STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505311	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seattle Medical Post Acute Care	555 16th Avenue Seattle, WA 98122

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review, the facility failed to ensure residents were free from misappropriation of controlled (narcotic or opioid) medication for 4 of 5 residents (Residents, 1, 2, 3 & 4), reviewed for misappropriation of controlled medications. This failure placed the residents at risk for pain, unmet care needs, ongoing misappropriation of medications, and a diminished quality of life.A past noncompliance was initiated on 02/20/2026 related to F602-Free from Misappropriation/Exploitation, for failure to protect Residents 1,2,3 and 4 from misappropriation of medications. The facility implemented the following interventions, which were initiated on 02/20/2026 and fully corrected by 03/02/2026:-Resident 1 was promptly assessed to rule out ingestion of narcotic medication.-The facility reconciled all narcotic medication inventory logbooks, and residents who received narcotic medications were assessed for pain. Any residents identified as potentially affected by misappropriation were followed up with as required. -The facility's narcotic inventory records were transferred into new logbooks, and the previous books were retired. -Resident 2, Resident 3, and Resident 4 were identified to be potentially affected by misappropriation of narcotic medication through interviews with residents and staff.-All identified residents were assessed and monitored for pain.-The facility arranged for their pharmacy to bill the facility for the identified residents' controlled medications for February 2026. -The identified staff was suspended pending investigation and subsequently terminated due to suspicion of diverting residents' narcotic medications.-Licensed nurses were re-educated on the facility's Abuse, Neglect and Misappropriation policy, as well as the procedures for documentation, receipt, transferred, destruction and endorsement of controlled substances (narcotic medications). -Periodic audits of residents with prescribed narcotic medications were initiated and conducted weekly for a duration of four weeks and then conducted monthly for a duration of two months to ensure compliance with the plan of correction. -Completed audits were reviewed during the facility's Quality Assurance and Performance Improvement Program (QAPI) meeting on 03/23/2026. - Plan for reviewing and reporting to the facility's QAPI future meetings for continued quality improvement.Findings included.Review of the facility's policy titled, Freedom from Abuse, Neglect.Misappropriation of Resident Property. updated March 2025, showed that an example of misappropriation of resident property included Missing prescription medications or diversion of a resident's medications, including, but not limited to, controlled substances for staff use or personal gain.RESIDENT 1 Review of the facility's investigation summary titled, Drug Diversion, dated 02/20/2026, showed Resident 1 did not have an active order for a narcotic medication but he was given a narcotic medication by Staff B, Licensed Practical Nurse, on the night of 02/19/2026 and that he was certain that it wasn't [was not] and he did not ask nor need it. It further showed, A review of [Resident 1's] current physician orders, February 2026 MAR [Medication Administration Record] and facility Narcotic book showed [Staff B] entered the order in PCC [Point Click Care - An electronic health record system] on her own without a provider's authorization. It further showed that Staff B was immediately suspended pending the result of the investigation for potential narcotic diversion, and for entering [physician] orders without a valid [physician] order.RESIDENT 2 Review of the facility's investigation summary titled, Drug Diversion, dated 02/20/2026, showed that Resident 2's February 2026 MAR showed as needed narcotic pain (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
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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication was administered on the night of 02/19/2026. It further showed that [Resident 2] stated that he did not ask for [narcotic medication] during the night shift and did not receive any.RESIDENT 3 Review of the facility's investigation summary titled, Drug Diversion, dated 02/20/2026, A review of the narcotic book documentation showed [Staff B] gave two doses of 15 mg [mg-a unit of measurement] of [narcotic medication] on 01/07/2026 and on 01/21/2026 [to Resident 3]. However, in an interview on 02/20/2026 at 10:00 AM, [Resident 3] stated that the nurses (all nurses) only gave her two tablets, and she never asked for three tablets (15 mg).RESIDENT 4 Review of the facility's investigation summary titled, Drug Diversion, dated 02/20/2026, showed that Resident 4 was interviewed on 02/20/2026 and that he stated that he did not receive pain medication from Staff B on 02/15/2026 at 6:00 AM, as requested. It further showed that Resident 4 stated, [Resident 4] remembered asking [Staff B] about it but was told he already took them.In an interview on 04/03/2026 at 12:45 PM, Staff A, Director of Nursing, stated that discrepancies identified in Resident 1's February 2026 MAR and physician orders for narcotic medications prompted the investigation into potential drug diversion involving Staff B. Staff A further stated that as a result of the investigation, it was concluded that Staff B practiced outside her license by putting in a [physician] order with the intent of misappropriating medication. When asked if misappropriation of resident property was not ruled out for Residents 1, 2, 3 and 4, Staff A stated, Yes, the intent of misappropriation was admitted by [Staff B] during the investigation. Staff A stated that they expected residents to be free from abuse, including misappropriation of property, and that facility nurses would follow standards of practice free from professional misconduct.Reference: (WAC) 388-97-0640 (2)(a), (3)(c)(d).