STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Mercer Island ALC LLC
Vineyard Park of Mercer Island
2959 76TH AVENUE SE
MERCER ISLAND, WA 98040

RE: Vineyard Park of Mercer Island License # 2698

Dear Administrator:

This letter addresses Compliance Determination(s) 76456 (Completion Date 04/27/2026) and 72996 (Completion Date 02/26/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/27/2026 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-2570, WAC 388-78A-2468-1, WAC 388-78A-2305-1, WAC 246-215-03339-2-a, WAC 246-215-04565-4, WAC 388-78A-2290-3, WAC 388-78A-2290-3-a, WAC 388-78A-2290-3-b, WAC 388-78A-2290-3-c, WAC 388-78A-2290-3-d, WAC 388-78A-2290-3-e, WAC 388-78A-2290-6, WAC 388-78A-24681-2, WAC 388-78A-2483-2, WAC 388-78A-2320-1-a, WAC 388-78A-3010-8-e, WAC 388-78A-2140-2-a, WAC 388-78A-2260-2-d, WAC 388-78A-2380-3, WAC 388-78A-2730-1-b, WAC 388-78A-2730-2-b-iii, WAC 388-78A-3090-1-a, WAC 388-78A-3090-1-b, WAC 388-78A-3090-1-c, WAC 388-78A-2100-2-b-i

The Department staff who did the on-site verification:

Thomas Forkgen, ALF Licensor
Jane Hermano, NCI
Michelle Yip, ALF Licensor

If you have any questions, please contact me at (206)305-3489.

Sincerely,

Jim Sherman

James Sherman, Field Manager
Region 2, Unit D
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HOME AND COMMUNITY LIVING 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 the unannounced on-site full inspection on 02/17/2026 and 02/23/2026 of:
Vineyard Park of Mercer Island
2959 76TH AVENUE SE
MERCER ISLAND, WA 98040

The following sample was selected for review during the unannounced on-site visit: 7 of 40 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Jane Hermano, NCI
Thomas Forkgen, ALF Licensor
Michelle Yip, ALF Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit D
20425 72nd Avenue S, Suite 400
Kent, WA 98032

Statement of Deficiencies	License #: 2698	Compliance Determination # 72996
Plan of Correction	Vineyard Park of Mercer Island	Completion Date
Page 2 of 30	Licensee: Mercer Island ALC LLC	02/26/2026

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.

Jim Sherman
Residential Care Services

03-04-2026
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)

3/11/26
Date

WAC 388-78A-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to notify the Department of a change in the assisted living facility administrator within 10 days of hire for 1 of 1 sampled staff (Staff A), as required. This failure placed 40 residents at risk of receiving care from an unqualified staff member.

Findings included...

Review of the facility's undated "Resident Characteristics Roster" showed 40 residents resided in the facility.

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) for tracking change in administrator showed that on 08/20/2024, Staff X, previous Administrator, was listed as the Administrator of record. Review of STARS on 02/26/2026 showed that Staff X name remained listed as the Administrator of record for the facility 331 days after Staff X separated from the facility as the Executive Director/Administrator.

During the entrance conference interview on 02/17/2026 at 9:10 AM, Staff I, Health and Wellness Coordinator, and Staff V, Resident Care Coordinator, stated that Staff A was considered the current Administrator. Staff I stated that Staff A worked as the Executive

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-2570 Notification of change in administrator. The licensee must notify the department in writing within ten calendar days of the effective date of a change in the assisted living facility administrator. The notice must include the full name of the new administrator and the effective date of the change.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to notify the Department of a change in the assisted living facility administrator within 10 days of hire for 1 of 1 sampled staff (Staff A), as required. This failure placed 40 residents at risk of receiving care from an unqualified staff member.

Findings included…

Review of the facility's undated "Resident Characteristics Roster" showed 40 residents resided in the facility.

Review of the Department's "Secure Tracking and Reporting Systems" (STARS) for tracking change in administrator showed that on 08/20/2024, Staff X, previous Administrator, was listed as the Administrator of record. Review of STARS on 02/26/2026 showed that Staff X name remained listed as the Administrator of record for the facility 331 days after Staff X separated from the facility as the Executive Director/Administrator.

During the entrance conference interview on 02/17/2026 at 9:10 AM, Staff I, Health and Wellness Coordinator, and Staff V, Resident Care Coordinator, stated that Staff A was considered the current Administrator. Staff I stated that Staff A worked as the Executive

Statement of Deficiencies	License #: 2698	Compliance Determination # 72996
Plan of Correction	Vineyard Park of Mercer Island	Completion Date
Page 3 of 30	Licensee: Mercer Island ALC LLC	02/26/2026

Director/Administrator before Staff A was promoted to the Regional Administrator role. Staff I stated that Staff A would remain as the current Executive Director/Administrator for the facility until a new Executive Director was hired.

During the entrance conference on 02/17/2026 at 10:30 AM, Staff A joined the entrance conference. Staff A stated that they were hired around late February 2025 or early March 2025 as the new Executive Director/Administrator. Staff A stated that they believed Staff X separated from the facility in May of 2025.

During an interview on 02/18/2026 at 2:00 PM, Staff A stated that they were hired as the facility Executive Director/Administrator on 03/03/2025. Staff A stated that they were promoted to Regional Administrator three weeks ago. Staff A stated that Staff X separated employment from the company on 07/25/2025 and no longer functioned in an official capacity for the facility. Staff A stated that they would remain as the administrator until a new administrator was hired. Staff A stated that Staff J, Regional Nurse/Nurse Delegator was their Administrator Designee.

Review of a document submitted by the facility on 02/18/2026, showed that Staff J was the Administrator designee in the absence of the administrator.

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 Mercer Island is or will be in compliance with this law and / or regulation on (Date) 3/10/26.

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

Administrator (or Representative) — Date: 3/11/26

WAC 388-78A-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

This requirement was not met as evidenced by:

Director/Administrator before Staff A was promoted to the Regional Administrator role. Staff I stated that Staff A would remain as the current Executive Director/Administrator for the facility until a new Executive Director was hired.

During the entrance conference on 02/17/2026 at 10:30 AM, Staff A joined the entrance conference. Staff A stated that they were hired around late February 2025 or early March 2025 as the new Executive Director/Administrator. Staff A stated that they believed Staff X separated from the facility in May of 2025.

During an interview on 02/18/2026 at 2:00 PM, Staff A stated that they were hired as the facility Executive Director/Administrator on 03/03/2025. Staff A stated that they were promoted to Regional Administrator three weeks ago. Staff A stated that Staff X separated employment from the company on 07/25/2025 and no longer functioned in an official capacity for the facility. Staff A stated that they would remain as the administrator until a new administrator was hired. Staff A stated that Staff J, Regional Nurse/Nurse Delegator was their Administrator Designee.

Review of a document submitted by the facility on 02/18/2026, showed that Staff J was the Administrator designee in the absence of the administrator.

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 Mercer Island 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-2468 Background checks Employment Conditional hire Pending results of Washington state name and date of birth background check. The assisted living facility may conditionally hire an administrator, caregiver, or staff person directly or by contract, pending the result of the Washington state name and date of birth background check, provided that the assisted living facility:

(1) Submits the background authorization form for the person to the department no later than one business day after he or she starts working;

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to submit a background check (BGI) to the Department of Social and Health Services Background Check Central Unit (BCCU) within one business day after hire for 1 of 9 sampled staff (Staff J). This failure placed 40 residents at risk for abuse and neglect from staff with unknown backgrounds.

Findings included...

STAFF J
Review of the facility's employee records showed that the facility hired Staff J, Facility Nurse Delegator/Regional Registered Nurse, as a conditional hire pending BGI results on 02/18/2025. A review of Staff J's, record showed an initial BGI check with results of "no record" was completed on 12/08/2025 293 days after hire. The facility allowed Staff J to have unsupervised access to residents for 293 days.

During an interview on 02/19/2026 at 12:10 PM, Staff T, Business Office Manager, stated that they were unable to locate the initial Washington State Name and Date of Birth background check (BGI) result for Staff J. Staff T stated that they did not have any documentation that showed they completed the BGI check for Staff J when they were hired.

During the exit conference on 02/23/2026 at 3:00 PM, Staff J stated that they did not have an explanation as to why the initial BGI was not done within one business day of first day worked for pay.

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 Mercer Island is or will be in compliance with this law and / or regulation on (Date) 3/6/26.

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

Administrator (or Representative) [signature] Date 3/11/26

WAC 246-215-03339 Preventing contamination from equipment, utensils, and linens Wiping cloths, use limitation (FDA Food Code 3-304.14).

(2) Cloths in-use for wiping counters and other equipment surfaces must be:

(a) Held between uses in a chemical sanitizer solution at a concentration specified under WAC 246-215-04565 ; and

Based on record review and interview, the facility failed to submit a background check (BGI) to the Department of Social and Health Services Background Check Central Unit (BCCU) within one business day after hire for 1 of 9 sampled staff (Staff J). This failure placed 40 residents at risk for abuse and neglect from staff with unknown backgrounds.

Findings included…

STAFF J
Review of the facility's employee records showed that the facility hired Staff J, Facility Nurse Delegator/Regional Registered Nurse, as a conditional hire pending BGI results on 02/18/2025. A review of Staff J's, record showed an initial BGI check with results of "no record" was completed on 12/08/2025 293 days after hire. The facility allowed Staff J to have unsupervised access to residents for 293 days.

During an interview on 02/19/2026 at 12:10 PM, Staff T, Business Office Manager, stated that they were unable to locate the initial Washington State Name and Date of Birth background check (BGI) result for Staff J. Staff T stated that they did not have any documentation that showed they completed the BGI check for Staff J when they were hired.

During the exit conference on 02/23/2026 at 3:00 PM, Staff J stated that they did not have an explanation as to why the initial BGI was not done within one business day of first day worked for pay.

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 Mercer Island 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 246-215-03339 Preventing contamination from equipment, utensils, and linens Wiping cloths, use limitation (FDA Food Code 3-304.14).

(2) Cloths in-use for wiping counters and other equipment surfaces must be:

(a) Held between uses in a chemical sanitizer solution at a concentration specified under WAC 246-215-04565 ; and

WAC 246-215-04565 Equipment Manual and mechanical warewashing equipment, chemical sanitization Temperature, pH, concentration, and hardness (FDA Food Code 4-501.114). A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under WAC 246-215-04710 must meet the requirements specified under WAC 246-215-07220 , must be used in accordance with the EPA-registered label use instructions, and must be used as follows:

(4) If another solution of a chemical specified under subsections (1) through (3) of this section is used, the permit holder shall demonstrate to the regulatory authority that the solution achieves sanitization and the use of the solution must be approved;

WAC 388-78A-2305 Food sanitation. The assisted living facility must:

(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to maintain a chemical sanitation solution at the correct concentration required to prevent contamination of clean equipment, counter surfaces, tables, and clean utensil for 2 of 3 kitchens (Kitchen #1, Main Kitchen and ALF Kitchen #2). This placed the 40 residents at risk for food borne illness.

Findings included...

REFERENCE
Review of WAC 246-215 showed the following: REFERENCE WAC 246-215-03339 Preventing contamination from equipment, utensils, and linens -- Wiping cloths, use limitation (2009 FDA Code 3-304.14). (2) Cloths in-use for wiping counters and other equipment surfaces must be: (a) Held between uses in a chemical sanitizer solution at a concentration specified under WAC 246-215-04565.

Reference WAC 246-215-03339: Preventing contamination from equipment, utensils, and linens -- Wiping cloths, use limitation (2009 FDA Code 3-304.14). (2) Cloths in-use for wiping counters and other equipment surfaces must be: (a) Held between uses in a chemical sanitizer solution at a concentration specified under WAC 246-215-04565.

Reference WAC 246-215-04565: a chemicalsanitizer used in asanitizing solution for a manual or mechanical operation at contact times specified under WAC 246-215-04710: (4) if another solution of a chemical specified under subsections (1) through (3) of this section is used, the permit holder shall demonstrate to the regulatory authority that the solution achieves sanitization, and the use of the solution must be approved.

Review of the facility's job description for the Director of Dining Services, dated October 2022, showed that responsibilities included establishing quality assurance and sanitation standards. The job description showed that essential functions included ensuring that "high sanitation standards" were maintained.

Review of facility's job description" for Dishwasher/Kitchen Helper dated October 2022, showed that essential job functions included assistance with "kitchen order and cleanliness by following prepared shift task list". The essential job functions showed the dishwasher/kitchen helper was "responsible for keeping food service areas clean and sanitized".

PREVENTING CONTAMINATION and CLEANLINESS OF FOOD SERVICE AREAS

The community provided food for Assisted Living and Memory Care residents. The community had one Main kitchen with two Satellite Kitchens, one in the Assisted Living (AL) and one in the Memory Care unit (MC).
- Kitchen #1, Main Kitchen, located on the ground floor, prepared and served food for the entire community. The main kitchen provided containers of food for both Satellite Kitchens that were transported by a "hotbox" (an enclosed heated container on wheels intended to keep food warm during transport).
- Kitchen #2, AL Satellite Kitchen, located on the first floor, plated food for the AL residents from containers that were held in the wells of a steam table.
- Kitchen #3, MC Satellite Kitchen, located on the third floor, prepared special diets and plated the food for Memory Care (MC) residents.

MC SATELLITE KITCHEN #3
Observation and interview on 02/19/2026 at 10:30 AM, Staff V, Resident Care Coordinator, stated that the sanitization solution test strips located on the wall of the Memory Care satellite kitchen were not the correct test strips for the sanitization solution used to clean the dining room tables and kitchen counters. Observation showed that the test strips were expired. Staff V stated that they needed to obtain the correct test strips from the main kitchen.

MAIN KITCHEN #1
Observation on 02/19/2026 at 11:17 AM, showed Staff Y, Cook, used a stainless-steel counter to plate food for the memory care residents. Observation showed Staff Y removed a wiping cloth from a sanitization bucket to remove splattered food from the rim of several plates, so the plated food looked presentable.

Observation and interview on 02/19/2026 at 11:40 AM, Staff Y stated that they changed out the sanitization solution buckets at breakfast, lunch, and dinner and replenished the buckets with new sanitization solution. Staff Y stated that the sanitization solution was tested each time the solution was changed. Observation showed a sanitization bucket partially filled with sanitization solution on the floor next to the stove behind the stainless-steel counter. At the request of the Department Representative, Staff Y removed a test strip from a container and tested the sanitization solution by dipping the test strip into the sanitization solution for several seconds. Observation of the test strip container showed a strip with a concentration range with several shades of purple which indicated levels of concentration strength. Observation showed that the test strip did not change color and showed the concentration was less than 100 ppm (parts per million). Observation showed Staff Y used a second test strip and stirred the test strip around in the sanitization solution for over 30 seconds. Observation showed that the test strip did not change color. Staff Y stated that the sanitization solution needed to be changed. Observation showed that Staff Y changed out the sanitization solution and refilled the sanitization bucket from a hose attached to a mixing valve (a valve that mixes water with the disinfectant solution) that was fastened to the wall located above

a 3-compartment sink. Observation showed Staff Y retested the fresh sanitization solution with a white test strip. Observation showed the test strip failed to change color. Asked by the Department Representative if Staff Y used the correct test strip Staff Y stated yes. At the request of the Department Representative Staff Y tested the sanitization solution directly from the dispensing hose. The test strip did not change color. Observation showed that the main concentrated sanitization solution bottle that supplied the mixing valve and dispensing hose was empty. Staff Y stated that the concentrated sanitization solution container needed to be replaced. Staff Y stated they did not test the sanitization solution in the buckets.

During observation and in an interview on 02/23/2026 at 8:33 AM, Staff Z, Director of Dining Services, stated that the sanitization buckets had not been filled with sanitization solution for the morning. Observation showed Staff Z filled the sanitization bucket with sanitization solution from the dispenser. Observation showed Staff Z tested the sanitization solution with the test strips which did not register a change in color. The Department Representative asked Staff Z if the correct test strips were being used. Staff Z stated that the chemical solution company supplied all the test strips for their products. Observation showed that the main concentrated bottle of sanitization solution located under the three-compartment sink was empty. Staff Z stated that Staff Y failed to change out the empty sanitization solution concentrate bottle with a full bottle on 02/19/2026. Staff Z stated that the sanitization solution bottle remained empty since it was first observed on 02/19/2026. Staff Z stated that the chemical supplier used by the facility was responsible for changing out all chemical solution containers in all three kitchens. Staff Z stated that there were no additional bottles of chemical sanitization solution. Observation showed Staff Z looked inside a black metal cabinet which showed multiple cleaning solution products. Observation showed two unused containers of sanitization solution. Observation showed Staff Z replaced the sanitization solution bottle, ran the solution through the dispenser hose and tested the solution. Observation showed that the test strip did not change color. Staff Z stated that the test strip tested zero ppm. Observation showed Staff Z ran sanitization solution through the dispenser hose for several minutes to remove air from the line. Observation showed that Staff Z refilled the sanitization bucket and tested the sanitization solution. The test strip did not change color. Observation showed Staff Z tested the sanitization solution directly from the dispensing tube. The test strip color remained unchanged. Observation showed Staff Z tested the sanitization solution directly from the main concentrated bottle. Observation showed the test strip failed to register and the color remained unchanged. Staff Z stated that the test strips were not the correct ones and they would need to contact the chemical solution supplier representative to obtain the correct test strips.

During an interview and observation on 02/23/2026 at 9:15 AM, showed a new container of test strips was retrieved from the MC satellite kitchen and brought down to the main kitchen. Staff Z stated that they did not know if the test strips were the correct ones. Observation showed Staff Z tested the sanitization solution in the bucket from the new container of test strips. Observation showed the test strip changed color and when compared to the concentration levels on the test strip container showed a strong contrate of solution. Staff Z stated that they contacted the chemical supply company representative and was told the supplier provided the facility with several bottles of the correct test strips for all the chemical solutions used.

AL SATELLITE KITCHEN #2
During observation and in an interview on 02/23/2026 at 9:30 AM, Staff Z pointed to a large bottle with a pump that contained a blue chemical sanitation solution set back in

the far corner underneath a stainless-steel counter in the AL satellite kitchen which was located on the first floor. Staff Z stated that the dietary staff used the solution to fill the sanitization buckets. Observation showed the sanitization buckets were empty. During an interview Staff AA, Kitchen Helper, stated that they used a wiping cloth from the sanitization solution buckets to clean the dining room tables. Staff AA stated that they used a sanitization solution from a dispenser located inside a cabinet inside of the satellite kitchen. Observation showed a dispenser fastened to one side of the cabinet. Observation showed Staff AA placed a sanitization bucket under the dispenser and attempted to fill the bucket. Observation showed that no solution came out. Staff AA stated that the sanitization solution was empty.

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 Mercer Island is or will be in compliance with this law and / or regulation on (Date) 3/5/26 .

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

Administrator (or Representative) — Date: 3/11/26

WAC 388-78A-2290 Family assistance with medications and treatments.

(3) If the assisted living facility allows family assistance with or administration of medications and treatments, and the resident and a family member(s) agree a family member will provide medication or treatment assistance, or medication or treatment administration to the resident, the assisted living facility must request that the family member submit to the assisted living facility a written plan for such assistance or administration that includes at a minimum:

(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(e) Other information determined necessary by the assisted living facility.

(6) The assisted living facility must require that whenever a resident's family provides medication assistance or medication administration services, the resident's significant medications remain on the assisted living facility premises whenever the resident is on

the far corner underneath a stainless-steel counter in the AL satellite kitchen which was located on the first floor. Staff Z stated that the dietary staff used the solution to fill the sanitization buckets. Observation showed the sanitization buckets were empty. During an interview Staff AA, Kitchen Helper, stated that they used a wiping cloth from the sanitization solution buckets to clean the dining room tables. Staff AA stated that they used a sanitization solution from a dispenser located inside a cabinet inside of the satellite kitchen. Observation showed a dispenser fastened to one side of the cabinet. Observation showed Staff AA placed a sanitization bucket under the dispenser and attempted to fill the bucket. Observation showed that no solution came out. Staff AA stated that the sanitization solution was empty.

Plan/Attestation Statement

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

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Administrator (or Representative) Date

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(a) By name, the family member who will provide the medication or treatment assistance or administration;

(b) A description of the medication or treatment assistance or administration that the family member will provide, to be referred to as the primary plan;

(c) An alternate plan if the family member is unable to fulfill his or her duties as specified in the primary plan;

(d) An emergency contact person and telephone number if the assisted living facility observes changes in the resident's overall functioning or condition that may relate to the medication or treatment plan; and

(e) Other information determined necessary by the assisted living facility.

(6) The assisted living facility must require that whenever a resident's family provides medication assistance or medication administration services, the resident's significant medications remain on the assisted living facility premises whenever the resident is on

the assisted living facility premises.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete a written family medication assistance plan for 1 of 1 sampled resident (Resident 3) and filed to keep additional significant medications on-site at the facility as required. This failure placed Resident 3 at risk of not receiving their medications as prescribed.

Findings included…

Review of the facility's undated "Medication Policy" showed that a licensed nurse may set-up medication organizers for residents who are otherwise independent with self-administration of medications". The policy did not address a family member or representative setting up a medication organizer for residents who are otherwise independent with self-administration of medications. The policy did not address or show a procedure for developing a family plan that included the requirements for family/Resident Representative mediation assistance .

Review of the facility's blank "Family Supplied Medication Agreement" showed that the family member/Resident Representative contact information, a list of prescribed medications, and an alternate plan was required.

RESIDENT 3
Review of the facility's undated Resident Characteristics Roster showed the facility admitted Resident 3 in [redacted] of 2025 with a diagnosis of [redacted].

Observation on 02/19/2026 at 2:25 PM, showed Resident 3 removed a Medi-set (medication organizer labeled with the days and times of the week) from a kitchen cabinet.

During an interview on 02/19/2026 at 2:25 PM, Resident 3 stated that they dispensed and administered their own medications. Resident 3 stated that the mediset was previously filled by a family member.

Review of Resident 3's records showed no documentation of a written family medication plan for Resident 3.

Observation on 02/23/2026 at 2:00 PM, Staff I, Health and Wellness Coordinator, searched Resident 3's apartment for backup medication containers with Resident 3's significant medications. Observation showed Staff I was unable to locate any additional medications.

During an interview on 02/23/2026 at 2:00 PM, Staff I, stated that there was no written family plan for Resident 3. Staff I stated that there were no additional backup medications with Resident 3's significant medications on-site. Staff I stated that additional backup medications needed to be kept on-site in a secured locked are in Resident 3's apartment in case they were needed.

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 Mercer Island is or will be in compliance with this law and / or regulation on (Date) 4/10/26 .

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

Administrator (or Representative) — Date: 3/11/26

WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

(2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete 1 of 9 sampled staff (Staff J) national fingerprint background check. This failure placed 40 residents at risk for potential abuse and neglect from staff with an unknown background.

Findings included...

STAFF J
Review of the facility's employee records showed that the facility hired Staff J, Facility Nurse Delegator/Regional Registered Nurse, as a conditional hire pending fingerprint results, on 02/18/2025. Staff J's record showed a final fingerprint background check with a result of "no record" was completed on 12/23/2026 297 days after hire. The facility allowed Staff J to have unsupervised access to residents for 297 days.

During an interview on 02/19/2026 at 12:10 PM, Staff T, Business Office Manager, stated that they did not have any documentation that showed that Staff J completed a

During an interview on 02/23/2026 at 2:00 PM, Staff I, stated that there was no written family plan for Resident 3. Staff I stated that there were no additional backup medications with Resident 3's significant medications on-site. Staff I stated that additional backup medications needed to be kept on-site in a secured locked are in Resident 3's apartment in case they were needed.

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

WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

(2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete 1 of 9 sampled staff (Staff J) national fingerprint background check. This failure placed 40 residents at risk for potential abuse and neglect from staff with an unknown background.

Findings included…

STAFF J
Review of the facility's employee records showed that the facility hired Staff J, Facility Nurse Delegator/Regional Registered Nurse, as a conditional hire pending fingerprint results, on 02/18/2025. Staff J's record showed a final fingerprint background check with a result of "no record" was completed on 12/23/2026 297 days after hire. The facility allowed Staff J to have unsupervised access to residents for 297 days.

During an interview on 02/19/2026 at 12:10 PM, Staff T, Business Office Manager, stated that they did not have any documentation that showed that Staff J completed a

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Washington state Department of Social and Health Services background name and date of birth or a fingerprint check when Staff J was hired.

During the exit conference on 02/23/2026 at 3:00 PM. Staff J and Staff T did not provide an explanation as to why a fingerprint check was not done within 120 days of Staff J's hire.

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 Mercer Island is or will be in compliance with this law and / or regulation on (Date) 3/6/26 .

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

Administrator (or Representative) — Date: 3/11/26

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a one-step test for Tuberculosis (TB)(a respiratory infection) for 1 of 4 sampled staff (Staff J) with a history of a negative blood test. This failure placed 40 residents at risk of potential exposure to tuberculosis, an infectious disease.

Findings included...

Review of the facility's undated "Tuberculosis Testing" policy, showed the definition of a "Staff Person" meant "any assisted living facility employee or temporary employee of the assisted living facility" ... The policy showed that all staff were to be tested for TB or compliance verified within three days of hire. The policy followed the Washington Administrative Code (WAC) for TB screening and testing requirements.

Review of the facility's undated "Resident Characteristics Roster" showed 40 residents currently resided in the facility.

Washington state Department of Social and Health Services background name and date of birth or a fingerprint check when Staff J was hired.

During the exit conference on 02/23/2026 at 3:00 PM. Staff J and Staff T did not provide an explanation as to why a fingerprint check was not done within 120 days of Staff J's hire.

Plan/Attestation Statement

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

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Administrator (or Representative) Date

WAC 388-78A-2483 Tuberculosis One test. The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

(2) A documented negative result from one skin or blood test in the previous twelve months.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to complete a one-step test for Tuberculosis (TB)(a respiratory infection) for 1 of 4 sampled staff (Staff J) with a history of a negative blood test. This failure placed 40 residents at risk of potential exposure to tuberculosis, an infectious disease.

Findings included…

Review of the facility's undated "Tuberculosis Testing" policy, showed the definition of a "Staff Person" meant "any assisted living facility employee or temporary employee of the assisted living facility" ... The policy showed that all staff were to be tested for TB or compliance verified within three days of hire. The policy followed the Washington Administrative Code (WAC) for TB screening and testing requirements.

Review of the facility's undated "Resident Characteristics Roster" showed 40 residents currently resided in the facility.

ONE-STEP TB TEST

STAFF J
Review of the facility's employee records showed that the facility hired Staff J as the Facility Nurse Delegator/Regional Registered Nurse on 02/18/2025. Review of Staff J's employee records showed documentation of an Interferon Gamma Release Assays [(IGRA) blood test], dated 03/18/2024, with negative results. Review of Staff J's employee record showed no documentation Staff J completed a one-step TB test upon hire, as required.

During an interview on 02/23/2026 at 3:00 PM, Staff J stated that they were initially hired as the Registered Nurse delegator for the facility. Staff J stated that they received the Bacillus Calmette-Guérin (BCG) vaccine [(vaccine that helps protect a person against an infection called tuberculosis (TB)] and therefore would always have a positive TB skin test result. Staff J stated that they received a chest X-Ray due to a positive TB skin test before they were hired by the facility. Staff J stated that they would look for documentation that showed a positive TB test result and documentation of a negative chest x-ray.

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 Mercer Island is or will be in compliance with this law and / or regulation on (Date) 4/10/26 .

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

Administrator (or Representative) [signature] Date 3/11/26

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure safe wound management was provided by a licensed nurse or a nurse delegated care staff for 1 of 1 sampled resident (Resident 6). This failure placed Resident 6 at risk for improper medical treatments and procedures administered by unlicensed care staff.

ONE-STEP TB TEST

STAFF J
Review of the facility's employee records showed that the facility hired Staff J as the Facility Nurse Delegator/Regional Registered Nurse on 02/18/2025. Review of Staff J's employee records showed documentation of an Interferon Gamma Release Assays [(IGRA) blood test], dated 03/18/2024, with negative results. Review of Staff J's employee record showed no documentation Staff J completed a one-step TB test upon hire, as required.

During an interview on 02/23/2026 at 3:00 PM, Staff J stated that they were initially hired as the Registered Nurse delegator for the facility. Staff J stated that they received the Bacillus Calmette-Guérin (BCG) vaccine [(vaccine that helps protect a person against an infection called tuberculosis (TB)] and therefore would always have a positive TB skin test result. Staff J stated that they received a chest X-Ray due to a positive TB skin test before they were hired by the facility. Staff J stated that they would look for documentation that showed a positive TB test result and documentation of a negative chest x-ray.

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

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(a) Develop and implement systems that support and promote the safe practice of nursing for each resident; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure safe wound management was provided by a licensed nurse or a nurse delegated care staff for 1 of 1 sampled resident (Resident 6). This failure placed Resident 6 at risk for improper medical treatments and procedures administered by unlicensed care staff.

Findings included…

Review of the facility's undated "Disclosure of Services" showed that the facility provided "intermittent nursing services, such as care of minor non-infected wounds or preventative skin care". The document showed that the facility used nursing assistants under the delegation of a registered nurse to provide some authorized nursing services. The document showed that a registered nurse worked in the building one day per week totaling eight hours per week. The document showed that a licensed practical nurse worked in the building for five days per week totaling 40 hours per week.

RESIDENT 6
Review of Resident 6's records showed that the facility admitted Resident 6 in [redacted] 2024. The records showed a provider order, dated 01/14/2026, of "for right breast wounds, cleanse with wound cleanser, pat dry, apply medihoney (a medical-grade topical product that treats acute and chronic wounds) to the wound bed. Cover with nonadherent gauze and secure with sports bra or apply adhesive foam dressing. If using adhesive foam, apply Sure Prep (a skin protective barrier) to the peri wound (the skin immediately surrounding a wound) before placing dressing. Change every other day and as needed (PRN) if soiled."

Observation of Resident 6 on 02/19/2026 at 2:05 PM, showed a wound, sized about a quarter-coin, under the right breast. Observation showed the wound was not covered with gauze or dressing. Further observation showed a tube of partially used topical gel labelled as "Iodosorb – Cadxoer Iodine Gel" (an antibacterial agent that is used in cleaning wet ulcers and wounds) and a box labelled as "foam dressing" were placed on the bedside console on the left side of the bed. During an interview at this time, Resident 6 stated that they developed a wound under the right breast in January 2026, and their nurse practitioner gave them instructions for monitoring their wound and an order of wound care. Resident 6 stated that the wound was located under the right breast, she had difficulty seeing the wound clearly. Resident 6 stated that their wound required to be cleaned with solution, applied topical, and covered with dressing every other day. Resident 6 stated that the facility's caregivers performed the wound management for them. Resident 6 stated that every other day, the facility's care staff checked their wound, cleaned the wound with cleanser spray, patted to dry it, applied the topical gel on the wound, and put the dressing on it. Resident 6 said that they did not know what the wound cleanser spray was that the care staff used. Resident 6 stated that the care staff provided the wound cleanser spray and the care staff kept the spray bottle. Resident 6 said that the dressing was "patted gauze". Resident 6 stated that the care staff also used the foam dressing they purchased from the store and they kept in their apartment. Resident 6 said that each caregiver did the wound dressing differently. Resident 6 stated that it depended on who the Medication Technician (unlicensed care staff) was. When Staff V did the dressing for them, Staff V covered the cleaned wound with the foam dressing they provided, then Staff V put the bra to hold the dressing. Resident 6 said that when Staff U did the dressing for them, Staff U did not put the dressing after they applied the topical and just put the bra on.

Review of Resident 6's January 2026 and February 2026 Medication Administration Records (MARs) showed that between 01/16/2026 and 02/20/2026, the facility's nursing assistants (unlicensed care staff) administered and signed off the provider's order of wound management for Resident 6. The MARs showed that Staff I, Certified Nursing Assistant (CNA)/Health and Wellness Coordinator, administered and signed off the wound management two times in January 2026 and two times in February 2026. The MARs showed that Staff V, CNA/Resident Care Coordinator, administered and signed off the wound management one time in January 2026 and one time in February 2026. The MARs showed that Staff U, Registered Nursing Assistant (NAR)/Medication Technician, administered and signed off the wound management five times in January 2026 and six times in February 2026. The MARs showed that Staff W, CNA/Caregiver, administered and signed off the wound management one time in February 2026.

Review of the facility's nurse delegation binders showed no documentation that the unlicensed care staff were delegated wound care tasks by a Registered Nurse Delegator for Resident 6.

Review of the facility's document titled "Skin Sheet" for Resident 6 showed that between 01/19/2026 and 02/23/2026, the facility nurse assessed Resident 6's wound and performed wound care one time a week on Monday.

During an interview on 02/19/2026 at 3:20 PM, Staff I stated that Resident 6 complained of having pain under the right breast in January 2026. Staff I stated that they observed the resident's right breast and identified a skin lesion under the right breast. Staff I stated that they immediately notified Resident 6's provider. Staff I stated that on 01/14/2026, Resident 6's provider gave an order for wound management. Staff I stated that they performed the initial wound care and dressing change for Resident 6. Staff I stated that they entered the provider's wound management order in their MAR system. Staff I stated that they notified the facility's nurse. Staff I stated that the facility's nurse worked in the facility and performed wound care for Resident 6 only once a week, instead of changing dressing every other day as the provider ordered. Staff I stated that their care staff provided wound management every other day when the facility nurse was unavailable. Staff I stated that they were unaware of the requirement for wound management under nurse delegation. Staff I stated that the facility's Registered Nurse Delegator did not assess the wound. Staff I stated that they were not delegated to perform the wound management for Resident 6.

During an interview on 02/23/2026 at 8:20 AM, Staff V, stated that they were aware Resident 6 had a wound under the right breast. Staff V stated that they followed the order and performed the wound dressing for Resident 6. Staff V stated that when they first observed Resident 6's wound, the wound was an open wound with white colored discharge coming out from the wound. Staff V stated that they did not know what the discharge was and they did not know whether the wound was infected. Staff V stated that the facility had a basket of wound care materials. When they provided wound care to Resident 6, they used those wound care materials including the wound cleanser spray. Staff V stated that they used the cleanser spray to clean Resident 6's wound, applied the prescribed topical on the wound, and covered the wound with gauze. Staff V stated that they were unfamiliar with the requirements for wound management through

nurse delegation. Staff V stated that they were not delegated to perform wound management for Resident 6.

During an interview on 02/23/2026 at 10:15 AM, Staff R, Registered Nurse/Regional Wellness Nurse, stated that they were the nurse of the facility and they worked one day a week, on every Monday. Staff R stated that they were responsible for providing intermittent nursing services for the residents. Staff R stated that they were aware Resident 6 had a wound under the right breast. Staff R stated that on 01/19/2026, they were notified about Resident 6's wound, and they initially assessed the wound and performed the dressing for Resident 6. Staff R stated that they were not the Registered Nurse Delegator and they did not delegate the wound management to the care staff.

During an interview on 02/23/2026 at 10:55 AM, Staff J, Registered Nurse Delegator/Regional Nurse, stated that they were aware Resident 6 had a wound. Staff J stated that from their knowledge, Resident 6 was able to manage the wound independently. Staff J stated that their nurse Staff R assessed the wound and provided the wound care for Resident 6 once a week that met the resident's needs. Staff J stated that they were not notified about the request of nurse delegation for the wound management. Staff J stated that they were unaware of the provider's order for wound management. Staff J stated that they did not delegate any care staff or Medication Technicians the wound management for Resident 6. Staff J, while reviewing Resident 6's provider's order for wound management, stated that the order of the wound dressing was not "a simple dressing" that required a licensed nurse to perform the wound care. Staff J stated that this wound dressing was not a delegable nursing task and that they did not delegate this nursing task to the care staff.

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 Mercer Island is or will be in compliance with this law and / or regulation on (Date) 3/6/26.

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

Administrator (or Representative) [signature] Date 3/11/26

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(8) Miscellaneous: Each sleeping room must have:

(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

nurse delegation. Staff V stated that they were not delegated to perform wound management for Resident 6.

During an interview on 02/23/2026 at 10:15 AM, Staff R, Registered Nurse/Regional Wellness Nurse, stated that they were the nurse of the facility and they worked one day a week, on every Monday. Staff R stated that they were responsible for providing intermittent nursing services for the residents. Staff R stated that they were aware Resident 6 had a wound under the right breast. Staff R stated that on 01/19/2026, they were notified about Resident 6's wound, and they initially assessed the wound and performed the dressing for Resident 6. Staff R stated that they were not the Registered Nurse Delegator and they did not delegate the wound management to the care staff.

During an interview on 02/23/2026 at 10:55 AM, Staff J, Registered Nurse Delegator/Regional Nurse, stated that they were aware Resident 6 had a wound. Staff J stated that from their knowledge, Resident 6 was able to manage the wound independently. Staff J stated that their nurse Staff R assessed the wound and provided the wound care for Resident 6 once a week that met the resident's needs. Staff J stated that they were not notified about the request of nurse delegation for the wound management. Staff J stated that they were unaware of the provider's order for wound management. Staff J stated that they did not delegate any care staff or Medication Technicians the wound management for Resident 6. Staff J, while reviewing Resident 6's provider's order for wound management, stated that the order of the wound dressing was not "a simple dressing" that required a licensed nurse to perform the wound care. Staff J stated that this wound dressing was not a delegable nursing task and that they did not delegate this nursing task to the care staff.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-3010 Resident units. The assisted living facility resident units must have the following:

(8) Miscellaneous: Each sleeping room must have:

(e) A lockable drawer, cupboard or other secure space measuring a least one-half cubic foot with a minimum dimension of four inches;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to provide a lockable storage area for 5 of 9 sampled residents (Resident 3, Resident 5, Resident 7, Resident 13, and Resident 14). This failure violated Resident 3, Resident 5, Resident 7, Resident 13, and Resident 14's rights to have a lockable storage area for their personal belongings.

Findings included…

Review of the facility's undated "Assisted Living Facility Resident Characteristic Roster" showed Resident 3, Resident 5, Resident 7, Resident 13, and Resident 14 received assisted living services.

RESIDENT 3
Observation of Resident 3's apartment on 02/23/2026 at 2:00 PM showed no lockable storage space in the apartment to secure personal items.

Observation and interview on 02/23/2026 at 2:00 PM, Staff I, Health and Wellness Coordinator, looked around Resident 3's apartment, kitchen, and bathroom and stated that there was no lockable storage to secure Resident 3's personal items.

RESIDENT 7 AND RESIDENT 14
Observation on 02/19/2026 at 8:30 AM showed Resident 7 and Resident 14 resided in the same apartment. Observation of Resident 7 and Resident 14's apartment showed no lockable storage space in the room for each resident to secure their personal items.

RESIDENT 5 AND RESIDENT 13
Observation on 02/19/2026 at 10:30 AM, showed Resident 5 and Resident 13 resided in the same apartment with separate sleeping rooms, a shared bathroom and common space. Observation showed no lockable storage space in Resident 5's room and Resident 13's room or in the shared bathroom and common area to secure their personal items.

During an interview on 02/19/2026 at 10:45 AM and 02/19/2026 at 11:05 AM, Staff H, Maintenance Director, stated that they were aware all assisted living residents' rooms were required to be equipped with a lockable storage area. Staff H stated that they were unaware several residents did not have a lockable storage space.

Plan/Attestation Statement

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Administrator (or Representative) [signature] Date 3/11/26

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in the resident records the responsibilities of medication assistance and back up interventions for 1 of 2 sampled residents (Resident 1) who independently managed their own medication. The facility failed to develop and document epilepsy monitoring and care instructions in 1 of 2 sampled residents' (Resident 12) service plan. These failures placed Resident 1 and Resident 12 at risk for unmet care needs and worsening medical conditions.

Findings included...

RESIDENT 1
Review of Resident 1's records showed that the facility admitted Resident 1 in [redacted] 2025.
Review of Resident 1's assessment dated, 11/05/2025, showed Resident 1 had multiple diagnoses including [redacted] and [redacted]

Plan/Attestation Statement

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Administrator (or Representative) Date

WAC 388-78A-2140 Negotiated service agreement contents. The assisted living facility must develop, and document in the resident's record, the agreed upon plan to address and support each resident's assessed capabilities, needs and preferences, including the following:

(2) Clearly defined respective roles and responsibilities of the resident, the assisted living facility staff, and resident's family or other significant persons in meeting the resident's needs and preferences. Except as specified in WAC 388-78A-2290 and 388-78A-2340 (5), if a person other than a caregiver is to be responsible for providing care or services to the resident in the assisted living facility, the assisted living facility must specify in the negotiated service agreement an alternate plan for providing care or service to the resident in the event the necessary services are not provided. The assisted living facility may develop an alternate plan:

(a) Exclusively for the individual resident; or

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to document in the resident records the responsibilities of medication assistance and back up interventions for 1 of 2 sampled residents (Resident 1) who independently managed their own medication. The facility failed to develop and document epilepsy monitoring and care instructions in 1 of 2 sampled residents' (Resident 12) service plan. These failures placed Resident 1 and Resident 12 at risk for unmet care needs and worsening medical conditions.

Findings included…

RESIDENT 1
Review of Resident 1's records showed that the facility admitted Resident 1 in [redacted] 2025.
Review of Resident 1's assessment dated, 11/05/2025, showed Resident 1 had multiple diagnoses including [redacted] and [redacted]

[redacted]. The assessment showed that Resident 1 was independent with medication management and used an outside pharmacy.

Observation on 02/18/2026 at 1:35 PM, showed a one week medication organizer (a multicompartment container for storing scheduled doses of medications) partially filled with medications on top of the sink counter. Observation showed inside the cupboard above the sink, were eight medication organizers filled with medications. Observation showed a continuous positive airway pressure machine (CPAP, a device that delivers air through the mouth and nose to help keep airways open during sleep) sat on top of the bedside table.

During an interview at this time, Resident 1 stated that the physician's clinic nurse and they ordered the medications. Resident 1 stated that the nurse filled the nine medication organizers on Mondays as scheduled. Resident 1 stated that they used the CPAP before they moved into the facility. Resident 1 stated that they independently set up the CPAP machine. Resident 1 stated that they clean and order supplies for their CPAP equipment.

Review of Resident 1's Negotiated Service Agreement (NSA), also known as "Service Plan Report," dated 11/05/2025, showed that Resident 1 was independent with medication management and treatments. The NSA showed that Resident 1's family was responsible to order and deliver medications to the facility. The NSA showed that an external nurse "did all the meds as per resident and family." The NSA showed no instructions about an alternate plan in the event Resident 2's family or the external nurse were unable to perform their responsibilities with medication management. The NSA showed no documentation that Resident 1 used a CPAP machine to treat their sleep apnea at night. There were no instructions about what assistance staff would provide if Resident 1 was unable to manage their CPAP machine.

During an interview on 02/23/2026 at 8:58 AM, Staff R, Facility Registered Nurse, stated that they worked on Mondays every week. Staff R stated that they did not perform Resident 1's assessment and was unaware that a back-up medication management plan was not developed. Staff R stated that they were unaware Resident 1 used a CPAP machine at night.

During an interview on 02/24/2026 at 12:52 PM, Collateral Contact 1 (CC1, Resident 1's family representative), stated that they do not order or deliver Resident 1's medications. CC1 stated that medications were ordered by the clinic's nurse and delivered by the outside pharmacy. CC1 stated that the clinic's nurse refilled Resident 1's medications. CC1 stated that they discussed with the facility nurses about Resident 1's ability to administer their own medications. CC1 stated that they did not know what service the facility would do if the clinic's nurse was unable to provide the medication assistance.

RESIDENT 12
Review of Resident 12's records showed that the facility admitted Resident 12 in [redacted]

2025. The records showed that on 08/14/2025 and on 02/16/2026, the facility completed an assessment for Resident 12. The assessments showed Resident 12's medical diagnoses included [redacted] and [redacted]. The assessments showed that Resident 12 required assistance with medication management.

Review of Resident 12's physician orders of medications, dated 02/18/2026, showed an order of "Levetiracetam (a medication that treats seizures) 750 milligram (MG), take one tablet by mouth twice daily [indications for use: anticonvulsants (medications that treat epilepsy)].

Review of Resident 12's December 2025, January 2026, and February 2026 Medication Administration Records (MARs) showed that between 12/01/2025 and 02/26/2026, Resident 12 received the Levetiracetam medication.

Review of Resident 12's "Department of Social and Health Services, Assessment Details", dated 10/01/2025, showed Resident 12's medical diagnoses included [redacted]. The document showed Resident 12 had unknown type of seizure, and Resident 12 reported "seizure in 2023 and 2025".

Review of Resident 12's "Service Plan Report", dated 09/23/2025, showed no documentation that explained the signs and symptoms of epilepsy for staff to monitor. The Service Plan showed no staff instructions about what actions were needed if Resident 12 experienced a seizure.

During an interview on 02/16/2026 at 3:01 PM, Staff I, Health and Wellness Coordinator, stated the facility's nurse completed the resident assessment on 08/14/2025 and 02/16/2026. Staff I stated that as of today, the service plan, which was available in Resident 12's records, was completed on 09/23/2025. Staff I stated that as of today, there was no documentation in Resident 12's records that showed the facility developed and documented epilepsy monitoring and care instructions.

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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 Mercer Island is or will be in compliance with this law and / or regulation on (Date) 4/10/26 .

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

Administrator (or Representative) [signature] Date 3/11/26

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 1 of 4 mobile medication carts (Memory Care Medication Cart 2) was locked. This failure placed residents in the memory care unit at risk of injury from ingestion of unprescribed medication.

Findings included...

Review of the facility's undated "Assisted Living Resident Characteristic Roster" showed that 17 residents resided on the third floor of the facility's Memory Care unit. The Roster identified all 17 residents were diagnosed with [redacted] or [redacted]. Six residents ambulated independently or independently used a mobility device, such as a manual wheelchair or a walker.

Observation on 02/17/2026 at 10:58 AM, during the environmental tour of the secured dementia care unit's dining room, showed Medication Cart 1 and Medication Cart 2 were unattended by staff. Medication Cart 2 was unlocked, which contained four drawers, three of which held the resident's routine and as-needed prescription medications. Observation showed that one resident sat on a table near to the unlocked cart, while two other residents moved around the dining area independently. Observation showed, Staff H, Maintenance Director immediately locked the medication cart.

During an interview on 02/17/2026 at 1:48 PM, Staff I, Wellness Care Coordinator stated

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Administrator (or Representative) Date

WAC 388-78A-2260 Storing, securing, and accounting for medications.

(2) The assisted living facility must ensure all medications under the assisted living facility's control are properly stored:

(d) In a locked compartment that is accessible only to designated responsible staff persons; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure that 1 of 4 mobile medication carts (Memory Care Medication Cart 2) was locked. This failure placed residents in the memory care unit at risk of injury from ingestion of unprescribed medication.

Findings included…

Review of the facility's undated "Assisted Living Resident Characteristic Roster" showed that 17 residents resided on the third floor of the facility's Memory Care unit. The Roster identified all 17 residents were diagnosed with [redacted] or [redacted]. Six residents ambulated independently or independently used a mobility device, such as a manual wheelchair or a walker.

Observation on 02/17/2026 at 10:58 AM, during the environmental tour of the secured dementia care unit's dining room, showed Medication Cart 1 and Medication Cart 2 were unattended by staff. Medication Cart 2 was unlocked, which contained four drawers, three of which held the resident's routine and as-needed prescription medications. Observation showed that one resident sat on a table near to the unlocked cart, while two other residents moved around the dining area independently. Observation showed, Staff H, Maintenance Director immediately locked the medication cart.

During an interview on 02/17/2026 at 1:48 PM, Staff I, Wellness Care Coordinator stated

that the medication carts were to be secured at all times and not be left unlocked under any circumstances. Staff I stated that the nurse delegated staff (staff that deliver, assist or administered medications to residents) received extensive training in safe medication services and practices.

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 Mercer Island is or will be in compliance with this law and / or regulation on (Date) 3/20/26 .

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

Administrator (or Representative) — Date: 3/11/26

WAC 388-78A-2380 Freedom of movement. An assisted living facility must ensure all of the following conditions are present before moving residents into units or buildings with exits that may restrict a resident's egress:

(3) The assisted living facility must have a system in place to inform and permit visitors, staff persons and appropriate residents how they may exit without sounding the alarm.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide information for visitors, facility staff, and external providers how to exit 1 of 1 dementia care unit (Memory Care) without sounding the alarm. This failure prevented visitors, staff, and external providers from departing the memory care unit without staff assistance.

Findings Included...

Review of the facility's undated Resident Characteristics Roster showed the facility provided care to 17 residents in memory care unit with primary diagnosis of [redacted], and [redacted].

Observation on 02/17/2026 at 10:40 AM, showed that the third floor of the building was identified as a secured memory care unit. Observation showed that the unit had three locked exits, one by the elevator and the two stairwells located at opposite ends of the hallway. There were keypads at the elevator and each stairwell exit door. All three exits showed no signage or instructions for visitors, facility staff, and external providers, such

that the medication carts were to be secured at all times and not be left unlocked under any circumstances. Staff I stated that the nurse delegated staff (staff that deliver, assist or administered medications to residents) received extensive training in safe medication services and practices.

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 Mercer Island 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-2380 Freedom of movement. An assisted living facility must ensure all of the following conditions are present before moving residents into units or buildings with exits that may restrict a resident's egress:

(3) The assisted living facility must have a system in place to inform and permit visitors, staff persons and appropriate residents how they may exit without sounding the alarm.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to provide information for visitors, facility staff, and external providers how to exit 1 of 1 dementia care unit (Memory Care) without sounding the alarm. This failure prevented visitors, staff, and external providers from departing the memory care unit without staff assistance.

Findings included…

Review of the facility's undated Resident Characteristics Roster showed the facility provided care to 17 residents in memory care unit with primary diagnosis of [redacted] and [redacted].

Observation on 02/17/2026 at 10:40 AM, showed that the third floor of the building was identified as a secured memory care unit. Observation showed that the unit had three locked exits, one by the elevator and the two stairwells located at opposite ends of the hallway. There were keypads at the elevator and each stairwell exit door. All three exits showed no signage or instructions for visitors, facility staff, and external providers, such

as Home Health care team, medical practitioners, and others how to depart the memory care unit without staff assistance.

During an interview, Staff H, Maintenance Director, stated that residents may have removed the signs. Staff H stated that the staff should know the keypad code to leave the unit. Staff H stated that the memory care staff were tasked to assist visitors or external providers to exit the unit to the building's ground, first or second floor area. Staff H assisted the Department Licensor leave the unit.

Observation on 02/18/2026 at 9:10 AM, showed a facility staff member used the north stairwell exit door. Observation showed the staff member was unable to leave the unit after three failed attempts with the incorrect pass code. The facility staff stated that they regularly worked on the first floor and unable to remember the code for the keypad. The facility staff left to get another staff who knew the pass code.

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 Mercer Island is or will be in compliance with this law and / or regulation on (Date) 3/6/26 .

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

Administrator (or Representative) — Date: 3/4/26

WAC 388-78A-2730 Licensee's responsibilities.

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

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

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow the required federal and state regulations to conduct medical tests for 1 of 1 sampled resident (Resident 12). The facility failed to publicly post 1 of 1 full inspection report

as Home Health care team, medical practitioners, and others how to depart the memory care unit without staff assistance.

During an interview, Staff H, Maintenance Director, stated that residents may have removed the signs. Staff H stated that the staff should know the keypad code to leave the unit. Staff H stated that the memory care staff were tasked to assist visitors or external providers to exit the unit to the building's ground, first or second floor area. Staff H assisted the Department Licensor leave the unit.

Observation on 02/18/2026 at 9:10 AM, showed a facility staff member used the north stairwell exit door. Observation showed the staff member was unable to leave the unit after three failed attempts with the incorrect pass code. The facility staff stated that they regularly worked on the first floor and unable to remember the code for the keypad. The facility staff left to get another staff who knew the pass code.

Plan/Attestation Statement

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_____ _____

Administrator (or Representative) Date

WAC 388-78A-2730 Licensee's responsibilities.

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

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

(2) The licensee must:

(b) Maintain and post in a size and format that is easily read, in a conspicuous place on the assisted living facility premises:

(iii) A copy of the report, including the cover letter, and plan of correction of the most recent full inspection conducted by the department; and

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow the required federal and state regulations to conduct medical tests for 1 of 1 sampled resident (Resident 12). The facility failed to publicly post 1 of 1 full inspection report

(Inspection Report 2024) in a common area of the facility. This failure placed Resident 12 at risk of potential errors from medical tests performed by facility's staff. This failure placed residents being uninformed about the facility deficiencies that may affect care and services provided by the facility.

Findings included…

MEDICAL TEST SITE WAIVER
Review of the facility's records showed the facility did not have a Medical Test Site Waiver (MTSW) license that included the Clinical Laboratory Improvement Amendment (CLIA) to meet the requirements for performing certain medical tests, such as, blood sugar test (a test that measures the level of glucose in the blood). The records showed that the facility sent the MTSW application and application fee to the Department of Health (DOH) on 02/17/2026, during the full licensing inspection.

During an interview on 02/18/2026 at 2:17 PM, Staff A, Executive Director, stated that they were unable to locate the DOH MTSW license for their facility. Staff A stated that they were unsure whether they obtained a valid DOH MTSW license since their facility was established in June 2024. Staff A stated that they were aware their staff performed medical tests that required the DOH MTSW license.

During an interview on 02/18/2026 at 2:50 PM, Staff I, Wellness Care Director, stated that Resident 12 received blood glucose tests performed by staff through nurse delegation. Staff I stated that when they assisted Resident 12 with blood glucose checks, Resident 12 sometimes pricked their fingers with the lancets. Staff I stated that their Medication Technicians placed the test strip into the blood glucose meter, used the test strip to collect a blood drop from Resident 12, then ran the test with the blood glucose meter.

Review of Resident 12's records showed that the facility admitted Resident 12 in [redacted] 2025. The records showed physician orders of "okay to perform as needed (PRN) blood sugar checks to assess for hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) at staff discretion" dated 10/08/2025 and "take and record blood sugars twice daily" dated 10/14/2025. The records showed on 12/27/2025, Staff J, Regional Nurse/Registered Nurse Delegator, delegated several facility's staff to administer blood sugar checks for Resident 12.

Observation on 02/23/2026 at 8:40 AM showed Staff S, Medication Technician, administered blood glucose test for Resident 12. Observation showed Staff S pricked Resident 12's right fifth or little finger with a lancet. Staff S placed the test strip into the blood glucose meter, used the test strip to collect a blood drop from the resident, and completed the test. Observation showed Resident 12 asked Staff S about the test result and Staff S informed Resident 12 of their blood glucose level.

During an interview 02/23/2026 at 8:45 AM, Staff S stated that the facility's Registered

Nurse Delegator delegated them to administer blood glucose tests for Resident 12.

During an interview on 02/24/2026 at 4:35 PM, Staff J stated that the facility staff administered blood sugar checks for Resident 12 since 07/22/2025.

FULL INSPECTION REPORT
Review of the Department's "Secure Tracking and Reporting Systems (STARS), showed the Department completed the facility's last full inspection in July 2024.

During an interview on 02/17/2026 at, Staff I stated that the most recent full inspection report was kept by the front desk. The Front Desk staff was unable to locate the full inspection report. Staff I found a copy of the report from the Business Manager's Office.

During an interview on 02/18/2026 at 2:10 PM, Resident 1 stated that they were unaware about the facility's full licensing report. Resident 1 stated interest in reading the report. Resident 1 stated that they did not know where to find the report.

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 Mercer Island is or will be in compliance with this law and / or regulation on (Date) 2/18/26 .

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

Administrator (or Representative) — 3/11/26 . Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observations and interviews, the facility failed to ensure 2 of 8 air exchange ventilation systems (third floor laundry and second floor common bathroom) vented to

Nurse Delegator delegated them to administer blood glucose tests for Resident 12.

During an interview on 02/24/2026 at 4:35 PM, Staff J stated that the facility staff administered blood sugar checks for Resident 12 since 07/22/2025.

FULL INSPECTION REPORT
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During an interview on 02/17/2026 at, Staff I stated that the most recent full inspection report was kept by the front desk. The Front Desk staff was unable to locate the full inspection report. Staff I found a copy of the report from the Business Manager's Office.

During an interview on 02/18/2026 at 2:10 PM, Resident 1 stated that they were unaware about the facility's full licensing report. Resident 1 stated interest in reading the report. Resident 1 stated that they did not know where to find the report.

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 Mercer Island 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-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(b) Keep exterior grounds, assisted living facility structure, and component parts safe, sanitary and in good repair;

(c) Keep facilities, equipment and furnishings clean and in good repair; and

This requirement was not met as evidenced by:

Based on observations and interviews, the facility failed to ensure 2 of 8 air exchange ventilation systems (third floor laundry and second floor common bathroom) vented to

the exterior of the building. The facility failed to ensure 1 of 1 equipment (third floor food waste disposal unit) and 1 of 1 furnishing (third floor storage unit) in good repair. The facility failed to ensure 1 of 1 dumpster enclosure (ground floor) was kept sanitary and well-maintained. These failures placed all residents at risk of harm and diminished quality of life.

Findings included…

During an interview on 02/17/2026 at 10:30 AM, Staff H, Maintenance Director, stated that the physical layout of the building had three floors with the main entrance on the ground floor. Staff H stated that the first and second floors were designated for assisted living units, and the third floor for memory care units.

INTERIOR
Observation on 02/17/2026 between 10:34 AM and 11:AM, showed a non-functioning outflow ventilation system in one third floor laundry room and the second floor common bathroom.

During an interview at the time of observation, Staff H, stated that an outside contractor tested the ventilation system and the air vents were functional at that time. Staff H Staff stated that they were unaware that the air exchange vents did not work. Staff H stated that they had to improve their vent inspections between the contractor's yearly visits.

Observation showed three lower cupboards below a counter right outside the third floor micro-kitchen (a compact kitchen space without stove or oven) accessible to residents. There were two cupboards, each had double doors with magnetic locks and the two left doors magnetic locks were broken and easily opened. Inside these cupboards were bottles of a clear nail polish, a wound cleanser, and a skin lotion. Observation showed three residents moved around independently. Observation of the third floor micro-kitchen, showed a rusty and corroded food waste disposal unit beneath an open dish table. Observation showed a light brown fluid leaking and draining into a plastic basin.

EXTERIOR
Observation on 02/17/2026 at 11:38 AM, showed the enclosed waste and dumpster area located at the end of the parking garage, across from the main entrance. The dumpster area's metal door was rolled up, and observation showed a wet floor and excess debris. The interior showed a rotted and decaying door frame and along the door frame, showed a warped drywall with the bottom portion missing and the upper sections with green and brown stains.

During an interview at the time of observation, Staff H stated that they were aware of the corroded leaking food garbage disposal and damaged door frame and drywalls.

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 Mercer Island is or will be in compliance with this law and / or regulation on (Date) 4/10/26 .

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

Administrator (or Representative) [signature] Date 3/11/26

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete 4 of 7 sampled residents' (Resident 1, Resident 2, Resident 5 and Resident 6) assessment for dementia at least annually. The facility failed to assess 4 of 4 sampled residents (Resident 8, Resident 9, Resident 10, and Resident 11) for their ability to safely use medical devices. These failures placed Resident 1, Resident 2, Resident 5, Resident 6, Resident 8, Resident 9, Resident 10, and Resident 11 at risk for unmet care needs and injury.

Findings included...

Notes: Washington Administrative Code (WAC) 388-78A-2090, Full assessment topics.
The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause: (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including: (e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility. (7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of: (c)

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 Mercer Island 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-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to complete 4 of 7 sampled residents' (Resident 1, Resident 2, Resident 5 and Resident 6) assessment for dementia at least annually. The facility failed to assess 4 of 4 sampled residents (Resident 8, Resident 9, Resident 10, and Resident 11) for their ability to safely use medical devices. These failures placed Resident 1, Resident 2, Resident 5, Resident 6, Resident 8, Resident 9, Resident 10, and Resident 11 at risk for unmet care needs and injury.

Findings included…

Notes: Washington Administrative Code (WAC) 388-78A-2090, Full assessment topics.
The assisted living facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a full assessment addressing the following, within fourteen days of the resident's move-in date, unless extended by the department for good cause: (6) Significant known behaviors or symptoms of the individual causing concern or requiring special care, including: (e) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted in the assisted living facility. (7) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool, to determine the presence of symptoms consistent with, and implications for care and services of: (c)

Dementia. While screening a resident for dementia, the assisted living facility must: (i) Base any determination that the resident has short-term memory loss upon objective evidence; and (ii) Document the evidence in the resident's record.

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must: (3) Evaluate, in order to determine if there is a need for further action: (a) The changes identified in the resident per subsection (2) of this section; and

MEDICAL DEVICE

Review of the facility's policy titled "Use of Side Rails and Transfer Poles", dated 2026, showed the required steps for evaluating, approving, monitoring, and documenting the use of side rails in accordance with state regulations. The policy defined a side rail as a device attached to a bed intended to assist with mobility or positioning. The policy showed that the resident's service plan must document the purpose of the device, instructions for safe use, level of assistance required, monitoring schedule and any risks identified during evaluation. The policy showed safety requirements for side rails, including no gaps that could lead to entrapment.

RESIDENT 8
Review of Resident 8's records, showed the facility admitted Resident 8 on [redacted]/2023 with multiple diagnoses including [redacted] and [redacted]

Review of Resident 8's assessment and service plan, dated 11/07/2025, showed that Resident 8 required one person assistance with transfer. The plan showed that Resident 8 used a bed cane transfer device.

Observation on 02/18/2026 at 9:55 AM, showed a U-shaped transfer device attached at the head of the bed, along the left side. Observation showed the device with a gap that measured 10 ½ inches wide and five and one half inch high from the mattress base. The transfer device metal base was slid between the mattress and the box frame. The device moved with minimal effort.

During an interview at this time, Resident 8 was unable to remember that the facility staff completed any assessment for them to use the transfer device. Resident 8 stated that the facility staff did not explain any of the risks of using the transfer device.

RESIDENT 9
Review of Resident 9's records, showed the facility admitted Resident 9 on [redacted]/2024 with multiple diagnoses including [redacted] and [redacted].

Review of Resident 9's assessment and service plan, dated 10/05/2025, showed that Resident 9 required minimal assistance with transfer. The plan showed that Resident 9 used a bed cane transfer device.

Observation on 02/18/2026 at 10:05 AM, showed a U-shaped transfer device attached at the head of the bed, along the left side. Observation showed the device measured 10 inches wide and the gap between two rails, a five inches and eight inches to the mattress base. The transfer device metal base was slid between the mattress and the box frame. The device moved with minimal effort.

RESIDENT 10
Review of Resident 10's records, showed the facility admitted Resident 10 on [redacted]/2021 with multiple diagnoses including [redacted] and [redacted].

Review of Resident 10's assessment and service plan, dated 08/03/2025, showed that Resident 10 required no assistance with transfer. The plan showed that Resident 10 used a bed cane transfer device.

Observation on 02/18/2026 at 10:16 AM, showed a half-rail transfer device attached at the head of the bed, along the left side. Observation showed the device measured 17 and one half inches long with three and quarter-inch gap between horizontal rails. The transfer device metal base was firmly slid between the mattress and the box frame.

During an interview on 02/25/2026 at 12:49 PM, Collateral Contact 2 (CC2, Resident 10's family representative), stated that an outside Physical Therapist (PT) evaluated Resident 10 in July 2025 and recommended the use of a bedrail. CC2 was unsure whether they received a copy of the PT evaluation for the bedrail. CC2 was unable to remember if the facility staff completed an assessment and explained any of the risk of using the bedrail.

RESIDENT 11
Review of Resident 11's records, showed the facility admitted Resident 11 on [redacted]/2024 with multiple diagnoses including [redacted] and [redacted].

Review of Resident 10's assessment and service plan, dated 12/09/2025, showed that Resident 11 required minimal assistance with transfer. The plan showed that Resident 11 used a bed cane transfer device.

Observation on 02/18/2026 at 10:16 AM, showed a triangular shaped transfer device attached at the head of the bed, along the left side. Observation showed the device measured 19 and one half inches long and 13 inches high from the base of the mattress. The transfer device metal base was anchored to the box frame.

During an interview on 02/18/2026 at 11:05 AM, Staff I, Wellness Care Coordinator, stated that Resident 8, Resident 9, and Resident 11 moved in with their transfer device. Staff I stated that the resident's family installed the transfer devices.

During an interview on 02/23/2026 at 9:02 AM, Staff R, Regional Wellness Nurse, stated that the facility did not consider bed canes under the category of bedrails or medical devices. Staff R stated that the resident's assessment and plan documented the use of bed canes for transfer and bed mobility. Staff J stated that they did not complete a safety assessment on the resident's use of the bed cane.

FULL ASSESSMENT COMPONENT

RESIDENT 1
Review of Resident 1's records showed the facility admitted Resident 1 on [redacted]/2025 with multiple diagnoses including [redacted].

Review of Resident 1's assessment, dated 11/05/2025, showed no documentation the facility initially screened Resident 1 for dementia.

RESIDENT 2
Review of Resident 2's records showed the facility admitted Resident 2 on [redacted]/2025 with multiple diagnoses including [redacted].

Review of Resident 2's assessment, dated 08/22/2025, showed no documentation the facility initially screened Resident 2 for dementia.

RESIDENT 5
Review of Resident 5's records showed that the facility admitted Resident 5 in [redacted] 2024 with a diagnosis of [redacted]. Review of Resident 5's records showed they resided in the secured Memory Care unit. Review of Resident 5's records showed that on 10/18/2024, the facility completed a dementia screening for Resident 5. The records showed that on 02/16/2026, the facility completed a full assessment for Resident 5. The current assessment showed no documentation that the facility assessed Resident 5 for dementia.

RESIDENT 6
Review of Resident 6's records showed that the facility admitted Resident 6 in [redacted] 2024. The records showed that on 12/02/2024, the facility completed dementia screening for Resident 6. The records showed that on 02/09/2026, the facility completed a full assessment for Resident 6. The current assessment showed no

documentation that the facility assessed Resident 6 for dementia.

During an interview on 02/23/2026 at 10:15 AM, Staff R, Registered Nurse/Regional Wellness Nurse, while reviewing the facility's electronic record system, stated that they were unable to locate additional dementia screening records for Resident 6 in their electronic record system. Staff R stated that they did not complete the dementia screening for Resident 6 in the most recent resident assessment. Staff R stated that Resident 6's most recent assessment for dementia was 12/02/2024 that was completed over 14 months ago. During the same interview, Staff R stated that the facility's licensed nurses were responsible for completing the residents' assessments. Staff R stated that the facility required them to complete dementia screening for each assisted living resident initially when they were admitted to the facility. Staff R stated that the facility required them to complete dementia screening every year only for the residents who received memory care in the memory care unit. Staff R stated that they did not reassess residents for dementia who received assisted living services in the assisted living unit. Staff R stated that they were unfamiliar with the requirements for resident assessment. Staff R stated that they did not complete the dementia screening every year for several residents.

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 Mercer Island is or will be in compliance with this law and / or regulation on (Date) 4/16/26 .

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

Administrator (or Representative) — Date: 3/11/26

documentation that the facility assessed Resident 6 for dementia.

During an interview on 02/23/2026 at 10:15 AM, Staff R, Registered Nurse/Regional Wellness Nurse, while reviewing the facility's electronic record system, stated that they were unable to locate additional dementia screening records for Resident 6 in their electronic record system. Staff R stated that they did not complete the dementia screening for Resident 6 in the most recent resident assessment. Staff R stated that Resident 6's most recent assessment for dementia was 12/02/2024 that was completed over 14 months ago. During the same interview, Staff R stated that the facility's licensed nurses were responsible for completing the residents' assessments. Staff R stated that the facility required them to complete dementia screening for each assisted living resident initially when they were admitted to the facility. Staff R stated that the facility required them to complete dementia screening every year only for the residents who received memory care in the memory care unit. Staff R stated that they did not reassess residents for dementia who received assisted living services in the assisted living unit. Staff R stated that they were unfamiliar with the requirements for resident assessment. Staff R stated that they did not complete the dementia screening every year for several residents.

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032

Mercer Island ALC LLC
Vineyard Park of Mercer Island
2959 76TH AVENUE SE
MERCER ISLAND, WA 98040

RE: Vineyard Park of Mercer Island # 2698

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 02/26/2026 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on many deficiency listed on the enclosed report; and
- May inspect your program to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Return the Plan/Attestation Statement and report with signatures to:

James Sherman, Field Manager
Residential Care Services
Region 2, Unit D
Preferred methods:

eFax: (253) 395-5071
Email: rcsregion2email@dshs.wa.gov
Optional method:
20425 72nd Avenue S, Suite 400
Kent, WA 98032

• Complete correction(s) within 45 calendar days of Last Date of Data Collection (02/26/2026), no later than 04/12/2026 or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):

In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must:

(2) Ensure animals living on the assisted living facility premises:

(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state;

(b) Are certified by a veterinarian to be free of diseases transmittable to humans;

The Assisted Living Facility failed to maintain the examination records for one pet (Pet 1). The facility failed to ensure two pets (Pet 2 and Pet 3) were veterinarian-certified to be free of diseases transmittable to humans. During the full inspection, the facility obtained the pets' records and veterinarian certifications.

This deficiency was corrected by the exit conference.

You Are Not:

• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:

• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:

• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.

- You can make an IDR request and find directions on the IDR web page at: https://www.dshs.wa.gov/altsa/idr

If You Have Any Questions:

- Please contact me at (206)305-3489.

Sincerely,

Jim Sherman

James Sherman, Field Manager
Region 2, Unit D
Residential Care Services

Enclosure

March 10th, 2026

James Sherman, Field Manager
Residential Care Services
Region 2, Unit D
20425 72nd Ave South, Suite 400
Kent, WA 98032

RE: Vineyard Park of Mercer Island #2698 – PLAN OF CORRECTION

Dear Mr. Sherman,

Please find the plan of correction for the following citations:

WAC 388-78A-2570 – Notification of Change in Administrator

- We have submitted the written notification to DSHS of the administrator change on March 10th 2026.

WAC 388-78A-2468(1) – Background Checks

- Implementing a pre-hire HR checklist requiring background checks for all employee's that work in the community which includes the Regional staff members.

WAC-388-78A-2305(1) WAC 246-215(03339)(2)(a)(04565)(4) – Food Sanitation

- Our Director of Dining Services has trained the kitchen staff on how to change out the chemical sanitation solution at the correct concentration required.

WAC-388-78A-2290(3)(b)(c)(d)(3)(e) - Family Assistance with Medications and Treatments

- Our Nurse is working with the families and getting the Medication Assistance Plan completed and signed.
- Nurse will provide staff training on monitoring and documenting family medication assistance.

WAC-388-78A-24681(2) - Background Checks

- Implementing a pre-hire HR checklist requiring background checks for all employee's that work in the community which includes the Regional staff members.

WAC-388-78A-2483(2) – Tuberculosis - One Test

- Implementing a pre-hire HR checklist requiring tuberculosis tests for all employee's that work in the community which includes the Regional staff members.
- Maintain TB documentation in personnel files.

WAC-388-78A-2320(1)(a) - Intermittent Nursing Services Systems

- Our Nurse will be working with Home Health on ensuring safe wound care management and will be provided by a Licensed Nurse.
- Nurse will train staff on reporting changes in resident condition requiring nursing evaluation.

WAC-388-78A-(3010(8)(e) - Resident Units - Lockable Drawer Space

- Maintenance Director has ordered lockable boxes and will begin installing upon arrival.
- Maintenance Director will inspect all other rooms for a lockable drawer/box.

WAC-388-78A-2140(2)(a) - Negotiated Service Agreement Content

- Our clinical team is updating our assessments to include missing service descriptions, risks and resident preferences.
- Our Nurse will audit all resident NSA's for completeness.
- Implement a NSA review during care conferences.

WAC-388-78A-2260(2)(d) - Storing, Securing and Accounting for Medications

- Wellness Director will provide refresher training to Medication Technicians.
- Will ensure medications carts and rooms remain locked when unattended.

WAC-388-78A-2380(3) - Freedom of Movement

- Signage has been posted in our memory care for visitors and external providers on how to exit the secured unit without staff assistance.

WAC-388-78A-2730(1)(b)(2)(b)(iii) - Licensee's Responsibilities

- We have applied for our Medical Test Site Certificate of Waiver License with the Department of Health on February 18th 2026.

WAC-388-78A-3090(1)(b)(c) - Maintenance and Housekeeping

- Maintenance Director is working with a licensed HVAC company to identify the issue with air exchange ventilation in the third-floor laundry room. Appointment has been scheduled for Friday 13th 2026.
- Maintenance Director has ordered a replacement garbage disposal for the third-floor.
- Executive Director is working with a contractor on fixing the wall by the exterior dumpster area. Contractor came to the community to assess the wall on March 9th and will start repairs.

WAC-388-78A-2100(2)(b)(i) - Ongoing Assessments

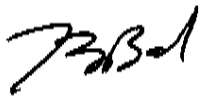
- Nurse will be doing assessments for dementia for all residents.
- Adding dementia assessments in our resident assessment tracking system for all residents.
- Nurse will be conducting evaluations for residents using medical devices ensuring they are safely being used.
- Adding medical device evaluations in our resident assessment tracking system.

Vineyard Park Mercer Island is committed to maintaining compliance with all Washington Administrative Code (WAC) requirements and ensuring the health, safety and well-being of all residents. Systems have been implemented to monitor ongoing compliance and prevent recurrence of the identified deficiencies.

If you have any questions, please do not hesitate to contact me.

Thank you

Sincerely,



TJ Bal
Executive Director
Vineyard Park Mercer Island
206-232-6565