STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

SUNSHINE HEALTH FACILITIES INC
SUNSHINE TERRACE
10412 E 9th Ave
Spokane Valley, WA 99206

RE: SUNSHINE TERRACE License # 950

Dear Administrator:

This letter addresses Compliance Determination(s) 58204 (Completion Date 04/18/2025) and 55441 (Completion Date 02/27/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/18/2025 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-2210-1-a, WAC 388-78A-2210-1-b, WAC 388-78A-2210-1, WAC 388-78A-2210-2-a, WAC 388-78A-2230-1-c, WAC 388-78A-2230-1-c-i, WAC 388-78A-2230-1-c-ii, WAC 388-78A-2240, WAC 388-78A-2090-2-a, WAC 388-78A-2130-3-a

The Department staff who did the on-site verification:
Carla Rose, NCI Community Licensor

If you have any questions, please contact me at (509)323-7315.

Sincerely,

J Salquist

Jessica Salquist, Regional Administrator
Region 1, Unit B
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 950	Compliance Determination # 55441
Plan of Correction	SUNSHINE TERRACE	Completion Date
Page 1 of 13	Licensee: SUNSHINE HEALTH FACILITIES INC	02/27/2025

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 the unannounced on-site full inspection and complaint investigation on 02/21/2025, 02/24/2025, 02/25/2025, 02/26/2025 and 02/27/2025 of:

SUNSHINE TERRACE
10412 E 9th Ave
Spokane Valley, WA 99206

This document references the following complaint numbers: 168007.

The following sample was selected for review during the unannounced on-site visit: 15 of 133 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Carla Rose, NCI Community Licensor
Veronica Jackson, Assisted Living Facility Licensor
Jennifer Lee, Assisted Living Facility Licensor
Tethra Wales, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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.

J Salquist
Residential Care Services

03/12/2025
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.

Shannon Bennett
Administrator (or Representative)

3/25/25
Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure a safe medication administration system was in place to administer medications as ordered for 1 of 15 residents (Resident 15) sampled for medication services. This failure resulted in Resident 15 to miss weeks of breathing treatments to improve lung function and placed them at risk of increased difficulty in breathing.

Findings included...

Review of Resident 15's Service Plan Report (the facility's titled negotiated service agreement) dated 03/19/2024 showed that the resident required supervised self-administration assistance with medications.

< Iptratropium-Albuterol>

Review of Resident 15's MAR for January 2025, showed an order for Iptratropium-Albuterol inhalation solution three milliliters to be given twice daily in the morning and evening by oral inhalation started on 01/24/2025 for treatment of chronic obstructive pulmonary disease (COPD, an ongoing lung disease that limits airflow in the lungs). Further review showed it was administered eight times and refused seven times for the period of 01/24/2025-01/31/2025.

Review of Resident 15's MAR for February 2025, showed from 02/01/2025 through 02/26/2025 the order for Iptratropium-Albuterol was administered 32 times and was refused by the resident 19 times.

An observation on 02/27/2025 at 9:30 AM, showed Staff I, Resident Assistant, administering medications to Resident 15. Staff I handed the resident an unopened multi-vial 20 dose package of Iptratropium-Albuterol inhalation solution (liquid medication used to improve breathing) for the resident to use in their nebulizer machine (turns liquid medications into an aerosolized solution for inhalation treatment that takes 10-15 minutes) in their room and stated they found it in a bottom drawer in the medication room. Staff I further stated that they had been signing it off as administered in the Medication Administration Record (MAR) because they believed the resident had the medication in their room. (Resident 15 had an order to keep and use an albuterol inhaler in their room when necessary) Resident 15 responded by saying they had been asking their doctor for that albuterol nebulizer treatment for over a month, and they believed the doctor had refused to order it for them since they had not received it yet.

In an interview on 02/27/2025 at 9:45 AM, Resident 15 stated they were happy to have the albuterol nebulizer treatments and stated they had been asking for this treatment since they had used it in the hospital, because it had helped improve their breathing so much better than the albuterol inhaler. Resident 15 confirmed that they had not used the medication yet in the facility since it was ordered last month.

< Budesonide Inhalation Suspension >

Review of a prescription order for Resident 15 showed that the prescription for the budesonide was ordered on 07/12/2024.

Review of Resident 15's December 2024 and January 2025 MARs, showed an order for budesonide inhalation suspension (medication used for long term management of COPD) with one vial to be given by nebulizer two times a day for COPD. Further review showed that Resident 15 refused the medication 24 times in December and 24 times in January and then discontinued on 01/24/2025.

In an interview on 02/26/2025 at 12:59 PM, Staff I stated that Resident 15 would not take the budesonide because it did not work.

In an interview on 02/26/2025 at 2:11 PM, Resident 15 stated that they told staff administering medications that the budesonide wasn't working and that they weren't getting any breathing help.

Review of Resident 15's December 2024 and January 2025 Progress Notes, showed Resident 15 notified the medication technician that the medication wasn't working on the following dates:
12/08/2024 "Said it doesn't work for him any longer"
12/09/2024 "Said that he does not take this med because it does not work"
12/16/2024 "Does not work for him"
12/22/2024 "Does not use this because it does not work for him"
12/27/2024 "Does not take this because he says that it does not work for him"
12/29/2024 "Does not use says it does not work for him"
12/30/2024 "Does not use it does not work for him"
01/04/2025 "Does not want to take because it does not work for him"
01/11/2025 "States not working for him"

In an interview on 02/27/2025 at 9:37 AM, Staff F, Nurse Manager, stated that Resident 15 hadn't used his budesonide "for months" during which time he saw the provider. Staff F further stated that the facility didn't tell Resident 15's provider that the budesonide wasn't working and "neither did the resident." When asked if they had spoken with Resident 15 about how budesonide differs from a rescue medication and that they may not feel immediate improvement, Staff F stated that the prescribing providers explain medications to residents when they order them and that they were confident Resident 15's provider did so when it was ordered.

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, SUNSHINE TERRACE is or will be in compliance with this law and / or regulation on (Date) 4/13/25 .

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

Shannon Bennett
Administrator (or Representative)

3/25/25
Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her

medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to notify the prescribing provider when a resident refused their medication for 3 of 15 residents (Resident 6, 13, and 15). This failure resulted in the provider being unaware that the residents were not receiving their medications as prescribed and placed the residents at risk of health complications.

Findings included...

Review of the facility policy titled "Missed or Refused Medication", dated 01/10/2023, showed that when a resident refuses medication the prescribing physician is to be notified immediately or in the time frame and according to the parameters as indicated by the physician using the Refusal of Medication Notification form. Further review showed that the Nurse Manager will re-appraise the resident and contact the physician and responsible party if the resident is continually refusing a medication.

In an interview on 02/25/2025 at 11:55 AM, Staff F, Nurse Manager, stated that staff completed monthly audits of the residents' Medication Administration Record (MAR) but that they did not currently audit for refusals.

In an interview on 02/26/2025 at 12:59 PM, Staff I, Resident Assistant, stated that when a resident refused a medication they talked to the resident. If they continued to refuse, they marked it as a refusal on the MAR. Staff I further stated that if the resident refused for several days, they spoke with the nurse directly, left them a message, or slipped a note under their door. When asked how they decide when to notify the nurse, Staff I stated they notified them when "it's becoming a problem" for the resident and they exhibited behaviors or symptoms.

<Resident 15>

Review of Resident 15's Service Plan Report (SPR, the facility's titled negotiated service agreement) dated 03/19/2024, showed that the resident received supervised

medication assistance from the facility.

Review of Resident 15's December 2024 and January 2025 MARs, showed an order for budesonide inhalation suspension (medication used for long term management of COPD, Chronic obstructive pulmonary disease – a group of progressive lung diseases that restrict your breathing) with one vial to be given by nebulizer (turns liquid medications into an aerosolized solution for inhalation treatment that takes 10-15 minutes) two times a day for COPD. Further review showed that Resident 15 refused the medication 24 times in December and 24 times in January and was discontinued on 01/24/2025.

In an interview on 02/26/2025 at 2:11 PM, Resident 15 stated that they told staff that the budesonide wasn't working and that they weren't getting any breathing help.

Review of Resident 15's December 2024 and January 2025 Progress Notes, showed Resident 15 notified the medication technician that the medication wasn't working on the following dates:
12/08/2024 "Said it doesn't work for him any longer"
12/09/2024 "Said that he does not take this med because it does not work"
12/16/2024 "Does not work for him"
12/22/2024 "Does not use this because it does not work for him"
12/27/2024 "Does not take this because he says that it does not work for him"
12/29/2024 "Does not use says it does not work for him"
12/30/2024 "Does not use it does not work for him"
01/04/2025 "Does not want to take because it does not work for him"
01/11/2025 "States not working for him"

In an interview on 02/27/2025 at 9:37 AM, Staff F stated that they did not have any documentation of communication with the provider about any of Resident 15's refusals of the budesonide or the resident's indications that it was not working.

<Resident 6>

Review of Resident 6's SPR dated 02/25/2025, showed that the resident required supervised self-administration assistance with medications. Further review showed diagnoses of [redacted].

Review of Resident 6's December 2024 and January 2025 MARs, showed an order for erythromycin ophthalmic ointment (used to treat bacterial eye infections) to be applied once daily at bedtime. Further review showed that the resident refused the medication 14 times in December and one time in January before it was discontinued on 01/08/2025.

Review of Resident 6's December and January 2025 Progress Notes showed a note

dated 01/07/2025 that indicated a communication had been placed in the provider's communication book regarding the erythromycin ophthalmic ointment refusals. Further review showed no additional communications with the provider regarding Resident 6's refusals of the erythromycin ophthalmic ointment.

Review of the Provider's Communication Binder showed an entry dated 01/07/2025 with Resident 6's name and a note that read "Has order for erythromycin opth oint since 10/16/2024. Res has stated since 12/24 to current she does not take this oint + has refused it. Can we d/c it? Refused multiple times."

Review of the Patient Plan from Resident 6's visit to the eye clinic on 01/08/2025 showed that Resident 6 reported that they are "noticing crusting in the mornings." Further review showed that the provider prescribed tobramycin-dexamethasone and discussed the chronic nature of the condition with the resident.

Review of Resident 6's January 2025 MAR, showed an order for tobramycin-dexamethasone ophthalmic suspension (an antibiotic and corticosteroid used to prevent permanent damage), with one drop to be given in both eyes, four times a day. The medication started on 01/10/2025 and was discontinued on 01/19/2025. Further review showed that Resident 6 refused the eye drops six times:
01/15/2025 1 of 4 scheduled doses
01/16/2025 2 of 4 scheduled doses
01/17/2025 1 of 4 scheduled doses
01/18/2025 2 of 4 scheduled doses

Review of Resident 6's January 2025 Progress Notes, showed a note dated 01/18/2025 that read "Resident has refused 5 administrations since 1/15/25. Resident stated to this LN [licensed nurse] this AM that [they] don't want to take it anymore because [they] is no longer having eye problems, and the eye drops sting. Scheduled to receive last dose tomorrow." Review also showed another entry on 01/18/2025 that read "Refused d/t eyes stinging." Further review showed no communications with the provider regarding Resident 6's refusals.

In an interview on 02/26/2025 at 3:07 PM, Resident 6 confirmed they did refuse the eye drops and stated they "just get tired of it". Resident 6 further stated that they "don't think they're really doing much" but confirmed they are "still getting gunk in [their] eyes."

In an interview on 02/27/2025 at 11:15 AM, Staff H, Director of Nursing Services, stated that the only communication to providers about Resident 6's refusals of the erythromycin ophthalmic ointment and tobramycin-dexamethasone ophthalmic suspension was the note in the Provider Communication Binder dated 01/07/2025. Resident 6 refused the erythromycin ophthalmic ointment 15 times before the facility notified the provider. The facility did not notify the provider after Resident 6 refused the tobramycin-dexamethasone ophthalmic suspension six times.

<Resident 13>

Review of Resident 13's SPR dated 03/19/2024, showed that the resident received supervised medication assistance from the facility.

Review of Resident 13's December 2024 and January 2025 MARs, showed an order for diclofenac sodium external gel to be applied topically four times a day for pain. Further review showed that Resident 13 refused the medication 115 times in December and 33 times in January before it was discontinued on 01/09/2025.

In an interview on 02/27/2025 at 9:37 AM, Staff F stated they did not have any documentation of communications with Resident 13's provider regarding the refusals.

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, SUNSHINE TERRACE is or will be in compliance with this law and / or regulation on (Date) 4/13/25 .

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

Shawn Bennett — Administrator (or Representative)

3/25/25 — 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 observation, interview and record review, the facility failed to ensure prescribed medications were obtained in a timely manner for 2 of 15 residents (Resident 13 and 15) sampled for medication services. This failure resulted in Resident 15 having increased hand tremors and decreased quality of life and contributed to Resident 13 experiencing inflammation and decreased quality of life.

Findings included...

Review of the facility policy titled "Medication Refills", dated 02/02/2022, showed that

"medication refills will be obtained in a timely manner to ensure residents have all physician ordered medication available" and that "medications are never allowed to run out unless directed to by the physician." Further review showed that "each shift of Med Techs are responsible to make necessary reminder and follow up phone calls to assist with receipt of medications."

<Resident 13>

Review of Resident 13's Service Plan Report (SPR, the facility's titled negotiated service agreement) dated 02/16/2025 showed that the resident required supervised self-administration assistance with medications.

Review of Resident 13's January and February 2025 Medication Administration Records (MAR), showed an order for naproxen (used to treat pain or inflammation) to be given twice daily and that the medication was not administered from 01/16/2025 through 2/26/2025.

Review of Resident 13's January and February 2025 Progress Notes, showed documentation from staff that indicated the medication was not available on the following dates:
01/16/2025 "waiting on meds"
01/18/2025 "out of supply"
01/20/2025 "none to give"
01/21/2025 "none to give"
01/22/2025 "none to give"
01/24/2025 "waiting on meds"
01/25/2025 "waiting on supply"
01/26/2025 "none to give"
01/27/2025 "out of supply"
01/28/2025 "out of supply"
01/29/2025 "out of supply"
01/30/2025 "waiting on med"
01/31/2025 "waiting on medication"
02/01/2025 "out"
02/02/2025 "out of supply"
02/03/2025 "out of supply"
02/04/2025 "out of supply"
02/05/2025 "out of supply"
02/07/2025 "He does not have on a card and we do not have for house supply"
02/09/2025 "out of supply"
02/12/2025 "NOT HERE YET"
02/14/2025 "we do not have this med"
02/21/2025 "he does not have this in his meds and we do not carry it any longer"
02/25/2025 "we do not have this med yet"
02/26/2025 "does not have"

In an interview on 02/25/2025 at 11:55 PM, Staff F, Nurse Manager, stated that they

were not aware that Resident 13 had been out of the medication for that length of time and that the medication technicians had not made them aware.

In an interview on 02/26/2025 at 12:59 PM, Staff I, Resident Assistant, stated that they did not think they've had it since it was ordered because the insurance did not cover it.

In an interview on 02/26/2025 at 1:15 PM, Resident 13 confirmed they had not received the naproxen in a long time and that they needed it for their inflammation and to get the swelling down. Resident 13 further stated that their knee is "pretty bad" and still swollen.

In an interview on 02/27/2025 at 9:37 AM, Staff F stated that the facility initially provided Resident 13's naproxen from their (the facility) supply but stopped doing so when the facility stopped carrying it in-house. Staff F further stated that they reached out to the pharmacy on 02/26/2025, confirmed that the naproxen is covered by Resident 13's insurance, and that it would be filled through their pharmacy going forward.

<Resident 15>

Review of Resident 15's SPR dated 03/19/2024, showed that the resident received supervised medication assistance from the facility.

Review of Resident 15's MAR for February 2025 showed an order for topiramate 25 mg tablet (used for hand tremors) to be given with 50 mg every morning for a total dose of 75mg. Further review showed the 25 mg tablet was not available to give on 02/21/2025, 02/25/2025 and 02/27/2025. The medication was documented as administered on 02/22/2025, 02/23/2025, 02/24/2025 which was after the pharmacy had communicated it was not able to refill the medication with the reason being it was too early to refill the medication.

An observation and interview on 02/27/2025 at 9:30 AM, showed Staff I administered medications to Resident 15. Staff I stated to the resident that they were out of topiramate 25 mg tablets, (a medication used to treat tremors). Staff I further stated that the medication had been reordered on 02/21/2025 but the pharmacy had replied it was too early to refill the medication when it was requested. Staff I stated that they would need to call the pharmacy.

In an interview on 02/27/2025 at 9:45 AM, Resident 15 stated that they had not received the 25 mg topiramate pills for about a week and that they had noticed an increase in their hand tremors and held their hands up to show the department licensor the tremors in both hands.

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, SUNSHINE TERRACE is or will be in compliance with this law and / or regulation on (Date) 4/13/25 .

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

Shannon Bennett — Administrator (or Representative)

3/25/25 — Date

WAC 388-78A-2090 Full assessment topics. The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause:

(2) Currently necessary and contraindicated medications and treatments for the individual, including:

(a) Any prescribed medications, and over-the-counter medications commonly taken by the individual, that the individual is able to independently self-administer, or safely and accurately direct others to administer to him/her;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to include a medication self-administration safety assessment for 1 of 15 sampled residents (Resident 15). This failure placed Resident 15 at risk of harm due to unsupervised self-administration of medication.

Findings included...

Review of Resident 15's SPR (Service Plan Report, the facility's titled negotiated service agreement) dated 03/19/2024, showed that the resident received supervised medication assistance from the facility.

Review of Resident 15's annual assessment dated 03/04/2024, showed it did not include an assessment of Resident 15's ability to safely self-administer medications.

Review of Resident 15's medication administration records (MARs) for January 2025 and February 2025, showed an order for an albuterol inhaler (fast acting medication used to help with shortness of breath) to be administered every four hours as needed. The

MARs also showed an order for mupirocin ointment (ointment used to treat skin infections) to be applied twice a day. Further review showed the directions for the albuterol and mupirocin orders included "unsupervised self-administration" and "may keep at bedside".

During an observation and an interview on 02/26/2025 at 2:11 PM, Resident 15 stated that they self-administered the albuterol inhaler and then showed the albuterol inhaler to the department licensor. Resident 15 further stated that they previously self-administered the mupirocin ointment, but they no longer needed it, so they did not have it.

In an interview on 02/25/2025 at 3:25 PM, Staff G, Compliance Officer, confirmed they did not have an annual self-medication safety assessment for Resident 15 because they were unaware of the requirement to do so.

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, SUNSHINE TERRACE is or will be in compliance with this law and / or regulation on (Date) 4/13/25 .

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

Shannon Bennett — Administrator (or Representative)

3/25/25 — Date

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

(3) Review and update each resident's negotiated service agreement consistent with WAC 388-78A-2120 :

(a) Within a reasonable time consistent with the needs of the resident following any change in the resident's physical, mental, or emotional functioning; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to update the negotiated service agreement with changes in mental health and the interventions implemented for 1 of 15 sampled residents (Resident 10). This failure placed residents at risk of receiving inadequate care and interventions during a mental health crisis.

Findings included...

Review of Resident 10's Service Plan Report (SPR, the facility's titled negotiated service agreement) dated 10/23/2024 had no mention of suicidal ideation (SI).

Review of Resident 10's Progress Notes, showed that Resident 10 reported SI with a plan to get a gun to harm themselves with on the following dates:

12/19/2024 Resident 10 told home health nurse that they wished to harm themself and had been thinking of suicide for some time using a gun.

12/20/2024 at 1:31 PM, Resident 10 stated they had been feeling helpless.

01/31/2025 at 8:42 PM, Resident 10 reported to staff that they were feeling depressed and had suicidal ideation.
Review of Resident 10's Service Plan Report (SPR, the facility's titled negotiated service agreement) on 02/21/2025 showed it had not been updated since 10/23/2024 and had not include any information related to Resident 10's suicidal ideation (SI) and did not include interventions that care staff would have implemented when Resident 10 reported SI.

In an interview on 02/24/2025 at 2:45 PM, Staff G, Compliance Officer, was asked if an updated SPR was completed to reflect Resident 10's changes in mental health and the interventions that were implemented. Staff G confirmed the SPR dated 10/23/2024 was the current SPR and it had not been updated.

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, SUNSHINE TERRACE is or will be in compliance with this law and / or regulation on (Date) 4/13/25.

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

Shannon Bennett
Administrator (or Representative)

3/25/25
Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

SUNSHINE HEALTH FACILITIES INC
SUNSHINE TERRACE
10412 E 9th Ave
Spokane Valley, WA 99206

RE: SUNSHINE TERRACE # 950

Dear Administrator:

This document references the following complaint numbers 168007.

The Department completed a full inspection and complaint investigation of your Assisted Living Facility on 02/27/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Return the Plan/Attestation Statement and report with signatures to:

Jessica Salquist, Regional Administrator
Residential Care Services

Region 1, Unit B
Preferred methods:
eFax: (509) 921-2426
Email: rcsregion1email@dshs.wa.gov
Optional method:
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

RCW 70.129.050 Privacy and confidentiality of personal and medical records. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility to provide a private room for each resident however, a resident cannot be prohibited by the facility from meeting with guests in his or her bedroom if no roommates object.

(2) The resident may approve or refuse the release of personal and clinical records to an individual outside the facility unless otherwise provided by law.

WAC 388-78A-2400 Protection of resident records. The assisted living facility must:

(2) Maintain resident records and preserve their confidentiality in accordance with applicable state and federal statutes and rules, including chapters 70.02 and 70.129 RCW;

The facility displayed a dry erase calendar on the wall of the second floor near the medication room that included resident's medical appointments with their first name and last initial and the name of the clinic and/or the procedure being completed. When brought to their attention, they immediately removed clinic names and procedures from the calendar and only displayed the time and the resident names.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:

- o What specific deficiency or deficiencies you disagree with;
- o Why you disagree with each deficiency; and
- o Whether you want an IDR to occur in-person, by telephone or as a paper review.
- o Send your request to:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

If You Have Any Questions:

• Please contact me at (509)323-7315.

Sincerely,

J Salquist

Jessica Salquist, Regional Administrator
Region 1, Unit B
Residential Care Services

Enclosure