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) 61499 (Completion Date 06/24/2025) and 52941 (Completion Date 01/29/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/24/2025 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:
WAC 388-78A-2371-1, WAC 388-78A-2371-2, WAC 388-78A-2371-3, WAC 388-78A-2371-4, WAC 388-78A-2371, WAC 388-78A-2640-1-a, WAC 388-78A-2640-1-b, WAC 388-78A-2640-3-a, WAC 388-78A-2640-3-b, WAC 388-78A-2640-3

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, Allied Health 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: 154136
Compliance Determination #: 52941
Region/Unit #: RCS Region 3 / Unit D
Investigator: Carol Gijima
Investigation Date(s): 11/05/2024 through 01/29/2025
Complainant Contact Date(s): 02/03/2025

Allegation(s):
1. Facility didn't investigate or protect resident after a fall resulted in a fracture

Investigation Methods:

Sample:	Total residents: Resident sample size: 4 Closed records sample size:
Observations:	General environment Residents in their rooms Staff-to-resident interactions Resident behaviors
Interviews:	Residents Staff Resident representatives
Record Reviews:	Resident Characteristic Roster Resident assessments and negotiated service agreements including the records of the named resident Staff records Staff progress notes Incident log / reports, Facility P & P- Incident/Accident Documentation and Reporting

Investigation Summary:
1. Per record review, interviews with resident's representative, collateral contacts, and staff, the facility failed to investigate an injury of unknown origin, failed to notify the resident's representative and provider of injury, fracture and transfer to the hospital. The ALF demonstrated failed provider practice as documented in a Statement of Deficiencies dated 01/29/2025.

Conclusion / Action:

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

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Statement of Deficiencies Plan of Correction Page 1 of 8	License #: 2553 Vineyard Park of Puyallup Licensee: Puyallup ALC LLC	Compliance Determination # 52941 Completion Date 01/29/2025

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 11/05/2024 and 12/30/2024 of:

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

This document references the following complaint number(s): 151075, 154136, 156135

The following sample was selected for review during the unannounced on-site visit: 4 of 0 current residents and 0 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

02/12/2025
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)

2.12.25
Date

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

(4) Protect residents during the course of the investigation.

This requirement was not met as evidenced by:

Based on interviews and record review, the Assisted Living facility (ALF) failed to investigate and protect a resident from potential abuse/neglect when they had an injury of unknown source for 1 of 4 sampled residents (Resident 1[R1]). This failure resulted in Resident 1 not receiving care which caused her to be in pain for days for a broken clavicle and placed all 20 memory care residents at risk for abuse/neglect from staff.

Findings included...

Record review of the ALF's undated "Protocol for Reporting Incidents" policy showed that the ALF would complete a "thorough documentation of the investigation and residents will be protected" during the process of the investigation of an incident.

There was no record of an investigation on file to review.

There was no documentation to show that changes or interventions put in place or temporary service plan on how to care for R1 while she had an injury and sling, or how to prevent the recurrence. There was no documentation to show staff were in-serviced to prevent similar events from occurring, or staff retraining on reporting requirements.

Documents provided by the ALF on 12/09/2024 showed that corrective action for the employees were written on 11/05/2024 (the day of the department's visit), and the employees were terminated on 11/08/2024.

R1's records showed that R1 was admitted to the ALF on [redacted]/2022 with diagnoses to include [redacted].

Review of the progress notes for R1 showed that on 10/30/2024 staff found a bruise on R1's right shoulder and R1 "expressed slight pain." A progress note dated 11/01/2024 at 9:46pm showed R1 being on alert for a "bruise and bump on R (right) shoulder." A progress note on 11/03/2024 showed that R1 was sent to the hospital for a fractured clavicle from an "unnoted fall." There were no records that showed that an investigation was completed as to the circumstances surrounding the bruise or the fall.

During an interview on 11/04/2024 at 10:23am, Anonymous Reporter stated that R1 had a fall on 10/29/2024 which was not investigated or reported to the state. Reporter stated that R1 sustained a fall the morning of 10/29/2024 and two caregivers helped R1 back up and didn't report or document the incident. Anonymous Reporter stated that Staff D, Resident Care Coordinator was notified on 10/30/2024 that R1 had a bruise of unknown origin. Anonymous Reporter stated that Staff D did not initiate an incident report, investigate or ask any staff about the bruise. Anonymous Reporter stated that the two caregivers responsible were not suspended or interviewed to find out what happened. Reporter stated that the caregivers were still working with "vulnerable residents." Reporter stated that they were concerned that R1 and all memory care residents were not being protected from potential abuse and neglect from the two staff.

During an interview on 11/05/2024 at 2:15pm, Staff C, Resident Care Coordinator stated they were notified by a caregiver the morning of 11/03/2025 that R1 had a bruise and a bump to their right shoulder. Staff C stated that when they checked on R1, R1 was "grimacing and guarding her arm." Staff C stated that they suspected a fracture and decided to call emergency services and have R1 evaluated at the hospital.

During an interview on 11/05/2024 at 2: 30pm, Staff E, Caregiver was asked if they knew what had happened with R1's fracture. Staff E stated that the morning of 10/29/2024 while they were still putting their belongings away, the night shift staff (Staff F) asked for help getting R1 off the floor. Staff E stated that when they asked if R1 had fallen, Staff F told them that R1 had not fallen but had slipped off the bed. Staff E stated that they didn't report this because Staff F was responsible for the resident when the incident happened. Staff E stated that Staff D, Resident Care Coordinator, was

notified that R1 had a bruise to their right shoulder on 10/30/2024. When asked if anyone had questioned them about the likely cause of the bruise, Staff E stated that no one asked about R1. When asked what care plan changes were made to care for R1 after the fracture, Staff E stated, "nothing changed." When asked if they had been retrained on reporting resident incidents after R1's incident, Staff E stated that they were not.

During an interview on 11/05/2024 at 2:45pm Staff B, Director of Nursing was asked what the circumstances were surrounding R1's bruise to the shoulder. Staff B stated that Staff D had found the bruise while R1 was getting dressed the morning of 10/30/2024. When asked what the investigation findings were, Staff B stated that R1 was sent to the hospital for a fractured clavicle. When asked for a copy of the investigation, Staff B stated that they were still working on it and would send it within a couple of days. When asked why the named staff were still working if they had not completed an investigation involved a significant injury of unknown origin, Staff B stated, "we just found out about the fracture."

In a separate interview on 12/09/2024, Staff B was asked what the findings of the investigation were, Staff B stated that Staff F had asked Staff E to assist getting R1 off the floor and both staff had been terminated for not reporting a fall. Staff B did not provide an answer when asked what had caused the fall or where the fall had occurred. When asked if the bruise had been investigated when it was initially found, Staff B stated they "assumed it was an unreported fall." Staff B was asked how they ruled out abuse or neglect of R1. Staff B stated, "I can't answer that question." Staff B was asked how they protected R1 and other residents from potential abuse/neglect since there was no investigation and the staff involved were still working on the day of the department's unannounced visit and that staff had not been interviewed about the bruise or the fall until after the department's visit on 11/05/2024, Staff B stated, "I can't answer that question."

During an interview on 01/14/2025 at 9:40am, Collateral Contact 1 (CC1) stated that they saw the bruise to R1's shoulder and heard "she had a fracture." When asked what caused the fracture, CC1 stated that they didn't know. CC1 stated that it was reported to them that R1 had "a couple of unwitnessed falls." When asked where those falls occurred, CC1 stated they "had no idea where she fell or when."

During an interview on 01/14/2024 at 9:56am, Collateral Contact 2 (CC2) stated that when they notified Staff D about the bruise on R1's shoulder the evening of 10/29/2024, Staff D stated they were aware and were taking care of it. When asked if R1 was on alert for the bruise, CC2 stated they were not. CC2 was asked what changes were made to the care plan after R1's fracture. CC2 stated that they were not aware of any changes to care.

During an interview on 01/14/2025 at 10:07am Collateral Contact 3 (CC3) was asked what had happened to result in R1 sustaining a clavicle fracture. CC3 stated they did not know. When asked if they did not get a report about residents when they came on

shift, CC3 stated that they were not given the report on R1's condition or what had caused the fracture. CC3 stated that they heard from other people that R1 might have fallen but that "she was ok." When asked if there were any changes to the care plan or in R1's care, CC3 stated that staff provided "extra care." CC3 was not able to explain what the extra care given was.

During an interview on 01/14/2025 at 10:23am, Collateral Contact 4 (CC4) stated that they did not know how R1 sustained the fracture. CC4 stated they asked what had happened when they saw R1 with a sling and no one knew what had happened. When asked if there were any temporary changes to R1's care for staff to follow, CC4 stated they were not aware of any changes. CC4 was asked if there were any in-services about reporting resident incidents or how to prevent falls. CC4 stated that there was not.

During an interview on 01/14/2025 at 10:56am, Collateral Contact 5 (CC5) stated that a caregiver noticed that R1 was not responding per their usual manner and was unable to move their right arm during a shower. CC5 stated that the caregiver notified the medication technician who suspected a fracture and called 911 for transport to the hospital. When asked what had happened to cause the fracture, CC5 stated that they were told R1 fell but "no one saw it...no one knows what happened." When asked if there were any changes to R1's care plan, CC5 stated there was not. When asked if staff received any form of education or training regarding reporting requirements for resident incidences, CC5 stated that they were no in-services.

During an interview on 01/23/2025 at 12:04pm, Staff A, Administrator stated that their policy required resident incidents to be investigated; that an incident report was to be completed immediately after the incident. Staff A stated that injuries of unknown source would be reported to the state, and if there was suspected abuse or neglect from staff, they would be suspended pending investigation. When asked who was responsible for investigations, Administrator stated that Resident Care Coordinators or the Director of Nursing. Administrator stated there was no reason for not investigating.

During an interview on 01/29/2025 at 2:02pm, Staff D, Resident Care Coordinator was asked what had happened with R1's bruise. Staff D stated that they found the bruise on 10/30/2024 while providing care for R1. Staff D stated that R1 was "babying her arm...showing nonverbal signs of pain." When asked what had caused the bruise, Staff D stated they didn't know. Staff D was asked what was done to follow up on the pain and guarding of the arm. Staff D stated that they couldn't remember and would have to go back and see. Staff D was asked why they didn't follow up or investigate the pain and guarding of the arm as the clavicle could have been fractured when they found the bruise. Staff D stated, "I did my job." Staff D was asked what had been done to manage R1's pain when the bruise was found. Staff D stated R1 was placed on alert for increased pain. When reminded that R1 was already in pain per their earlier statement and nothing was done for days until another staff sent R1 to the hospital, Staff D stated that R1 was "monitored for 72hrs, and if pain worsened, then they would send her out." Staff D was asked who was responsible for investigating incidents, Staff D stated that Resident Care Coordinators and the Director of Nursing. When asked why they didn't complete the investigation since they had discovered the injury, Staff D stated that they

completed an incident report and notified the director of nursing. When asked about the fracture, Staff D stated that they didn't find out about the fracture until the day R1 was sent to the hospital. Staff D was asked what had caused the fracture, Staff D stated, "I don't know if they found the cause." When asked if the fracture could have been present when they found the bruise on 10/30/2024, and if they could have managed pain then, Staff stated that it was possible, that resident wasn't showing signs of pain and had been placed on alert to monitor for increased pain. Staff D stated that they would look up the incident and send the report.

No documents were received as of the writing of this statement of statement of deficiency.

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) ~~3.20.2025~~ 3.19.2025

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

Administrator (or Representative) 2.22.25 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;

(b) The resident is relocated to a hospital or other health care facility; or

(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 review and interviews, the Assisted Living Facility (ALF) failed to notify the resident's representative or provider of an injury of unknown origin, sustained a

fracture and was sent to the hospital for 1 of 4 sampled residents (Resident 1 [R1]). This failure resulted in delayed care for Resident 1 and placed resident at risk for a decrease in quality of life.

Findings included...

Review of the ALF's "Incident/Accident Documentation and Reporting" policy dated 10/01/2020 stated that "Staff will report all incidents/accidents involving residents to the Director of Nursing or Administrator in the nurse's absence, resident representative (as applicable), and resident physician."

Review of R1's records showed that R1 was admitted to the ALF on [redacted]/2022 with diagnoses to include [redacted].

Review of the R1's progress notes showed that on 10/30/2024, R1 had a "yellow/purple bruise on right shoulder." An incident report dated 11/03/2024 showed that R1 was sent to the hospital for signs of pain to right shoulder and a fracture resulting from an "unnoted fall." There was no documentation in R1's records that showed that R1's representative or provider were notified on 10/30/2024 when the bruise was found or on 11/03/2024 when R1 was sent to the hospital.

During an interview on 11/05/2024 at 2:45pm, Staff B Director of Nursing was unable to state who notified R1's representative of the bruise or the fracture. When asked who notified R1's provider, and when, of the transfer to the hospital, Staff B stated R1's provider was onsite.

During an interview on 01/13/2025 at 2:16pm, Collateral Contact 6 (CC6) stated that the facility did not notify R1's representative that R1 was being sent to the hospital for a suspected fracture. CC6 stated that the EMT's were the ones who notified R1's representative. CC6 stated that the ALF did not inform R1's representative about a fall or an explanation of how R1 could have sustained a clavicle fracture. CC6 stated that R1's representative was informed of the fracture by the hospital nurse. CC6 stated that the ALF had still not informed R1's representative of what could have happened.

During an interview on 01/24/2025 at 9:43am, Collateral Contact 7 (CC7) stated that the provider was not notified of R1's bruise to the shoulder, the transfer to the hospital or the fracture. When asked if the provider was at the facility on 11/03/2024 to see R1, CC7 stated that the provider was not at the facility on that day. CC7 stated that the provider saw R1 on 11/05/2024 as part of a regularly scheduled visit and was then informed that R1 had a fall and sustained a right clavicle fracture. CC7 stated that the provider then ordered some pain medication.

Statement of Deficiencies	License #: 2553	Compliance Determination # 52941
Plan of Correction	Vineyard Park of Puyallup	Completion Date
Page 8 of 8	Licensee: Puyallup ALC LLC	01/29/2025

During an interview on 01/23/2025 at 12:04pm, Staff A, Administrator stated that the facility policy was to report resident incidents to their representatives, their provider, the nurse and to the Administrator and that notification would be documented on the incident report.

During an interview on 01/29/2025 at 2:02pm, Staff D, Resident Care Coordinator was asked what the facility policy was regarding reporting significant changes or hospital transfers. Staff D stated that the nurse, resident's representative, Administrator and R1's provider was notified. Staff D stated they discovered the bruise on 10/30/2024 while providing care for R1. When asked who they had notified upon discovering the bruise. Staff D stated that the nurse, resident's representative, Administrator and resident provider were notified. When asked where that documentation was, Staff D stated that it would be on the incident report, that they would look up the incident and send documentation.

No documents were received as of the writing of this statement of statement of deficiency.

This is a recurring deficiency that was 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) ~~2.28.2025~~ 3.15.2025.

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

Administrator (or Representative) — Date: 2.22.2025