STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

SUNSHINE HEALTH FACILITIES INC
SUNSHINE TERRACE
10410 E 9th Ave
Spokane Valley, WA 99206

RE: SUNSHINE TERRACE License # 950

Dear Administrator:

This letter addresses Compliance Determination(s) 82606 (Completion Date 08/20/2026) and 77884 (Completion Date 06/25/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/20/2026 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-2120-2-a, WAC 388-78A-2120-3, WAC 388-78A-2120-3-a, WAC 388-78A-2120-3-b, WAC 388-78A-2120-4, WAC 388-78A-2371-3, WAC 388-78A-2100-2-a, WAC 388-78A-2130-3-a, WAC 388-78A-2130-3-b, WAC 388-78A-2130-3, WAC 388-78A-2600-1-b, WAC 388-78A-2230-1-c-i, WAC 388-78A-2230-1-c-ii, WAC 388-78A-2230-1-c, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a, WAC 388-78A-2670-3, WAC 388-78A-2400-2, RCW 70.129.050.1, WAC 388-78A-3090-1-c, WAC 388-78A-2483-2

The Department staff who did the on-site verification:
Joy Pipgras, LTC Surveyor
Brian Zbylski, ALF Licensor
Tethra Wales, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)993-7821.

Sincerely,

Stephanie Jenks, Community Field Manager

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

Region 1, Unit B
Residential Care Services

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Residential Care Services
Investigation Summary Report

Provider/Facility: SUNSHINE TERRACE
Provider Type: Assisted Living Facility
License/Cert.#: 950
Compliance Determination #: 77884
Intake ID: 225728
Investigator: Carla Rose
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 06/01/2026 through 06/25/2026
Complainant Contact Date(s): 05/28/2026, 06/12/2026, 06/16/2026

Allegation(s):

1. Inappropriate staff behavior in front of residents.
2. Staff charting on residents that were no longer in the building.
3. Medications being given at the wrong times.
4. housekeeping/dirty floors
5. Staff not assisting residents with incontinence care.

Investigation Methods:

Sample:	Total residents: 130 Resident sample size: 22 Closed records sample size: 2
Observations:	Visitor and resident sign out sheets Shift report sheets Staff behaviors in resident areas Staff availability to assist residents Staff care and treatment of residents Environment
Interviews:	Residents Resident representatives Staff management
Record Reviews:	Progress notes Medication records Shift to shift reports Visitor and resident sign in/out sheets Care plans Assessments

Investigation Summary:

1. Staff were observed throughout the inspection and no inappropriate behaviors were observed. Identified residents and additional sampled residents did not report concerns of inappropriate behaviors of staff. During the resident group meeting, multiple residents reported that staff behave professionally and that they did not have concerns. No failed practice identified.

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2. The identified resident's records were reviewed and none found to have charting that occurred while the resident was off-site. Residents signed in and out of the building. Staff reported that they were informed whenever a resident was out of the building. No failed practice identified.
3. Medications in the records showed that medications were being given at appropriate times. Staff interviewed were able to verbalize understanding of scheduled medication times. Medication records did show that multiple medications were marked as not given without reasons why they were not given. Failed practice identified under Medication Services WAC 388-78A-2210 (1)(b)(2)(a).
4. During the environmental tour, the resident dining room in the main building was dirty with spilled liquids and food debris. The staff reported that the dining room floors were cleaned by residents who had voluntary work incentive jobs. Management personnel stated that a resident that used to clean the floor had left a month prior. Management also reported that they had not reassigned the job and they were unaware that it was not being cleaned. Failed practice identified under Maintenance and Housekeeping WAC 388-78A-3090 (1)(c).
5. Identified residents and additional sampled residents reported that staff provide excellent care. During a resident group meeting, the residents all stated that staff did a good job and there were no concerns reported. Progress notes and care plans did not show any indication that care was not being provided as agreed upon. No failed practice identified.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: SUNSHINE TERRACE
Provider Type: Assisted Living Facility
License/Cert.#: 950
Compliance Determination #: 77884
Intake ID: 224675
Investigator: Carla Rose
Region/Unit #: RCS Region 1 / Unit B
Investigation Date(s): 06/01/2026 through 06/25/2026
Complainant Contact Date(s):

Allegation(s):
Unexpected resident death

Investigation Methods:

Sample:	Total residents: 130 Resident sample size: 22 Closed records sample size: 2
Observations:	Residents Availability of staff Resident rooms
Interviews:	Residents Staff
Record Reviews:	Progress notes Medication records Care plans assessments medical/cardiology records shift to shift reports

Investigation Summary:
The facility failed to to implement new interventions after recognizing a need for improved processes, monitor and assess a resident's concerning medical signs and symptoms, and to assess the resident's ability to safely monitor their cardiologist appointments and their internally implanted medical device. Monitoring Residents Wellbeing 388-78A-2120 (2)(a)(3)(a)(b)(4), Investigations 388-78A-2371 (3), and Ongoing Assessments 388-78A-2100 (2)(a).

Conclusion / Action:

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

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
8517 E Trent Ave, Ste 102, Spokane Valley, WA 99212

Statement of Deficiencies	License #: 950	Compliance Determination #:77884
Plan of Correction	SUNSHINE TERRACE	Completion Date
Page 1 of 30	Licensee: SUNSHINE HEALTH FACILITIES INC	06/25/2026

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 06/01/2026, 06/02/2026, 06/03/2026, 06/04/2026, 06/05/2026, 06/09/2026, 06/10/2026 and 06/12/2026 of:
SUNSHINE TERRACE
10412 E 9th Ave
Spokane Valley, WA 99206

This document references the following complaint numbers: 224675, 225728.

The following sample was selected for review during the unannounced on-site visit: 22 of 130 current residents and 2 former residents.

The department staff that inspected the Assisted Living Facility:

Carla Rose, NCI Community Licensor
Tethra Wales, Assisted Living Facility Licensor
Joy Pipgras, LTC Surveyor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 1 , Unit B
8517 E Trent Ave, Ste 102
Spokane Valley, WA 99212

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Statement of Deficiencies	License #: 950	Compliance Determination # 77884
Plan of Correction	SUNSHINE TERRACE	Completion Date
Page 2 of 30	Licensee: SUNSHINE HEALTH FACILITIES INC	06/25/2026

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.

Residential Care Services — 07/02/2026 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) — 7/16/26 Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to evaluate and take appropriate action for reported changes in health condition, for 1 of 17 sampled residents (Resident 16). These failures resulted in the resident's ongoing symptoms and changes in condition not being assessed, evaluated, or addressed through timely intervention, resulting in missed opportunities for emergency medical evaluation and treatment, and placed the resident at risk for unrecognized and untreated cardiac symptoms.

Findings included...

Review of a list of discharged residents, provided to the department by the facility, showed that Resident 16 had passed away on [redacted]/2026.

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Review of Resident 16's Service Plan Report (the facility's titled Negotiated Service Agreement, NSA) dated 03/30/2026, showed the resident was diagnosed with [redacted] and [redacted]. Further review showed that Resident 16 was followed by an outside cardiologist (heart doctor) and that the facility oversaw the scheduling of and transportation to their cardiology appointments.

Review of Resident 16's progress notes for March 2026 showed the following:

- 03/02/2026 at 3:45 PM, the activities aide noted that when they went to Resident 16's room, the resident stumbled backwards, fell against their bed and appeared briefly confused. The Certified Nurse Assistant (CNA) was notified.

- 03/02/2026 at 3:49 PM, the CNA checked Resident 16's vitals and noted that their Blood Pressure (BP) was low. The BP measurement was not documented.

- 03/02/2026 at 7:52 PM, Resident 16 told the Nurse Assistant Certified (NAC) that they still felt dizzy. The NAC noted "Will continue to monitor and record."

- 03/03/2026 at 10:52 PM, Resident 16 was at the medication window and told the NAC that they still felt "a little bit dizzy." Vitals were obtained and the NAC wrote "will continue to monitor."

- 03/05/2026 at 12:38 AM, the night shift NAC completed a "weekly chart note," that included a note that read, the resident "has been showing signs of confusion lately."

- 03/09/2026 at 1:00 PM, the social worker noted that during a check-in, Resident 16 confirmed that they had experienced dizziness when they stood up.

Further review of the March 2026 progress notes showed there was no documentation of nurse notification or a nurse assessment.

Review of an email, dated 05/15/2026, showed that Staff J, Social Worker/Clinician,

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notified Staff H, Director of Nursing Services, at 11:12 AM that day, of concerns for Resident 16's wellbeing. The email indicated that Staff J checked on the resident the day prior and that the resident "wasn't looking too great." The email noted that Resident 16's roommate mentioned to Staff J, that the resident was sleeping on the bathroom floor and had vomited in the shower.

Review of a progress note, dated 05/15/2026 at 1:54 PM, showed that Staff I, Medication Technician, wrote that Staff K, ARTF (Adult Residential Treatment Facility (another unit within the building that was not part of the assisted living) Licensed Practical Nurse, asked them to go check on Resident 16 due to concerns reported by a Home Health (HH) nurse that had just seen Resident 16. Staff I's note showed that Resident 16 was not opening their eyes, only gave one-word responses, could not sit up and struggled to move their arm so that blood pressure could be taken. Staff I further wrote that they relayed that information to Staff K and was told that Staff H, Director of Nursing Services, felt it may have been a behavior.

Review of Resident 16's medical records showed no documentation of an emergency responder (911) or emergency room evaluation following the aforementioned symptoms reported to the Staff H.

In an interview on 06/09/2026 at 11:40 AM, Staff I stated that after they spoke to Staff K, they called Staff H and notified them that Resident 16 was not at their baseline (usual self) and was not to be able to answer questions appropriately. Staff I stated that after they voiced their concern to Staff H, they were instructed to tell the evening and night shift care staff to check on Resident 16 and for staff to deliver Resident 16's meals and medications.

In an interview on 06/09/2026 at 2:12 PM, Staff H stated that on 05/15/2026, Staff K called them and notified them of the HH nurses' concerns. Staff H confirmed that they did not go to Resident 16's room to assess them and instead had Staff I go take Resident 16's vital signs (blood pressure, heartrate, temperature, and oxygen level) instead. Staff H indicated that they instructed Staff I to pass on to the next shifts to monitor Resident 16 and bring them their meals and medications. When asked if Staff H had instructed Staff I on the frequency in which to conduct safety checks or what symptoms to monitor, Staff H stated they did not.

Review of the Medication Administration Record (MAR) for [redacted]/2026, showed that Resident 16's morning and noon medications were marked as not administered due to "no show," despite the instructions to deliver medications to the resident.

Review of Resident 16's Treatment Administration Record (TAR) for May 2026, showed that Resident 16 had scheduled safety checks at 10:00 PM and 3:00 AM. The TAR showed that no additional checks had been added to the TAR after Resident 16 had a change in condition on 05/15/2026. Further review showed that breakfast and lunch were marked as "no show" on [redacted]/2026, despite the instructions to deliver meals to the resident.

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Review of the facility's "24-Hour Report – North [building]," dated 05/15/2026, showed a note written by day shift for Resident 16, that read "only semi-responsive, see PN [Progress Note]. Possibly a behavior. On evening shift please check on [Resident 16], take vitals and call [Staff H] with an update." Further review showed a notation by evening shift that read "no meds."

Review of the "24-Hour Report – North [building]", dated [redacted]/2026, showed night shift notes for Resident 16, that read "slept," and the words, "passed away," written across both day and evening shifts. Further review showed there were no entries from night shift to day shift to indicate that Resident 16 was checked on, brought their meals, or brought their medications.

Review of Resident 16's progress notes showed that on [redacted]/2026, the evening shift Nursing Assistant Certified (NAC) documented that they began their shift at 2:00 PM that day. The note showed that the NAC asked the dayshift NAC, if anyone had checked on Resident 16 during their shift. The note indicated that the dayshift NAC had not checked on Resident 16 during their shift. The note showed that both NACs then checked on Resident 16, and discovered the resident unresponsive in their room. The note further showed that Resident 16 was pronounced deceased at 2:48 PM by emergency medical services.

In an interview on 06/09/2026 at 2:12 PM, Staff F, Administrator, confirmed that the last check on Resident 16 occurred on [redacted]/2026 during the 3:00 AM rounds. Staff F further acknowledged that Resident 16 went without safety checks, medications, and meals (breakfast and lunch) between the times of 03:07 AM through 2:10 PM, at which point they were found unresponsive in their room.

In an interview on 06/10/2026 at 12:05 PM, Staff D, Resident Coordination Services, stated that when care staff became aware of a resident's change in condition, they were supposed to notify they themself or Staff H so they could be evaluated by the nurse. When asked who read the progress notes, Staff D stated that they along with Staff H were responsible for reading the "weekly chart notes [progress notes]," and that any noted changes in condition not previously evaluated by the nurse, would be assessed by Staff H.

In an interview on 06/10/2026 at 2:40 PM, Staff H stated that they were not notified and were unaware of reports of the dizziness and confusion that Resident 16 had in March 2026. When asked who routinely reviewed the progress notes, Staff H replied "probably nobody." Staff H stated that changes in condition were supposed to be noted on the 24-Hour Report, which was read by Staff D and that any concerns on that report, were supposed to be addressed in the morning meeting. Staff H was asked if they were responsible for changes to the TARs when additional safety checks needed to be implemented by care staff. Staff H stated that they and Staff D were responsible for adding safety checks to the TAR. Staff H then confirmed that they did not add additional safety checks to the Resident 16's TAR on 05/15/2026.

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Review of a cardiology report provided to the facility on 05/27/2026, [redacted] after Resident 16's death, showed that the resident had 33 episodes of Supraventricular Tachycardia (SVT, an abnormally fast heartbeat, typically between 150 and 250 beats per minute) between 02/15/2026 and 04/28/2026.

In an interview on 06/12/2026 at 9:00 AM, Staff H was asked if they had any contact with Resident 16's cardiologist to assist with management of their pacemaker at any time since they began overseeing their care in December 2025. Staff H stated that they did not have any contact with Resident 16's cardiologist at any time until after Resident 16 passed away. Staff H further stated they were unaware that Resident 16 was six months overdue for their follow-up appointment to check their pacemaker.

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) 8/9/26.

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

Administrator (or Representative) — Date 7/16/26

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

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement new interventions after recognizing a need for improved processes while investigating the death of 1 of 2 residents (Resident 16). This failure placed current residents at risk of harm in similar situations.

Findings included...

Review of the facility's policy, titled, "Reporting Incidents," dated August 2021, showed that when an incident occurred, the facility was to create an incident report that included action taken and interventions to prevent recurrence. Further review showed that the incident report would document what staff were required to do, that included

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the preventative measures put in place, and that the administrator would determine if additional actions were required, including staff education, training, or discipline.

Review of a list of discharged residents provided to the department by the facility, showed that Resident 16 passed away on [redacted]/2026.

Review of Resident 16's undated investigation report provided to the department on 06/09/2026, showed that the facility identified "shift reports lacking detailed information," and "communication between eve [evening] and noc [night] shift is lacking." Further review showed that the facility planned to discuss the events of Resident 16's death, on 06/01/2026.

Review of the facility's June 2026 Inservice Nurses Meeting Minutes showed there were no discussions related to Resident 16's death. Further review showed no record of discussion on new processes or interventions to be implemented to prevent similar events.

In an interview on 06/09/2026 at 2:12 PM, Staff F, Administrator, stated that no new processes had been implemented as a result of their investigation into Resident 16's unexpected death.

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) 8/9/26.

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

Administrator (or Representative) 7/16/26 Date

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete an assessment of a resident's ability to safely manage an implanted medical device along with associated

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medical appointments for 1 of 4 residents (Resident 16) sampled for medical devices. This failure resulted in a missed cardiologist appointment and undetected cardiac events prior to the resident's death.

Findings included...

Review of Resident 16's Service Plan Report (the facility's titled negotiated service agreement), dated 03/30/2026, showed that Resident 16 had a pacemaker and that the resident was able to coordinate their cardiologist appointments independently. Further review showed that Resident 16 received their pacemaker services from an outside cardiologist who they were to see yearly.

Review of Resident 16's Recovery Plan (a plan created with their behavioral health clinician that included strengths, weaknesses, and goals), dated 01/23/2026, showed an identified health goal for the resident to continue to go to cardiology appointments for their pacemaker.

Review of Resident 16's annual assessment, dated 03/30/2026, showed that the resident was diagnosed with [redacted] and [redacted]. Further review showed no assessment of Resident 16's ability to safely oversee their cardiology appointments to manage their pacemaker.

Review of a health care provider After Visit Summary (AVS), dated 12/23/2024, showed that Resident 16 had an appointment with their cardiologist that day. Further review showed the cardiologist recommended that Resident 16 follow up in a year.

Review of Resident 16's facility file, showed they passed away on [redacted]/2026. Additional review showed no documentation of any follow up appointments with their cardiologist after 12/23/2024.

Review of a cardiology report provided to the facility on 06/27/2026, [redacted] after Resident 16's death, showed the resident's pacemaker recorded 33 episodes of Supraventricular Tachycardia (SVT, an abnormally fast heartbeat, typically between 150 and 250 beats per minute) between 02/15/2026 and 04/28/2026.

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Statement of Deficiencies	License #: 950	Compliance Determination # 77884
Plan of Correction	SUNSHINE TERRACE	Completion Date
Page 9 of 30	Licensee: SUNSHINE HEALTH FACILITIES INC	06/25/2026

In an interview on 06/12/2026 at 9:00 AM, Staff H, Director of Nursing Services, confirmed that they completed Resident 16's annual assessment on 03/30/2026. Staff H were asked if they had assessed the resident's ability to manage the pacemaker at that time. Staff H stated they did not. Staff H stated they were unaware that Resident 16 was six months overdue for their follow-up appointment to check their pacemaker.

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) 8/9/26.

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

Administrator (or Representative) Date 7/16/26

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

(b) Whenever the negotiated service agreement no longer adequately addresses the resident's current assessed needs and preferences.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to update the negotiated service agreement, after medical and mental health changes occurred, for 1 of 17 sampled Residents (Resident 21). This failure placed Resident 21 at risk of harm due to staff not having appropriate interventions in place in the event of a medical or mental health emergency.

Findings included...

Review of Resident 21's Full Assessment, dated 10/05/2025, showed the resident was diagnosed with [redacted]

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[redacted] and a history of suicidal ideation and thoughts of taking poison or drinking bleach.

Review of Resident 21's Progress Notes showed the following:

- On 05/24/2026 at 10:40 PM, the resident came to the medication window for PRNs (as needed medications) and stated that "[they] told God if you don't help me, I'm going to drink bleach." Staff stated please don't do that and the resident stated they would not. The resident was asked if they needed to see a doctor and they declined. The note further stated that it was to be passed on to the next shift.

- On [redacted]/2026 at 2:23 PM, the resident spoke to Staff H about going to the hospital with stomach pain that they rated 9 out of 10 (10 being the highest possible pain) and that the resident thought it was their PCOS. The resident was transferred to the hospital for evaluation.

- On [redacted]/2026 at 11:20 PM, staff received a call from the hospital stating Resident 21 needed surgery for gallstones but had refused and wanted to discharge themselves. Staff told the hospital that the resident would have to take a cab back to the facility.

- On [redacted]2026 at 7:25 AM, Staff H, Director of Nursing Services, was informed by Staff D, Resident Coordination Services, that Resident 21 had not returned. The hospital care coordinator was contacted by phone, and they shared with Staff H that Resident 21 needed surgery to remove their gallbladder. The hospital coordinator stated they would call with an update once a plan was in place to pursue surgery or schedule another procedure. The progress note showed, "No return call as of 16:29 [4:29 PM] PM today."

-On [redacted]/2026 at 3:00 PM, Staff Q, Clinician, saw the resident walking through the back side parking lot and asked where they were coming from. The resident stated they had been dropped off down the street and had to walk. The clinician walked Resident 21 to their room as the resident appeared to be fatigued and struggled to speak coherently.

Review of the Progress Notes after [redacted]/2026 showed no follow-up documentation from nursing regarding Resident 21's returned to the facility or that the resident was placed on any alert charting (documentation that records a significant change in a person's condition, behavior, or health status that requires monitoring, communication, assessment, or interventions). Further review showed no documentation of any facility contact to the hospital as of 06/12/2026, [redacted] later, to see if a plan or procedure had been discussed, or that staff talked to Resident 21 regarding the harmful effects of not having the surgery.

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In an interview on 06/12/2026 at 9:50 AM, Resident 21 stated that they were frightened to have surgery. Resident 21 further stated that the facility had not discussed the potential harm that could arise if they did not have the surgery.

In an interview on 06/09/2026 at 2:12 PM, Staff H stated that communication between staff in regard to residents, was written on the "24-Hour Reports" (shift-to-shift) sheets each day and included care and changes in condition.

Review of the "24-Hour Reports," dated 05/24/2026, showed no documentation of Resident 21's comment regarding drinking bleach or what staff were to monitor for signs and symptoms of suicidal ideation.

Review of the "24-Hour Reports" dated [redacted]/2026, showed "hospital" written for Resident 21. The report did not indicate that Resident 21 had returned from the hospital and did not include any instructions to monitor the resident.

Review of Resident 21's Service Plan (negotiated service agreement), dated 04/17/2026, showed it had not been updated to reflect suicidal ideation or their gallbladder condition. Further review showed it had not been updated with signs and symptoms for staff to be aware of if the resident's condition declined.

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

Administrator (or Representative) Date: 7/16/26

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

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Based on interview and record review, the facility failed to follow their policy guidelines regarding documentation of missed medications for 3 of 17 residents (Resident 10, 13, and 14). This failure prevented nursing staff from having knowledge of why medications were not given and placed the residents at risk due to not receiving their medications.

Findings included...

Review of the facility's policy, titled, "Missed or Refused Medication," dated 01/10/2023, showed that missed or refused medications were to be documented in the Medication Administration Record (MAR) and progress notes.

<Resident 10>

Review of Resident 10's Service Plan Report (the facility's titled Negotiated Service Agreement, NSA), dated 07/17/2025, showed the resident was diagnosed with [redacted] and [redacted].
Further review showed that the facility would supervise medication administration for Resident 10.

Review of Resident 10's March 2026, April 2026, and May 2026 MARs showed a key that indicated a "9" entered meant "see progress notes." Further review showed that a "9" was entered when the following medications were not administered:

- Aripiprazole (a medication used to treat schizophrenia): two doses.

- Hydrochlorothiazide (a medication used to treat hypertension): two doses.

- Januvia (a medication used to treat diabetes): two doses.

- Jardiance (a medication used to treat diabetes): two doses.

- Lasix (a medication used to help rid the body of extra water): two doses.

- Levothyroxine Sodium (a medication used to treat low thyroid): two doses.

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- Lexapro (a medication used to treat depression): two doses.

- Metoprolol succinate (a medication used to treat hypertension): two doses.

- Ozempic (weekly injection used to treat diabetes): one dose.

- Potassium chloride (a medication used to treat hypokalemia): three doses.

- Buspirone HCl (a medication used to treat anxiety): three doses.

- Lantus SoloStar Solution (a long-acting insulin injection used to treat diabetes): two doses.

- Humalog Kwikpen (a fast-acting insulin injection used to treat diabetes) ordered dose of 27 units (fast-acting insulin used to treat diabetes): seven doses.

- Humalog Kwikpen ordered per sliding scale (amount of medication to give based on a person's blood sugar level): nine doses.

Review of Resident 10's March 2025, April 2026 and May 2026 progress notes showed no documentation for why these medications were not given.

<Resident 13>

Review of Resident 13's NSA, dated 11/23/2025, showed diagnoses of [redacted] and [redacted]. Further review showed that the facility would supervise medication administration for Resident 13.

Review of Resident 13's March 2026, April 2026, and May 2026 MARs showed that a "9" was entered when the following medications were not administered:

- Buprenorphine HCl-Naloxone (a medication used to treat opioid dependence): five doses.

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- Docusate sodium (a medication used to treat constipation): seven doses.

- Fish Oil (a medication used to treat hyperlipidemia): seven doses.

- Melatonin (a medication used to treat insomnia): one dose.

- Prozac (a medication used to treat bipolar disorder): six doses.

- Risperdal (a medication used to treat bipolar disorder): seven doses.

- Senna Plus (a medication used to treat constipation): seven doses.

- Strattera (a medication used to treat ADHD): seven doses.

- Trazodone (a medication used to treat insomnia): one dose.

- Wellbutrin XL (a medication used to treat bipolar disorder): seven doses.

- Buspirone (a medication used to treat anxiety): seven doses.

Review of Resident 13's March 2026, April 2026, and May 2026 progress notes, showed no documentation as to why the above medications were not administered.

<Resident 14>

Review of Resident 14's facility assessment, dated 10/08/2025, showed that the resident had diagnosis of [redacted] and [redacted]. Further review showed that the facility would supervise medication administration for Resident 14.

Review of Resident 14's March 2026, April 2026, and May 2026 MARs showed that a "9" was entered when the following medications were not administered:

- Benztropine mesylate (medication for restlessness): eight doses.

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- Buprenorphine HCl-Naloxone (medication for opioid dependence): 16 doses.

- ClearLax (medication for constipation): 11 doses.

- Depakote (medication to stabilize moods), 250 mg: nine doses.

- Depakote 500 mg: 10 doses.

- Omeprazole 40 mg (medication for heart burn): nine doses.

- Omeprazole 20 mg: 11 doses.

- Prazosin (medication to prevent nightmares): two doses.

- Senna (medication for constipation): nine doses.

- Wellbutrin (medication for depression): 10 doses.

- Clotrimazole-betamethasone (medication to prevent yeast growth): 21 doses.

- Zyprexa (medication for psychosis): 10 doses.

- Buspirone, (medication for anxiety) 10 mg: 23 doses.

- Buspirone 25 mg: eight doses.

- Gabapentin (medication for nerve pain): 15 doses.

Review of Resident 14's March 2026, April 2026, and May 2026 progress notes, showed no documentation for why these medications were not given.

In an interview on 06/04/2026 at 10:50 AM, Staff H, Director of Nursing Services, stated that they did not know why residents 10, 13, and 14, did not receive their medications and that they assumed that a code "9" entered on the MAR meant it was refused. Staff H acknowledged that it is not uncommon for medication technicians to enter a "9" on the MAR when a medication is not administered without adding any additional information to the progress notes.

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

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In an interview on 06/05/2026 at 11:17 AM, Staff H confirmed they did not review the progress notes to determine why a medication was not given and that they only tallied up the number of missed medications.

Plan/Attestation Statement

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

Administrator (or Representative) — Date 7/16/26

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 of consistent patterns of medication refusals by 4 of 16 residents (Resident 10, 12, 13, and 14) with medication refusals. This failure precluded the residents' providers from being informed that residents were not taking their medications as prescribed, preventing timely clinical assessment and intervention, which placed the residents at risk for health complications.

Findings included...

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

Review of the facility's policy, titled, "Missed or Refused Medication," dated 01/10/2023, showed that missed or refused medications were to be documented in the Medication Administration Record (MAR) and progress notes, that steps were to be taken to avoid refused medications, that when a resident refused a medication three attempts were to be made to offer the medication, and that the prescribing physician would be notified.

<Resident 10>

Review of Resident 10's Service Plan Report (the facility's titled Negotiated Service Agreement, NSA), dated 07/17/2025, showed the resident was diagnosed with [redacted] and [redacted]. Further review showed that the facility would supervise medication administration and remind Resident 10 when they were late or had missed a medication pass.

Review of Resident 10's March 2026, April 2026, and May 2026 MARs and progress notes showed that Resident 10 refused or did not show up to the medication room for the following medications:

- Ambien (a medication used to treat difficulty sleeping): one dose in May.

- Aripiprazole (a medication used to treat mental illness): two doses in March, two doses in April, and one dose in May.

- Hydrochlorothiazide (a medication used to treat hypertension): two doses in March, two doses in April, and one dose in May.

- Januvia (a medication used to treat diabetes): two doses in March, two doses in April, and one dose in May.

- Jardiance (a medication used to treat diabetes): two doses in March, two doses in April, and one dose in May.

- Lasix (a medication used to help rid the body of extra water): two doses in March, two doses in April, and one dose in May.

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- Levothyroxine sodium (a medication used to treat hypothyroidism): two doses in March, two doses in April, and one dose in May.

- Lexapro (a medication used to treat depression): two doses in March, two doses in April, and one dose in May.

- Losartan potassium (a medication used to treat hypertension): one dose in May.

- Melatonin (a medication used to treat difficulty sleeping): one dose in May.

- Metoprolol succinate (a medication used to treat hypertension): two doses in March, two doses in April, and one dose in May.

- Potassium chloride (a medication used to treat hypokalemia): two doses in March, two doses in April, and one dose in May.

- Risperidone (a medication used to treat schizophrenia): one dose in May.

- Buspirone HCl (a medication used to treat anxiety): two doses in March, two doses in April, and two doses in May.

- Lantus SoloStar Solution (a long-acting insulin injection used to treat diabetes): two doses in March, two doses in April, and two doses in May.

- Humalog Kwikpen ordered dose of 27 units (a fast-acting insulin used to treat diabetes): 12 doses in March, 12 doses in April, and eight doses in May.

- Humalog Kwikpen ordered per sliding scale: 12 doses in March, 12 doses in April, and seven doses in May.

Review of the undated medical record showed no documentation that Resident 10's medical provider was notified of their refusals.

<Resident 12>

Review of Resident 12's NSA, dated 10/12/2025, showed the resident was diagnosed with [redacted]

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[redacted] and [redacted]. Further review showed that the facility would supervise medication administration and remind Resident 12 when they were late or had missed a medication pass.

Review of Resident 12's March 2026, April 2026, and May 2026 MARs and progress notes, showed that Resident 12 refused or failed to show up to the medication room for the following medications and on the:

- Bupropion (a medication used to treat depression): two doses in March, four doses in April, and three doses in May.

- Caplyta (a medication used to treat schizophrenia): one dose in May.

- Escitalopram oxalate (a medication used to treat anxiety and depression): one dose in March, six doses in April, and 10 doses in May.

- Melatonin: one dose in May.

- Metoprolol succinate (a medication used to treat tachycardia): two doses in March, four doses in April, and three doses in May.

- Pepcid Oral Tablet (a medication used to treat gastroesophageal reflux disease): two doses in March, four doses in April, and three doses in May.

- Penicillin v potassium (a medication used to treat infection): one dose in March.

Review of the undated medical record showed no documentation that Resident 12's medical provider was notified of their refusals.

<Resident 13>

Review of Resident 13's NSA, dated 11/23/2025, showed diagnoses of [redacted] and [redacted].

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[redacted]. Further review showed that the facility would store medications, supervise medication administration and remind Resident 13 when they were late or missing a medication pass.

Review of Resident 13's March, April, and May 2026 MARs and Progress Notes, showed that Resident 13 refused or failed to show up to medication room for the following medications:

- Buprenorphine HCl-Naloxone (a medication used to treat opioid dependence): one dose in March.

- Buspirone: two doses in March and one dose in May.

- Docusate sodium (a medication used to treat constipation): one dose in March.

- Fish Oil (a medication used to treat hyperlipidemia): one dose in March.

- Melatonin (a medication used to treat insomnia): one dose in March.

- Prazosin (a medication used to treat nightmares):20 doses in March and seven doses in April.

- Prozac (a medication used to treat bipolar disorder): one dose in March.

- Risperdal (a medication used to treat bipolar disorder): two doses in March and one in May.

- Senna Plus (a medication used to treat constipation): one dose in March.

- Strattera (a medication used to treat ADHD): one dose in March.

- Trazodone (a medication used to treat insomnia): one dose in March.

- Wellbutrin XL (a medication used to treat bipolar disorder): one dose in March.

Review of the undated medical record showed no documentation that Resident 13's medical provider was notified of their refusals.

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

<Resident 14>

Review of Resident 14's Assessment, dated 10/06/2025, showed that the resident had a diagnosis of [redacted] and [redacted]. Further review showed Resident 14 received assistance with medication administration.

Review of Resident 14's March, April, and May 2026 MARs and progress notes showed that Resident 14 refused or failed to show up to medication room for the following medications:

- Buprenorphine HCl-Naloxone 25 mg (medication for opioid dependence): three doses in April.

- Bupropion (medication for depression): eight doses in March.

- ClearLax (medication for constipation): four doses in March, six doses in April, and 10 doses in May.

- Prazosin (medication to prevent nightmares): two doses in March and one dose in April.

- Omeprazole (medication for acid reflux disease): two doses in April.

- Clotrimazole-betamethasone (medication to prevent yeast): 14 doses in March, 21 doses in April, and 28 doses in May.

- Buspirone 20 mg (medication for anxiety): two doses in March and two doses in April.

- Buspirone 25 mg: four doses in April.

- Gabapentin (medication for nerve pain): three doses in March, five doses in April, and two doses in May.

Review of the undated medical record showed no documentation that Resident 14's medical provider was notified of their refusals.

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In an interview on 06/04/2026 at 10:50 AM, Staff H, Director of Nursing Services, stated that they tracked and communicated missed medications in a weekly, written report that they provided to the in-house medical provider on Mondays and the in-house psych provider on Wednesdays. When a request was made by the Department for a copy of the most recent report written, Staff H stated that they had only begun compiling a written report that week and did not have a completed report to provide. Staff H further stated that they did not have documentation from the providers that confirmed they only required weekly updates.

This is a recurring citation previously cited on 02/27/2025.

Plan/Attestation Statement

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Administrator (or Representative) Date 7/16/26

WAC 388-78A-2210 Medication services.

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

(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 interview and record review the facility failed to administer medications as prescribed to 1 of 16 residents (Residents 12). This failure resulted in medication errors and placed the residents at risk of harm.

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

Findings included...

Review of the facility's policy, titled, "Medication Administration", dated 07/11/2022, showed that the Director of Nursing Services (DNS) or charge nurse would ensure that medication related services required or requested by each resident were provided. Further review showed that all medications that staff members handled, stored and assisted with would be documented in the Medication Administration Record (MAR) and in accordance with state regulations.

Review of Resident 12's negotiated service agreement, dated 10/12/2026, showed that the facility would store medications, and supervise medication administration.

Review of Resident 12's March 2026, April 2026, and May 2026 MARs showed an order for Pepcid to be given twice daily to treat gastro-esophageal reflux disease (digestive condition where stomach acid flows back into the esophagus).

Review of Resident 12's progress notes showed that on 03/01/2026, 03/02/2026, and 03/04/2026, the Pepcid oral tablet was noted as "finished," and that the medication was only to be given for 14 days.

Review of Resident 12's provider order for Pepcid, dated 02/09/2026, showed instructions to give 1 tablet by mouth two times a day, with no timeframe for discontinuing the medication.

Review of Resident 12's March 2026, April 2026, and May 2026 progress notes, showed a note dated 03/14/2026, that indicated that the resident told the medication technician that the order for Pepcid had been discontinued in their recent care meeting. Review of the progress note documenting the care team meeting, dated 03/10/2026, showed no discussion of discontinuing the Pepcid order. Further review showed that the Pepcid oral tablet was ordered twice a day and noted as not being available for one of the two doses on 03/06/2026, 03/07/2026, 03/11/2026, 05/06/2026, 05/14/2026, 05/21/2026, 05/22/2026, 05/24/2026, and 05/26/2026.

In an interview on 06/05/2026 at 11:17 AM, Staff H confirmed that Resident 12's Pepcid that was noted as not available, was available to be administered on those dates. When asked how the medication technician's inability to locate the medication was not discovered, Staff H stated that they did not review progress notes and had not followed up with staff or the resident to determine why the medication was not given.

This is a recurring citation previously cited on 02/27/2025.

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

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WAC 388-78A-2670 Services by resident for assisted living facility. If a resident performs services for the assisted living facility, the assisted living facility must ensure:

(3) If the resident regularly performs voluntary services for the benefit of the assisted living facility, the volunteer activity is addressed in the resident's negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to include work program elements in negotiated service agreements for 6 of 6 residents (Residents 2, 10, 13, 14, 15, and 19) who provided services for the facility. This failure placed the residents at risk for participating in work activities without appropriate care planning.

Findings included...

Review of two "Work Incentive," weekly payment lists, dated May 22, 2026 thru May 28, 2026 and May 22, 2026 thru June 4, 2026, showed Residents 2, 10, 13, 14, 15, and 19 had performed work duties for the facility during those time periods.

<Resident 2>

Review of Resident 2's Service Plan Report (the facility's title Negotiated Service Agreement, NSA), dated 10/02/2026, showed no documentation of voluntary work incentive duties (light cleaning jobs that residents agree to do).

<Resident 10>

In an interview on 06/05/2026 at 9:25 AM, Resident 10 stated that they watered the

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flowers in front of the facility for their work incentive duties.

Review of Resident 10's NSA, dated 07/17/2025, showed no documentation of work incentive duties.

<Resident 13>

Observation on 06/04/2026 at 3:23 PM, showed Resident 13 mopped the facility's activity room floor.

In an interview on 06/04/2026 at 3:25 PM, Resident 13 confirmed they mopped the activity room floor for their work incentive program job.

Review of Resident 13's NSA, dated 11/23/2025, showed no documentation of work incentive duties.

<Resident 14>

In an interview on 06/05/2026 at 9:30 AM, Resident 14 stated that they swept the dining room after dinner every day.

Review of Resident 14's NSA, dated 10/07/2025, showed no documentation of work incentive duties.

<Resident 15>

Review of Resident 15's NSA dated 04/07/2026, showed no documentation of work incentive duties.

<Resident 19>

Observation on 06/04/2026 at 1:20 PM, showed Resident 19 wiped down the facility's stair railings.

Review of Resident 19's NSA, dated 04/07/2026, showed no documentation of work incentive duties.

In an interview on 06/03/2026 at 11:40 AM, Staff L, Adult Residential Treatment Facility

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Program Manager, stated that there were 35 residents in the assisted living portion of the facility that had work program jobs.

In an interview on 06/05/2026 at 10:50 AM, Staff H, Director of Nursing, stated they did not include work incentive program jobs in resident NSAs.

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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.

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;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to protect protected health information in 2 of 4 resident units (South Building and Memory Care). This failure resulted in residents' personal information being displayed in public areas and placed them at risk for violated privacy.

Findings included...

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

Observation of the Memory Care unit on 06/01/2026 at 11:09 AM showed a list of residents and their brief sizes, and contact information for residents' representatives, posted on the wall, next to the medication cart.

Observation on 06/01/2026 at 11:09 AM, showed a document titled, "Memory Care Cheat Sheet," pinned to a bulletin board in the main sitting area, accessible to residents and visitors. The cheat sheet showed 15 residents' names, room numbers, and care instructions for each resident. Further review showed that the care instructions included, "[they] cannot have butter knives with [their] meals," "[they] need powder in their groin," "undresses in inappropriate places," "[they] are on hospice," "suffers from paranoid delusions/statements," and "wears 2XL pull up."

In an interview on 06/01/2026 at 11:20 AM, Staff P, Director of Nursing who was assigned to the memory care unit, stated that the Memory Care Cheat Sheet with residents' personal information should not have been posted in sight of residents and visitors.

Observation on 06/01/2026 at 12:23 PM, showed a document titled, "Fasting Labs," posted to the left of the south medication room window. Further review showed the first name and last initial of seven residents in the north and south buildings.

In an interview on 06/01/2026 at 12:25 PM, Staff D, Resident Coordination Services, stated that Staff H, Director of Nursing Services who was assigned to the north and south buildings, provided them with copies of the list of residents that needed fasting labs and instructed them to hang the list outside the medication window. Staff D confirmed a new list was hung outside the window every Friday.

In an interview on 06/03/2026 at 10:31 AM, Staff H confirmed that they printed the list of residents that needed fasting labs and instructed Staff D to hang them up outside the medication room window.

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Administrator (or Representative) Date 7/16/26

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to keep a well maintained, safe and sanitary interior and environment for 1 of 4 units (Sunshine Terrace Behavioral Health). This failure placed all residents at risk of injury and decreased quality of life.

Findings included...

The environmental tour on 06/01/2026 at 10:00 AM, showed the following in the facility's Behavioral Health and Sunshine Terrace building:

The second-floor bathroom across from the medication room, had a strong urine odor. The grout throughout the tile floor, that included the perimeter, had a black residue.

The second-floor activity room contained four large lounge chairs that had holes and tears in the vinyl on the arms and sides.

The Sunshine Terrace dining room had food and liquid on the floor throughout the room, and debris on the tabletops and chairs. A five-gallon beverage container used for activities was on a table, had liquid inside, and had dirt and debris on it's exterior.

In an interview on 06/02/2026 at 8:50 PM, Staff F, Administrator, confirmed the activity room chairs needed to be replaced.

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In an interview on 06/03/2026 at 11:20 AM, Staff L, Adult Residential Treatment Facility Program Manager, stated that after breakfast and dinner the residents might not have a chance to clean up the dining room if it is being used for meetings or activities.

In an interview on 06/04/2026 at 10:22 AM, Staff M, Maintenance Supervisor, stated that the dining room deep cleaning was maintained by a resident who left a month prior, and the job had not been reassigned in over a month.

In an interview on 06/05/2026 at 9:30 AM, Resident 14 stated that they were on the facility's work program, and was assigned to sweep the dining room daily after dinner. Resident 14 further stated that the residents assigned to breakfast and lunch from the work program sometimes couldn't get into the dining room to sweep because there were meetings after those meals, and that they had a difficult time completing the task with the mess left from the earlier meals.

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WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure tuberculosis screenings were conducted within three days of employment for 1 of 5 staff (Staff C). This failure placed residents at risk of exposure to a communicable disease.

Findings included...

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

Review of Staff C's, Medication Technician, personnel file showed that they were hired on 06/25/2025. Further review showed a Tuberculosis (TB) blood test was completed on 05/22/2025, prior to Staff C's hire, and that no additional testing was completed by the facility upon hire.

In an interview on 06/10/2026 at 3:55 PM, Staff G, Compliance, confirmed that no testing for TB had been completed by the facility for Staff C after they were hired.

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