

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505226	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2026
NAME OF PROVIDER OR SUPPLIER Sunnyside Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of drugs) to meet the needs of 1 of 3 residents (Resident 1) reviewed for pharmacy services. This failed practice placed the residents at risk for ongoing, uncontrolled pain and emotional distress. Findings included. Review of a policy titled, Administering Medications, dated 04/2019, showed medications were administered in a safe and timely manner as prescribed. Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including rheumatoid arthritis (a chronic, progressive disorder where the immune system attacks joint linings, causing painful inflammation, stiffness, and potential deformity) and a history of compression fractures (a collapse of weakened bones that cause severe back pain) in the spine. The 01/09/2026 comprehensive assessment showed Resident 1 required maximum assistance/dependent on one to two staff members for activities of daily living: independent with eating. The assessment also showed Resident 1 had an intact cognition. Review of Resident 1's January 2026 Medication Administration Record (MAR), showed they had a 10/01/2025 physician order for their narcotic pain medication to be given every six hours for rheumatoid arthritis. The MAR showed missed doses of the narcotic pain medication on 01/27/2026 at 6:00 PM, 01/28/2026 at 12:00 AM, 6:00 AM, 12:00 PM, 6:00 PM, and 01/29/2026 at 12:00 AM. An observation and interview on 02/02/2026 at 9:48 AM, showed Resident 1 lying in bed on their back. Their fingers on both hands were deformed. Resident 1 stated the facility did not have their narcotic pain medication available and they had missed six doses. They stated they had pain all over their body, including their hands, back, feet, and elbows. Resident 1 stated the staff told them they had ran out of their narcotic pain medication and the pharmacy would not refill it until a doctor wrote a new prescription for the medication. They stated they used an over-the-counter anti-inflammatory and pain reliever for temporary pain relief. Resident 1 stated the facility did not have a back up for the narcotic pain medication and they were not able to get it from the emergency supply. During an interview on 02/02/2026 at 10:31 AM, Staff C, Licensed Practical Nurse, stated the process for reordering medications included reviewing the medication card and placing the refill request when the remaining medication in the card was in the blue section (indicating seven doses left). Staff C stated if the medication ran out before they received the refill, they could obtain a dose from the emergency backup supply by using a pharmacy authorization code to open the medication dispenser. Staff C stated, for Resident 1, there was a problem with receiving their narcotic pain medication from the pharmacy. They stated the provider was contacted and a new prescription was sent to the pharmacy, however they were unable to obtain an authorization code from the pharmacy to pull the narcotic pain medication due to confusion with the order. Staff C stated Resident 1 went without until the pharmacy straightened out the orders. During an interview on 02/02/2026 at 12:28 PM, Staff B, Director of Nursing Services, stated the process for refilling narcotic medication included the provider sending a</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 505226	Facility ID: 505226 If continuation sheet Page 1 of 2

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>prescription, either by telephone or signing a paper prescription in the facility, and faxing that to the pharmacy. They stated refills needed to be requested at least seven days prior to the resident running out of medication to ensure they were available for use. Staff B stated narcotics were available in the emergency supply, however the staff would need to get an authorization code from the pharmacy to obtain the medication. Staff B stated the process for refilling/administering medications was not followed. During an interview on 02/02/2026 at 4:06 PM, Staff A, Administrator, stated the licensed nurses should be communicating with the provider and the pharmacy to ensure the residents have the medications they need and to ensure they are requesting refills of medication prior to the resident running out. Reference: WAC 388-97-1300(1)(a)(b)(ii)</p>