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

09/09/2025

Sunnyside Care LLC
Sunnyside Care
907 Ida Belle St
Sunnyside, WA 98944

RE: Sunnyside Care # 2754

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 65305 (Completion Date 09/09/2025) and 61823 (Completion Date 07/31/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 09/09/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

(1) Develop an initial resident service plan, based upon discussions with the resident and the resident's representative if the resident has one, and the preadmission assessment of a qualified assessor, upon admitting a resident into an assisted living facility. The assisted living facility must ensure the initial resident service plan:

(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

The Department staff who did the On Site verification:
Melissa Milanez, Community Complaint Investigator

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

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Sunnyside Care
Provider Type: Assisted Living Facility
License/Cert.#: 2754
Compliance Determination #: 61823
Intake ID: 183247
Investigator: Melissa Milanez
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 06/30/2025 through 07/31/2025
Complainant Contact Date(s): 08/06/2025

Allegation(s):
Identified resident had a fall with injury.

Investigation Methods:

Sample:
Total residents: 57
Resident sample size: 3
Closed records sample size: 1

Observations:
Residents
Activities
Resident care equipment
Resident rooms
Staff to resident interactions
Resident to resident interactions

Interviews:
Identified staff
Nursing staff
Residents
Family members

Record Reviews:
Medical records
Hospital records
State reporting log
Incident investigation
Facility policies
Staff patterns
Personnel files

Investigation Summary:
Identified resident was admitted to the assisted living facility without an initial resident service plan. Staff stated they were unaware of the resident's care needs or high fall risk status due to not having the necessary information to safely provide care. Failed practice identified WAC 388-78A-2130 Service planning agreement dated 07-31-2025.

Conclusion / Action:

- [x] 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 06/30/2025 of:

Sunnyside Care
907 Ida Belle St
Sunnyside, WA 98944

This document references the following complaint number(s): 183247

The following sample was selected for review during the unannounced on-site visit: 3 of 57 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Melissa Milanez, Community Complaint Investigator

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

Statement of Deficiencies	License #: 2754	Compliance Determination # 61823
Plan of Correction	Sunnyside Care	Completion Date
Page 2 of 5	Licensee: Sunnyside Care LLC	07/31/2025

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.

Laura Williams-Davis
Residential Care Services

08/11/2025
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.

Administrator (or Representative)

8/14/2025
Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

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(a) Integrates the assessment information provided by the department's case manager for each resident whose care is partially or wholly funded by the department or the health care authority;

(b) Identifies the resident's immediate needs; and

(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to ensure an initial service plan was developed and implemented upon admission for 1 of 3 residents (Resident 1), who had a high risk for falls and a complex medical history. This failure resulted in the lack of and/or no direction for staff to meet resident care needs which contributed to the delayed recognition of a fall with injury and an emergency room visit, placing the resident at significant risk for harm.

Findings included...

Review of Resident 1's undated Face Sheet, showed that the resident moved into the facility on [redacted]/2025 and resided in the outside cottages. Additionally, the face sheet showed that Resident 1 had a history of repeated falls.

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.

Laura Williams-Davis
Residential Care Services

08/11/2025
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.

Administrator (or Representative)

Date

WAC 388-78A-2130 Service agreement planning. The assisted living facility must:

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(c) Provides direction to staff and caregivers relating to the resident's immediate needs, capabilities, and preferences.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the facility failed to ensure an initial service plan was developed and implemented upon admission for 1 of 3 residents (Resident 1), who had a high risk for falls and a complex medical history. This failure resulted in the lack of and/or no direction for staff to meet resident care needs which contributed to the delayed recognition of a fall with injury and an emergency room visit, placing the resident at significant risk for harm.

Findings included...

Review of Resident 1's undated Face Sheet, showed that the resident moved into the facility on [redacted]/2025 and resided in the outside cottages. Additionally, the face sheet showed that Resident 1 had a history of repeated falls.

Review of Resident 1's Department annual assessment details, dated 05/13/2025, showed that the resident required one-person physical assist and oversight with walking. Additionally, the assessment showed that staff were to keep the client within sight.

Review of Resident 1's hospital records dated 05/24/2025 showed that the resident was admitted to the hospital on [redacted]/2025-[redacted]/2025 for a head injury, frequent falls, hypertensive urgency (blood pressure that is dangerously high) and anemia (not having enough red blood cells). Records also showed that the resident's discharge was postponed for a day due to requiring 2 units of a blood transfusion. Records also showed that Resident 1 reported having multiple falls at home and felt it would not be safe for them to be by themselves anymore.

Review of Resident 1's fall incident report dated 05/26/2025, showed that Resident 1 was found lying on their left side in a fetal position. Resident 1 was observed with no pants or brief on and were covered in emesis. Additionally, records showed that the staff had observed emesis smeared onto the walls. Records also showed that Resident 1 had extreme swelling to their face and a bump/bruise to the right side of their forehead. Records showed that Resident 1 had not been wearing their pendent (alert system to call for help when needed).

Review of Resident 1's Emergency Room (ER) note dated 05/26/2025, showed that the resident arrived in the ER after being found on the floor at the assisted living facility and was found face down in vomit, with an unknown time down and unknown last seen normal. Additionally, Resident 1 appeared with altered mental status, stertorous breathing (noisy, snoring-like respirations) and swollen face and neck.

In an interview on 06/30/2025 at 11:50 PM, Collateral Contact 1 (CC1), stated that Resident 1had been in the hospital for a week due to having several falls at home. They stated they felt the admission process was rushed due to it being Memorial Day weekend and did not feel that Resident 1 had been properly assessed prior to moving into the facility. CC1 stated they had concerns about the safety of Resident 1 upon arriving at the facility and had stayed with them until midnight that day on 05/24/2025. CC1 stated they had concerns that Resident 1 would be living outside in the cottages, away from staff, due to recent falls at home. CC1 stated that they had made Staff A aware of the concerns they had and were told that there were no available rooms inside but was reassured that staff would be providing 2-hours safety checks.

In an interview on 06/30/2025 at 12:50 PM, Staff A, Administrator, stated that Resident 1 had only been at the facility for a few days and had been sent out to the hospital on [redacted]/2025 due to being confused. Staff A stated they had not been made aware of a fall that had taken place. Additionally, they stated that they assessed Resident 1 prior to admission and that Resident 1 was not a fall risk.

In an interview on 06/30/2025 at 1:11 PM, Staff B, Residential Care Coordinator, stated that Resident 1 had a fall in their room and was found on the floor. Staff B stated that they were not sure when Resident 1 was last checked on but that all new residents required safety checks and that staff would do their rounds throughout their shifts.

In an interview on 06/30/2025 at 1:28 PM, Staff C, Medication Technician, stated that they had worked the day shift 6:00 AM-10:00 PM on 05/26/2025. Staff C stated they had gone to get Resident 1 for breakfast that morning and found them lying on the floor on their left side, initially they had thought they had been sleeping due to them hearing a snoring noise but then they noticed that Resident 1 was not responding. They stated they observed what appeared to be dark colored stool on the walls and floors, but later confirmed it was dark bloody emesis. They stated that Resident 1's left side of face was severely swollen and bruised. Staff C stated they were not sure if Resident 1 had an initial care plan because they had not seen one.

In an interview on 06/30/2025 at 2:03 PM, Staff D, Caregiver, stated that Resident 1 arrived at the facility over the weekend during their shift. They stated that they were unaware of the residents' required care because there was no care plan available for review. Staff D stated that they were told Resident 1 was independent; however, they expressed concerns about the resident being alone in the outside cottages due to appearing confused, unsteady and unsafe when ambulating. Staff D stated they observed Resident 1 holding onto furniture and objects while walking and stated they did not believe the resident could walk safely on their own. Staff D also stated that they were not instructed to complete two-hour safety checks.

In an interview on 06/30/2025 at 2:10 PM, Staff A stated that they had completed the pre-admission assessment on paper and were unable to provide the records due to them being archived. Staff A stated that everything else had been previously done in their old electronic health record (EHR) and that they did not have access to them at the moment. Staff A stated that they had recently changed EMAR systems on 06/01/2025.

In an interview on 07/31/2025 at 11:22 AM, Staff E, Caregiver, stated that they worked the night shift on 05/25/2025. Staff E stated that they were told that Resident 1 was independent and had not checked on the resident during their shift. Staff E stated that they did not complete checks on Resident 1 because independent residents are not routinely checked on. Staff E stated they were not aware of there being a temporary service plan for Resident 1 or any paperwork available for review of Resident 1's needs.

Statement of Deficiencies	License #: 2754	Compliance Determination # 61823
Plan of Correction	Sunnyside Care	Completion Date
Page 5 of 5	Licensee: Sunnyside Care LLC	07/31/2025

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, Sunnyside Care is or will be in compliance with this law and / or regulation on (Date) 8/21/2025.

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

Administrator (or Representative)

8/11/2025
Date