STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505226	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Healthcare Center	721 Otis Avenue Sunnyside, WA 98944

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45117 Based on observation, interview, and record review, the facility failed to provide a dining experience that promoted resident respect and dignity for 1 of 6 residents (Resident 1) reviewed for dignity. This failure placed the resident at risk for low self-esteem and an undignified dining experience. Findings included . Review of a policy titled, Resident Rights, dated 02/2021, showed federal and state laws guarantee certain rights to all residents, including the right to a dignified existence and the right to be treated with respect, kindness, and dignity. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including heart failure, arthritis, and weakness. The 03/12/2025 comprehensive assessment showed Resident 1 required substantial assistance of one staff member for activities of daily living and supervision for eating. The assessment also showed Resident 1 had a moderately impaired cognition. Resident 1 was able to make their needs known. A concurrent observation and interview on 03/25/2025 at 3:16 PM, showed Resident 1 sitting in their room in their wheelchair with the bedside table in front of them. There was a Styrofoam cup of ice water on the bedside table. Resident 1 had their head down and was crying. Resident 1 stated They take away my dignity. I get my food in a paper plate or Styrofoam. They say the dishwasher is not working and the patients are suffering. I am treated like an animal, I sit with my paper plate and tiny spoon [(spork) a small, plastic combination utensil that is shaped like a spoon, with two to four fork-like tines). Resident 1 stated one of the girls told them the dishwasher had been broken. Resident 1 stated they had been served on paper plates for a long time and asked, how long can a dishwasher be broken - they took away my dignity. During an interview on 03/25/2025 at 4:21 PM, Staff B, Director of Nursing Services, stated they were not aware that the facility was using paper products for meal service. During a follow up interview on 03/27/2025 at 1:44 PM, Staff B stated the process for maintaining respect and dignity for the residents included training staff and using the grievance process. Staff B stated they were not involved in switching to paper items because that was a kitchen issue. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-0180(1)(2)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 45117 Based on observation, interview, and record review, the facility failed to ensure 2 of 3 residents (Resident 2 and 3), reviewed for activities of daily living, received goods and services to maintain their ability to eat independently. This failure placed the residents at risk for low self-esteem, the inability to feed themselves, and dissatisfaction with their dining experience. Findings included . <Resident 2> Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including rheumatoid arthritis (a chronic arthritis that affects the small joints in the hands and feet, often causing joint deformity) and muscle weakness. The 12/09/2024 comprehensive assessment showed Resident 2 was independent with eating. The assessment also showed Resident 2 was cognitively intact. A concurrent observation and interview on 03/26/2025 at 11:59 AM, showed Resident 2 lying in bed. Both hands were on top of the blankets and showed deformed fingers. Resident 2 was able to slightly flex their fingers with difficulty. They stated they preferred to eat with metal silverware. They stated plastic silverware was acceptable but all they gave us to eat with is a spork (a small, plastic combination utensil that is shaped like a spoon, with two to four fork-like tines. Resident 2 stated they were unable to use the plastic spork due to their arthritis. They stated one of the nursing assistants told them they were having problems with the water when they brought their meal tray on maybe Thursday of the previous week. Resident 2 stated the meals were served in Styrofoam containers and it was hard for them to eat out of those containers. They stated it was difficult to get to the food with the angle of the Styrofoam container and use of the plastic spork. Resident 2 stated they used to look forward to eating but now it is just a problem. Resident 2 stated they told staff they were unable to use the plastic spork for eating, but it came with every meal. <Resident 3> Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), anxiety, and depression. The 02/19/2025 comprehensive assessment showed Resident 3 required step-up assistance from one staff member for eating. The assessment also showed Resident 3 was cognitively intact. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 03/26/2025 at 2:51 PM, showed Resident 3 lying in bed with a Styrofoam cup on the bedside table. Resident 3 stated they were getting their meals on thin paper plates, but they are better than the Styrofoam ones. They stated that had been going on for about two weeks. Resident 3 stated they had heard it was the dishwasher's fault, but no one had specifically told them. They stated they had problems using the plastic spork, it's garbage, I am not able to eat with it. Resident 3 stated they had neuropathy (a condition that affects the nerves with a gradual onset of numbness or tingling in the hands or feet) and could not feel their fingers. They stated they were able to feed themselves with a metal fork, and somewhat with a plastic fork, but not at all with the plastic spork. During an interview on 03/26/2025 at 11:30 AM, Staff C, Nursing Assistant, stated they did not remember when the facility started using the paper plates. Staff C stated the residents had complained to them about using the sporks. They stated they would exchange the spork for a regular plastic fork, if there was one available. During an interview on 03/26/2025 at 12:29 PM, Staff D, Dietary Manager, stated they were using sporks because a pipe had broken in the kitchen and they were unable to use the dishwasher. Staff D stated they ran out of the regular plastic forks, knives, and spoons and provided the residents with a spork to eat their meals. During an interview on 03/27/2025 at 1:44 PM, Staff B, Director of Nursing, stated they were not aware that the facility had switched to paper/plastic products. Staff B stated they were not involved with that decision as it was a kitchen issue. During a telephone interview on 03/28/2025 at 8:35 AM, Staff A, Administrator, stated when the pipe broke in the kitchen, they had put a plan in place to use the paper/plastic items for just one meal, the lunch meal on Friday (03/21/2025), and had put a system in place to return to use of the regular dishware after that one meal. They stated they were not aware that the facility had continued to use the paper/plastic items. Reference: WAC 388-97-1060(1)(2)(a)(iv)(b)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45117 Based on observation, interview, and record review, the facility failed to maintain a clean and sanitary environment in 1 of 1 kitchen (Main Kitchen) reviewed for food preparation and storage safety. This failure placed all residents, staff, and visitors that ate out of the Main Kitchen at risk for food contamination (the unintended presence of potentially harmful substances including microorganisms or chemicals in food) and food borne illnesses. Findings included . Review of a policy titled, Sanitation, dated 11/2022, showed the facility would maintain a clean and sanitary food service area. During an interview on 03/25/2025 at 3:58 PM, Staff F, Maintenance Director, stated there was a pipe under the kitchen floor, about four feet underground that had broken. They stated they had put the restrooms, located on the other side of the kitchen wall of the dishwasher area, out of service and the doors were locked so they could not be used. They stated the dishwasher was also out of service, not because it was broken, but because it could not drain. They stated the incident happened yesterday (03/24/2025). In a concurrent observation and interview on 03/25/2025 at 4:13 PM, Staff E, Cook, in the Main Kitchen, stated the water from the restrooms was coming up into the kitchen through the drains. They stated there was a pipe under the kitchen that had broken and did not allow the catch basin to drain properly. An observation of the dishwasher area showed a 10 inch by seven-inch white catch basin that was inset into the floor under the dishwasher counter space. There were two pipes that drained into the catch basin, including one from the dishwasher. There was a hole in the bottom of the catch basin to drain the water. The bottom of the catch basin was soiled with a dark brown residue. There was a folded blanket placed over the corner of the catch basin, and a second folded blanket over a drain in the floor, three feet from the catch basin. Staff E stated water also came out of that floor drain. There was a shop vac (a powerful vacuum that can suck up wet or dry substances and blows out exhaust) located in the dishwasher area that had a long hose pushed into the catch basin. Staff E stated they were able to run the dishwasher if they used the shop vac to suck the water out of the drain. Staff E turned on the dishwasher and water began to drain into the catch basin. Staff E turned on the shop vac, which blew exhaust onto three open meal delivery carts, that were located across from the dishwasher area. Staff E stated they had been using the three-compartment sink sanitation method until Staff F, Maintenance Director, put the shop vac in use so they could use the dishwasher. Staff E stated the dishwasher area and Main Kitchen was not sanitary and should not be used. During a follow up interview on 03/25/2025 at 4:17 PM, Staff F stated they knew about the issue on Monday (03/24/2025). They stated they had a contractor create a proposal for the repairs. Staff F stated the repairs had not been scheduled, as they needed approval from Staff A, Administrator, before scheduling. Staff F stated they had removed the shop vac from the Main Kitchen and staff would have to go back to not using the dishwasher until the drain was fixed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of a plumbing invoice dated 03/21/2025, showed a camera was used in the main sewer line and found a potential break/separation or offset in kitchen under concrete that was no allowing full drainage. During an observation and interview on 03/25/2025 at 4:21 PM, Staff B, Director of Nursing Services, toured the Main Kitchen and observed the dishwasher area where the shop vac was set up. Staff B stated the kitchen was not sanitary and I would not eat out of this kitchen. During an observation and interview on 03/25/2025 at 4:54 PM, Staff G, Infection Preventionist, toured the dishwasher area of the Main Kitchen. Staff G stated they were not involved in the plans for preventing cross contamination in the Main Kitchen. Staff G stated they were not aware that the toilets had backed up into the kitchen. They stated they were only told there was a broken pipe. During an interview on 03/26/2025 at 12:29 PM, Staff D, Dietary Manager, stated the drain problem started Thursday (03/20/2025) or Friday (03/21/2025) of the previous week. They stated they had made the decision to switch to the paper products because they were not able to use the permanently fixed three-compartment sink for cleaning and sanitizing the dishes. Staff D stated the drains backed up into those sinks as well. They stated they were currently using a smaller two-compartment sink with a bin that contained sanitizer and were not able to keep up with the number of dishes that were used per meal. Staff D stated they were in the Main Kitchen when the drain first backed up. They stated they saw the back flow of water and it smelled like bathroom water; it was brown and gunky. Staff D stated the backflow stayed in the dishwasher area. They stated Staff F contacted a plumber that came out that same day and found a broken pipe. Staff F closed the restrooms that same day and put the dishwasher out of service. Staff D stated Staff F brought them the shop vac on Tuesday (03/25/2025) and told the kitchen staff they could use it to suck up the dishwasher drainage. During an interview on 03/28/2025 at 8:35 AM, Staff A stated the pipes went down on Friday (03/21/2025). They stated they formulated a plan with Staff F that included using the three-compartment system. They stated they the plan also included collecting drainage and disposing of it in a sink that had a working drain. Staff A stated they were not aware that they were using a shop vac for drainage and that was not the plan I had put in place. Reference: WAC 388-97-2980(1)(3)(6)