STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Covington ALC LLC
Vineyard Park of Covington
17016 SE Wax Rd
Covington, WA 98042

RE: Vineyard Park of Covington License # 2593

Dear Administrator:

This letter addresses Compliance Determination(s) 43114 (Completion Date 06/24/2024) and 37990 (Completion Date 04/12/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/24/2024 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:
WAC 388-78A-2170-1

The Department staff who did the on-site verification:
Harrison Udoye, Community Complaint Investigator

If you have any questions, please contact me at (253)234-6020.

Sincerely,

Laurie Anderson

Laurie Anderson, Field Manager
Region 2, Unit D
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Vineyard Park of Covington **Provider Type:** Assisted Living Facility

License/Cert.#: 2593
Intake ID: 120424
Compliance Determination #: 37990
Region/Unit #: RCS Region 2 / Unit D
Investigator: Harrison Udoye
Investigation Date(s): 03/08/2024 through 04/12/2024
Complainant Contact Date(s): 03/08/2024

Allegation(s):
Missing Resident

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Activities Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Identified staff Nursing staff Residents Family members Staff development coordinator Maintenance staff
Record Reviews:	Incident investigation State reporting log Hospital records Personnel files Facility policies Staff training records Staff patterns

Investigation Summary:
Report of Resident locked in the storage closet in the Assisted Living Facility (ALF). Interview and record review showed that Named Resident was seen by facility care staff on [redacted]/2024 at around 10:10 PM in the common area without any shoes. Facility staff told Named Resident to go back to the room and get some shoes on. At 5:00 AM

on [redacted]/2024, facility med tech went in to give morning medication and Named Resident was nowhere to be found. Facility staff initiated their missing person protocol, notified Named Resident representative and local law enforcement. Per facility staff, they searched the entire building and still no sign of the Named Resident. Law enforcement deployed their search and rescue in the surrounding area. Named Resident was found by the local search and rescue team on the morning of [redacted]/2024 in the storage closet next to the front desk of the entrance. Facility staff failed to lock the storage closet that was not intended for Resident access. Facility failed practice identified. Citation issued.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Vineyard Park of Covington **Provider Type:** Assisted Living Facility

License/Cert.#: 2593
Intake ID: 121129
Compliance Determination #: 37990
Region/Unit #: RCS Region 2 / Unit D
Investigator: Harrison Udoye
Investigation Date(s): 03/08/2024 through 04/12/2024
Complainant Contact Date(s): 03/08/2024

Allegation(s):
Missing Resident

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Activities Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions Medication administration
Interviews:	Nursing staff Residents Family members Business office manager Staff development coordinator
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies Personnel files Staff training records Staff patterns

Investigation Summary:
Report of Resident locked in the storage closet in the Assisted Living Facility (ALF). Interview and record review showed that Named Resident was seen by facility care staff on [redacted]/2024 at around 10:10 PM in the common area without any shoes. Facility staff told Named Resident to go back to the room and get some shoes on. At 5:00 AM

on [redacted]/2024, facility med tech went in to give morning medication and Named Resident was nowhere to be found. Facility staff initiated their missing person protocol, notified Named Resident representative and local law enforcement. Per facility staff, they searched the entire building and still no sign of the Named Resident. Law enforcement deployed their search and rescue in the surrounding area. Named Resident was found by the local search and rescue team on the morning of [redacted]/2024 in the storage closet next to the front desk of the entrance. Facility staff failed to lock the storage closet that was not intended for Resident access. Facility failed practice identified. Citation issued.

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

20425 72nd Avenue S, Suite 400, Kent, WA 98032

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 03/08/2024, 03/08/2024, 04/12/2024 and 03/08/2024 of:

Vineyard Park of Covington
17016 SE Wax Rd
Covington, WA 98042

This document references the following complaint number(s): 120424, 121129

The following sample was selected for review during the unannounced on-site visit: 3 of 51 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Harrison Udoye, Community Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

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.

Staci Dilly IDR PM for Region 2D
Residential Care Services

June 14, 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.

Statement of Deficiencies	License #: 2593	Compliance Determination # 37990
Plan of Correction	Vineyard Park of Covington	Completion Date
Page 2 of 3	Licensee: Covington ALC LLC	04/12/2024

Administrator (or Representative)

6/24/24
Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 51of 51 residents (Residents 1 to 51) resided in a safe environment by not securing a closet door that should have been locked and conducting a thorough search of the facility. This failure resulted in Resident 1 not being found in a storage room closet for 36 hours and placed all residents at risk of harm and injury from unsafe conditions.

Finding included...

Review of the facility's undated policy titled, "Elopement-Missing Person", showed that the facility provided a safe environment for all their residents with cognitive or mental health concerns. The policy showed that the facility encouraged independence and freedom of movement of all their residents.

Review of the facility incident investigation, dated 02/28/2024, showed that facility staff last saw Resident 1 on [redacted]2024 at 10:10 PM, on the first-floor hallway outside their room. The investigation showed that staff noted Resident 1 had no shoes, was encouraged to go back to their room and get some shoes. Resident 1 obliged and went back to their room. On [redacted]2024 at 6:00 AM, care staff went to Resident 1's room to administer medication. Resident 1 was not in their room. The investigation showed that care staff initiated the facility's missing person procedure. Staff searched the entire facility to make sure that Resident 1 was not in the building before staff notified the facility management. The investigation showed the facility staff contacted law enforcement, Search and Rescue, and Resident 1's family. A search of the neighborhood was initiated. The investigation showed that on the morning of [redacted]/2024, Resident 1 was discovered located in a locked storage room, inside the facility, that staff did not initially search. The investigation showed that staff failed to secure the storage room, as required.

During an interview on 03/08/2024 at 2:35 PM, Staff B, Director of Nursing, stated that Resident 1 was found on [redacted]2024 around 11:00 AM in the utility storage room, on the floor, wedged between boxes. Staff B stated that Resident 1 was alert, vital signs were stable, and there were no apparent physical injuries. Staff B stated that Resident 1 was severely dehydrated and was taken to the hospital for further evaluation and treatment.

Administrator (or Representative) Date

WAC 388-78A-2170 Required assisted living facility services.

(1) The assisted living facility must provide housing and assume general responsibility for the safety and well-being of each resident, as defined in this chapter, consistent with the resident's assessed needs and negotiated service agreement.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure 51of 51 residents (Residents 1 to 51) resided in a safe environment by not securing a closet door that should have been locked and conducting a thorough search of the facility. This failure resulted in Resident 1 not being found in a storage room closet for 36 hours and placed all residents at risk of harm and injury from unsafe conditions.

Finding included...

Review of the facility's undated policy titled, "Elopement-Missing Person", showed that the facility provided a safe environment for all their residents with cognitive or mental health concerns. The policy showed that the facility encouraged independence and freedom of movement of all their residents.

Review of the facility incident investigation, dated 02/28/2024, showed that facility staff last saw Resident 1 on [redacted]/2024 at 10:10 PM, on the first-floor hallway outside their room. The investigation showed that staff noted Resident 1 had no shoes, was encouraged to go back to their room and get some shoes. Resident 1 obliged and went back to their room. On [redacted]2024 at 5:00 AM, care staff went to Resident 1's room to administer medication. Resident 1 was not in their room. The investigation showed that care staff initiated the facility's missing person procedure. Staff searched the entire facility to make sure that Resident 1 was not in the building before staff notified the facility management. The investigation showed the facility staff contacted law enforcement, Search and Rescue, and Resident 1's family. A search of the neighborhood was initiated. The investigation showed that on the morning of [redacted]2024, Resident 1 was discovered located in a locked storage room, inside the facility, that staff did not initially search. The investigation showed that staff failed to secure the storage room, as required.

During an interview on 03/08/2024 at 2:35 PM, Staff B, Director of Nursing, stated that Resident 1 was found on [redacted]2024 around 11:00 AM in the utility storage room, on the floor, wedged between boxes. Staff B stated that Resident 1 was alert, vital signs were stable, and there were no apparent physical injuries. Staff B stated that Resident 1 was severely dehydrated and was taken to the hospital for further evaluation and treatment.

Statement of Deficiencies	License #: 2593	Compliance Determination # 37990
Plan of Correction	Vineyard Park of Covington	Completion Date
Page 3 of 3	Licensee: Covington ALC LLC	04/12/2024

Staff B stated that the storage room located next to the front desk entrance was only used by staff. Staff B stated that the staff were required to always keep the storage room locked when not in use. Staff B stated that the investigation was unable to determine who left the storage room unlocked. Staff B stated that the investigation did not determine why the storage room was excluded from the original search of the building. Staff B stated that the investigation was unable to determine how Resident 1 became locked in the storage room.

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 Covington is or will be in compliance with this law and / or regulation on (Date) [redacted] 5/26/24 (60).

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

Administrator (or Representative) 6/24/24 Date

Staff B stated that the storage room located next to the front desk entrance was only used by staff. Staff B stated that the staff were required to always keep the storage room locked when not in use. Staff B stated that the investigation was unable to determine who left the storage room unlocked. Staff B stated that the investigation did not determine why the storage room was excluded from the original search of the building. Staff B stated that the investigation was unable to determine how Resident 1 became locked in the storage room.

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 Covington 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