STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505383	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan Park Care Center	14820 East Fourth Spokane, WA 99216

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 - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure pharmacy services were provided to meet the needs of 1 of 3 sampled residents (Resident 1) reviewed for medication management. The failure to ensure medications were acquired and administered as ordered placed residents at risk for adverse events related to missed medications. This constituted a Past Non-Compliance (the facility was not in compliance at the time the situation occurred; however, there was sufficient evidence that the facility corrected the non-compliance after it was identified). The facility educated staff, updated training methods, and monitored for additional missed medications, by 02/02/2026. The facility was notified of the past non-compliance on 06/18/2026.Findings included .Review of Resident 1's Skilled Nursing Facility Transfer Orders, dated 01/30/2026, showed the resident had diagnoses of diabetes (chronic condition that affects how the body uses blood sugar) and hypothyroidism (condition in which the thyroid gland does not produce enough thyroid hormone). Medication orders included the following:-daily levothyroxine (used to treat hypothyroidism) -daily liothyronine (used to treat hypothyroidism) -Novolog insulin (used to treat high blood sugar in diabetes) with meals and at bedtime-Gaviscon (used to relieve heartburn, acid indigestion, sour and upset stomach) after meals and at bedtime-methocarbamol (muscle relaxer) four times daily-daily losartan/hydrochlorothiazide (a combination medication that lowers blood pressure and prevents the body from absorbing too much salt)-daily fluoxetine (antidepressant)Review of the January 2026 Medication Administration Record showed on 01/30/2026 and 01/31/2026 Resident 1 did not receive all their ordered medications. Review of a facility investigation dated 02/02/2026 showed Resident 1 did not receive the following medications on the evening shift of 01/30/2026: Novolog, levothyroxine, methocarbamol, and Gaviscon. Additionally, the investigation showed medication errors on 01/31/2026 were noted. Follow up with the staff working on 01/31/2026 showed all ordered medications were given that day after they were received from the pharmacy.In a telephone interview on 05/26/2026 at 11:31 AM a representative for Resident 1 stated the resident discharged to the facility from a hospital on Friday evening, and nursing staff reported they did not have orders or medications for the resident. The representative stated they were especially concerned about the resident missing their insulin as their blood sugar was very high and required intervention during the first 48 hours they were at the facility. In an interview on 06/16/2026 at 12:36 PM Staff C, Licensed Practical Nurse, confirmed Resident 1 admitted to the facility on a Friday and when they worked with the resident on Saturday 01/31/2026 their medications had not yet arrived from the pharmacy. Staff C stated they called the pharmacy and had the medications delivered later that day, and administered ordered medications once they were available from the pharmacy. Staff C stated Resident 1 was a brittle diabetic (severe and unpredictable diabetes requiring frequent medical attention) and their blood sugar was elevated on 01/31/2026, requiring physician notification and additional doses of insulin.In an interview on 06/18/2026 at 9:57 AM Staff A, Director of Nursing, stated the facility followed up with Staff B, Registered Nurse, who did not acquire and administer Resident 1's medications on 01/30/2026. Per Staff A, medications such as insulin were available in the facility in their emergency medication supplies and the facility had a process in place to obtain medications timely from the pharmacy, but (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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff B was unaware of these measures. Staff A stated additional training was provided for staff and the facility had systems in place to monitor for medication errors.This was a Past Non-Compliance, corrected on 02/02/2026, and is no longer outstanding.Reference: (WAC) 388-97-1300 (1)(a)(4)(e)