

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505226	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER Sunnyside Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, interview, and record review, the facility failed to serve meals at a preferred temperature for 3 of 4 residents (Resident 1, 2, and 3) reviewed for food temperatures. This failure placed the residents at risk for inadequate nutritional intake, weight loss, and dissatisfaction with their dining experience.</p> <p>Findings included .</p> <p>&lt;Resident 1&gt;</p> <p>Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including diabetes (a group of diseases that result in too much sugar in the blood), paraplegia (the loss of muscle function in the lower half of the body, including both legs), and depression. The 03/27/2025 comprehensive assessment showed Resident 1 was independent with activities of daily living (ADLs); dependent on one to two staff for transfers and showering. The assessment also showed Resident 1 was cognitively intact.</p> <p>A concurrent observation and interview on 06/17/2025 at 12:16 PM, showed Resident 1 sitting in their wheelchair in their room at their over the bed table. They stated they were waiting for their lunch tray. Resident 1 stated their food was often cold when it was delivered. They stated they were told that Staff B, Dietary Manager, was trying to buy something to keep the food warmer. Resident 1 stated they had voiced their concerns about the cold food to Staff B, but their concerns go in one ear and out the other (heard but disregarded or quickly forgotten). At 12:18 PM, Resident 1's meal tray was delivered. Observation of the meal showed cooked spinach, chicken strips, and french fries. Resident 1 stated the meal did not look appetizing. They picked up a chicken strip and stated it was not even lukewarm (slightly warm). Resident 1 stated the lack of hot meals made them feel frustrated and it's not right, I pay to stay here (at the facility), and they should be giving me quality food to eat that is nutritious and hot. Resident 1 stated they had filed a grievance regarding the food temperature but nothing was done.</p> <p>Record review of a grievance dated 06/02/2025, showed Resident 1 had reported their concerns with cold food. The grievance showed management was aware of the resident's concern and was working on getting a better system to keep food warm .</p> <p>&lt;Resident 2&gt;</p> <p>(continued on next page)</p>

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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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including rheumatoid arthritis (a condition where the body's immune system attacks its own tissues, causing joint pain, swelling, stiffness, and fatigue), muscle weakness, and depression. The 04/18/2025 comprehensive assessment showed Resident 2 was dependent on one to two staff for ADLs; independent with eating. The assessment also showed Resident 2 had an intact cognition.</p> <p>A concurrent observation and interview on 06/17/2025 at 12:26 PM, showed Resident 2 lying in bed with an over the bed table across the bed. Resident 2 stated the food was consistently cold and was frequently delivered without the plate warmers or covers. At 12:29 PM, a meal tray was delivered to Resident 2. A nursing assistant (NA) placed the tray on the over the bed table and removed the plate cover. Resident 2 touched their plate and stated, the plate is cold, how can the food be hot when the plate is cold, please feel my plate. Resident 2's plate was cool to the touch and the plate cover was cold. They picked up a chicken strip and took a bite. Resident 2 stated it was not warm; its cooler than the temperature of my mouth. Resident 2 stated that was the normal temperature of their meals. They stated they were very frustrated with their dining experience. They stated they have reported their concerns and filed grievances, but nothing ever changes.</p> <p>&lt;Resident 3&gt;</p> <p>Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including heart failure, high blood pressure, and diabetes. The 05/20/2025 comprehensive assessment showed Resident 3 was dependent on one to two staff members for toileting and bathing and was independent with eating. The assessment also showed Resident 3 was cognitively intact.</p> <p>During an interview on 06/17/2025 at 1:02 PM, Resident 3 stated their meals were not always hot. They stated they had told staff the food was cold. Resident 3 stated they would prefer my food hotter.</p> <p>During an interview on 06/17/2025 at 1:34 PM, Staff B stated they were aware of the complaints of cold food. They stated the facility had purchased thermal pellets (a heated device that is placed under a plate to keep food warm for up to 60 minutes) to improve food temperatures. They stated they did not have the approval to purchase the warming device to heat the pellets. Staff B stated the kitchen did not have insulated carts to keep the food warm. They stated they had identified issues with the length of time it took for staff to deliver the food once it left the kitchen, which could be contributing to the cold food complaints.</p> <p>During an interview on 06/18/2025 at 7:49 AM, Staff A, Administrator, stated they were aware of the concerns with cold food. They stated they had purchased the pellets for the plate warmers but needed to purchase additional parts. Staff A stated they were not able to identify why the food was cold when it reached the residents when it left the kitchen at the appropriate temperature. Staff A stated the plan was to purchase the additional parts to ensure food arrived at the resident warm, but did not have the funds to purchase the additional parts.</p> <p>Reference: WAC 388-97-1100(2)</p>		