STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Sunrise Senior Home LLC

Sunrise Senior Home LLC
1820 224th St SW
Bothell, WA 98021

RE: Sunrise Senior Home LLC License # 754607

Dear Provider:

This letter addresses Compliance Determination(s) 45341 (Completion Date 08/08/2024) and 41562 (Completion Date 06/10/2024).

The Department completed a follow-up inspection of your Adult Family Home on 08/08/2024 and found that you have corrected the violations listed in the Complaint report dated 06/10/2024. Your home is back in compliance as of 06/04/2024 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10340-1, WAC 388-76-10400-2, WAC 388-76-10400-3, WAC 388-76-10400-3-a, WAC 388-76-10400-3-b, WAC 388-76-10400-3-c, WAC 388-76-10545-1, WAC 388-76-10545-1-a, WAC 388-76-10545-1-b

The Department staff who did the on-site verification:
Theresia Karundeng, NCI

If you have any questions, please contact me at (206)914-5042.

Sincerely,

Renee' Bourque

Renee Bourque, Field Manager
Region 2, Unit I
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 754607	Compliance Determination # 41562
Plan of Correction	Sunrise Senior Home LLC	Completion Date
Page 1 of 8	Licensee: Sunrise Senior Home LLC	06/10/2024

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 05/21/2024 and 06/06/2024 of:

Sunrise Senior Home LLC
1820 224th St SW
Bothell, WA 98021

This document references the following complaint number(s): 130334, 131990

The following sample was selected for review during the unannounced on-site visit: 2 of 4 current residents and 1 former residents.

The department staff that investigated the Adult Family Home:

Theresia Karundeng, NCI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit I
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Renee' Bourgua
Residential Care Services

06/25/2024
Date

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

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The department staff that investigated the Adult Family Home:

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From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit I
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

As a result of the on-site visit(s), the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Residential Care Services _____ Date _____

I understand that to maintain an Adult Family Home license, I must be in compliance with all the licensing laws and regulations at all times.

Provider (or Representative)

06/04/2024
Date

WAC 388-76-10340 Preliminary service plan. The adult family home must ensure that each resident has a preliminary service plan that includes:

(1) The resident's specific problems and needs identified in the assessment;

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure the Preliminary Service Plan (PSP) included resident's specific problems for 1 of 3 resident's (Resident 1). This failure placed Resident 1 at risk of unrecognized and unmet care needs.

Findings included...

Review of Resident 1's face sheet showed the AFH admitted Resident 1 on [redacted]'2024, with multiple diagnoses including [redacted].

Review of Resident 1's Assessment, dated 04/11/2024, showed diagnoses included [redacted]. Further review showed Resident 1 had multiple pressure wounds including a stage four pressure injury (Full thickness tissue loss with exposed bone, tendon, or muscle) to their sacrum that was managed with a wound vac (wound vacuum – a device that removes pressure over the area of the wound). Resident 1's assessment showed Resident 1 needed a two-person assistance to reposition in bed due to painful wounds and needed to be repositioned at least every two hours to prevent further skin breakdown.

Review of Resident 1's PSP with admit date [redacted]'2024, showed Resident 1 had eight areas marked on the body as pressure ulcers. Resident 1's PSP did not show the wound vac device noted in the PSP. Further review of Resident 1's PSP showed Resident 1 needed assistance with positioning and frequency of repositioning was left blank. The PSP did not show that Resident 1 needed to be repositioned every 2 hours.

In an interview, on 05/21/2024 at 11:39 AM, Staff D, Caregiver, stated that Resident 1 would be repositioned when they ask for it. Staff D also stated that there was no specific timing on how often Resident 1 was repositioned. Staff D further stated that Resident 1 was repositioned 1-2 times a day.

In an interview, on 05/24/2024 at 1:12 PM, Staff C, Caregiver, stated that Resident 1 required repositioning and it was done three times a day and when Resident 1 would

Provider (or Representative) Date

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This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure the Preliminary Service Plan (PSP) included resident's specific problems for 1 of 3 resident's (Resident 1). This failure placed Resident 1 at risk of unrecognized and unmet care needs.

Findings included…

Review of Resident 1's face sheet showed the AFH admitted Resident 1 on [redacted]/2024, with multiple diagnoses including [redacted].

Review of Resident 1's Assessment, dated 04/11/2024, showed diagnoses included [redacted]. Further review showed Resident 1 had multiple pressure wounds including a stage four pressure injury (Full thickness tissue loss with exposed bone, tendon, or muscle) to their sacrum that was managed with a wound vac (wound vacuum – a device that removes pressure over the area of the wound). Resident 1's assessment showed Resident 1 needed a two-person assistance to reposition in bed due to painful wounds and needed to be repositioned at least every two hours to prevent further skin breakdown.

Review of Resident 1's PSP with admit date [redacted]/2024, showed Resident 1 had eight areas marked on the body as pressure ulcers. Resident 1's PSP did not show the wound vac device noted in the PSP. Further review of Resident 1's PSP showed Resident 1 needed assistance with positioning and frequency of repositioning was left blank. The PSP did not show that Resident 1 needed to be repositioned every 2 hours.

In an interview, on 05/21/2024 at 11:39 AM, Staff D, Caregiver, stated that Resident 1 would be repositioned when they ask for it. Staff D also stated that there was no specific timing on how often Resident 1 was repositioned. Staff D further stated that Resident 1 was repositioned 1-2 times a day.

In an interview, on 05/24/2024 at 1:12 PM, Staff C, Caregiver, stated that Resident 1 required repositioning and it was done three times a day and when Resident 1 would

request for it.

In an interview, on 05/31/2024 at 2:50 PM, Resident 1 stated that they needed assistance with turning and repositioning at night. Resident 1 stated that staff did not come to assist with turning and repositioning overnight.

In an interview, on 06/07/2024 at 10:09 AM, Staff A, Provider, stated that Resident 1's repositioning frequency of every 2 hours and wound vac device should have been noted in the preliminary service plan.

Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Sunrise Senior Home LLC is or will be in compliance with this law and / or regulation on (Date)__06/04/2024____ .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Provider (or Representative) — 06/04/2024 — Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

(2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.

(3) The care and services in a manner and in an environment that:

(a) Actively supports, maintains or improves each resident's quality of life;

(b) Actively supports the safety of each resident; and

(c) Reasonably accommodates each resident's individual needs and preferences except when the accommodation endangers the health or safety of the individual or another resident.

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to follow the intervention specified in the assessment plan for 1 of 3 resident's (Resident 1) related to turning/repositioning and overnight care. This failure placed Resident 1 at risk for harm, unmet care needs, and decreased quality of life.

Findings included...

request for it.

In an interview, on 05/31/2024 at 2:50 PM, Resident 1 stated that they needed assistance with turning and repositioning at night. Resident 1 stated that staff did not come to assist with turning and repositioning overnight.

In an interview, on 06/07/2024 at 10:09 AM, Staff A, Provider, stated that Resident 1's repositioning frequency of every 2 hours and wound vac device should have been noted in the preliminary service plan.

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Provider (or Representative) Date

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(b) Actively supports the safety of each resident; and

(c) Reasonably accommodates each resident's individual needs and preferences except when the accommodation endangers the health or safety of the individual or another resident.

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to follow the intervention specified in the assessment plan for 1 of 3 resident's (Resident 1) related to turning/repositioning and overnight care. This failure placed Resident 1 at risk for harm, unmet care needs, and decreased quality of life.

Findings included…

Review of Resident 1's face sheet showed the AFH admitted Resident 1 on [redacted]/2024, with multiple diagnoses including [redacted].

Review of Resident 1's Assessment, dated 04/11/2024, showed diagnoses included [redacted] and [redacted]. Further review showed Resident 1 had multiple pressure wounds including a stage four pressure injury (Full thickness tissue loss with exposed bone, tendon, or muscle) to their sacrum that was managed with a wound vac (wound vacuum – a device that removes pressure over the area of the wound). Resident 1's assessment showed that they needed a two-person assistance to reposition in bed due to painful wounds and needed to be repositioned at least every two hours to prevent further skin breakdown. Resident 1's assessment showed Resident 1 was incontinent (inability to control excretion of urine or feces) and needed a two-person assistance for toileting.

In an interview, on 05/21/2024 at 11:39 AM, Staff D, Caregiver, stated that Resident 1 was able to make their needs known. Staff D stated that Resident 1 would be repositioned when they asked for it. Staff D also stated that there was no specific timing on how often Resident 1 was repositioned. Staff D further stated that Resident 1 was repositioned one to two times a day. Staff D further stated that they would check on Resident 1 at night if they used the call button.

In an interview, on 05/23/2024 at 3:06 PM, Collateral Contact 3 (CC3), Resident 1's Representative, stated that Resident 1 needed to be turned every couple of hours and the AFH staff had not turned Resident 1 at night. CC3 also stated that before bedtime the AFH staff told Resident 1 to be in a comfortable position and Resident 1 did not receive care again until the next morning. CC3 stated that the AFH shouldn't have accepted Resident 1 if they couldn't provide 24-hour care.

In an interview, on 05/24/2024 at 1:12 PM, Staff C, Caregiver, stated that Resident 1 required repositioning and it was done three times a day and when Resident 1 would request for it. Staff C also stated that Resident 1 was in a lot of pain, and they had as needed pain medication. Staff C stated that Resident 1 did not require any specific care overnight and Resident 1 was only turned/repositioned if they requested it at night.

In an interview, on 05/24/2024 at 8:37 AM, Collateral Contact 2 (CC2), Case Manager, stated that Resident 1 was alert, decisional, and able to state their needs. CC2 also stated that Resident 1 was bed bound and the AFH staff were not turning/repositioning Resident 1 at night. CC2 reported that when Resident 1 asked for care at night, the AFH staff stated that they were not a 24-hour facility. CC2 reported that the AFH was not very patient with Resident 1.

In an interview, on 05/28/2024 at 12:19 PM, Staff B, Resident Manager, stated that based on Resident 1's assessment Resident 1 had not required overnight care. Staff B stated that Resident 1 was repositioned during the day but not at night.

In an interview, on 05/31/2024 at 2:50 PM, Resident 1 stated that they stayed at the AFH for a week and the staff had not provided overnight care. Resident 1 stated that they needed assistance with turning/repositioning, pain medications, and incontinence care at night but staff had not come to help them. Resident 1 stated that they notified staff of their care needs and staff notified them multiple times that they were not available to provide care overnight and the call button was to be used at night for emergencies only.

In an interview, on 06/07/2024 at 9:08 AM, Staff A, Provider, stated that Resident 1 had not required overnight care. Staff A also stated that there were no overnight awake caregivers, however, staff would be available if residents called for assistance. Staff A stated that Resident 1 required to be turned/repositioned every 2 hours during the day but not at night. Staff A reported that residents were encouraged to use the call bell at any time and denies the call bell being used for emergencies only.

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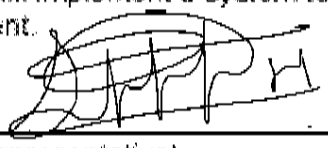

Provider (or Representative)

06/04/2024

Date

WAC 388-76-10545 Resident rights Admitting and keeping residents. The adult family home must:

(1) Only admit or keep individuals whose needs the home can safely meet:

(a) With qualified available staff; and

(b) Through the provision of reasonable accommodations required by state and federal law;

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure they were able to provide care to 1 of 3 residents (Resident 1) that were admitted to the AFH. This failure placed Resident 1 at risk for harm, unmet care needs, and decreased quality of life.

In an interview, on 05/28/2024 at 12:19 PM, Staff B, Resident Manager, stated that based on Resident 1's assessment Resident 1 had not required overnight care. Staff B stated that Resident 1 was repositioned during the day but not at night.

In an interview, on 05/31/2024 at 2:50 PM, Resident 1 stated that they stayed at the AFH for a week and the staff had not provided overnight care. Resident 1 stated that they needed assistance with turning/repositioning, pain medications, and incontinence care at night but staff had not come to help them. Resident 1 stated that they notified staff of their care needs and staff notified them multiple times that they were not available to provide care overnight and the call button was to be used at night for emergencies only.

In an interview, on 06/07/2024 at 9:08 AM, Staff A, Provider, stated that Resident 1 had not required overnight care. Staff A also stated that there were no overnight awake caregivers, however, staff would be available if residents called for assistance. Staff A stated that Resident 1 required to be turned/repositioned every 2 hours during the day but not at night. Staff A reported that residents were encouraged to use the call bell at any time and denies the call bell being used for emergencies only.

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Findings included…

Review of Resident 1's face sheet showed the AFH admitted Resident 1 on [redacted]/2024, with multiple diagnoses including [redacted].

Review of Resident 1's Assessment, dated 04/11/2024, showed diagnoses included [redacted] and [redacted]. Further review showed Resident 1 had multiple pressure wounds including a stage four pressure injury (Full thickness tissue loss with exposed bone, tendon, or muscle) to their sacrum (area between lower back and tail bone) that was managed with a wound vac (wound vacuum – a device that removes pressure over the area of the wound).

Review of Resident 1's May 2024 Medication log showed that Resident 1 had an order for H-chlor 12 0.125% solution (a medicated topical solution used for wound care and skin infections) apply topically twice a day to affected areas on peri wound of sacrum and ischium (lower and back side of the hip bone). Further review showed that the treatment was completed on [redacted]/2024 twice a day and [redacted]/2024 morning. Medication log showed that the treatment was not provided for Resident 1 from 05/04/2024 through 05/08/2024 (5 days).

Review of Resident 1's progress notes dated 05/06/2024, 05/07/2024, and 05/08/2024 showed that AFH reached out to home health staff. Review showed home health staff had not come to the AFH.

Review of Resident 1's progress notes, dated [redacted]/2024, showed the Home Health Nurse came to see Resident 1 on [redacted]/2024 and removed the wound vac because the AFH staff were not delegated to manage the wound vac and the AFH staff would not be able manage the wound vac if something happened at night.

Review of Resident 1's progress notes, dated [redacted]/2024, showed communication with Home Health Nurse and that Resident 1 would go back to the hospital as "we are unable to provide the care that" Resident 1 was to receive.

In an interview, on 05/17/2024 at 9:40 AM, Collateral Contact 1, Home Health Nurse, stated the wound vac was unplugged and the AFH was not sure what to do with the wound vac if anything happened overnight.

In an interview, on 05/21/2024 at 11:39 AM, Staff D, Caregiver, stated that they had not done anything related to the wound dressings, and that the nurse does it. Staff D also stated that Resident 1 had four to five wounds and they had a wound vac . Staff D further stated that they had not done anything for the wound vac.

In an interview, on 05/21/2024 at 12:01 PM, Staff B, Resident Manager, stated that Resident 1 was seen once by the wound nurse and then Resident 1 went back to the hospital. Staff B stated that they were not delegated to manage the wound vac. Staff B stated that home health was not able to meet Resident 1's wound treatment needs and that was the reason Resident 1 was sent to the hospital. Staff B stated that they were not aware whether the wound vac was charged or not and they were not instructed to do anything related to the wound vac. Staff B reported that Resident 1's wound dressing was not changed until the visiting nurse came.

In an interview, on 05/24/2024 at 1:12 PM, Staff C, Caregiver, stated that Resident 1 came with a wound vac, and it was located on Resident 1's lower back. Staff C stated that the home health nurse said the wound vac needed to be turned on. Staff C further stated that they were not aware on what to look for related to the wound vac because no one had said anything on how to manage the wound vac.

In an interview, on 05/24/2024 at 8:37 AM, Collateral Contact 2 (CC2), Case Manager, stated that the AFH was aware that Resident 1 would be admitted with a wound vac and the wound vac was risky to manage. CC2 stated that the AFH staff needed to look if something went wrong with the wound vac, the AFH were not doing that part. CC2 further stated that it was a failed placement. CC2 reported that Resident 1 was sent back to the hospital because the home health nurse called and was worried about the wounds.

In an interview, on 05/24/2024 at 9:24 AM, Resident 1 stated that they had not liked living at the AFH because the AFH was not prepared to handle their needs. Resident 1 further stated that the home health nurse was upset because the AFH had not known how to manage the wound vac because there was no one with credentials to manage the wound vac. Resident 1 reported that by the time the home health nurse came ([redacted]/2024), the wound vac was leaking and needed to be changed. Resident 1 also stated that the home health nurse removed the wound vac and Resident 1 was sent to the hospital the next day ([redacted]/2024).

In an interview, on 06/07/2024 at 9:08 AM, Staff A, Provider, stated that they were aware that Resident 1 would be admitted with a wound vac. Staff A also stated that they had not done wound vac care and home health could not accept Resident 1. Staff A reported that Resident 1 was sent back to the hospital on [redacted]/2024 (7 days after being admitted to the AFH).

Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Sunrise Senior Home LLC is or will be in compliance with this law and / or regulation on (Date) 06/04/2024 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

In an interview, on 05/21/2024 at 12:01 PM, Staff B, Resident Manager, stated that Resident 1 was seen once by the wound nurse and then Resident 1 went back to the hospital. Staff B stated that they were not delegated to manage the wound vac. Staff B stated that home health was not able to meet Resident 1's wound treatment needs and that was the reason Resident 1 was sent to the hospital. Staff B stated that they were not aware whether the wound vac was charged or not and they were not instructed to do anything related to the wound vac. Staff B reported that Resident 1's wound dressing was not changed until the visiting nurse came.

In an interview, on 05/24/2024 at 1:12 PM, Staff C, Caregiver, stated that Resident 1 came with a wound vac, and it was located on Resident 1's lower back. Staff C stated that the home health nurse said the wound vac needed to be turned on. Staff C further stated that they were not aware on what to look for related to the wound vac because no one had said anything on how to manage the wound vac.

In an interview, on 05/24/2024 at 8:37 AM, Collateral Contact 2 (CC2), Case Manager, stated that the AFH was aware that Resident 1 would be admitted with a wound vac and the wound vac was risky to manage. CC2 stated that the AFH staff needed to look if something went wrong with the wound vac, the AFH were not doing that part. CC2 further stated that it was a failed placement. CC2 reported that Resident 1 was sent back to the hospital because the home health nurse called and was worried about the wounds.

In an interview, on 05/24/2024 at 9:24 AM, Resident 1 stated that they had not liked living at the AFH because the AFH was not prepared to handle their needs. Resident 1 further stated that the home health nurse was upset because the AFH had not known how to manage the wound vac because there was no one with credentials to manage the wound vac. Resident 1 reported that by the time the home health nurse came ([redacted]/2024), the wound vac was leaking and needed to be changed. Resident 1 also stated that the home health nurse removed the wound vac and Resident 1 was sent to the hospital the next day ([redacted]/2024).

In an interview, on 06/07/2024 at 9:08 AM, Staff A, Provider, stated that they were aware that Resident 1 would be admitted with a wound vac. Staff A also stated that they had not done wound vac care and home health could not accept Resident 1. Staff A reported that Resident 1 was sent back to the hospital on [redacted]/2024 (7 days after being admitted to the AFH).

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Statement of Deficiencies	License #: 75460	Compliance Determination # 41562
Plan of Correction	Sunrise Senior Home LLC	Completion Date
Page 8 of 8	Licensee: Sunrise Senior Home LLC	08/10/2024

Provider (or Representative)

06/04/2024
Date

Provider (or Representative) Date