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

12/12/2025

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) 70025 (Completion Date 12/12/2025) and 66291 (Completion Date 10/15/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/12/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

RCW 70.129.140 Quality of life -- Rights.

(2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to:

(a) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;

(b) Interact with members of the community both inside and outside the facility;

(c) Make choices about aspects of his or her life in the facility that are significant to the resident;

(4) A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(5) A resident has the right to:

(a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

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 #: 66291
Intake ID: 194852
Investigator: Melissa Milanez
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 09/29/2025 through 10/15/2025
Complainant Contact Date(s):

Allegation(s):
Residents are being told they are not allowed in the dining room for meals.

Investigation Methods:

Sample:	Total residents: 64 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions Kitchen
Interviews:	Identified resident Identified staff Nursing staff Residents Family members Kitchen staff
Record Reviews:	Characteristic roster Resident agreement Resident records Cottage resident dining agreement State reporting log Incident investigation Facility policies Staff patterns

Investigation Summary:
Observations, interviews, and record review showed that residents who resided in the outside cottages were not allowed to eat in the main dining room. Record

review showed that the residents were told to sign an agreement stating that all residents who reside in the cottages would be required to dine in the designated dining areas located within their individual cottages. Record review also showed that the facility failed to provide a 30-day notice for any change in the facility's rules. Observations of the dining room showed that there were multiple empty tables and chairs available, contradicting the facility's claim that there was no space. Failed practice identified. Please see the Statement of Deficiency for Washington Administrative Code (WAC) 388-78A-2660 (1), RCW 70.129.030 (2), RCW 70.129.140.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2754	Compliance Determination # 66291
Plan of Correction	Sunnyside Care	Completion Date
Page 1 of 6	Licensee. Sunnyside Care LLC	10/15/2025

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 09/29/2025 and 09/30/2025 of:

Sunnyside Care
907 Ida Belle St
Sunnyside, WA 98944

This document references the following complaint number(s): 194852, 194785, 192843, 194177, 195627

The following sample was selected for review during the unannounced on-site visit: 4 of 64 current residents and 0 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 # 66291
Plan of Correction	Sunnyside Care	Completion Date
Page 2 of 6	Licensee: Sunnyside Care LLC	10/15/2025

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

10/27/2025
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)

11/10/25
Date

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

RCW 70.129.140 Quality of life – Rights.

(2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to:

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(4) A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(5) A resident has the right to:

(a) Reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; and

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to give a 30-day notice of changes to the facility's rules and ensure resident rights related to dignity, choice, and inclusion were upheld when residents were told they no longer can eat in the main building dining room for 4 or 4 residents (Residents 1,2, 3, & 4.) This failed practice resulted in restricting residents' rights to make choices about their daily life and activities, including where to dine and socialize, which caused residents to feel excluded and isolated from others.

Findings included....

Review of a record titled "Cottage Resident Dining Agreement," dated 09/12/2025, showed that beginning 09/15/2025 (three-day notice), all cottage residents were required to dine only in the designated dining areas within their individual cottages. The agreement included a resident acknowledgment section that required residents to sign, indicating their understanding of this policy.

Review of the characteristic roster printed on 09/29/2025, showed that Resident 1 moved into the facility on [redacted]/2025, Resident 2 moved into the facility on [redacted]/2025, Resident 3 moved into the facility on [redacted]/2025, and Resident 4 moved into the facility on [redacted]/2025.

In an interview on 09/29/2025 at 12:48 PM, Staff A, Executive Director stated that currently there were eleven residents residing in the cottages located outside of the main building. Staff A confirmed that these residents had been told that they could not eat in the main dining room and that they had each resident sign a document acknowledging that they must eat their meals in their apartments and/or shared kitchenette, located within each cottage. They further stated that any new residents would also be required to sign that form upon admission.

In an interview on 09/29/2025 at 2:08 PM, Staff B, Caregiver, stated that the facility recently made a change affecting the residents who live in the cottages located outside of the main building. They stated that for the past 2-3 weeks, those residents have not been allowed to come into the main dining room for meals as there was not enough space. When asked about the smaller dining room located in the main building, Staff B stated that it had been converted into a formal dining area that was available upon reservation and intended for resident use when dining with visiting family members.

They stated that residents were not permitted to eat there during regular mealtimes.

In an interview on 09/29/2025 at 2:30 PM, Staff C, Caregiver stated that all residents living in the cottages were currently receiving meal trays due to what the facility identified as "capacity issues" in the main dining room. They stated that the private dining room had been converted into a management break room used for meetings, and that the smaller dining room in the main building was being utilized only for when residents' families wanted to dine together. Additionally, Staff C stated that they observed one table completely empty with chairs, another table that was empty but without chairs, and approximately 15 empty dining seats overall. Staff C further stated that residents were required to sign a form acknowledging that they would begin receiving meal trays in their cottages. They confirmed that they saw a copy of this form and expressed that they felt the restriction was wrong, as there was sufficient room in the dining room. They stated that several residents had expressed wanting to come inside for meals because they missed socializing with other residents.

In an interview on 09/29/2025 at 3:16 PM, Resident 1 stated they previously went to the main dining room for meals but was no longer allowed to do so, due to what staff had described as "safety" and "overcrowding" concerns. They stated that they miss going to the main building dining room and being around other residents, explaining that they used to sit with friends and enjoyed socializing during meals. Additionally, Resident 1 stated that they currently felt isolated and stated they wanted to move back to their old facility because they felt they were not receiving the help they needed. Resident 1 stated that staff did not check on them regularly and that they felt lonely and forgotten.

In an interview on 09/29/2025 at 3:36 PM, Resident 2 stated that they now eat their meals in their room at a small table because they are no longer allowed to go to the main building dining room. They reported that they did not know why this change occurred, only that they were asked to sign a paper saying that they would no longer be eating in the main building dining room. Resident 2 stated that eating in their room was an inconvenience because they could not make changes to their meal orders or request alternate items easily. They stated that there had been times when they have asked staff for something extra, and that staff often say they will return and never come back. Resident 2 stated they felt left out and singled out, stating that they missed eating in the dining room with other residents and that being restricted to their room during mealtimes had made them feel more depressed. Additionally, Resident 2 stated that since they began eating in their room, they noticed more ants and flies in their living space. They stated that they would prefer to eat in the dining room where they could socialize with other residents.

In an interview on 09/29/2025 at 4:37 PM, Resident 3 stated that not long ago they were told that they could no longer eat in the main building dining room because it was "filled up" and that they were required to eat their meals in their room. Resident 3 stated that they had observed that the dining room was not actually full, which made them feel sad and confused about why they were being excluded. They stated that they had been restricted from coming to the dining room for approximately 2 weeks. Resident 3 stated they felt left out, noting that other residents continued to dine in the main dining room

while they were restricted to their room.

Review of Resident 3's "Cottage Resident Dining Agreement," dated 09/12/2025, showed a handwritten note on the same document stated, "P.S. he would rather continue to eat in cafeteria."

In an interview on 10/15/2025 at 9:23 AM, Collateral Contact 1 (CC1), Durable Power of Attorney, stated that they were never informed that Resident 3 had been restricted from dining in the main dining room. They had learned from the restriction only after Resident 3 told them that they had been required to eat meals in their room for approximately two weeks. CC1 stated that Resident 3 did not seem to understand why they were no longer permitted to eat in the dining room and that no one had ever explained the reason to the resident or them. CC1 stated that Resident 3 was very sociable and stated the restriction negatively affected them emotionally. CC1 stated that they had not been advised of, nor consented to, any written agreement regarding the restriction. CC1 stated that after expressing their concerns to Staff A, Resident 3 was allowed to return to the dining room; however, they had been informed that once the dining room was full, Resident 3 would be required to resume eating meals in their room.

In an interview on 09/30/2025 at 1:11 PM, Resident 4 stated that they were informed that all residents living in the cottages would have their meals brought to them. They stated that they sometimes enjoyed visiting and socializing with friends, including friends from their church, but being restricted to their room during mealtimes prevented them from doing so. Resident 4 stated, "I felt like they couldn't tell me what I can and cannot do and I felt that it was wrong, but I couldn't say much about it." Additionally, Resident 4 stated they regretted not getting their friends phone numbers so they could at least call them on the phone. They stated they felt left out, secluded, and isolated because of the facilities policy requiring cottage residents to eat separately from other residents.

In an interview on 09/29/2025 at 4:46 PM, Staff D, Administrative Assistant, stated that they were told by Staff A to have each resident who resided outside in the cottages sign the agreement that they were not allowed to come into the main dining room for meals. Staff D stated that it was their understanding that the residents who resided outside had their own designated kitchen area and it would be best if they had meals out there to not compact the dining room.

In an interview on 09/30/2025 at 1:27 PM, Staff E, Dietary Manager stated that from 09/15/2025-09/29/2025, residents living in the cottages were not allowed to dine in the main dining room. They stated that while there were a few empty tables available in the dining room, the residents were still prohibited from entering because they were told there was not enough space. Staff E further stated that two additional tables were added to the dining room on the 09/30/2025, with plans to order one more table, and that as of that day, residents from the cottages were allowed to return to the dining room.

During an observation of the dining room on 09/29/2025 at 4:45 PM, there were two tables in the main dining room that were unoccupied during dinner service; one table was located upon entering the dining room and the other table was located at the other entrance near the kitchen entry. Each table could accommodate four residents. Additionally, in the smaller dining room area, which contained a large table with chairs, that was completely empty and not being utilized for resident meals.

Record review of a facility letter dated 09/30/2025, from Staff A, Executive Director, to all residents, showed that management had previously made the executive decision to require residents to eat meals in their designated cottages. Following further discussion, the stakeholders and the review of resident rights and regulations, the facility decided that all residents would again be allowed to eat in the main building dining area.

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) 11/26/25.

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

Administrator (or Representative) Date 11/10/25