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

Laurel Glen ALC LLC
Vineyard Park of Bremerton
2707 Clare Ave
Bremerton, WA 98310

RE: Vineyard Park of Bremerton License # 2695

Dear Administrator:

This letter addresses Compliance Determination(s) 63494 (Completion Date 08/05/2025) and 46959 (Completion Date 11/12/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/05/2025 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-2660-1

The Department staff who did the on-site verification:
Shelley Neeleman, ALF Complaint Investigator

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 Bremerton **Provider Type:** Assisted Living Facility

License/Cert.#: 2695
Intake ID: 149385
Compliance Determination #: 46959
Region/Unit #: RCS Region 3 / Unit D
Investigator: Shelley Neeleman
Investigation Date(s): 09/10/2024 through 11/12/2024
Complainant Contact Date(s):

Allegation(s):

Other - Admission, Discharge, Transfer Rights:
1) The AV2 was driven by facility staff to daughter's home without proper notification.
2) The AV2 was dropped off without the ordered medications.
3) There was an appeal date set for October 15th, 2024 to pause the AV2's discharge on the grounds that the daughter's home was not a safe location for the discharge. The prehearing conference through the Office of Administrative Hearing was not honored.
4) There is no bed at the AV2's daughter's home, and the AV2 was discharged to the person who was under an open [redacted] investigation. The AV2's discharge was not safe.

Investigation Methods:

Sample:
Total residents: 1
Resident sample size: 1
Closed records sample size:

Observations:
General environment
Residents
Resident rooms
Staff
Staffing levels
Resident to staff interactions

Interviews:
Staff
Collateral Contacts
AV2

Record Reviews:
Resident Characteristic Roster
Face Sheet
Notice of Prehearing Conference, request date 09.20.2024
Service Plan
Progress Notes
CPMG Resident services Policies and Procedures: Resident Discharge, annual review 09.01.2024
Boarding Home Transfer and Discharge Notice, dated

07/15/2024
Boarding Home Transfer and Discharge Notice, dated 09/01/2024
AV2's Resident Rental and Admission Agreement, dated 06/19/2024
Email from ALTSA Social Services Specialist 5 to the AV2's daughter, dated 06/26/2024 at 11:35 a.m.
Email from DSHS Public Benefits Specialist 4/Home and Community Services to Social Services Specialist 5, Biz Office VP, Executive Director, AV2's daughter, dated 07/22/2024 at 4:35 p.m.
Email from Executive Director to Ombudsman, dated 09/19/2024 at 1:09 p.m.
Email from Executive Director to Ombudsman, dated 10/03/2024
Email from Executive Director, dated 10/31/2024 at 5:05 p.m.
Email from Executive Director, dated 10/31/2024 at 5:19 p.m.
Email from Executive Director, dated 11/05/2024 at 3:48 p.m.
Email from Care Partners CEO, dated 11/05/2024 at 4:04 p.m.
Email from Care Partners CEO, dated 11/06/2024 at 9:52 a.m.
Email from Executive Director with attached statement of the timeline of events from Business Office Manager, dated 10/31/2024 at 3:42 p.m.
Statement from Maintenance Director, dated 11/05/2024

Investigation Summary:

1) Per interview and record review, the AV2 was driven by facility staff to the daughter's home on [redacted]/2024 with three boxes of clothing and some medications, and was unaware of a discharge date.

Record review of "Boarding Home Transfer and Discharge Notice", dated 09/01/2024, documented "date notice is given" was 07/16/2024, the date notice was "mailed out" was 07/16/2024, the original notice was sent out on 07/15/2024, and the discharge "effective date" was 09/25/2024. The "discharge address" indicated on the notice was a Willow Street address, which was not the actual discharge location. The form did not indicate where the notice was sent or if the notice was received.

A record review did not identify a written notification of an [redacted], 2024 discharge date to the AV2.

The facility failed to notify the resident of the discharge in writing and in a language and manner understood by the resident, and failed to provide the effective date of discharge, as outlined in WAC 388.78A.2660(1) and RCW 74.129.110(3)(b)(5)(b).

2) Per interview and record review, the AV2 received some medications at the time of discharge, but not the as-needed narcotic medications, which the AV2 was taking regularly for chronic pain. The AV2 had to retrieve the narcotic medications from the facility the following morning.

The facility failed to provide sufficient preparation and orientation to ensure a safe and orderly discharge from the facility, as outlined in WAC 388.78A.2660(1) and RCW 74.129.110(6).

3) Per interview and record review, the Washington State Office of Administrative Hearings scheduled a prehearing conference for October 15, 2024 at 1:00 p.m. regarding Medical Assistance Transfer. The AV2 was discharged from the facility on [redacted] 2024.

There was no indication that the facility was required to postpone the AV2's discharge in order to honor the October 15th hearing date.

Unable to substantiate allegation.

4) Per interviews, there was no indication that the AV2 did not have a safe place for the AV2 to sleep at the daughter's house and no indication that the daughter's house was unsafe. There continues to be an open [redacted] investigation, and at this time there is no indication that the issues being investigated are indicative of an unsafe discharge.

Unable to substantiate allegation.

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 Bremerton **Provider Type:** Assisted Living Facility

License/Cert.#: 2695
Intake ID: 151696
Compliance Determination #: 46959
Region/Unit #: RCS Region 3 / Unit D
Investigator: Shelley Neeleman
Investigation Date(s): 09/10/2024 through 11/12/2024
Complainant Contact Date(s):

Allegation(s):

Other - Admission, Discharge, Transfer Rights:
1) The AV2 was playing Bingo when the facility boxed up his belongings, got him out of Bingo and took him to his daughters with no notice.
2) The AV2 did not have his medications at his daughter's house and had to go back to get his medications from the facility.

Investigation Methods:

Sample:	Total residents: 1 Resident sample size: 1 Closed records sample size:
Observations:	General environment Residents Resident rooms Staff Staffing levels Resident to staff interactions
Interviews:	Staff Collateral Contacts AV2
Record Reviews:	Resident Characteristic Roster Face Sheet Notice of Prehearing Conference, request date 09.20.2024 Service Plan Progress Notes CPMG Resident services Policies and Procedures: Resident Discharge, annual review 09.01.2024 Boarding Home Transfer and Discharge Notice, dated 07/15/2024 Boarding Home Transfer and Discharge Notice, dated 09/01/2024 AV2's Resident Rental and Admission Agreement, dated 06/19/2024 Email from ALTSA Social Services Specialist 5 to the AV2's

daughter, dated 06/26/2024 at 11:35 a.m.
Email from DSHS Public Benefits Specialist 4/Home and Community Services to Social Services Specialist
5, Biz Office VP, Executive Director, AV2's daughter, dated 07/22/2024 at 4:35 p.m.
Email from Executive Director to Ombudsman, dated 09/19/2024 at 1:09 p.m.
Email from Executive Director to Ombudsman, dated 10/03/2024
Email from Executive Director, dated 10/31/2024 at 5:05 p.m.
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Email from Executive Director, dated 11/05/2024 at 3:48 p.m.
Email from Care Partners CEO, dated 11/05/2024 at 4:04 p.m.
Email from Care Partners CEO, dated 11/06/2024 at 9:52 a.m.
Email from Executive Director with attached statement of the timeline of events from Business Office
Manager, dated 10/31/2024 at 3:42 p.m.
Statement from Maintenance Director, dated 11/05/2024

Investigation Summary:

1) Per interview and record review, the AV2 was driven by facility staff to the daughter's home on [redacted]/2024 with three boxes of clothing and some medications, and was unaware of a discharge date.

Record review of "Boarding Home Transfer and Discharge Notice", dated 09/01/2024, documented "date notice is given" was 07/16/2024, the date notice was "mailed out" was 07/16/2024, the original notice was sent out on 07/15/2024, and the discharge "effective date" was 09/25/2024. The "discharge address" indicated on the notice was a Willow Street address, which was not the actual discharge location. The form did not indicate where the notice was sent or if the notice was received.

A record review did not identify written notification of an [redacted] 2024 discharge date to the AV2.

The facility failed to notify the resident of the discharge in writing and in a language and manner understood by the resident, and failed to provide the effective date of discharge, as outlined in WAC 388.78A.2660(1) and RCW 74.129.110(3)(b)(5)(b). A Statement of Deficiency outlining the failed practice is being submitted for the related intake #149385.

2) Per interview and record review, the AV2 received some medications at the time of discharge, but not the as-needed narcotic medications, which the AV2 was taking regularly for chronic pain. The AV2 and daughter had to retrieve the narcotic medications from the facility the following morning.

The facility failed to provide sufficient preparation and orientation to ensure a safe and orderly discharge from the facility, as outlined in WAC 388.78A.2660(1) and RCW 74.129.110(6). A Statement of Deficiency outlining the failed practice is being submitted for the related intake #149385.

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 #: 2695	Compliance Determination # 46959
Plan of Correction	Vineyard Park of Bremerton	Completion Date
Page 1 of 5	Licensee: Laurel Glen ALC LLC	11/12/2024

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 09/10/2024 and 11/12/2024 of:

Vineyard Park of Bremerton
2707 Clare Ave
Bremerton, WA 98310

This document references the following complaint number(s): 142634, 149385, 151696

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

The department staff that investigated the Assisted Living Facility:

Shelley Neeleman, ALF Complaint Investigator

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.

Jody Just
Residential Care Services

11/21/2024
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) Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 1 sampled resident (Resident 1 [R1]) had a safe and orderly discharge from the facility. This failure resulted in R1 being discharged from the facility without sufficient preparation to ensure R1's safety and put R1 at risk for a decreased quality of life.

Findings included...

"RCW 70.129.110(3)(b)(5)(b)(6) Disclosure, transfer, and discharge requirements...(3) Before a long-term care facility transfers or discharges a resident, the facility must...; (b) Notify the resident and resident representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand...; (5) The written notice specified in subsection (3) of this section must include the following...; (b) The effective date of transfer or discharge; (6) A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility; (7) A resident discharged in violation of this section has the right to be readmitted immediately upon the first availability of a gender-appropriate bed in the facility."

Record review of the facility's policy titled, "CPMG Resident Services Policies and Procedures – Resident Discharge", annual review on 09/01/2024, showed that "If necessary and allowed by applicable law, the facility will, with proper written notification, ensure an efficient, safe, and organized transfer.... (2) CarePartners Senior Living will attempt through reasonable accommodations to avoid transfer or discharge. If the transfer or discharge is unavoidable then the facility will: (a) notify the resident and his or her representative and make reasonable efforts to notify, if known, any interested family members of the resident and the reasons for the move in writing and in a language and manner that they can understand...; (c) include in the notice...: ii) the effective date of transfer/discharge...; (4) CarePartners Senior Living will provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility...; (6) A resident discharged in violation of this section has the right to be readmitted immediately or as soon as the first gender-appropriate bed or apartment in the facility becomes available."

Record review of R1's Face Sheet, no date provided, showed that R1 moved into the facility on [redacted]/2024.

Administrator (or Representative) Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure 1 of 1 sampled resident (Resident 1 [R1]) had a safe and orderly discharge from the facility. This failure resulted in R1 being discharged from the facility without sufficient preparation to ensure R1's safety and put R1 at risk for a decreased quality of life.

Findings included...

"RCW 70.129.110(3)(b)(5)(b)(6) Disclosure, transfer, and discharge requirements...(3) Before a long-term care facility transfers or discharges a resident, the facility must...; (b) Notify the resident and resident representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand...; (5) The written notice specified in subsection (3) of this section must include the following...; (b) The effective date of transfer or discharge; (6) A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility; (7) A resident discharged in violation of this section has the right to be readmitted immediately upon the first availability of a gender-appropriate bed in the facility."

Record review of the facility's policy titled, "CPMG Resident Services Policies and Procedures – Resident Discharge", annual review on 09/01/2024, showed that "If necessary and allowed by applicable law, the facility will, with proper written notification, ensure an efficient, safe, and organized transfer.... (2) CarePartners Senior Living will attempt through reasonable accommodations to avoid transfer or discharge. If the transfer or discharge is unavoidable then the facility will: (a) notify the resident and his or her representative and make reasonable efforts to notify, if known, any interested family members of the resident and the reasons for the move in writing and in a language and manner that they can understand...; (c) include in the notice...: ii) the effective date of transfer/discharge...; (4) CarePartners Senior Living will provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility...; (6) A resident discharged in violation of this section has the right to be readmitted immediately or as soon as the first gender-appropriate bed or apartment in the facility becomes available."

Record review of R1's Face Sheet, no date provided, showed that R1 moved into the facility on [redacted]/2024.

Record review of R1's Service Plan, initiated on 06/22/2024, showed that R1 required community staff to prepare all meals and snacks, provide diabetes (a chronic disease in which the body has high blood sugar levels) monitoring, and administer all ordered medications and treatments.

Record review of "Boarding Home Transfer and Discharge Notice", dated 09/01/2024, showed that the "Reason for Discharge or Transfer" was that R1's bill for services at the facility have not been paid after reasonable and appropriate notice to pay.

Record review of the facilities "Boarding Home Transfer and Discharge Notice," dated 07/15/2024, documented "date notice is given" was 07/16/2024, discharge "effective date" was 08/25/2024, and the date notice was "mailed out" was 07/16/2024. There was no discharge location provided on the notice, and no indication of where the notice was sent or if the notice was received.

Record review of the facilities second "Boarding Home Transfer and Discharge Notice", dated 09/01/2024, documented "date notice is given" was 07/16/2024, the date notice was "mailed out" was 07/16/2024, the "original notice was sent out on 07/15/2024," and the discharge "effective date" was 09/25/2024. The "discharge address" indicated on the notice was a Willow Street address, which was not the actual discharge location. The form did not indicate where the notice was sent or if the notice was received by R1 or their representative.

Record review of Progress Note, dated [redacted]/2024 at 4:07 p.m., showed that R1 discharged from Vineyard Park to daughter's house.

Record review of R1's Medication Administration Records (MAR), dated September 2024, showed that R1 had seven ordered medications to be administered either daily or twice daily. R1 has Oxycodone (a strong pain medication), 10 milligram tabs, ordered to be administered every four hours as needed for chronic pain. R1 received the as needed pain medication five times on one day, four times on 15 different days, three times on 11 different days, two times on two different days, and one time on one day during the month of September.

Record review of Progress Note, dated 10/18/2024 at 1:30 p.m., showed that the facility "received a call from [R1's daughter] letting us know that [they] needed the rest of [their] medication." R1's daughter "arrived at Vineyard Park at approximately 9:00 a.m. and signed [R1's pain medications] out."

During an interview with Staff A, the Executive Director (ED), on 10/17/2024 at 3:05 p.m., Staff A stated that R1's [redacted] funding was not approved, and that R1 would therefore be considered private pay.

During an interview with Collateral Contact 1 (CC1), Resident Advocate, on 10/21/2024 at 2:26 p.m., CC1 stated that R1 did not experience a safe discharge to the daughter's home. CC1 stated that R1's rights were violated when R1 was pulled out of an activity on [redacted]/2024 and discharged from the facility without notice. CC1 stated that R1 did not have ordered medications at the time of discharge.

During an interview with Collateral Contact 2 (CC2), R1's Representative, on 10/31/2024 at 1:52 p.m., CC2 stated that R1 was in the facility playing Bingo while staff went into R1's room and packed up all belongings without R1's knowledge. CC2 stated that staff then dropped R1 off at the daughter's house without medications, and that R1 had to pick up the medications the next morning. CC2 stated that R1 believed the discharge would occur after the appeal hearing scheduled on 10/15/2024. CC2 stated that they did not know the date or time of the discharge.

During an interview with Staff A, on 10/31/2024 at 2:06 p.m., Staff A stated that there were multiple conversations with R1 about the discharge, including the day of discharge where Staff A stated to R1 that it was "moving day." Staff A stated that Staff B, the Business Office Manager (BOM), had multiple conversations about discharge with R1, and provided R1 two written discharge notices. Staff A stated that notification was handed to R1.

During an interview with Staff A, on 11/05/2024 at 1:24 p.m., Staff A stated that R1 received all medications at discharge except the as-needed pain medications. Staff A stated that R1's daughter was called the day of discharge to inform that pain medications were left at the facility. Staff A stated that the facility offered to deliver the pain medications to R1.

During an interview with Collateral Contact 3 (CC3), State Employee, on 11/7/2024 at 2:49 p.m., CC3 stated that R1 reported staff came and got R1 from Bingo with a couple of boxes and informed R1 that they were going to the daughter's house. CC3 stated R1 reported that there was no notice, no medications, no inventory of items, and that they had to get a cab ride back to the facility to pick up medications the next day.

During an interview with R1, dated 11/12/2024 at 12:07 p.m., R1 stated that there were discussions about a discharge, but "no one told me it was going to happen that day." and there was no written discharge notice provided. R1 also stated that there was no reason for discharge provided. R1 stated staff packed up belongings, pulled R1 out of Bingo, and drove R1 to the daughter's house without notice and without ordered pain medications. R1 stated that there is no bed at the daughter's house and R1 is sleeping on a small "love seat." R1 stated that the daughter does not help with medication administration.

There was no documentation found indicating the facility provided any preparation and orientation to ensure R1 had a safe and orderly discharge from the facility.

Statement of Deficiencies	License #: 2695	Compliance Determination # 46959
Plan of Correction	Vineyard Park of Bremerton	Completion Date
Page 5 of 5	Licensee: Laurel Glen ALC LLC	11/12/2024

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 Bremerton is or will be in compliance with this law and / or regulation on (Date) 12/10/2024 .

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

Tonya Stone, VP Nursing CarePartners Senior Living

Administrator (or Representative) — Date: 12/02/2024