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) 34855 (Completion Date 02/06/2024) and 23425 (Completion Date 09/06/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/06/2024 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, 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 70.129.110.6, WAC 388-78A-2640-1-a, WAC 388-78A-2640-3-a, WAC 388-78A-2640-3-b, WAC 388-78A-2640-3, RCW 70.129.030.4

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,

Jody Just Jody Just Region 3 Field Serices Administrator signing for Manfay Chan

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: 76069
Compliance Determination #: 23425
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 05/03/2023 through 09/06/2023
Complainant Contact Date(s):

Allegation(s):

1. Improper discharge
2. Resident not notified of additional charges
3. Facility did not notify resident's representative of a change in condition

Investigation Methods:

Sample:	Total residents: Resident sample size: Closed records sample size: 1
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 Staff progress notes Therapy notes Facility P & P Notice of transfer / discharge Financial records

Investigation Summary:

1. Per record review and interviews with resident representative and staff, the facility failed to give a proper discharge notice as required. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 09/06/2023.
2. Per record review and interviews with resident representative and staff, the facility failed to give advance notice of additional charges for services. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 09/06/2023.

3. Per record review and interviews with resident representative and staff, the facility failed to notify resident representative of a change in condition. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 09/06/2023.

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 # 23425
Plan of Correction	Vineyard Park of Puyallup	Completion Date
Page 1 of 8	Licensee: Puyallup ALC LLC	09/06/2023

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 05/03/2023 and 08/22/2023 of:

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

This document references the following complaint number(s): 76069

The following sample was selected for review during the unannounced on-site visit: 0 of 0 current residents and 1 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

09/07/2023
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.

Statement of Deficiencies Plan of Correction Page 2 of 8	License #: 2553 Vineyard Park of Puyallup Licensee: Puyallup ALC LLC	Compliance Determination # 23426 Completion Date 09/06/2023

Administrator (or Representative)

9.15.2023
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 (6) 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 record reviews and interviews, the Assisted Living Facility (ALF) failed to properly discharge a resident and give them a written notice prior to the discharge for 1 of 1 sampled resident (Resident 1, R1). This resulted in resident not receiving an orderly transfer and placed her at risk for emotional distress.

Findings included...

Record review on 05/03/2023 of R1's assessment and negotiated care plan showed that R1 was admitted to the facility on [redacted]2020 with diagnoses to include [redacted] and [redacted] where she needed a staff member to provide total assist with transfers.

Review of facility documents on 05/03/2023 showed no documentation showing communication with the resident's representative regarding discharges or transfers to a different facility.

A progress note dated [redacted]/2021 at 7:04pm stated that R1 had been discharged and transferred to another community with her belongings and was transported by her husband. An incident investigation note dated 03/10/2021 at 12:13pm stated that R1 had an emergency discharge to another community for resident safety after a 03/07/2021 incident where R1 had aggressive behaviors towards staff. Per progress note dated [redacted]/2021 at 6:22pm, the progress note stated that R1 was transferred to another

Administrator (or Representative) Date

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(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.

(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 record reviews and interviews, the Assisted Living Facility (ALF) failed to properly discharge a resident and give them a written notice prior to the discharge for 1 of 1 sampled resident (Resident 1, R1). This resulted in resident not receiving an orderly transfer and placed her at risk for emotional distress.

Findings Included…

Record review on 05/03/2023 of R1's assessment and negotiated care plan showed that R1 was admitted to the facility on [redacted]/2020 with diagnoses to include [redacted] and [redacted] where she needed a staff member to provide total assist with transfers.

Review of facility documents on 05/03/2023 showed no documentation showing communication with the resident's representative regarding discharges or transfers to a different facility.

A progress note dated [redacted]/2021 at 7:04pm stated that R1 had been discharged and transferred to another community with her belongings and was transported by her husband. An incident investigation note dated 03/10/2021 at 12:13pm stated that R1 had an emergency discharge to another community for resident safety after a 03/07/2021 incident where R1 had aggressive behaviors towards staff. Per progress note dated [redacted]/2021 at 6:22pm, the progress note stated that R1 was transferred to another

community and was not at the facility. At 6:27pm, a progress note dated [redacted]/2021 stated that R1 was transferred to another community and at 7:43pm that R1 was discharged to another community.

Record review of facility records on 05/03/2023 showed a discharge notice written on [redacted]/2021 with an effective date of [redacted]/2021. It was not signed by R1's representative. There were no records indicating that reasonable accommodations had been attempted to avoid the transfer. The facility did not have any record of notifying the resident's representative of the reasons for the transfer or what the urgent medical needs that necessitated the transfer.

During an interview on 04/26/2023 at 4:04pm, R1's representative (RR1) stated that he received a call from the facility on [redacted]/2021 stating he needed to pick up R1 because physical therapy had decided she was a two-person transfer. RR1 stated that he was told that R1 had to leave the facility as they did not have the staff to assist her. RR1 stated that he was told R1 had to be out of the facility on that day. When RR1 stated that it was late and a Friday, the facility stated they would keep her until Monday, [redacted]/2021, to give him time to find a place for R1. RR1 stated he never received advance written notice about the reasons for discharging R1.

During an interview on 08/22/2023 at 10:30am, Staff A, Administrator stated that R1 was discharged on a Friday afternoon after an appointment with physical therapy. When asked what the reason for the transfer was, Staff A stated because therapy had written an order that R1 was a two-person transfer, and they did not have the staff to provide the two-person assist care.

During an interview on 08/23/2023 at 12:09pm, Staff E, Marketing Director, was asked what the reasons for R1's discharge. Staff E stated that Staff B, Former Administrator, told her that R1 was "smacking and throwing feces at staff."

During an interview on 08/25/2023 at 10:51am, Staff B stated that residents were given a 30-day written notice prior to discharge. When asked about R1, Staff B stated she didn't remember if she had been given a 30-day discharge notice. When asked if she had any urgent medical needs that could not be met at the facility, Staff B stated that she did not think so.

During an interview on 09/05/2023 at 1:14pm, Staff A was asked why R1 was not given a proper discharge notice. Staff A stated that she had urgent medical needs that the facility could not provide. When asked what the urgent medical needs where, Staff A stated that they did not have staff to provide a two-person transfer. Staff A was asked how that was an emergency when R1 had been receiving two person transfers since 02/25/2021. Staff A stated she was not aware of R1 being transferred by two staff, and that it was before her time. Staff A stated that staff could have been documenting as a way of providing feedback about R1's needs.

During an interview on 09/05/2023 at 1:45pm, Staff F, Rehab Manager, was asked if R1's therapy notes or orders meant R1 needed 1:1 care. Staff F stated that resident was not able to perform tasks on her own or be able to return home as she needed assistance with activities such as transfers and toileting. Staff F stated that resident would need someone to assist with her care and that she did not need 1:1 private care.

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) 10.20.2023

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

Administrator (or Representative) 9.15.2023 Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to consult with a resident's representative when there was a significant change in condition for 1 of 1 sampled resident (Resident 1, R1). This failure placed R1 at risk for not timely receiving needed services and poor quality of life.

Findings included...

Record review on 05/03/2023 showed that R1 was admitted to the facility on [redacted]/2020 with diagnoses to include [redacted] and [redacted] R1's assessment dated [redacted]2020 and care plan dated 02/03/2021 showed that R1 needed a one staff member total assist with transfers, physical assist with wheelchair, and maximum staff assist with personal hygiene.

During an interview on 09/05/2023 at 1:45pm, Staff F, Rehab Manager, was asked if R1's therapy notes or orders meant R1 needed 1:1 care. Staff F stated that resident was not able to perform tasks on her own or be able to return home as she needed assistance with activities such as transfers and toileting. Staff F stated that resident would need someone to assist with her care and that she did not need 1:1 private care.

Plan/Attestation Statement

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Administrator (or Representative) Date

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Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to consult with a resident's representative when there was a significant change in condition for 1 of 1 sampled resident (Resident 1, R1). This failure placed R1 at risk for not timely receiving needed services and poor quality of life.

Findings Included…

Record review on 05/03/2023 showed that R1 was admitted to the facility on [redacted]/2020 with diagnoses to include [redacted] and [redacted] R1's assessment dated [redacted]/2020 and care plan dated 02/03/2021 showed that R1 needed a one staff member total assist with transfers, physical assist with wheelchair, and maximum staff assist with personal hygiene.

Progress notes showed that R1 had a significant deterioration in physical and mental status where she had difficulties with transfers, had confusion and aggression starting 02/24/2021.Progress notes showed that at times R1 required two person transfers. Progress notes were as follows:

02/24/2021 at 9:50pm - resident was weak and hard to transfer, and it took over an hour and a half to assist her.
02/25/2021 at 10:58pm - resident was weak during transfer and staff provided two-person assistance.
02/26/2021 at 6:48am - resident complained about right knee not being strong enough to stand up.
02/26/2021 at 10:56pm-resident was not able to support herself on the right side and was difficult to transfer.
02/27/2021 at 9:58pm -resident was having trouble with transfers.
03/02/2021 at 6:43am -resident was still having issues with her right knee.
03/02/2021 at 11:51am - note stated that resident was being placed on alert for possible bladder infection.
03/02/2021 at 2:08pm - note stated that resident was difficult to transport as she was not able to stand.
03/02/2021 at 10:11pm - note stated that resident continued with transfer difficulty and increase in confusion and weakness.
03/03/2021 at 11:04am - resident was a two-person transfer, was agitated and verbally aggressive, and will continue to monitor.
03/04/2021 at 09:30pm - resident was highly agitated and yelling at staff.
[redacted]/2021 at 2:46pm - resident was tired and will continue to monitor for changes.

There was no documentation to show that R1's representative was notified of these changes until [redacted]/2021, the day he was notified of intent to discharge resident. On [redacted]/2021 at 7:42pm, the progress note stated that R1 received new therapy orders for a two-person transfer, R1's representative (RR1) and Administrator (Staff A) were notified, and that the staff would continue to monitor.

During an interview on 04/26/2023 at 4:04pm, RR1 stated he had not been notified of the changes in R1's condition. RR1 stated that the only time someone spoke to him about any changes was when he received a call in the afternoon of [redacted]/2021 notifying him of the discharge. RR1 stated he was at the facility almost daily to visit, and no one mentioned any changes.

During an interview on 08/07/2023 at 1:23pm, Staff D, Director of Nursing, stated when a resident had a change in condition, they would place them on alert, notify the doctor and the resident representative. Staff D stated that they would document notification in the progress notes. Staff D stated that if the change was significant, they would update the care plan, go over care plan and sign it with the resident or their representative.

During an interview on 09/05/2023 at 1:14pm, Staff A was asked about the process for

Statement of Deficiencies	License #: 2553	Compliance Determination # 23425
Plan of Correction	Vineyard Park of Puyallup	Completion Date
Page 6 of 8	Licensee: Puyallup ALC LLC	09/06/2023

notifying resident's representatives or doctors when there was a resident change in condition. Staff A stated that it would have been the Director of Nursing's responsibility. When asked if R1's family was notified of her change in condition, Staff A stated that it was prior to her time.

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) 9.15.2023 Date

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(4) The facility must inform each resident in writing in a language the resident or his or her representative understands before admission, and at least once every twenty-four months thereafter of: (a) Services, items, and activities customarily available in the facility or arranged for by the facility as permitted by the facility's license; (b) charges for those services, items, and activities including charges for services, items, and activities not covered by the facility's per diem rate or applicable public benefit programs; and (c) the rules of facility operations required under RCW 70.129.140 (2). Each resident and his or her representative must be informed in writing in advance of changes in the availability or the charges for services, items, or activities, or of changes in the facility's rules. Except in emergencies, thirty days' advance notice must be given prior to the change. However, for facilities licensed for six or fewer residents, if there has been a substantial and continuing change in the resident's condition necessitating substantially greater or lesser services, items, or activities, then the charges for those services, items, or activities may be changed upon fourteen days' advance written notice.

This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to notify the resident's representative in advance of extra charges for services when the facility hired a private caregiver for 1 of 1 sampled resident (Resident 1, R1). This failure placed a financial burden on R1, and at risk for mental anguish and a decrease in quality of life.

notifying resident's representatives or doctors when there was a resident change in condition. Staff A stated that it would have been the Director of Nursing's responsibility. When asked if R1's family was notified of her change in condition, Staff A stated that it was prior to her time.

Plan/Attestation Statement

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Administrator (or Representative) Date

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This requirement was not met as evidenced by:

Based on record reviews and interviews, the Assisted Living Facility (ALF) failed to notify the resident's representative in advance of extra charges for services when the facility hired a private caregiver for 1 of 1 sampled resident (Resident 1, R1). This failure placed a financial burden on R1, and at risk for mental anguish and a decrease in quality of life.

Findings Included…

Record review on 05/03/2023 showed that R1 was admitted to the facility on [redacted]/2020 with diagnoses to include [redacted] and [redacted] R1's assessment dated [redacted]/2020 and care plan dated 02/03/2021 showed that R1 needed one staff member total assist with transfers, physical assist with wheelchair, and maximum staff assist with personal hygiene.

Further review of the progress notes showed that R1 was transferred/discharged to another facility on [redacted]/2021.

Review of the financial statements showed that R1 was charged for a private caregiver, 24 hours a day on [redacted]/2021, [redacted]/2021 and [redacted]/2021 for a total of $3360.00. Facility records did not have documentation of R1's representative being notified in writing of the need for a private caregiver or the extra charges that would be incurred for services.

During an interview on 04/26/2023 at 4:04pm, R1's representative (RR1) stated that Staff A, Administrator, called him on [redacted]/2021 telling him to pick up R1 from the facility as they could not care for her. RR1 stated it was late on a Friday afternoon and when he expressed that concern, Staff A told him they would keep R1 until the following Monday, [redacted]/2021, to give him some time. RR1 stated that Staff A did not tell him that R1 would require a one-to-one personal caregiver round the clock or that there would be additional charges for care. RR1 stated that there was no verbal, telephone or written communication regarding a 1:1 caregiver and/or extra charges. RR1 stated that Staff A informed him they would continue to care for R1 until he moved her out.

During an interview on 05/03/2023 at 12:00pm, Staff C, Business Office Manager, stated that R1 was charged $3360.00 for home care charges for additional care. When asked what the additional care consisted of, Staff C deferred question to Staff A. Staff C stated that nursing and Staff A were responsible for obtaining signatures on the level of care change form, and then she would get the signed copy for record keeping. In an email dated 08/21/2023 at 3:36pm, Staff C was asked for copy of R1's signed change of service that reflected the additional care charges. On 08/23/2023 at 2:18pm, Staff C responded that she would need to look in storage and would send the information. On 08/30/2023 at 2:35pm, another email request was sent to Staff C for a copy of the signed change of service. On 08/31/2023 at 8:23am, Staff C responded stating that she could not locate the document.

During an interview on 08/07/2023 at 1:23pm, Staff D, Director of Nursing, stated that when a resident had a change in care needs, they or their representative would sign a change of service form that showed prior cost and new cost. Staff D stated that she and resident or representative would go over old and new charges, sign the form, and the form would be given to the business office for record keeping. When asked about R1's change of care form, Staff D stated that she was not an employee at the time.

Statement of Deficiencies Plan of Correction Page 8 of 8	License #: 2553 Vineyard Park of Puyallup Licensee: Puyallup ALC LLC	Compliance Determination # 23426 Completion Date 09/06/2023

During an interview on 08/22/2023 at 10:30am, Staff A stated that RR1 was aware of the extra charges for the caregiver. When asked if she had spoken to RR1 about the caregiver and the charges, Staff A stated that Staff E. (Marketing Director) had set up the private caregiver and had explained the charges to him. When asked if this was in writing, Staff A stated it was not. When asked if the facility was responsible for getting private caregivers for residents, Staff A stated that it was the family's responsibility. When asked why a staff member would set up the private caregiver for R1, Staff A stated that they were trying to help.

During an interview on 08/23/2023 at 12:09pm, Staff E stated that she did not call RR1 regarding a private care giver and/or additional care charges. Staff E stated that Staff A and B (Former Administrator) told her that they had notified R1's representative to pick R1 up or get her a one to one caregiver. Staff E stated that she was asked by Staff A and B to find home care agencies that would respond fast, and that was all she did. Staff E stated that she was later informed that RR1 did not pay his bill. Staff E stated she then reached out to RR1, and he told her that there was no discussion about having a one-to-one private caregiver for R1 around the clock. Staff E stated she asked Staff B if RR1 had been notified, and Staff B stated that she thought somebody did.

During an interview on 08/25/2023 at 10:51am, Staff B stated that the facility did not charge residents for services without written consent. Staff B stated that if there were changes in care levels, the facility would go over them with the resident and their representative during a care conference. Staff B stated that residents or their representative sign a level of care change form, where both the facility and resident sign and agree to the new charges. Staff B stated she could not remember if R1 had a private caregiver or if she had been charged extra for services. Staff B stated that it was the family's responsibility to find a private caregiver if one was needed, not the facility.

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) 10.20.2023

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

Administrator (or Representative) 9.19.2023 Date

During an interview on 08/22/2023 at 10:30am, Staff A stated that RR1 was aware of the extra charges for the caregiver. When asked if she had spoken to RR1 about the caregiver and the charges, Staff A stated that Staff E. (Marketing Director) had set up the private caregiver and had explained the charges to him. When asked if this was in writing, Staff A stated it was not. When asked if the facility was responsible for getting private caregivers for residents, Staff A stated that it was the family's responsibility. When asked why a staff member would set up the private caregiver for R1, Staff A stated that they were trying to help.

During an interview on 08/23/2023 at 12:09pm, Staff E stated that she did not call RR1 regarding a private care giver and/or additional care charges. Staff E stated that Staff A and B (Former Administrator) told her that they had notified R1's representative to pick R1 up or get her a one to one caregiver. Staff E stated that she was asked by Staff A and B to find home care agencies that would respond fast, and that was all she did. Staff E stated that she was later informed that RR1 did not pay his bill. Staff E stated she then reached out to RR1, and he told her that there was no discussion about having a one-to-one private caregiver for R1 around the clock. Staff E stated she asked Staff B if RR1 had been notified, and Staff B stated that she thought somebody did.

During an interview on 08/25/2023 at 10:51am, Staff B stated that the facility did not charge residents for services without written consent. Staff B stated that if there were changes in care levels, the facility would go over them with the resident and their representative during a care conference. Staff B stated that residents or their representative sign a level of care change form, where both the facility and resident sign and agree to the new charges. Staff B stated she could not remember if R1 had a private caregiver or if she had been charged extra for services. Staff B stated that it was the family's responsibility to find a private caregiver if one was needed, not the facility.

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

Plan of Correction

Agency Name: Vineyard Park Puyallup	Citation Date
	9.7.2023
Submitted by: Marissa Canada Executive Director	Date of POC Submission
	9.15.2023
☒ Complaint Citation ☐ Certification Citation	

Citation: (list WAC) WAC 388-78A-2640	
	Reporting significant change in a residents condition
How will you apply the correction to all clients you support?	Director of nursing and or Executive director will document any verbal communication with family in progress notes. Change of condition form will be completed for any significant change, verbal communication will take place immediately and an in person care conference will be scheduled to discuss and obtain signature from resident or residents POA.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Marissa Canada Executive Director, Letisha Leyva DNS LPN,
Date by which lasting correction will be achieved	10/20/2023
Additional Information	SOD received on 9.7.23

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 9-7-23
Submitted by: Marissa Canada Executive Director	Date of POC Submission
	9-15-23
☐ Complaint Citation ☐ Certification Citation	

Citation: (list WAC) RCW 70.129.030	
	Notice of rights and services: Admission of individuals
How will you apply the correction to all clients you support?	Executive Director will review and have signed Exhibit 2A from our contract titled: Additional services, items and activities not covered in the Basic Service Rate. Private duty aids are listed here. Residents or POA will be required to obtain their own private care aid and contract that service directly.
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Marissa Canada Executive Director, Letisha Leyva DNS LPN,
Date by which lasting correction will be achieved	10/20/2023
Additional Information	SOD received on 9/7/2023

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 9-07-2023
Submitted by: Marissa Canada Executive Director	Date of POC Submission:
	9.15.2023
☒ 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?	**System or Operational Changes:** **Progress note will be entered by DNS and ED for any verbal communications with residents or family for required discharges. Written notice will be certified mailed to POA/ resident for written documentation and certification of receipt.**
Who will be responsible to implement change and monitor the corrections to ensure the problems do not reoccur?	Marissa Canada Executive Director, Letisha Leyva DNS
Date by which lasting correction will be achieved	10/20/2023
Additional Information	SOD received on 9/7/2023

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

Manfay Chan, Field Manager

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