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	05/06/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was notified when the facility's pharmacy could not provide medication for 1 of 7 residents (Resident 1), reviewed for significant medication error. The failure to notify the physician when the pharmacy could not provide a steroid medication (used to reduce swelling) placed the resident at risk for unmet care needs and a diminished quality of life.Findings included . A review of Resident 1's admission record dated 04/03/2026 showed they were admitted to the facility on [DATE] from the hospital with a diagnosis list that included Mucopurulent Chronic Bronchitis (a severe form of bronchitis [inflamed airway tubes in the lungs]). A review of the hospital discharge medication list dated 04/03/2026 showed a physician's order for Methylprednisolone (a steroid medication) give 40 milligrams (mg-a unit of measurement) IV (intravenous administration of fluids and/or medications directly into the bloodstream) daily, start taking on 04/04/2026. Record review of the April 2026 Electronic Medication Administration Record (EMAR showed a physician's order for Methylprednisolone 40 mg IV daily, with a start date of 04/04/2026 revealed that on 04/04/2026 and 04/05/2026 they were marked OO's [the steroid medication was on order from the pharmacy and were not administered]. Record review of a nursing progress notes dated 04/04/2026 and 04/05/2026 did not show that the physician had been notified when the medication was on order from the pharmacy and could not be administered to Resident 1. In interview on 05/05/2026 at 11:33 AM with Staff C, Licensed Practical Nurse (LPN), stated that if a medication was not available they would contact the physician and let them know the pharmacy did not deliver the medication and that the medication was not in the facility emergency medication kit. Staff C further stated that the physician might change the medication to one that was in the facility or change the times or dates of the prescribed medication. In an interview on 05/05/2026 at 12:04 PM, with Staff D, LPN, stated that if a medication was not available they would notify the physician to see if the medication could be changed to a medication that was in stock at the facility.A joint record review and interview on 05/05/2026 at 1:50 PM with Staff E, Registered Nurse/Unit Manager, showed a physician's order for Methylprednisolone 40 mg IV daily, with a start date of 04/04/2026 had not been administered on 04/04/2026 and 04/05/2026 as ordered. Review of the nursing progress notes dated 04/04/2026 through 04/05/2026 did not show that the physician had been notified when the medication was not available from the pharmacy or of the missed medication. Staff E stated the physician should have been notified when the pharmacy did not deliver the medication. Staff E further stated the physician would have been able to change the medication order to something that was available in the facility's emergency medication kit, change the route of the medication or maybe the time of the medication. In an interview on 05/06/2026 at 3:27 PM with Staff B, Director of Nursing Services, stated the nurses were expected to notify the physician when the medication was not administered to Resident 1 on 04/04/2026 and 04/05/2026. Staff B further stated the physician may have changed the order to a medication that was available or provided orders to transport Resident 1 back to the hospital until the medication was available in the facility. In an interview on 05/06/2026 at 3:43 PM with Staff A, Administrator, stated the nurses were expected (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
	505311	A. Building B. Wing	05/06/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to notify the physician when medications were not administered to the residents. Reference: (WAC) 388-97-0320 (1)(b)Refer to F760 - Residents are Free of Significant Medication Errors

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	05/06/2026

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 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. Based on record review and interview, the facility failed to ensure pharmacy services were provided to meet the needs of 5 of 7 residents (Residents 2, 3, 4, 6 and 7), reviewed for medication administration. The failure to administer and/or document medication administration in accordance with professional standards of practice placed the residents at risk for negative outcomes and a diminished quality of lifeFindings included .Review of the facility policy titled, Medication Administration General Guidelines, dated 01/26 [January 2026] showed, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. The individual who administers the medication dose records the administration on the resident's MAR [Medication Administration Record] immediately following the medication being given. Review of the investigation report dated 04/28/2026 showed it was reported that two identified nurses allegedly did not administer medications as ordered by the physician for Residents 2, 3, 4, 6 and 7. The report further showed that the two identified nurses indicated on the MAR that the medications were administered for Residents 2, 3, 4, 6 and 7. RESIDENT 2 Review of the investigation report dated 04/28/2026 showed Resident 2 had a brain injury that caused a vegetative state (a medical disorder when a person is awake but shows no signs of awareness). The report showed the resident had a diagnosis of heart failure, diabetes (inability to control blood sugar in the body) and high blood pressure among other diagnoses. Further review of the report showed Resident 2 potentially missed their morning medications on 04/25/2026 for Spironolactone (medication used to release excess fluids from the body) 12.5 milligrams (mg-a unit of measurement) Metoprolol (medication used to treat high blood pressure) 50 mg give two tablets, Metformin (medication used to control blood sugar)1,000 mg and Warfarin (medication used to treat heart disease) 1 mg, the investigation report showed the medications were not given to Resident 2. RESIDENT 3 Review of the investigation report dated 04/28/2026 showed Resident 3 had a brain injury that caused a vegetative state and was dependent on staff for all care which included medication management. The report showed Resident 3 potentially missed their morning medication on 04/25/2026 for Levetiracetam (medication used to treat seizures [excessive activity in the brain]) 1,000 mg. Further review of the report showed that the medication was documented as administered on the MAR, however, the investigation report showed the medication was not given to Resident 3. RESIDENT 4 Review of the investigation report dated 04/28/2026 showed Resident 4 had a brain injury that caused a vegetative state and was dependent on staff for all care which included medication management. The report showed Resident 4 potentially missed their morning medication on 04/25/2026 for Lisinopril (medication used to treat high blood pressure) 20 mg. Further review of the report showed that the medication was documented as administered on the MAR, however, the investigation report showed the medication was not given to Resident 4. RESIDENT 6Review of the investigation report dated 04/28/2026 showed Resident 6 had diagnoses that included heart disease and diabetes and was dependent on staff for all care which included medication management. Review of the investigation report dated 04/28/2026 showed Resident 6 potentially missed their medications on 04/25/2026 and 04/26/2026 for Carvedilol (medication used to treat high blood pressure)12.5 mg, Lisinopril 5 mg, Apixaban (medication used to reduce the risk of heart attack) 5 mg and Metformin 1,000 mg. The report further showed that the medications were documented as administered on the MAR, however, the investigation report showed the medications were not given to Resident 6. RESIDENT 7Review of the investigation report dated 04/28/2026 showed Resident 7 had a brain injury and high blood pressure. The report showed Resident 7 was dependent on staff for all care which included medication administration. The report showed Resident 7 potentially missed their medications on 04/25/2026 and 04/26/2026 for Amlodipine (medication used to treat high blood pressure) 5 mg. The report further showed the medication was documented (continued on next page)

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	05/06/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as administered on the MAR, however, the investigation report showed the medication were not given to Resident 7. Review of the investigation summary report/findings dated 05/01/2026 showed that Residents 2, 3, 4, 6 and 7 did not receive their medications as ordered by their physician. In an interview on 05/06/2026 at 1:49 PM with Staff F, Licensed Practical Nurse/Unit Manager, stated they did the investigation report dated 04/28/2026. Staff F stated the investigation report was initiated on 04/28/2026 because it was alleged that two identified nurses were documenting on the MAR that medications were administered, however, it was observed that Residents 2, 3, 4, 6, and 7's medications remained on the medication carts after the identified nurses had documented they administered the medications.In an interview on 05/06/2026 at 3:09 PM, Staff B, Director of Nursing Services, stated Residents 2, 3, 4, 6 and 7's medications were not administered, and it was confirmed that they were not given. Staff B further stated all necessary people/agencies were notified and the identified nurse's employment at the facility had been terminated.Reference: (WAC) 388-97-1060(3)(k)(iii) .

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	05/06/2026

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide/administer medication for 1 of 7 residents (Resident 1), reviewed for significant medication error. Resident 1 experienced harm when they did not receive their steroid medication (used to reduce swelling), had a sudden change in condition and was transported/admitted to the hospital where they were diagnosed with adrenal crisis (a serious medical condition caused by a sudden stoppage of steroid medication). This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included . A review of the admission record dated 04/03/2026 showed Resident 1 was admitted to the facility on [DATE] from the hospital with a diagnosis list that included Mucopurulent Chronic Bronchitis (a severe form of bronchitis [inflamed airway tubes in the lungs]). A review of the hospital discharge medication list dated 04/03/2026 showed a physician's order for Methylprednisolone (steroid medication) give 40 milligrams (mg-a unit of measurement) IV (intravenous administration of fluids and/or medications directly into the bloodstream) daily, start taking on 04/04/2026. Review of the April 2026 Electronic Medication Administration Record (EMAR) showed a physician's order for Methylprednisolone 40 mg IV daily, with a start date of 04/04/2026. The EMAR further showed that on 04/04/2026 and 04/05/2026 they were marked 00's [the steroid medication was on order from the pharmacy and were not administered]. Review of a nursing progress note in the electronic medical record dated 04/06/2026 showed Resident 1 had a sudden change of condition and emergency services were called, and Resident 1 was transported to the hospital. Review of the hospital summary report dated 04/06/2026 showed Resident 1 was admitted to the medical intensive care unit of the hospital due to hypotensive shock (a life-threatening emergency that causes inadequate blood flow to vital organs). The hospital summary report further showed Resident 1's hypotensive shock was ultimately thought to be secondary due to adrenal crisis in the setting of not receiving IV steroids at the facility to which they were discharged to on 04/03/2026. In an interview on 05/05/2026 at 11:33 AM with Staff C, Licensed Practical Nurse, stated that if a medication was not delivered from the pharmacy to the facility, they would check the emergency medication kit and depending on the medication that was ordered, the resident may need to be sent to the hospital to prevent a change of condition.A joint record review and interview on 05/05/2026 at 1:50 PM with Staff E, Registered Nurse/Unit Manager, showed a physician's order for Methylprednisolone 40 mg IV daily, with a start date of 04/04/2026. The EMAR further showed the medication had not been administered on 04/04/2026 or 04/05/2026 as ordered. Staff E stated they found out that the medication had not been administered to Resident 1 on 04/06/2026, after they had been transported to the hospital by emergency services for a change of condition. Staff E further stated Resident 1's change of condition and hospitalization could have potentially been caused by the missed steroid medication. A joint record review and interview on 05/06/2026 at 3:27 PM with Staff B, Director of Nursing Services, showed the hospital summary in the electronic medical record dated 04/06/2026, revealed that Staff B concurred [agreed] with the hospital summary that showed Resident 1's shock was ultimately thought to be secondary due to adrenal crisis in the setting of not receiving IV steroids at the facility to which they were discharged to on 04/03/2026. In an interview on 05/06/2026 at 3:43 PM with Staff A, Administrator, stated their expectation was for the nurses to give medications as ordered by the physician. Reference: (WAC) 388-97-1060(3)(k)(iii) .