STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Queen Anne ALC LLC
Vineyard Park at Queen Anne Manor
100 Crockett St
Seattle, WA 98109

RE: Vineyard Park at Queen Anne Manor License # 2745

Dear Administrator:

This letter addresses Compliance Determination(s) 68930 (Completion Date 11/18/2025) and 65716 (Completion Date 10/02/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/18/2025 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2710-3-b

The Department staff who did the on-site verification:
Cathy Prentice, Complaint Investigator

If you have any questions, please contact me at (253)312-1446.

Sincerely,

Jamie Singer

Jamie Singer, Field Manager
Region 2, Unit J
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Vineyard Park at Queen Anne Manor
License/Cert.#: 2745
Compliance Determination #: 65716
Investigator: Cathy Prentice
Provider Type: Assisted Living Facility
Intake ID: 194692
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 09/16/2025 through 10/02/2025
Complainant Contact Date(s): 09/15/2025, 10/07/2025

Allegation(s):

1. The Named Resident (NR) has not been getting proper meals when the facility stated they were out of oatmeal and eggs and the NR received only dry toast.
2. The facility runs out of food and the Administration not responding.
3. The NR has to go out for meals.

Investigation Methods:

Sample:	Total residents: 81 Resident sample size: 3 Closed records sample size: 0
Observations:	Named Resident (NR); delivery of care and services; staff interactions with residents; residents' appearance; environment including kitchen.
Interviews:	Named Resident, other residents, staff, administration, collateral contacts.
Record Reviews:	Resident care records, Assessment, Negotiated Service Agreement (NSA), investigations, grievances, facility policies, other pertinent records.

Investigation Summary:

According to interview, observation and record review,
1. The NR had a recent incident when the new cook misread her menu selection and thought it said toast only for breakfast. There was a miscommunication between the kitchen and the care staff who deliver meals to resident rooms, and the NR called her family and went out for breakfast. The NR stated one other time when the breakfast tray delivered without correct breakfast, the kitchen corrected it and prepared food and sent it to the NR's room. The facility is working on the food service to resident rooms. No failed practice identified.
2. The facility was not out of food supply. The new cook threw away the oatmeal after breakfast hours per protocol.
The facility had food storage as required and a large supply of breakfast foods. Other residents interviewed stated they had no food concerns. There was no failed practice identified.

3. The NR chose to go out for breakfast with family. The facility stated food prep is available anytime for residents during open kitchen hours. The facility did retraining with kitchen staff. The resident and family had medical reasons for the room delivery of breakfast and did not know how to call the facility nurse to discuss concerns. The resident and family did not know the facility no longer had a nurse in the building. The facility failed to give residents and families 30 day notice of change in nurse staff in building from 40 hours per week to 0. See Statement of deficiencies dated 10/02/2025.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Vineyard Park at Queen Anne Manor
License/Cert.#: 2745
Compliance Determination #: 65716
Investigator: Cathy Prentice
Provider Type: Assisted Living Facility
Intake ID: 194409
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 09/16/2025 through 10/02/2025
Complainant Contact Date(s): 09/16/2025, 10/07/2025

Allegation(s):

1. The whole floor got Covid a month ago.
2. The Named Resident (NR) had no Bowel Movement from 09/05/2025 to 09/10/2025 and staff were not aware or tracking.
3. A medication was ordered by urgent care 09/10/25 for preventing constipation and facility did not give until 09/13/2025 due to staffing for paperwork processing.
4. There is no way for the staff to call the nurse when requested by a family member of a resident.
5. An unnamed resident said she does not feel safe because there are so many staff changes.

Investigation Methods:

Sample:	Total residents: 81 Resident sample size: 3 Closed records sample size: 0
Observations:	Named Resident (NR); delivery of care and services; staff interactions with residents; residents' appearance; environment.
Interviews:	Named Resident, other residents, staff, administration, collateral contacts.
Record Reviews:	Resident care records, Assessment, Negotiated Service Agreement (NSA), investigations, grievances, facility policies, other pertinent records.

Investigation Summary:

Observation, interview and record review showed:

1. The facility no longer had Covid in the building and an Infection Control investigation was done for the outbreak on 09/02/2025 with no failed practice identified.
2. The record showed the facility had a tracking system for bowel movements and the NR had a charted bowel movement on 09/05/2025, 09/08/2025 and 09/10/2025. No failed practice identified.
3. The NR went to the urgent care with family on 09/10/2025 for constipation check.

A constipation prevention medication was started on 09/12/2025 per the facility record and the pharmacy process. No failed practice identified.
4. The facility does not have a nurse in the building. The facility failed to give the residents and families 30 day notice of the decreased nursing services. See Statement of Deficiency dated 10/02/2025.
5. The facility has had staffing turnover. The NR and other residents interviewed stated they felt safe at the facility. No failed practice identified.

Conclusion / Action:

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 09/16/2025 of:

Vineyard Park at Queen Anne Manor
100 Crockett St
Seattle, WA 98109

This document references the following complaint number(s): 194692, 194409, 191943, 196134

The following sample was selected for review during the unannounced on-site visit: 3 of 81 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Cathy Prentice, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

Statement of Deficiencies	License #: 2745	Compliance Determination # 65716
Plan of Correction	Vineyard Park at Queen Anne Manor	Completion Date
Page 2 of 4	Licensee: Queen Anne ALC LLC	10/02/2025

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.

Jessie Seigel
Residential Care Services

10/8/2025
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)

10/13/25
Date

WAC 388-78A-2710 Disclosure of services.

(3) The assisted living facility must provide a minimum of thirty days written notice to the residents and the residents' representatives, if any:

(b) Before the effective date of any voluntary decrease in the scope of care or services provided by the assisted living facility, and any such decrease in the scope of services provided will not result in the discharge of one or more residents.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to provide the required 30 day notice to residents and their representatives, at least 30 days before they changed the Disclosure of Services (DOS) to reduced and then eliminate the hours of nurse availability in the building. This failure placed 81 residents and legal representatives at risk for lack of knowledge of current nursing services.

Findings included...

Record review, on 09/16/2025, showed the DOS noted in Section 3C titled "Intermittent Nursing Services", stated the facility typically had a registered nurse in the building for five days per week totaling 40 hours per week.

During a meeting with Staff A (Administrator) on 09/16/2025 at 12:45 PM, Staff A confirmed the facility did not have a licensed nurse in the building 40 hours per week as stated in the DOS, and the registered nurse was in the facility usually one day per week. When Department Representative pointed out the DOS stated the facility had an RN in the building 40 hours per

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-2710 Disclosure of services.

(3) The assisted living facility must provide a minimum of thirty days written notice to the residents and the residents' representatives, if any:

(b) Before the effective date of any voluntary decrease in the scope of care or services provided by the assisted living facility, and any such decrease in the scope of services provided will not result in the discharge of one or more residents.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to provide the required 30 day notice to residents and their representatives, at least 30 days before they changed the Disclosure of Services (DOS) to reduced and then eliminate the hours of nurse availability in the building. This failure placed 81 residents and legal representatives at risk for lack of knowledge of current nursing services.

Findings included...

Record review, on 09/16/2025, showed the DOS noted in Section 3C titled “Intermittent Nursing Services”, stated the facility typically had a registered nurse in the building for five days per week totaling 40 hours per week.

During a meeting with Staff A (Administrator) on 09/16/2025 at 12:45 PM, Staff A confirmed the facility did not have a licensed nurse in the building 40 hours per week as stated in the DOS, and the registered nurse was in the facility usually one day per week. When Department Representative pointed out the DOS stated the facility had an RN in the building 40 hours per

week, Staff A stated she was currently working on updating the DOS.

Review of an email, dated 09/17/2025, Staff A stated the DOS had been updated and a copy was attached. The updated DOS, signed by Staff A, showed in Section 3C titled “Intermittent Nursing Services”, the facility did not have a licensed nurse in the building.

Review of an email, dated 09/18/2025, Staff A confirmed the reduction in having a licensed nurse in the building had occurred when the facility changed ownership on 04/01/2025. Staff A stated the new DOS would be sent to the legal representatives and a copy given to the residents now.

In interview, on 10/02/2025 at 2:10 PM, Staff A confirmed that if the nursing care in the building was reduced prior to the DOS distributed to residents that stated the building typically had a registered nurse five days per week totaling 40 hours per week, that did not meet the requirement of notifying the resident of a reduction in care with a 30 day notice.

Statement of Deficiencies	License #: 2745	Compliance Determination # 65716
Plan of Correction	Vineyard Park at Queen Anne Manor	Completion Date
Page 4 of 4	Licensee: Queen Anne ALC LLC	10/02/2025

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 at Queen Anne Manor is or will be in compliance with this law and / or regulation on (Date) 11/4/25 .

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

Administrator (or Representative) Alex Clark Date 10/13/25

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 at Queen Anne Manor 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

Plan of Correction – Queen Anne Manor Assisted Living

Date of Investigation: October 2, 2025

Facility: Queen Anne Manor, operated by CarePartners

Deficiency: Failure to provide 30-day written notice of a voluntary decrease in scope of care or services as required under Washington State licensing regulations.

Summary of Findings

The Department of Residential Services completed a complaint investigation on October 2, 2025, and identified a deficiency in licensing requirements. Specifically, the assisted living facility did not provide a 30-day written notice to residents and/or their representatives prior to implementing a voluntary decrease in the scope of care or services provided. Per regulation, assisted living facilities must provide this notice before any change in services that does not result in resident discharge.

Plan of Correction

Immediate Action:

Effective immediately, Queen Anne Manor will issue a 30-day written notice to all residents and their representatives informing them of upcoming changes to the facility's Disclosure of Services. The notice will clearly state that the revised disclosure will take effect 30 days from the date of the notice. This notice will be given out no later then 10/15/25.

The specific change to the Disclosure of Services will clarify that:

"Registered Nurse available for consult and direction 24/7; additional licensed nursing hours as needed based on resident need."

After the 30-day notice period has concluded, updated copies of the Disclosure of Services will be distributed to all residents and their designated representatives.

Ongoing Compliance and Prevention

To ensure ongoing compliance with state regulations, Queen Anne Manor will implement the following measures:

1. Notification Procedure: Any future changes to the Disclosure of Services or scope of care will be communicated to residents and their representatives at least 30 days in advance in writing.
2. Administrative Review: All changes to services will be reviewed and approved by the Executive Director prior to implementation to ensure proper notice and documentation.
3. Recordkeeping: Copies of all notices and updated disclosures will be maintained in facility administrative files for verification during future surveys.
4. Staff Training: The management team will be trained on state requirements related to notification and disclosure updates to prevent recurrence of this issue.

Completion Date: 11/14/25

Person Responsible: Abby Chand Executive Director