Healthcare Center	721 Otis Avenue Sunnyside, WA 98944

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the corresponding December 2024 MAR showed on 12/10/2024 Resident 7 complained of leg and back pain, received the oxycodone and reported that the medication was effective. On 12/11/2024 at 4:07 PM, Staff E, LPN, documented administering the oxycodone to Resident 7; however, they did not include an assessment or location of the resident's pain. Review of a 12/11/2024 4:44 PM progress note showed that Resident 7 expressed partial relief rating their pain at 3 out of 10 on a scale with 10 being the highest level of pain. There were no further entries on the MAR or progress notes for 12/11/2024 regarding the oxycodone signed out of the Narcotic Book at 8:45 PM by Staff E. Review of a facility 12/16/2024 investigation showed that on 12/12/2024, Resident 7 recalled receiving oxycodone twice on the 12/11/2024 evening shift about four hours apart since the first dose did not give them relief. During a telephone interview on 12/16/2024 at 10:30 AM, Staff E stated that they recalled Resident 7 asked for pain medication early in their shift [on 12/11/2024] for leg and back pain. They stated two hours later the resident reported they were still in significant pain and Staff E gave the resident more oxycodone about four hours later. Staff E stated they normally document in the MAR and progress notes why the resident received the medication and the results; however, they must have forgotten this time. During an interview on 12/16/2024 at 10:30 AM, Staff C, Assistant Director of Nursing, stated that stated it was concerning that the nurses were not documenting pain medication in the MAR and progress notes because we review the MAR for the frequency a resident needs pain to determine the effectiveness of the medication and frequency and this cannot be done effectively when the nurses do not document their administration of the pain medication, the assessment prior and results after. During an interview on 12/16/2024 at 10:40 AM, Staff B, Director of Nursing, stated we have already started to fix this problem, the nurses know better. Reference: WAC 388-97-1060(1)(2)(b)(4)