



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Avenue, Suite#220, Vancouver, WA 98684

May 6, 2016

Daniela L Tira
SUNSHINE CARE
15405 NE 50TH ST
VANCOUVER, WA 98682

RE: SUNSHINE CARE License #461401

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on May 3, 2016 for the deficiency or deficiencies cited in the report/s dated April 1, 2016 and found no deficiencies.

The Department staff who did the inspection:
Sarah Bjork, Licensors

If you have any questions please, contact me at (360) 397-9549.

Sincerely,

Karyl Ramsey, Field Manager
Region 3, Unit E
Residential Care Services

04/04/16
Onbud



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800 NE 136th Avenue, Suite#220, Vancouver, WA 98684

Statement of Deficiencies	License #: 461401	Completion Date
Plan of Correction	SUNSHINE CARE	April 1, 2016
Page 1 of 4	Licensee: Daniela Tira	

You are required to be in compliance with all of the licensing laws and regulations at all times to maintain your adult family home license.

The department has completed data collection for the unannounced on-site full inspection of: 3/30/2016

SUNSHINE CARE
15405 NE 50TH ST
VANCOUVER, WA 98682

The department staff that inspected the adult family home:
Sarah Bjork, Licensor

RECEIVED
APR 25 2016
DSHS/ADSA/RCS

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3, Unit E
800 NE 136th Avenue, Suite#220
Vancouver, WA 98684
(360)397-9549

As a result of the on-site full inspection 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.

C. Bunnick for Kayla Bessie
Residential Care Services

04/04/2016
Date

I understand that to maintain an adult family home license I must be in compliance with all the licensing laws and regulations at all times.

[Signature]
Provider (or Representative)

4/15/2016
Date

04/26/16

✓ 05/16/16

WAC 388-76-10355 Negotiated care plan. The adult family home must use the resident assessment and preliminary care plan to develop a written negotiated care plan. The home must ensure each resident's negotiated care plan includes:

- (1) A list of the care and services to be provided;
- (2) Identification of who will provide the care and services;
- (3) When and how the care and services will be provided;
- (7) If needed, a plan to:
 - (a) Follow in case of a foreseeable crisis due to a resident's assessed needs;
 - (b) Reduce tension, agitation and problem behaviors;
 - (c) Respond to resident's special needs, including, but not limited to medical devices and related safety plans;
 - (d) Respond to a resident's refusal of care or treatment, including when the resident's physician or practitioner should be notified of the refusal;

This requirement was not met as evidenced by:

Based on interview and record review, the provider failed to ensure one sampled resident's (Resident #1) negotiated care plan contained interventions for documented behaviors and known safety risks. This failure placed Resident #1 at risk for harm.

Findings include:

Interview and record review took place on 3/30/2016.

Resident #1 was admitted to the home on [REDACTED] with diagnoses including [REDACTED] and a history of alcohol abuse. Resident #1's assessment, dated 9/1/2015, indicated Resident #1 had a choking incident on [REDACTED] which resulted in acute respiratory failure (when the lungs cannot remove carbon dioxide from the blood). The assessment documented Resident #1 had periods of trouble eating, coughed at times when eating, and required small bites for safety. It indicated Resident #1 had a history of having a seizure in [REDACTED] after mixing [REDACTED] medications with alcohol.

The negotiated care plan, dated 9/8/2015, did not document information about Resident #1's history of choking or any interventions to ensure Resident #1's safety while eating. The negotiated care plan did not document alcohol abuse or any interventions for safety and monitoring. The negotiated care plan documented Resident #1 had behaviors including [REDACTED] and [REDACTED]. No interventions related to address Resident #1's [REDACTED] or [REDACTED] had been added to the negotiated care plan nor was information about the use of psychotropic medications.

The provider stated she had interventions in place for all of Resident #1's care needs but had not added them to the negotiated care plan. The provider stated she would add the interventions as soon as possible.

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 CARE is or will be in compliance with this law and / or regulation on (Date) 4/15/2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency. ✓



Provider (or Representative)

4/15/2016

Date

WAC 388-76-10750 Safety and maintenance. The adult family home must:

(6) Provide storage for toxic substances, poisons, and other hazardous materials that is only accessible to residents under direct supervision, unless the resident is assessed for and the negotiated care plan indicates it is safe for the resident to use the materials unsupervised;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the provider failed to ensure hazardous items were stored securely to prevent unauthorized access. This failure placed both residents at risk for harm.

Findings include:

Observation, interview and record review took place on 3/30/2016.

The provider stated two residents lived in the home and both residents had diagnoses which included [REDACTED]. During a tour of the home, cleaning wipes were observed on a table in the hallway and on the floor in the main bathroom used by residents. A cleaning spray bottle was observed was also observed on the floor in the bathroom used by residents. A bleach-based cleaning spray bottle was observed on the floor in the bathroom primarily used by household members, but was unlocked and accessible to residents. None of the cleaning materials were stored securely to prevent unauthorized access.

A bottle of rubbing alcohol was observed on a table in Resident #1's bedroom and was not stored securely to prevent access. Review of Resident #1's assessment revealed Resident #1 had a history of alcohol abuse.

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 CARE is or will be in compliance with this law and / or regulation on (Date) 4/02/2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency. ✓



Provider (or Representative)

04/15/2016
Date