STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

SUNSHINE ADULT FAMILY HOME LLC

SUNSHINE ADULT FAMILY HOME LLC
2920 89TH ST SE
EVERETT, WA 98208

RE: SUNSHINE ADULT FAMILY HOME LLC License # 751636

Dear Provider:

This letter addresses Compliance Determination(s) 81183 (Completion Date 07/28/2026) and 78249 (Completion Date 06/01/2026).

The Department completed a follow-up inspection of your Adult Family Home on 07/28/2026 and found that you have corrected the violations listed in the Complaint report dated 06/01/2026. Your home is back in compliance as of 07/14/2026 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 388-76-10430-2-d, WAC 388-76-10475-1, WAC 388-76-10475-3-a, WAC 388-76-10475-3-c-i, WAC 388-76-10475-3-c-ii, WAC 388-76-10380-2

The Department staff who did the on-site verification:
Jennifer Nichols, Community Complaint Investigator
Rhodah Makayoto, Nursing Consultant Institutional

If you have any questions, please contact me at (206)348-9350.

Sincerely,

Nicholette Flynn

Nicholette Flynn, AFH Field Manager
Region 2, Unit B
Residential Care Services

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

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HOME AND COMMUNITY LIVING ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

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 06/01/2026 of:

SUNSHINE ADULT FAMILY HOME LLC
2920 89TH ST SE
EVERETT, WA 98208

This document references the following complaint number(s): 225123

The following sample was selected for review during the unannounced on-site visit: 4 of 4 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Jennifer Nichols, Community Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223

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

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.

Nicholette Flynn
Residential Care Services

06/09/2026
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 · 16 · 2026
Date

WAC 388-76-10430 Medication system.

(2) When providing medication assistance or medication administration for any resident, the home must ensure each resident:

(d) Receives medications as required.

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to ensure caregivers administered medications as required for 1 of 4 residents (Resident 1). This failure placed Resident 1 at risk for pain and bowel difficulty.

Findings included...

Record review showed the AFH admitted Resident 1 on [redacted]2024 with multiple diagnoses that included [redacted]. Review of Resident 1's assessment, dated 02/23/2026, showed Resident 1 required caregiver administration with medications.

Review of Resident 1's physician order from their health care provider (HCP), dated 05/08/2026, showed they were prescribed Hydromorphone (a medication used to manage moderate to severe pain) 2 milligrams (MG) routinely at 7:00 AM, 12:00 PM and 4:00 PM. Review of Resident 1's physician order from their HCP, dated 05/15/2026, showed orders to discontinue Resident 1's routine Hydromorphone 2 MG at 7:00 AM, 12:00 PM and 4:00 PM. Review of Resident 1's ML, dated 05/01/2026 – 05/31/2026, showed no caregiver initials documented to indicate that Resident 1 received their routine Hydromorphone 2 MG at 7:00 AM, 12:00 PM and 4:00 PM on 05/14/2026.

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

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.

Nicholette Flynn
Residential Care Services

06/09/2026
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)

Date

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(2) When providing medication assistance or medication administration for any resident, the home must ensure each resident:

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Based on interview and record review, the Adult Family Home (AFH) failed to ensure caregivers administered medications as required for 1 of 4 residents (Resident 1). This failure placed Resident 1 at risk for pain and bowel difficulty.

Findings included...

Record review showed the AFH admitted Resident 1 on [redacted]/2024 with multiple diagnoses that included [redacted]. Review of Resident 1's assessment, dated 02/23/2026, showed Resident 1 required caregiver administration with medications.

Review of Resident 1's physician order from their health care provider (HCP), dated 05/08/2026, showed they were prescribed Hydromorphone (a medication used to manage moderate to severe pain) 2 milligrams (MG) routinely at 7:00 AM, 12:00 PM and 4:00 PM. Review of Resident 1's physician order from their HCP, dated 05/15/2026, showed orders to discontinue Resident 1's routine Hydromorphone 2 MG at 7:00 AM, 12:00 PM and 4:00 PM. Review of Resident 1's ML, dated 05/01/2026 – 05/31/2026, showed no caregiver initials documented to indicate that Resident 1 received their routine Hydromorphone 2 MG at 7:00 AM, 12:00 PM and 4:00 PM on 05/14/2026.

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Review of Resident 1's physician order from their HCP, dated 05/08/2026, showed they were prescribed Sennosides (a medication used to help bowel regulation) 8.6 MG twice daily routinely. Review of Resident 1's physician order from their HCP, dated 05/19/2026, showed orders to increase Sennosides to 17.2 MG twice daily routinely. Review of Resident 1's ML, dated 05/01/2026 – 05/31/2026, showed caregiver initials documented to indicate that Resident 1 received Sennosides 8.6 MG twice daily routinely instead of the ordered Sennosides 17.2 MG twice daily routinely on 05/20/2026.

In an interview, on 06/01/2026 at 10:52 AM, Staff A (Entity Representative) stated that they did not realize Resident 1's increased Sennosides 17.2 MG twice daily routinely was not implemented on 05/20/2026 as ordered by their HCP on 05/19/2026. Staff A stated that Resident 1 did not receive their routine Hydromorphone 2 MG at 7:00 AM, 12:00 PM and 4:00 PM on 05/14/2026 because Resident 1's home health nurse told staff to discontinue it before Resident 1's HCP wrote an order to discontinue it on 05/15/2026.

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, SUNSHINE ADULT FAMILY HOME LLC is or will be in compliance with this law and / or regulation on (Date) 6·01·2026 .

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

Provider (or Representative) — Date: 6·16·2026

WAC 388-76-10475 Medication Log. The adult family home must:

(1) Keep an up-to-date daily medication log for each resident except for residents assessed as medication independent with self-administration.

(3) Ensure the medication log includes:

(a) Initials of the staff who assisted or gave each resident medication(s);

(c) Documentation of any changes or new prescribed medications including:

(i) The change;

(ii) The date of the change;

This requirement was not met as evidenced by:

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Review of Resident 1's physician order from their HCP, dated 05/08/2026, showed they were prescribed Sennosides (a medication used to help bowel regulation) 8.6 MG twice daily routinely. Review of Resident 1's physician order from their HCP, dated 05/19/2026, showed orders to increase Sennosides to 17.2 MG twice daily routinely. Review of Resident 1's ML, dated 05/01/2026 – 05/31/2026, showed caregiver initials documented to indicate that Resident 1 received Sennosides 8.6 MG twice daily routinely instead of the ordered Sennosides 17.2 MG twice daily routinely on 05/20/2026.

In an interview, on 06/01/2026 at 10:52 AM, Staff A (Entity Representative) stated that they did not realize Resident 1's increased Sennosides 17.2 MG twice daily routinely was not implemented on 05/20/2026 as ordered by their HCP on 05/19/2026. Staff A stated that Resident 1 did not receive their routine Hydromorphone 2 MG at 7:00 AM, 12:00 PM and 4:00 PM on 05/14/2026 because Resident 1's home health nurse told staff to discontinue it before Resident 1's HCP wrote an order to discontinue it on 05/15/2026.

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, SUNSHINE ADULT FAMILY HOME LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Provider (or Representative) Date

WAC 388-76-10475 Medication Log. The adult family home must:

(1) Keep an up-to-date daily medication log for each resident except for residents assessed as medication independent with self-administration.

(3) Ensure the medication log includes:

(a) Initials of the staff who assisted or gave each resident medication(s);

(c) Documentation of any changes or new prescribed medications including:

(i) The change;

(ii) The date of the change;

This requirement was not met as evidenced by:

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Based on interview and record review, the Adult Family Home (AFH) failed to ensure the medication log (ML) for 2 of 4 residents (Resident 1 and 2) was up to date with documented staff initials of who gave medication, changes and dates of medication changes. These failures placed Resident 1 and 2 at risk for medication errors and medical condition complications.

Findings included...

Resident 1 >

Record review showed the AFH admitted Resident 1 on [redacted]/2024 with multiple diagnoses that included [redacted]. Review of Resident 1's assessment, dated 02/23/2026, showed Resident 1 required caregiver administration with medications.

Review of Resident 1's physician orders from the pharmacy, dated 05/01/2026 – 05/31/2026, showed they were prescribed Refresh Tears (a medication used to help aid eye moisture) 0.5 percent eye drop in both eyes five times daily at 8:00 AM, 12:00 PM, 3:00 PM, 6:00 PM and 9:00 PM. Review of Resident 1's ML, dated 05/01/2026 – 05/31/2026, showed the caregiver did not document their initials to indicate the administration of Resident 1's Refresh Tears 9:00 PM doses 05/24/2026 through 05/31/2026.

Review of Resident 1's physician order from their health care provider (HCP), dated 05/05/2026, showed they were prescribed Bisacodyl Suppository (a medication used to help bowel regulation) 10 milligrams (MG) daily as needed and Sennosides (a medication used to help bowel regulation) 8.6 MG twice daily as needed. Review of Resident 1's ML, dated 05/01/2026 – 05/31/2026, showed the caregiver did not document the date of these changes.

Review of Resident 1's physician order from their HCP, dated 05/08/2026, showed they were prescribed the following:

- Hydromorphone (a medication used to manage moderate to severe pain) two MG routinely at 7:00 AM, 12:00 PM and 4:00 PM
- Hydromorphone two MG an hour prior to wound care and transfers and hourly as needed
- Sennosides 8.6 MG twice daily routinely
- Lorazepam (a medication used to help ease excessive worry or fear) 0.5 MG orally every four hours as needed
- Lorazepam two MG in cheek for seizure (a sudden, uncontrolled surge of electrical activity in the brain that can cause uncontrolled body shaking)

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Review of Resident 1's ML, dated 05/01/2026 – 05/31/2026, showed the caregiver did not document the date of these changes and did not document the HCP orders of Lorazepam for seizures or Hydromorphone two MG prior to wound care and transfers.

Review of Resident 1's physician order from their HCP, dated 05/15/2026, showed orders to discontinue Resident 1's routinely prescribed Hydromorphone. Review of Resident 1's ML, dated 05/01/2026 – 05/31/2026, showed the caregiver did not document this change.

Review of Resident 1's physician order from their HCP, dated 05/19/2026, showed orders to change Sennosides from 8.6 MG twice daily routinely to 17.2 MG twice daily routinely and reinstate Hydromorphone two MG routinely at 7:00 AM, 12:00 PM and 4:00 PM. Review of Resident 1's ML, dated 05/01/2026 – 05/31/2026, showed the caregiver did not document the date of these changes.

Resident 2 >

Record review showed the AFH admitted Resident 2 on [redacted]/2023 with multiple diagnoses that included [redacted]. Review of Resident 2's assessment, dated 04/01/2026 showed Resident 2 required caregiver administration with medications.

Review of Resident 2's physician orders from the pharmacy, dated 05/01/2026 – 05/31/2026, showed they were prescribed Sennosides 8.6 MG daily at 8:00 PM. Review of Resident 2's ML, dated 05/01/2026 – 05/31/2026, showed the caregiver did not document their initials to indicate the administration of Resident 2's Sennosides 8:00 PM doses 05/01/2026 through 05/31/2026.

Review of Resident 2's electronically transmitted physician order from the pharmacy, dated 05/15/2026, showed they were prescribed Keflex (a medication used to treat an infection) 500 MG four times daily for seven days. Review of Resident 2's ML, dated 05/01/2026 – 05/31/2026, showed the caregiver did not document the date of this change.

In an interview, on 06/01/2026 at 10:45 AM, Staff B (Caregiver) stated that Resident 1 did get their Refresh Tears 9:00 PM doses 05/24/2026 through 05/31/2026, and that it was a staff oversight not documenting it. Staff B stated that Resident 2 did get their Sennosides 8:00 PM doses 05/01/2026 through 05/31/2026, and that it was staff oversight not documenting it. Staff B stated that they did not know that a date of a medication change was required on the ML or that all medication changes were not documented for Resident 1.

In an interview, on 06/01/2026 at 10:52 AM, Staff A (Entity Representative) stated that

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they reviewed MLs, and did not notice caregivers did not document their initials to indicate Resident 1 got their Refresh Tears 9:00 PM doses 05/24/2026 through 05/31/2026 or Resident 2 got their Sennosides 8:00 PM doses 05/01/2026 through 05/31/2026. Staff A stated they did not know that a date of a medication change was required on the ML or that all medication changes were not documented for Resident 1.

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, SUNSHINE ADULT FAMILY HOME LLC is or will be in compliance with this law and / or regulation on (Date) 7-19-2026 .

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

Provider (or Representative) — Date: 6-16-2026

WAC 388-76-10380 Negotiated care plan Timing of reviews and revisions. The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:

(2) When the plan, or parts of the plan, no longer address the resident's needs and preferences;

This requirement was not met as evidenced by:

Based on interview, and record review, the Adult Family Home (AFH) failed to ensure that 1 of 4 resident's (Resident 1) Negotiated Care Plan (NCP) was revised to address their Hospice and wound care. This failure placed Resident 1 at risk for unrecognized and unmet care needs.

Findings Included...

Record review showed the AFH admitted Resident 1 on [redacted]/2024 with multiple diagnoses that included [redacted] Review of Resident 1's assessment, dated 02/23/2026 showed Resident 1 required caregiver assistance with activities of daily living.

Review of Resident 1's Kaiser Hospice plan of care, dated 05/08/2026, showed Resident 1 received hospice care.

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they reviewed MLs, and did not notice caregivers did not document their initials to indicate Resident 1 got their Refresh Tears 9:00 PM doses 05/24/2026 through 05/31/2026 or Resident 2 got their Sennosides 8:00 PM doses 05/01/2026 through 05/31/2026. Staff A stated they did not know that a date of a medication change was required on the ML or that all medication changes were not documented for Resident 1.

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, SUNSHINE ADULT FAMILY HOME LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Provider (or Representative) _____ Date _____

WAC 388-76-10380 Negotiated care plan Timing of reviews and revisions. The adult family home must ensure that each resident's negotiated care plan is reviewed and revised as follows:

(2) When the plan, or parts of the plan, no longer address the resident's needs and preferences;

This requirement was not met as evidenced by:

Based on interview, and record review, the Adult Family Home (AFH) failed to ensure that 1 of 4 resident's (Resident 1) Negotiated Care Plan (NCP) was revised to address their Hospice and wound care. This failure placed Resident 1 at risk for unrecognized and unmet care needs.

Findings included...

Record review showed the AFH admitted Resident 1 on [redacted]/2024 with multiple diagnoses that included [redacted]. Review of Resident 1's assessment, dated 02/23/2026 showed Resident 1 required caregiver assistance with activities of daily living.

Review of Resident 1's Kaiser Hospice plan of care, dated 05/08/2026, showed Resident 1 received hospice care.

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Review of Resident 1's Kaiser Hospice Patient Information Sheet, dated 05/21/2026, showed Resident 1 had an open wound to their bottom area and both hips that required caregiver dressing changes if soiled before their next Hospice nurse visit.

Review of Resident 1's NCP, dated 02/23/2026, showed no documentation that Resident 1 received Home Health Hospice care, and no documentation that Resident 1 had three wounds that required dressings.

In an interview, on 06/01/2026 at 10:52 AM, Staff A (Entity Representative) stated that they did not think they could revise Resident 1's NCP because they were a private pay source and not state funded like other residents in the AFH.

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, SUNSHINE ADULT FAMILY HOME LLC is or will be in compliance with this law and / or regulation on (Date) 6.01.2026.

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

Provider (or Representative) — Date: 6.16.2026

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

Review of Resident 1's Kaiser Hospice Patient Information Sheet, dated 05/21/2026, showed Resident 1 had an open wound to their bottom area and both hips that required caregiver dressing changes if soiled before their next Hospice nurse visit.

Review of Resident 1's NCP, dated 02/23/2026, showed no documentation that Resident 1 received Home Health Hospice care, and no documentation that Resident 1 had three wounds that required dressings.

In an interview, on 06/01/2026 at 10:52 AM, Staff A (Entity Representative) stated that they did not think they could revise Resident 1's NCP because they were a private pay source and not state funded like other residents in the AFH.

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, SUNSHINE ADULT FAMILY HOME LLC is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Provider (or Representative) _____ Date _____

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SUNSHINE AFH LLC

2920 89TH ST SE

EVERETT, WA 98208

Plan of Correction

June 16th, 2026

Nicholette Flynn, AFH Field Manager

Residential Care Services

Region 2, Unit B

eFax (360) 651-6940

email: rcsregion2email@dshs.wa.gov

WAC 388-76-10430 – Medication System

Plan of Correction:

- The identified medication system deficiency was corrected immediately upon discovery.
- The resident's assessment was reviewed and updated to accurately reflect the level of medication assistance required.
- The negotiated care plan was reviewed and revised to clearly identify medication services provided to the resident.
- All medication administration records (MARs) and medication logs were audited to ensure they are current, accurate, and consistent with physician orders.
- A complete review of all resident medication records, including prescribed and over-the-counter medications, was conducted to verify medication names, dosages, frequencies, and practitioner information.
- All caregivers received retraining on medication administration, MAR documentation, and medication system requirements.
- The Provider will conduct weekly medication record audits to ensure ongoing compliance.
- The Provider is responsible for monitoring and maintaining compliance with medication system requirement

- Completion Date: 6-01-2026

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

WAC 388-76-10475 – Resident Records/Medication Log

Plan of Correction:

- The identified resident's records deficiency was corrected immediately.
- A complete review of all resident MAR's was conducted to ensure required documentation is present, accurate, and up to date.
- The Provider implemented a resident record checklist to verify required documents are maintained in each resident file.
- Weekly record audits will be conducted to ensure continued compliance.
- The Provider is responsible for ongoing monitoring and corrective action if deficiencies are identified.
- Completion Date: from 06-01-2026 to 7-14-2026

WAC 388-76-10380 – Negotiated Care Plan

Plan of Correction:

- The identified resident's negotiated care plan was reviewed and updated to accurately reflect the resident's current condition and care needs.
- A comprehensive audit of all resident negotiated care plans was completed to ensure they are current, accurate, and consistent with assessments, physician orders, and services being provided.
- The Provider and caregiving staff received retraining on negotiated care plan requirements, including timely updates following significant changes in condition and required review schedules.
- A care plan tracking system has been implemented to ensure negotiated care plans are reviewed, updated, and signed as required.
- The Provider will conduct monthly audits of resident records to verify negotiated care plans remain current and accurately reflect resident needs and services.
- The Provider is responsible for ongoing monitoring and ensuring compliance with above WAC.
- Completion Date: from 06-01-2026 to 07-14-2026

Sincerely,



Alena Startsev
Sunshine AFH, LLC
Entity Representative
206-234-8354

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