



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
AGING AND LONG-TERM SUPPORT ADMINISTRATION  
**1200 Alder Street, Union Gap, WA 98903**

Community Pride Sunnyside LLC  
Community Pride Sunnyside LLC  
906 North Ave  
Sunnyside, WA 98944

RE: Community Pride Sunnyside LLC License # 2632

Dear Administrator:

This letter addresses Compliance Determination(s) 28216 (Completion Date 08/28/2023) and 23076 (Completion Date 06/27/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/28/2023 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-2240, WAC 388-78A-2640-1, WAC 388-78A-2640-1-a, WAC 388-78A-2640-1-b, WAC 388-78A-2640-1-c, WAC 388-78A-2640-3, WAC 388-78A-2640-3-a, WAC 388-78A-2640-3-b, WAC 388-78A-2100-2, WAC 388-78A-2100-2-a, WAC 388-78A-2100-2-b, WAC 388-78A-2100-2-c

The Department staff who did the on-site verification:  
Felicia Cantu, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

*Gwin Kaercher*

Gwin Kaercher, Field Manager  
Region 1, Unit G  
Residential Care Services



## Residential Care Services Investigation Summary Report

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**Provider/Facility:** Community Pride Sunnyside **Provider Type:** Assisted Living Facility LLC

**License/Cert. #:** 2632

**Intake ID:** 79732

**Compliance Determination #:** 23076

**Region/Unit #:** RCS Region 1 / Unit G

**Investigator:** Felicia Cantu

**Investigation Date(s):** 04/26/2023 through 06/27/2023

**Complainant Contact Date(s):** 04/25/2023, 06/11/2023

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### Allegation(s):

1) a resident was given too much medication which resulted in hospitalization.

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### Investigation Methods:

|                        |                                                                                                                                                                              |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sample:</b>         | Total residents: 10<br>Resident sample size: 2<br>Closed records sample size:                                                                                                |
| <b>Observations:</b>   | Residents<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions<br>Medication administration<br>Facility environment                      |
| <b>Interviews:</b>     | Residents<br>Facility staff<br>Others not associated with the facility                                                                                                       |
| <b>Record Reviews:</b> | Characteristic roster<br>Facility policies<br>Hospital records and other agency records<br>Resident records(face sheet, care plans, assessments, chart notes, doctor orders) |

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### Investigation Summary:

Interviews and record reviews showed that the named resident was not assessed and was given medication which caused hospitalization. The facility failed to monitor and assess the sampled residents for changes in condition and make required notifications. Failed practice Identified for 388-78A-2100(2), and 388-78A-2640. Additionally, the facility failed to obtain prescribed pain medication timely for a sampled resident referring to citation written for 388-78A-2240. Reference Statement of Deficiencies dated, 07/10/2023.

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### Conclusion / Action:

- ☒ Failed Provider Practice Identified / Citation(s) Written
- ☐ Failed Provider Practice Not Identified / No Citation Written
- ☐ N/A



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|                           |                                         |                                  |
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You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 04/26/2023 and 04/26/2023 of:

Community Pride Sunnyside LLC  
906 North Ave  
Sunnyside, WA 98944

This document references the following complaint number(s): 79732

The following sample was selected for review during the unannounced on-site visit: 2 of 10 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Felicia Cantu, Community Complaint Investigator

From:  
DSHS, Aging and Long-Term Support Administration  
Residential Care Services, Region 1, Unit Z  
1200 Alder Street  
Union Gap, WA 98903

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.

*Gwin Kaercher*  
Residential Care Services

07/10/2023  
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

This document was prepared by Residential Care Services for the Locator website.



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erin addison  
Administrator (or Representative)

7/20/2023  
Date

**WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.**

**This requirement was not met as evidenced by:**

Based on interviews and record review, the Assisted Living Facility (ALF) failed to ensure prescribed pain medication was obtained timely for 1 of 2 sampled residents (Resident 2). This failure resulted in Resident 2 not receiving pain medication as prescribed by their physician and experiencing pain.

Findings included...

Record review of the ALF's policy titled "Medication Ordering and Delivery" dated 09/27/2004, showed that the facility must have medications ordered and delivered in a timely and efficient manner to promote an excellent medication system. The designated staff would contact the Licensed Nurse, who would evaluate the significance of the medication not being delivered timely and take appropriate action to ensure resident safety and welfare.

Record review of hospital records showed that Resident 2 had a fall on 04/20/2023 at the ALF that resulted in a pelvic fracture. Resident 2 returned the same day to the ALF on 04/20/2023.

Review of Resident 2's records showed on 04/21/2023 at 9:33 AM, the physician ordered Tramadol (pain medication) 50 milligrams (mg) orally two times a day for 15 days. The prescription was sent to a local pharmacy.

Record review of Resident 2's Medication Administration Record (MAR) showed that the first dose of Tramadol was given the next day on 04/22/2023 at an undetermined time.

On 05/05/2023 at 11:08 AM, Collateral Contact 2 (CC2), Resident 2's Physician/Nurse Practitioner (NP), stated that they were disappointed that the prescribed pain medication was not given timely and caused Resident 2 to be in pain for a prolonged time. CC2 stated it was unnecessary Resident 2 had to wait one day for pain medication.

On 06/01/2023 at 11:00 AM, Staff C, Office Manager, acknowledged that the pain medication was prescribed on 04/21/2023. Staff C stated that the medication required

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payment and that the pharmacy charged "around 40 dollars." Because the facility does not normally pay for residents' medications The facility contacted Resident 2's Durable Power of Attorney (DPOA), Collateral Contact (CC4) to pick up the pain medication. It was picked up the next day.

On 06/01/2023 at 1:08 PM, CC4 stated that Resident 2 did not get their ordered pain medication until the following day after it was prescribed. It was picked up at the local pharmacy by CC4, early afternoon on 04/22/2023. Facility staff had notified CC4 that it was against their policy to pay for medication that was not covered by insurance. CC4 expressed that they observed Resident 2 in bed on 04/22/2023 at 1:00 PM and Resident 2 was in a significant amount of pain. Resident 2 was moaning, and grimacing "I thought it was unreasonable [Resident 2] they had to wait for pain medication, I could have reimbursed the facility for the medication."

On 06/05/2023 at 10:37 AM, Staff B, Administrator, stated that Staff C should have purchased the medication at the ALF's cost.

**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, Community Pride Sunnyside LLC is or will be in compliance with this law and / or regulation on (Date) 8/8/2023.

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

erin addison  
Administrator (or Representative)

7/20/2023  
Date

**WAC 388-78A-2640 Reporting significant change in a resident's condition.**

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

- (a) There is a significant change in the resident's condition;
- (b) The resident is relocated to a hospital or other health care facility; or
- (c) The resident dies.

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

- (a) The date and time each individual was contacted; and
- (b) The individual's relationship to the resident.

**This requirement was not met as evidenced by:**

This document was prepared by Residential Care Services for the Locator website.

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Based on interview and record review, the Assisted Living Facility (ALF) failed to report significant change in conditions and consult with the residents' representatives and residents' physicians for 2 of 2 residents (Resident 1 & 2). These failures resulted in Resident 1 being overdosed on a medication which contributed to their hospitalization and a delay in medical treatment for Resident 2's pressure injuries.

#### Findings included...

Record review of facility's policy titled, "Limited Nursing Services," undated, showed that the facility should contact the Registered Nurse to reassess resident's needs when staff notices a change in residents' functional ability or health status.

Record review of facility's undated job description for care staff showed that care staff must monitor residents by monitoring for changes in condition and keep family informed.

On 05/18/2023 at 1:52 PM, Staff B, Administrator, verified through email that their policy for change of condition, is that staff document and report any change in condition or decline and notify facility nurse or assistant manager. The assistant manager or nurse then informs the physician, power of attorney or representative, and facility manager.

#### Resident 1

Record review of Resident 1's chart face sheet showed that they were admitted to the ALF on [REDACTED]/2022. Resident 1 diagnosis included [REDACTED] and [REDACTED].

Record review of Negotiated Service Agreement (NSA) 03/13/2023 showed that Resident 1 was able to make needs known and moved about independently and received assistance from staff for medication and were to monitor for any side effects to the medications. The record showed that in addition to an assigned primary physician the resident also met with a behavioral specialist, Nurse Practitioner (NP) twice a week.

Record review of Resident 1's record showed:

- On 01/29/2023 Lorazepam (medication that works by slowing activity in the brain to allow relaxation, can cause drowsiness, weakness, and dizziness) 0.5 mg every 8 hours as needed for catatonic symptoms (repetitive movements, restlessness, muscle stiffness, and sadness).
- On 04/01/2023 Resident 1 was shaky and their right hand was shaky while eating.



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- On 04/02/2023 Resident 1 continued to have shakiness to their right hand, dropping food on floor, appeared tired, refused lunch, walked slower, looked tired, and was unsteady.
- On 04/03/2023, the resident had continued tremors, shakiness restlessness, unusual tiredness and unable to hold utensils for meals. The facility's nurse notified the NP about continued tremors, shakiness restlessness, unusual tiredness, and unable to hold utensils for meals. The record did not show the resident's primary physician was notified.
- On 04/04/2023 Resident 1 continued to be weak and refused medications. The facility staff notified the NP that Resident 1 had continued weakness and refused medications. The record did not show the resident's primary physician was notified.
- On 04/05/2023, the ALF notified the NP that Resident 1 was still weak and lethargic (lack of energy), the ALF received orders to give Lorazepam 0.5mg (4 tabs) one time and in addition to the Lorazepam 0.5 mg (2 tabs) four times a day. The record did not show the resident's primary physician was notified.
- On 04/06/2023, the MAR showed Resident 1 received 4 doses of Lorazepam 0.5 mg 2 tabs (1mg).
- On 04/06/2023 Resident 1 slipped off their chair in the dining room. Staff A notified NP and received orders on 04/07/2023 to give an increased dose of Lorazepam 1.5 mg 4 times a day and tizanidine (muscle relaxer that can cause drowsiness, weakness, and dizziness) 2 mg at bedtime. The record did not show the resident's primary physician was notified.
- On 04/07/2023 Resident 1 was sleeping more, had difficulty swallowing medications, and could not lift their hand to grab utensils to eat. Resident 1 was found on floor trying to move around while seated on floor. The MAR showed Resident 1 received 4 doses of Lorazepam 0.5 mg 2 tabs (1mg), and Tizanidine 1 tab(2mg) (muscle relaxer).
- On [REDACTED]/2023 Resident 1 was found unresponsive by care staff. The resident was taken to the hospital by ambulance.

On 05/18/2023 at 12:20 PM, Staff A, Health Care Aide, stated they notified the NP on 04/06/2023 at 3:00 PM that Resident 1 had received the scheduled doses of Lorazepam at 3:00 PM and that Resident 1 could not eat, could not pick up their fork, was drowsy, and was drooling. The Psychiatric NP instructed Staff A to give another scheduled dose of Lorazepam. "I could not believe it." Staff A expressed she felt uncomfortable to administer more Lorazepam. Staff A notified Staff C, Office Manager, and Staff D, Licensed Nurse immediately. "Both [Staff C] and [Staff D] told me we could not hold the medication, and that we had to follow doctor's orders." Staff A stated that in the past "we" have held medications for signs of over sedation. "We could have done better and prevented [Resident 1's] hospitalization." Staff A expressed that the medication was initially

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prescribed to decrease Resident 1's agitation and had already notified Staff C and Staff D of her concern that Resident 1 received too much medication on 04/05/2023. Staff A acknowledged and stated they were not sure why Resident 1's primary physician was not notified when resident experienced a decline in their condition.

On 05/22/2023 at 10:45 AM, Staff D, stated that she was slightly concerned about Resident 1 received too much Lorazepam but felt like her "hands were tied" and followed the NP's orders.

On 06/01/2023 at 11:00 AM, Staff C, stated that they were concerned that Resident 1 may have received too much Lorazepam but that they were following the NP's orders.

Record Review of April 2023 chart notes showed no documentation that the physician or Residents 1's representative were notified while the incidents occurred.

Record review of Resident 1's hospital record dated [REDACTED]/2023 showed that Resident 1 thought they were getting too much medication at the ALF and spent seven days in the hospital. Resident 1 was diagnosed with [REDACTED], and had a benzodiazepine (medication to treat anxiety that can cause sedation) overdose.

On 05/05/2023 at 9:50 AM, Collateral Contact 1 (CC1), Resident's Representative, stated that the facility did not call to notify them about Resident 1 being in the hospital. Hospital staff called to notify CC1. "I called [Staff C], the next day, Staff C seemed shocked that I knew about the hospitalization."

On 06/05/2023 at 10:37 AM, Staff B, Administrator, stated that the ALF should have consulted with Resident 1's primary physician and family when the resident was declining, and the change of condition was occurring.

#### Resident 2

Record review of Resident 2's updated NSA, dated 11/04/2022, showed that staff would monitor for skin issues and report to manager.

Record review of Resident 2's most recent assessment dated 11/04/2022 showed that there was no documentation of a change in condition regarding skin issues.

Record review of Resident 2's chart showed:

- On 04/02/2023 Staff E, Caregiver, documented a quarter sized skin rip was bleeding to



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the buttocks and notified Staff D, Licensed Nurse. There was no documentation found that the resident's representative or physician was notified.

- On 04/21/2023 care staff noted "bed sore" on Resident 2's bottom, received an order for skin barrier cream from Resident 2's Physician.
- On 04/22/2023 while repositioning Resident 2, care staff noticed that the red spot on Resident 2's bottom was getting bigger.
- On 4/28/2023 care staff noticed a "bed sore" was red and skin was peeling off, the sore was cleansed, and a barrier cream was applied.
- On 05/01/2023 Staff A notified PCP that "bed sores" were getting worse, eight days after the last notification of change of conditions of the "bed sores" were getting worse.

Review of the record from 04/02/2023 through 04/20/2023 showed no notification to the physician regarding the worsening of the wound. The record showed the physician was notified 19 days later, on 04/21/2023.

Record review of Resident 2's physician notes showed that the ALF requested a hospice referral on 05/01/2023. On 05/05/2023 Collateral Contact 3 (CC3), Hospice Nurse, assessed the skin and found that Resident 2 had significant pressure sores to the buttocks and right heel. CC3's notes showed that the wound to buttocks was draining fluid and was a Stage 3 Pressure injury (full thickness tissue loss). The wound on the heel was a Stage 2 (partial thickness tissue loss).

On 05/05/2023 at 11:08 AM, Collateral Contact 2 (CC2), Physician was concerned that the facility did not notify them that the skin injuries and now they have become pressure injuries and gotten worse.

On 05/31/2023 at 3:57 PM, CC3 stated that Resident 2 was only on their services for two days. On 5/05/2023 CC3 found the Stage 2 and Stage 3 pressure injuries.

On 06/01/2023 at 1:08 PM, Collateral Contact (CC4), Representative and Durable Power of Attorney (DPOA), stated that the facility had notified them of "redness" to Resident 2's buttocks, but they were not aware of the Stage 2 and Stage 3 pressure injuries or when the pressure injuries occurred.

On 06/05/2023 at 10:37 AM, Staff B, Administrator, stated that the ALF should have notified Resident 2's physician and family.



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**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, Community Pride Sunnyside LLC is or will be in compliance with this law and / or regulation on  
(Date) 8/8/2023

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

erin addison  
Administrator (or Representative)

7/20/2023  
Date

**WAC 388-78A-2100 On-going assessments. The assisted living facility must:**

- (2) Complete an assessment specifically focused on a resident's identified problems and related issues:
- (a) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;
  - (b) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;
  - (c) When the resident has an injury requiring the intervention of a practitioner.

**This requirement was not met as evidenced by:**

Based on interview and record review, the Assisted Living Facility (ALF) failed to complete a focused assessment when a change of condition occurred for 2 of 2 residents (Resident 1 & 2). These failures contributed to a medication overdose and hospitalization for Resident 1 and to Resident 2's unmet treatment needs of pressure injuries (wounds that occur from prolonged pressure on skin).

Findings included...

Record review of facility's undated policy titled, "Limited Nursing Services," showed that the facility should contact directly with the Registered Nurse to reassess resident's needs when staff notice a change in residents' functional ability or health status and amend the resident's care plan accordingly.

On 05/18/2023 at 1:52 PM, Staff B, Administrator, verified through email that the facility's policy for monitoring a resident was that care staff, assistant manager, and nurse monitor all residents. If there was a condition that was specific to monitor or assess, the resident is placed on alert charting.

Resident 1

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Record review of Resident 1's chart showed that they were admitted to the ALF on [REDACTED]/2022. Resident 1's diagnosis included [REDACTED] and [REDACTED].

Record review of facility's most recent assessment dated 03/13/2023 showed that Resident 1 was able to make needs known, moved independently and was independent with transfers, and staff assisted with medication. Staff were to monitor and assess for side effects of medications that Resident 1 was taking.

Review of a 03/22/2023 provider note written by Psychiatric Nurse Practitioner (NP, Practitioner that specializes in psychiatry) evaluation of Resident 1 and showed no signs of new or worsening problems reported by facility staff. The evaluation also showed that Resident 1 did not show signs of anxiety, or mental status changes.

Record review of Resident 1 ALF's chart notes showed:

- On 04/01/2023 Resident 1 was shaky and their right hand was shaky while eating.
- On 04/02/2023 Resident 1 continued to have shakiness to the right hand, dropping food on floor, appeared tired, refused lunch, walked slower, and was unsteady.
- On 04/03/2023, Resident 1 had continued tremors, shakiness restlessness, unusual tiredness and unable to hold utensils for meals.
- On 04/05/2023, Resident 1 was still weak and lethargic (lack of energy and weak).
- On 04/06/2023 Resident 1 slipped off a chair in the dining room.
- On 04/07/2023 Resident 1 was sleeping more, could not eat meals on their own, had difficulty swallowing medication, could not lift their hand to grab utensils to eat, and needed assistance to eat.
- On 04/07/2023 Resident 1 was restless all night and was found on the floor trying to move around while seated on the floor.
- On [REDACTED]/2023 Resident 1 was found unresponsive by care staff. The resident was taken to the hospital by ambulance.

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Review of Resident 1's ALF chart for 04/01/2023 to 04/08/2023 did not show that there was an updated assessment or change to the Negotiated Service Agreement (NSA) related to Resident 1's acute (sudden onset) mental status changes.

On 05/05/2023 at 11:08 AM, Collateral Contact 2 (CC2), Primary Care Doctor (PCP), stated "I was upset that I was not notified about their [Resident 1's] condition while it was happening." CC2 stated that they told the ALF residents needed to be properly assessed and monitored to prevent harm.

On 06/05/2023 at 10:37 AM, Staff B, Administrator, stated that the ALF should have consulted with Resident 1's PCP and acknowledged that Resident 1 should have been assessed and a new assessment should have been documented.

On 06/27/2023 at 11:23 AM, Collateral Contact (CC1), Resident's Representative, stated that Resident 1 is currently residing at higher level of care facility for continued rehabilitation. CC1 expressed that their mental and physical status had still not returned to their baseline function prior to the hospitalization. "[Resident 1] is not the same person."

Record review of most recent assessment dated 06/19/2023 completed by the skilled nursing facility's health care professional showed that Resident 1's needs can still not be met in a lesser care setting at this time. Resident 1 was still weak and had still not regained enough strength and function to return to previous living situation, the ALF.

#### Resident 2

Record review of Resident 2's updated Negotiated Service Agreement (NSA) dated 11/04/2022 showed that Resident 2 was an independent transfer, and staff would monitor for skin issues and report to manager. The assessment did not show that pressure injuries were present.

Record review of Resident 2's ALF chart showed:

- On 04/02/2023 Staff E, Caregiver, noticed a quarter sized skin tear was bleeding and notified Staff D, Licensed Nurse (LN). No further documentation was found until 04/21/2023.
- On 04/21/2023 care staff noted "bed sore" on Resident 2's bottom and received an order for skin barrier cream from Resident 2's PCP.
- On 04/22/2023 while repositioning Resident 2, care staff noticed that the red spot-on Resident 2's bottom was getting "bigger."



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• On 4/28/2023 caregivers noticed a "bed sore" was red and skin was peeling off, the sore was cleansed, and a barrier cream was applied.

• On 05/01/2023 the facility notified the PCP that "bed sores" were getting worse. A Hospice referral was also requested.

Review of Resident 2's April 2023 and May 2023 chart did not show that there was an updated assessment or NSA was updated related to Resident 2's pressure injuries.

Review of Resident 2's photographs dated 05/05/2023 at 12:50 PM, taken by Collateral Contact 3 (CC3), Hospice Nurse, showed that the pressure injury to the right heel measured 6 cm wide with the top layer of skin gone. The center of the pressure wound to right heel was bright red. The skin surrounding the pressure wound appeared mushy and purple.

Review of Resident 2's photographs dated 05/05/2023 at 12:50 PM, taken by CC3 showed the pressure wound to Resident 2's bottom measured around 4x4 cm with the top layer of skin off, tissue exposed with a small amount of slough (dead tissue) surrounding the center of the wound. The skin surrounding the center of the wound appeared scaly, soft, and red.

On 05/31/2023 at 3:57 PM, CC3 stated that Resident 2 was only on their services for two days and was assessed by CC3 on 5/05/2023 when they found the stage three (full thickness tissue loss) pressure injury to the resident's bottom and a stage two (partial thickness tissue loss) pressure injury to the right heel.

On 05/31/2023 at 5:00 PM, Collateral Contact 2 (CC2), Primary Care Provider (PCP), stated they were not notified of the significance of both pressure injuries. "I was notified of some redness to the buttocks." CC2 stated that they told the ALF residents needed to be properly assessed and monitored to prevent harm.

On 06/01/2023 at 1:26 PM Staff E, Caregiver, stated that she did not recall of any sores or pressure injuries to Resident 2's sacrum, only recalled "redness." "I do not remember the last time I seen [Resident 2's] bottom."

On 06/05/2023 at 10:37 AM, Staff B, Administrator, stated they were not aware that a skin assessment was not done. Staff B acknowledged that Resident 2 should have been assessed and a skin assessment should have been documented. "We can do better."

Plan/Attestation Statement

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(Date) 8/8/2023

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

erin addison  
Administrator (or Representative)

7/20/2023  
Date