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) 46108 (Completion Date 08/23/2024) and 43995 (Completion Date 07/25/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/23/2024 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-2371-4, WAC 388-78A-2990-1-b-iii

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

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, Field Manager
Region 1, Unit Z
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Community Pride Sunnyside LLC **Provider Type:** Assisted Living Facility
License/Cert.#: 2632
Intake ID: 137254
Compliance Determination #: 43995
Region/Unit #: RCS Region 1 / Unit G
Investigator: Michelle Closner
Investigation Date(s): 07/11/2024 through 07/25/2024
Complainant Contact Date(s): 07/25/2024

Allegation(s):
A named resident stated a named caregiver sexually assaulted them.

Investigation Methods:

Sample:	Total residents: 9 Resident sample size: 9 Closed records sample size:
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Facility environment
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster Incident investigation Facility policies Staff records Resident records

Investigation Summary:
Observations showed that the named resident was no longer in the facility. The facility notified all entities of the allegation, and sent the named resident to the hospital for evaluation. The facility investigated and ruled out abuse and neglect. The alleged perpetrators continued to work pending investigation. Failed practice identified. 388-78A-2371

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ]

Failed Provider Practice Not Identified / No Citation Written

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Community Pride Sunnyside LLC **Provider Type:** Assisted Living Facility
License/Cert.#: 2632
Intake ID: 138031
Compliance Determination #: 43995
Region/Unit #: RCS Region 1 / Unit G
Investigator: Michelle Closner
Investigation Date(s): 07/11/2024 through 07/25/2024
Complainant Contact Date(s):

Allegation(s):

The facility's air conditioner unit broke down and the residents were living in the facility with high temperatures.

Investigation Methods:

Sample:	Total residents: 9 Resident sample size: 9 Closed records sample size:
Observations:	Facility temperatures Residents Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Facility environment
Interviews:	Residents Facility staff Others not associated with the facility
Record Reviews:	Characteristic roster House policies Maintenance records Resident records (face sheet, care plan, assessments ,chart notes)

Investigation Summary:

Observations showed that the facility thermostat was 78 degrees Fahrenheit. Interviews and record review showed that the the facility's temperature reached up to 90 degrees Fahrenheit. Failed practice identified. 388-78A-2990 1b(iii)

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

1200 Alder Street, Union Gap, WA 98903

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 07/11/2024 and 07/17/2024 of:

Community Pride Sunnyside LLC
906 North Ave
Sunnyside, WA 98944

This document references the following complaint number(s): 137254, 138031

The following sample was selected for review during the unannounced on-site visit: 9 of 9 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Felicia Cantu, Community Complaint Investigator
Michelle Closner, Complaint Nurse Field Manager

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.

Michelle Closner
Residential Care Services

08/06/2024
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.

Raphael Ngwano
Administrator (or Representative)

8/16/24
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on record review and interview the Assisted Living Facility (ALF) failed to protect 9 of 9 residents (Resident 1,2,3,4,5,6,7,8, and 9) who lived in the facility after an allegation was made of sexual assault against two staff members (Staff F and G). This failure put the residents at risk of being harmed before abuse was ruled out.

Findings included...

Review of the facility's undated policy titled, "Policy on Abuse, Neglect, and Exploitation" showed that the facility would protect each resident who became an alleged victim of abuse and prevent potential future incidences from occurring. If a resident accused staff of abuse, the facility would report to the Complaint Resolution Unit (CRU) immediately and suspend the caregiver from working while the facility investigated the incident.

Resident 1

Review of Resident 1's face sheet showed that they were admitted to the ALF on [redacted]/2024. Resident 1 had a diagnosis of [redacted].

Review of Resident 1's investigation report showed that Resident 1 alleged that Staff F, Caregiver and Staff G, Caregiver sexually assaulted them on 07/02/2024. The investigation was initiated on 07/03/2024.

Review of Resident 1's incident report dated 07/03/2024 showed that the internal investigation was still ongoing.

On 07/12/2024 at 9:54 AM Staff A, Manager, stated that his investigation was initiated on 07/03/2024 and completed on 07/05/2024. Staff A stated that he could not substantiate that the incident occurred. Staff A stated both Staff F and Staff G returned to work before the investigation was complete. Staff A stated that they were both scheduled to work on 07/03/2024.

Administrator (or Representative) Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

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This requirement was not met as evidenced by:

Based on record review and interview the Assisted Living Facility (ALF) failed to protect 9 of 9 residents (Resident 1,2,3,4,5,6,7,8, and 9) who lived in the facility after an allegation was made of sexual assault against two staff members (Staff F and G). This failure put the residents at risk of being harmed before abuse was ruled out.

Findings included...

Review of the facility's undated policy titled, "Policy on Abuse, Neglect, and Exploitation" showed that the facility would protect each resident who became an alleged victim of abuse and prevent potential future incidences from occurring. If a resident accused staff of abuse, the facility would report to the Complaint Resolution Unit (CRU) immediately and suspend the caregiver from working while the facility investigated the incident.

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Review of Resident 1's incident report dated 07/03/2024 showed that the internal investigation was still ongoing.

On 07/12/2024 at 9:54 AM Staff A, Manager, stated that his investigation was initiated on 07/03/2024 and completed on 07/05/2024. Staff A stated that he could not substantiate that the incident occurred. Staff A stated both Staff F and Staff G returned to work before the investigation was complete. Staff A stated that they were both scheduled to work on 07/03/2024.

Statement of Deficiencies	License #: 2632	Compliance Determination # 43995
Plan of Correction	Community Pride Sunnyside LLC	Completion Date
Page 3 of 5	Licensee: Community Pride Sunnyside LLC	07/25/2024

Review of the Facility's Staff schedule for July 2024 showed that Staff F and Staff G both worked night shift in the ALF on 07/03/2024 and 07/04/2024.

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) 8/16/24.

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

Raphael Nguen — Administrator (or Representative)

8/16/24 — Date

WAC 388-78A-2990 Heating-cooling Temperature. The assisted living facility must:

(1) Equip each resident-occupied building with an approved heating system capable of maintaining a minimum temperature of 70 F. The assisted living facility must:

(b) Maintain the assisted living facility at a minimum of 68 F during waking hours, except in rooms:

(iii) Where residents cannot individually control the temperature in their own living units, maintain all living units at a temperature range of 70 F to 75 F;

This requirement was not met as evidenced by:

Based on observation, interviews, and record review the Assisted Living Facility (ALF) failed to ensure that their cooling system was maintained at the required temperature for 3 of 3 areas of the ALF (common area, hallway 1, and hallway 2). This failure resulted in all 9 residents to live with high temperatures for three days that caused them to be uncomfortable. Additionally, the failure could have caused significant harm to the residents.

Findings included...

Review of the Facility's Staff schedule for July 2024 showed that Staff F and Staff G both worked night shift in the ALF on 07/03/2024 and 07/04/2024.

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)_____ .

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Administrator (or Representative) Date

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Based on observation, interviews, and record review the Assisted Living Facility (ALF) failed to ensure that their cooling system was maintained at the required temperature for 3 of 3 areas of the ALF (common area, hallway 1, and hallway 2). This failure resulted in all 9 residents to live with high temperatures for three days that caused them to be uncomfortable. Additionally, the failure could have caused significant harm to the residents.

Findings included...

On 07/11/224 at 09:02 AM, Staff C, Caregiver, stated that the air conditioning unit in the ALF broke on 07/07/2024. Staff A, Manager was notified on 07/07/2024. The wall air conditioning units(ac) were purchased and installed on 07/11/2024. The temperatures between that time reached up to 90 degrees Fahrenheit(F).

On 07/11/2024 at 09:10 AM, Staff B, Health and Wellness Director, stated that when she came to work on 07/08/2024 the air conditioning unit was not working. The thermostat in the facility read 87 degrees F in the late afternoon. The wall ac units were purchased on 07/10/24.

On 07/11/2024 at 09:17 AM, Resident 2 stated that there have been mornings that it is" hot", and that their room heated up quickly.

On 07/11/2024 at 09:28 AM, Resident 3 stated that in the afternoon s few days prior that the temperature in the ALF got "hot".

An observation on 07/11/2024 at 09:24 AM, showed that Resident 4's room in hallway 1 was warmer than normal room temperature.

An observation on 07/11/2024 at 11:00 AM showed that the ALF's central thermostat read 78 degrees F. The ALF had one thermostat that controlled all three areas (common area, hallway 1, and hallway 2) of the ALF.

An observation on 07/11/2024 at 11:45 AM showed that Resident 5's room located in hallway 2 was noticeably warmer than the common area.

Review of Resident 5's chart notes dated 07/10/2024 at 9:00 AM showed that they complained of feeling lightheaded due to the high temperatures.

On 07/11/2024 at 06:30 PM Staff E, Caregiver stated that she had left her shift at 6:30 PM and the thermostat read 85 degrees F.

On 07/12/2024 at 10:48 AM Staff D, Caregiver stated that she worked in the ALF on 07/8/2023, 07/09/2023, and 07/10/2024. Staff D stated that she observed the residents were uncomfortable. Staff D stated Resident 5 became dizzy. Other residents in the ALF stated they could not handle the heat. The wall ac units were not installed until 7/10/2024. "I believe the thermostat read as high as 86 degrees F before the ac wall units were installed."

Statement of Deficiencies	License #: 2632	Compliance Determination # 43995
Plan of Correction	Community Pride Sunnyside LLC	Completion Date
Page 5 of 5	Licensee: Community Pride Sunnyside LLC	07/25/2024

Plan/Attestation Statement

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Raphael Nguno — Administrator (or Representative)

8/16/24 — Date

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

_____ _____

Administrator (or Representative) Date