STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Puyallup ALC LLC
Vineyard Park of Puyallup
1813 S Meridian St
Puyallup, WA 98371

RE: Vineyard Park of Puyallup License # 2553

Dear Administrator:

This letter addresses Compliance Determination(s) 43372 (Completion Date 07/12/2024) and 35338 (Completion Date 04/17/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/12/2024 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:
RCW 70.129.110.3.a, RCW 70.129.110.3.b, RCW 70.129.110.3.c, RCW 70.129.110.3.d, RCW 70.129.110.3, RCW 70.129.110.6, WAC 388-78A-2100-2-b-i, WAC 388-78A-2100-2-b-ii

The Department staff who did the on-site verification:
Carol Gijima, Community Compaint Investigator (NCI)

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Manfay Chan, Field Manager
Region 3, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Vineyard Park of Puyallup
Provider Type: Assisted Living Facility

License/Cert.#: 2553
Intake ID: 107655
Compliance Determination #: 35338
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 02/29/2024 through 04/17/2024
Complainant Contact Date(s):

Allegation(s):
1. Resident not discharged properly from facility

Investigation Methods:

Sample:	Total residents: Resident sample size: Closed records sample size: 3
Observations:	General environment Residents in their rooms Staff-to-resident interactions
Interviews:	Resident Representative Staff Collateral contacts
Record Reviews:	Resident Characteristic Roster List of discharged residents Resident assessments and negotiated service agreements including the discharged records of the named resident Medication administration records (MAR) Staff progress notes Incident log / reports Discharge notice

Investigation Summary:
1. Per record review, interviews with resident's representative, collateral contacts, and staff, the facility failed to properly discharge a resident. The ALF demonstrated failed provider practice as documented in a Statement of Deficiency dated 04/17/2024.

Conclusion / Action:

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

☐ N/A

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

Statement of Deficiencies	License #: 2553	Compliance Determination # 35338
Plan of Correction	Vineyard Park of Puyallup	Completion Date
Page 1 of 6	Licensee: Puyallup ALC LLC	04/17/2024

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 an unannounced on-site complaint investigation on 02/29/2024 and 02/29/2024 of:

Vineyard Park of Puyallup
1813 S Meridian St
Puyallup, WA 98371

This document references the following complaint number(s): 107655

The following sample was selected for review during the unannounced on-site visit: 0 of 0 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Carol Gijima, Community Compaint Investigator (NCI)

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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

4/24/2024
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)

4.29.2024
Date

RCW 70.129.110 Disclosure, transfer, and discharge requirements.

(3) Before a long-term care facility transfers or discharges a resident, the facility must:

(a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;

(b) Notify the resident and representative and make a reasonable effort to notify, if known, an interested family member of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand;

(c) Record the reasons in the resident's record; and

(d) Include in the notice the items described in subsection (5) of this section.

(8) A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to give a proper discharge notice and transported resident to a locked unit under false pretenses for 1 of 3 sample residents (Resident 1). This failure and transport caused emotional distress for the resident and unnecessary transfer to the hospital for extreme agitation.

Findings included...

Review of the facility's discharge notice dated [redacted]2023 showed that Resident 1 (R1) was given a three days' notice on the day of discharge, [redacted]2023.

There was no pre-admit assessment within 14 days after admission to review.

Record review of R1's records showed that R1 was admitted to the ALF on [redacted]2023 and discharged [redacted]2023. R1 was given a discharge notice the day he was discharged, and after R1 was already transferred to the new facility. Review of an assessment dated 10/30/2023 showed that R1 was admitted with wandering behaviors, took his dog out at night and was verbally aggressive towards staff, with interventions to redirect.

Progress notes reviewed from 09/28/2023 to [redacted]2023 showed that the facility agreed with the family on 10/21/2023 that staff "accompany resident and pet outdoors" during the night shift. There was no documentation prior to the discharge showing that R1 had

Administrator (or Representative) Date

RCW 70.129.110 Disclosure, transfer, and discharge requirements.

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(a) First attempt through reasonable accommodations to avoid the transfer or discharge, unless agreed to by the resident;

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(c) Record the reasons in the resident's record; and

(d) Include in the notice the items described in subsection (5) of this section.

(6) A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to give a proper discharge notice and transported resident to a locked unit under false pretenses for 1 of 3 sample residents (Resident 1). This failure and transport caused emotional distress for the resident and unnecessary transfer to the hospital for extreme agitation.

Findings included...

Review of the facility's discharge notice dated [redacted]/2023 showed that Resident 1 (R1) was given a three days' notice on the day of discharge, [redacted]/2023.

There was no pre-admit assessment within 14 days after admission to review.

Record review of R1's records showed that R1 was admitted to the ALF on [redacted]/2023 and discharged [redacted]/2023. R1 was given a discharge notice the day he was discharged, and after R1 was already transferred to the new facility. Review of an assessment dated 10/30/2023 showed that R1 was admitted with wandering behaviors, took his dog out at night and was verbally aggressive towards staff, with interventions to redirect.

Progress notes reviewed from 09/28/2023 to [redacted]/2023 showed that the facility agreed with the family on 10/21/2023 that staff "accompany resident and pet outdoors" during the night shift. There was no documentation prior to the discharge showing that R1 had

unmanageable behaviors leading to the discharge.

During an interview on 01/17/2024 at 2:25pm, Collateral Contact (CC1) stated that facility did not discharge R1 properly and had not been given a 30-day notice. CC1 stated that the facility moved R1 to a locked facility under false pretenses that his services were needed at the other facility. CC1 stated that R1 was extremely agitated and became physically aggressive when he found out he would not be returning home to his wife. CC1 stated that the facility refused to take R1 back from the hospital and "demanded" that R1 be under heavy medications and be admitted to a locked unit.

During an interview on 02/15/2024 at 12:45pm, Resident 1's Representative (RR1) stated that R1 was admitted to the facility with wandering behaviors, and the facility knew he had a dog that he took out. RR1 stated the facility complained that R1 was putting a rock to hold doors when he took the dog out. RR1 stated that Administrator decided R1 belonged in a locked unit. RR1 stated that she was notified by the EMTs that Administrator and the maintenance staff had taken him to the new facility under false pretense that they needed him to do some carpentry. RR1 stated when R1 realized he couldn't leave, he became agitated, and was shaking the exit gates and threw a rock at the gate. RR1 stated when she arrived at the locked facility, R1 was calm and stated he was not staying at this facility and wanted to "go home". RR1 stated there were prior discussions about discharging him and neither did they get a 30-day notice to discharge because of unsafe behaviors. RR1 stated that this event caused intense emotional distress for the resident who was being separated from his wife, placed in a locked new environment and not being allowed to leave. RR1 stated R1 was sent to the hospital, and they had to find alternate housing as Staff A would not accept him back to his shared apartment with spouse.

During an interview on 02/29/2024 at 11:15am, Staff A, Administrator stated that R1 was a wandering risk, took his dog out at night and propped the door open and could not figure out how to get back inside the building. Administrator stated that R1 would "tinker with things in the building", was "fixing stuff" around the facility and "messed with the fuse box" and was discharged to a secured unit. When asked if there were discussions with the family about behavior changes and possible discharge prior to [redacted]/2023, Administrator stated there was and it was documented in progress notes. Administrator stated he was given a 30-day notice to which Administrator responded that R1 was given a 3-day notice.

During an interview on 04/11/2024 at 10:36am, Staff B, House Manager stated that R1 was transported to the locked facility because he was propping doors open. Staff B was asked if they were aware of R1 being issued a 30-day discharge notice. Staff B stated that R1 was issued a 3-day notice on the day he was discharged, after he had arrived at the locked facility. Staff B stated that Staff A asked her to write the discharge notice on the discharging facility's behalf. When asked who transported R1 to the new facility, Staff B stated that Staff A did. Staff B stated that R1 was told that he was going to assist with some work at the locked facility and that is how they got him to leave. Staff B stated that when R1 realized that he couldn't leave and was not home, he got extremely agitated and 911 was called resulting in R1 being transferred to the hospital.

During an interview on 04/16/2024 at 12:56pm, Collateral Contact 2 (CC2) stated that the

facility was not transparent to the family and resident about the discharge. CC2 stated that the only complaint that the facility had that they were aware of was that R1 was propping doors open when he took the dog out at night. CC2 stated they were not aware of any safety concerns, changes or increase in behaviors or prior discussions about R1 discharging to alternate housing until R1 was being moved to the locked facility. CC2 stated the facility called her towards the evening time alleging that R1 had "messed with the fuse", and "they couldn't keep him for the weekend" and was therefore being transferred to a locked unit. CC2 stated she did not receive a copy of a discharge notice. CC2 stated that the incident "was traumatic for the resident and family."

This is a recurring deficiency previously cited on 09/06/2023.

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, Vineyard Park of Puyallup is or will be in compliance with this law and / or regulation on (Date) 5.29.2024

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

Administrator (or Representative) — Date 4.25.2024

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to conduct an assessment when a resident had a change in condition for 1 of 3 sample residents (Resident 1). This failure resulted in Resident 1 not receiving proper services, being hospitalized, and causing mental anguish.

Findings included...

facility was not transparent to the family and resident about the discharge. CC2 stated that the only complaint that the facility had that they were aware of was that R1 was propping doors open when he took the dog out at night. CC2 stated they were not aware of any safety concerns, changes or increase in behaviors or prior discussions about R1 discharging to alternate housing until R1 was being moved to the locked facility. CC2 stated the facility called her towards the evening time alleging that R1 had "messed with the fuse", and "they couldn't keep him for the weekend" and was therefore being transferred to a locked unit. CC2 stated she did not receive a copy of a discharge notice. CC2 stated that the incident "was traumatic for the resident and family."

This is a recurring deficiency previously cited on 09/06/2023.

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

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to conduct an assessment when a resident had a change in condition for 1 of 3 sample residents (Resident 1). This failure resulted in Resident 1 not receiving proper services, being hospitalized, and causing mental anguish.

Findings included...

Record review of R1's records showed that R1 was admitted to the ALF on [redacted]2023 and discharged [redacted]2023. R1 was given a discharge notice the day he was discharged. Review of an assessment dated 10/30/2023 showed that R1 was admitted with wandering behaviors, took his dog out at night and was verbally aggressive towards staff, with interventions to redirect.

There was no updated assessment on file to show a change in condition regarding unsafe behaviors.

There was no documentation in progress notes regarding behaviors that were unsafe or new concerning behaviors.

During an interview on 02/15/2024 at 12:45pm, Resident 1's Representative (RR1) stated that R1 did not have any changes to his behaviors and that he wandered around the facility. RR1 stated that the facility knew he had a dog that he took out. RR1 stated the facility complained that R1 was having unsafe behaviors such as putting a rock to hold doors when he took the dog out and was not aware of any other issues. RR1 stated the only meeting she had with the facility was to address the door being propped at night, and they agreed that staff would be assisting R1 to take the dog out. RR1 stated there was no assessment completed or a note from the doctor stating that he needed to be in a locked unit.

During an interview on 02/29/2024 at 11:15am, Staff A, Administrator stated that R1 was discharged to a locked unit as he was not safe to remain in the facility because he was a wandering risk and would prop the door open when he took his dog out at night. Staff A stated R1 was not able to figure out how to get back inside the building after taking the dog outside, that he would "tinker with things in the building" and fix things around the building. When asked if these behaviors were new, Administrator stated they were. When asked if he had an assessment for a change in condition, Staff A stated there was not. When asked why there would not be a change in condition assessment, Staff A stated "there is no valid reason in my book." Staff A was asked if these changes were documented. Staff A stated they should be documented in the progress notes.

In a separate interview on 04/17/2024 at 2:17pm, Staff A stated R1 had "messed" with the fuse box causing a power outage and needed to be moved to a secure unit. Administrator stated R1 was not safe in the building.

Plan/Attestation Statement

Statement of Deficiencies	License #: 2563	Compliance Determination # 353386
Plan of Correction	Vineyard Park of Puyallup	Completion Date
Page 6 of 6	Licensee: Puyallup ALC LLC	04/17/2024

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, Vineyard Park of Puyallup is or will be in compliance with this law and / or regulation on (Date) 5.29.2024

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

Administrator (or Representative)

4.25.2024
Date

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, Vineyard Park of Puyallup is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

Plan of Correction

Agency Name: Vineyard Park Puyallup	Citation Date
	4.17.2024
Submitted by: Marissa Canada Executive Director	**Date of POC Submission**
	4.25.2024
☒ **Complaint Citation** ☐ Certification Citation	

Citation: (list WAC) WAC 388-78A-2100	
	Ongoing Assessments
How will you apply the correction to all clients you support?	DNS will complete change of condition assessment as needed for changes with residents condition or behaviors. Care conference will be conducted with resident and/or POA.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Marissa Canada Executive Director, Brenda Farmer DNS LPN
Date by which lasting correction will be achieved	5/29/2024
Additional Information	SOD received on 4.24.2024

Submit to RCS within 10 calendar days of receipt of letter to

Manfay Chan, Field Manager

Residential Care Services
Region 3, Unit D
PO Box 99250
Lakewood, WA 98496

Plan of Correction

Agency Name: Vineyard Park Puyallup	Citation Date
	4.17.2024
Submitted by: Marissa Canada Executive Director	**Date of POC Submission**
	4.25.2024
☐ **Complaint Citation** ☐ Certification Citation	

Citation: (list WAC) RCW 70.129.110	
	Disclosure, transfer, and discharge requirements
How will you apply the correction to all clients you support?	DNS will complete change of condition assessment prior to a discharge need. All attempts to accommodate the resident will be documented leading up to a 30 day notice. 30 day notice will be provided unless it is documented that the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Marissa Canada Executive Director, Brenda Farmer DNS LPN
Date by which lasting correction will be achieved	5/29/2024
Additional Information	SOD received on 4.24.2024

Submit to RCS within 10 calendar days of receipt of letter to

Manfay Chan, Field Manager

Residential Care Services
Region 3, Unit D
PO Box 99250
Lakewood, WA 98496