

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/24/2026
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to provide supervision and implement care plan interventions to prevent a resident-to-resident altercation for 2 of 8 residents (Resident 1 and 2) reviewed for avoidable accidents. This failure placed the residents at risk for physical abuse, serious pain and injury, and emotional distress. Findings included. Review of a policy titled, Safety and Supervision of Residents, revised 07/2017, showed resident safety and supervision and assistance to prevent accidents were facility-wide priorities. The care team would obtain information from assessments and observations to identify hazards or risks for individual residents. The care team would target interventions to reduce individual risks related to hazards including adequate supervision. Implementing the interventions included communicating these specific interventions to all relevant staff and ensuring the interventions were implemented. Resident 1 Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including Down Syndrome (a genetic condition that alters how the brain and body develop, resulting in distinct physical features and intellectual disabilities), post-traumatic stress disorder (a mental health condition that's caused by an extremely stressful or terrifying event), and anxiety. The 02/23/2026 comprehensive assessment showed Resident 1 required set up assistance of one staff member for activities of daily living [(ADLs) activities related to personal care] and was dependent on one to two staff members for showering. The assessment also showed Resident 1 had a moderately impaired cognition (a group of thinking and social symptoms that interferes with daily functioning). Resident 2 Review of the medical record showed Resident 2 was admitted to the facility with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and dementia (a decline in memory, thinking, and reasoning that interferes with daily life). The 05/19/2026 comprehensive assessment showed Resident 2 required assistance of one staff member for ADLs. The assessment also showed Resident 2 had a severely impaired cognition. Record review of a facility investigation dated 06/20/2026 at 12:15 PM, showed Resident 2 was in the dining room passing out clothing protectors to the other residents. Resident 2 attempted to give a clothing protector to Resident 1 by placing it on their lap. Resident 1 became agitated and slapped Resident 2 on their arms a few times. Record review of Resident 1's care plan dated 05/27/2026, showed they had five prior dining room related resident-to-resident altercations dated 08/04/2022, 12/29/2022, 01/26/2023, 12/12/2023, and 03/11/2026. A care plan behavior management intervention, dated 01/26/2023, showed please help resident obtain clothing protector when (Resident 1) goes into dining room for meals. Record review of Resident 2's care plan dated 05/27/2026, showed the resident required cueing, reorientation, and supervision related to their memory loss and impaired decision making. During an observation on 06/24/2026 at 12:07 PM, Resident 2 was in the dining room in their wheelchair. There were six other residents in the dining room. Resident 2 wheeled over to the sink/cabinet area, stood up, and obtained sugar/sweetener packets from the cabinet area. They obtained napkins and silverware from the same area. Resident 2 gave the sugar/sweetener packets and silverware to a resident sitting at their table. Resident 2 went back to the cabinet area, obtained additional sugar/sweetener packets and silverware and returned to their table. Resident 2 (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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/24/2026
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gave silverware to a second resident sitting at the same table. There were no staff present in the dining room, despite Resident 2 obtaining items from the cabinets and requiring supervision. During a concurrent observation and interview on 06/24/2026 at 12:57 PM, Staff C, Nursing Assistant (NA), was standing in the dining room, observing residents at mealtime. They stated there were usually two NAs in the dining room to supervise during meals. Staff C stated Resident 2 always goes around and helps everyone, and were unsure if they were care planned to help out in the dining room with clothing protectors. They stated they would look on the Kardex (a quick reference guide that identifies essential resident information) if there were care needs identified for Resident 1 or Resident 2 related to the dining room. Staff C stated they were not aware of any identified needs for either resident. During an interview on 06/24/2026 at 1:26 PM, Staff E, Resident Care Manager, stated Resident 1 was territorial with their spot in the dining room. They stated Resident 2 liked to help the other residents in the dining room by passing out clothing protectors. Staff E stated they had talked to Resident 2 after the altercation and reminded them to place the clothing protectors on the table. They stated Resident 2 had cognitive and memory impairments and would not remember the conversation. Staff E stated there was supposed to be staff supervising the residents when they were in the dining room. Upon review of Resident 1's care plan, Staff E stated the NAs would not know to put the clothing protector on Resident 1 as they entered the dining room, because the intervention was not entered correctly on the care plan and did not populate on the Kardex for staff to see. During an interview on 06/24/2026 at 1:39 PM, Staff B, Assistant Director of Nursing, stated there should always be at least one staff member supervising the dining room. They stated the resident-to-resident altercation occurred because Resident 2 gave Resident 1 a clothing protector, and Resident 1 reacted to that. They stated the NAs would not have been aware of the intervention to place a clothing protector on Resident 2 to avoid an altercation. Staff B stated the NAs did not have access to the residents' care plans, and the intervention was not on the Kardex. They stated the residents care plans were not followed and there was clearly no supervision. During an interview on 06/24/2026 at 1:50 PM, Staff A, Director of Nursing, declined to respond to questions related to the resident-to-resident altercation as they had not yet completed their full investigation. Staff A stated Resident 2 required more supervision, and the plan would be to move them to an area that would provide them with the additional supervision. Reference: WAC 388-97-1060(3)(g)		