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

03/03/2025

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

RE: Vineyard Park of Bremerton # 2695

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 55655 (Completion Date 03/03/2025) and 50937 (Completion Date 01/08/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/03/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

(c) The care and services provided to the assisted living facility residents.

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

The Department staff who did the On Site verification:

Nikolas Jennings, Community Nurse Complaint Investigator

If you have any questions, please contact me at (360)397-9556.

Sincerely,

Jody Just, Field Services Administrator
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: 156295
Compliance Determination #: 50937
Region/Unit #: RCS Region 3 / Unit D
Investigator: Nikolas Jennings
Investigation Date(s): 11/25/2024 through 01/08/2025
Complainant Contact Date(s):

Allegation(s):

1) Resident/Patient/ Client Rights
2) State monitoring- Ombudsmen are being retaliated against and impeded from doing their work.
3) Resident/Patient/Client Abuse

Investigation Methods:

Sample:	Total residents: 94 Resident sample size: 5 Closed records sample size: 0
Observations:	Residents Activities Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Executive Director CEO of management group
Record Reviews:	Medical records Facility policies Admission agreement Grievance forms and policy Correspondence between legal council Correspondence with ombudsmen

Investigation Summary:

1) Resident Patient Client Rights
Based on interview and record review there was sufficient evidence to support failed practice. The facilities Management Company retaliated against the State Ombudsman. Failing to comply with State and Federal guidelines placed all residents living in the facility, volunteers and ombudsman entering the facility at risk for infringement of rights and a decreased quality of life.

2) State monitoring- Ombudsmen are being retaliated against and impeded from doing their work.
3) Resident/Patient/Client Abuse. The facility management company failed to report suspect abuse to the department's CRU hotline
Failed Practice Identified.

Conclusion / Action:

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

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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 11/25/2024 and 11/25/2024 of:

Vineyard Park of Bremerton
2707 Clare Ave
Bremerton, WA 98310

This document references the following complaint number(s): 156295

The following sample was selected for review during the unannounced on-site visit: 5 of 94 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Nikolas Jennings, Community Nurse Complaint Investigator
Jody Just, Field Services Administrator

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

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-2730 Licensee's responsibilities.

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(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

(c) The care and services provided to the assisted living facility residents.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to comply with the requirements of chapter 18.20 Revised Code of Washington (RCW), when the Licensee interfered with 3 of 3 Long-Term Care (LTC) Ombuds' (Collateral Contacts 1, 2, & 4[CC1, 2, & 4]) ability to complete their responsibilities and duties as a resident advocate. This failure resulted in the ombuds being accused of abuse, ombuds feeling intimidated, and impacted the ability of the ombuds to effectively advocate for all 94 residents. This placed all residents at risk for infringement of their rights and a decreased quality of life.

Findings included…

RCW 18.20.180, Resident Rights, stated: RCW 70.129.050 through 70.179.170 apply to this chapter and persons regulated under this chapter.

RCW 70.129.090 Advocacy, Access, and Visitation rights, subsection 1(c) stated: The resident has the right and the facility must not interfere with access to any resident by the following: The state long-term care ombuds as established under chapter 43.190 RCW.

Washington Administrative Code 365-18-120, Interference with the Ombudsman's Liability, stated:
(1) It is unlawful under 42 U.S.C. Sec. 3058g(j) and RCW 43.190.090 to take any discriminatory, disciplinary, or retaliatory action against the following persons:
(a) Any employee of a facility or agency;
(b) Any resident or client of a long-term care facility or family member of a resident;
(c) Any ombudsman; or
(d) Any person;
for any communication made, or information given or disclosed, to an ombudsman

carrying out his or her duties unless that person acted maliciously or without good faith.
(2) It is unlawful to willfully interfere with ombudsmen in the performance of their official duties.

Record review of the Department's Complaint Investigation working papers, dated 11/05/2024 at 1:24 PM, showed that Collateral Contact 8 (CC8), the Department Investigator, notified Staff A, the Facility's Administrator, that the facility would be receiving a citation related to the discharge of Resident 1 (R1). The Complaint Investigation working papers showed that R1 was receiving advocacy support from CC2, a LTC ombuds, to appeal the discharge.

Record review of an email dated 11/06/2024, showed Staff B, the facility's Management Company's CEO, sent an email to the following people: Staff A (Facility Administrator), The Department, CC2 (LTC Ombuds), and the Facility's Management Company's attorney. This email was sent one day after the facility was informed that they would be receiving a citation and included CC2, the LTC ombuds, on the email. The email was inviting The Department to attend a meeting discussing current Resident 2's pending discharge from the facility. In the email, Staff B stated, "The fact is a certain party is coaching our residents, and their families, that they do not have to pay their residency invoices and they can stay in our community without any consequences. All you have to do is object to place of discharge as 'unsafe.' Or claim falsely you didn't receive the notice. This in my mind is elder abuse because it promotes unlawful actions and it creates false hope and expectations. This sort of action isn't 'advocacy but illegal activism.' To me as a mandatory reporter, I will call anything like this – even if suspected – to APS and have them investigate. This is elder abuse at its highest."

In an Interview with CC1, a LTC ombuds, on 11/21/2024 at 10:23AM, CC1 stated that Staff B "has a right to complain but the way that he does to me is intimidating to my team members and has caused them stress. CC2 is tough, and even she is distressed by this." CC1 stated that a complaint was filed (to the department) because they feel that Staff B will continue to retaliate against ombuds advocacy. CC1 stated, "I speculate that this is all about the corporation not liking the fact that there is an advocate who is presenting all options to a resident who is being involuntarily discharged."

In an interview with CC2 on 11/21/2024 at 2:02PM, CC2 stated that there has been a lack of respect for resident rights ever since the facility was obtained by the Facility's Management Company. CC2 stated, "I feel like my legs were cut off, getting an email from Staff B insinuating that I have questionable ethics and that I am misleading residents and giving them false hope. There was a pit in my stomach, why should I be upset and aggravated walking into the building to just do my job. It became an aggressive defensive situation, but having to bring the assistant state ombuds on the phone with me, it just infuriated me." CC2 stated that they expect things to get worse following these emails but isn't going to stop doing their job.

In an interview with CC4, LTC ombuds, on 11/27/2024 at 1:47PM, CC4 stated, "I walk lightly when I go in there especially when I talk to the administration. They will tell me one thing, then do the opposite. If they don't like what I am doing, they will file a

complaint against me."

In an interview with Staff B on 12/03/2024 at 4:00PM, Staff B was asked about the email dated 11/06/2024 referenced above, that was sent to Staff A, The Department, and CC2 (LTC ombuds). Staff B stated that they did not email CC2. Staff B stated that in Staff B's judgement, the residents are being coached to lie by CC2. Staff B stated "I have never had an activist like that. This is a person who will proudly say that everything she is doing is advocating for the residents. What she is actually doing is being an activist."

In an interview with Staff A on 12/04/2024 at 2:53PM, Staff A stated that after receiving notification from The Department on 11/05/2024 that the facility would be receiving a citation, Staff A notified Staff B. Staff A, when asked if they thought that the communication they had with Staff B regarding the citation was what led to the emails Staff B sent on 11/06/2024, stated "yes."

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)_____ .

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

_____ _____

Administrator (or Representative) Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to report potential abuse and exploitation concerns to the Complaint Resolution Unit (CRU) for 1 of 2 sampled residents (Resident 1 [R1]). Failure to notify CRU placed all 94 of 94 Residents at risk of unreported abuse and prevented the department from evaluating facility systems in place to protect residents.

Findings included…

“RCW 74.34.035 Reports—Mandated and Permissive—Contents—Confidentiality. (1) When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department.

Record review of an email dated 11/06/2024 from Staff B, Care Partners Management Group CEO to Staff A, Administrator, The Department, Collateral Contact 2 (CC2), Ombudsman, and Care Partner’s attorney, Staff B stated, “This is likely to result in an “anonymous” complaint so why not get ahead of the curve? I second the motion to have RCS attend this family conference. The fact is a certain party is coaching our residents, and their families, that they do not have to pay their residency invoices and they can stay in our community without any consequences. All you have to do is object to place of discharge as ‘unsafe.’ Or claim falsely you didn’t receive the notice. This in my mind is elder abuse because it promotes unlawful actions and it creates false hope and expectations. This sort of action isnt ‘advocacy but illegal activism.’ To me as a mandatory reporter, I will call anything like this – even if suspected – to APS and have them investigate. This is elder abuse at its highest. We exert our legal rights under our legal Admission Agreements, in accordance with the rules and, in turn, certain parties file false complaints and claims. This is manipulation and subversion of the regulatory system against our legal rights. I am here to tell you I will not allow this. I have legal rights and I intend to defend them vigorously. So, we welcome RCS to join the meeting. We have nothing to hide and are within our legal rights when it comes to collection and eviction notices.”

In an interview on 12/03/2024 at 4:00 PM, Staff B stated, “My feeling is that they (R1) are coached, and there is only one person who is coaching and that’s CC2. I have been around the block and there is enough there to believe they have been coached. And in my view coaching someone is abusing for a elderly person.”

Staff B stated he had not reported his concerns to the Complaint Resolution Unit (CRU).

Record review of the Departments CRU intakes do not show any records that facility staff or Staff B submitted a report for suspected abuse against CC2.

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)_____ .

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

Administrator (or Representative) Date