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

This document was prepared by Residential Care Services for the Locator website.

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

RE: Vineyard Park at Queen Anne Manor # 2745

Dear Administrator:

This document references Compliance Determination 67220 (11/25/2025), which included complaint number(s) 197655, 197275, 197139, 198823, 200268.

The Department completed a complaint investigation of your Assisted Living Facility on 11/25/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Cathy Prentice, Complaint Investigator

Consultation:

WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.

The Assisted Living Facility (ALF) failed to ensure medications available in the facility. This failure placed residents at risk for health issues due to missed medications.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:
- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:
- Inspect the facility to determine if you have corrected all deficiencies.

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:
  - What specific deficiency or deficiencies you disagree with;
  - Why you disagree with each deficiency; and
  - 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 (253)312-1446.

Sincerely,

Jamie Singer

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Vineyard Park at Queen Anne Manor
License/Cert.#: 2745
Compliance Determination #: 67220
Investigator: Cathy Prentice
Provider Type: Assisted Living Facility
Intake ID: 197275
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 10/15/2025 through 11/25/2025
Complainant Contact Date(s): 10/06/2025, 12/01/2025

Allegation(s):

1. The NR had a fall 09/26/2025 with bruising and bleeding because the wheelchair was not locked and the legal representative was not notified of the fall.
2. The NR may have missed medication 10/04/2025, as well as multiple other days and the facility medication list does not match the MD orders from clinic visits.
3. The facility did not want to re-admit the NR from the hospital due to being on oxygen unless the NR was on hospice.
4. Facility called 911 to try to evict the NR.

Investigation Methods:

Sample:	Total residents: 81 Resident sample size: 4 Closed records sample size: 1
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:

1. Interview and record review showed the facility completed an assessment and negotiated service agreement (NSA) appropriate showing the NR had cognitive loss and transferred self without calling for assistance . Record record showed the facility investigated the fall and ruled out abuse and neglect, could not substantiate whether the brakes were unlocked, followed up with appropriate interventions and notified the POA. There was no significant change of condition noted that required a notification. The NSA did not include hourly safety checks at the time of the fall. No failed practice identified.
2. The facility failed to have medications available as ordered by the physician in October 2025. The NR missed 2 doses of a pain medication and 1 dose of a heart

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medication due to medication unavailability and the facility not reordering the medication on time per policy. The Assisted Living Facility (ALF) failed to ensure medications were available in the facility. Record review and interview showed the facility put systems in place following this issue that corrected the finding. A consultation was written for the facility regarding medication non-availability. The facility worked with the pharmacy to update the medication list per MD notes from clinic visits provided by the POA.
3. The facility accommodated the NR for oxygen according to the MD orders and in collaboration with family monitoring although oxygen was not on the facility disclosure of services (DOS). In interview, ALF staff denied they were pressuring the resident to be on hospice stating their DOS showed they did not provide oxygen care. In interview, the NR's representative stated the eviction and hospice issue was a misunderstanding. No failed practice identified.
4. The facility called 911 for a possible change in condition per facility policy. The facility did not give a discharge notice to the NR. No failed practice identified.

Conclusion / Action:

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

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Residential Care Services
Investigation Summary Report

Provider/Facility: Vineyard Park at Queen Anne Manor
License/Cert.#: 2745
Compliance Determination #: 67220
Investigator: Cathy Prentice
Provider Type: Assisted Living Facility
Intake ID: 198823
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 10/15/2025 through 11/25/2025
Complainant Contact Date(s): 11/04/2025, 11/26/2025

Allegation(s):

1. The NR is not receiving medications all the time due to running out of meds. Has happened multiple times.
2. The NR is left at dining room table for hours.
3. There is concern for the NR's food intake which is not monitored. The NR forgets if he ate.

Investigation Methods:

Sample:	Total residents: 81 Resident sample size: 4 Closed records sample size: 1
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:

1. The facility changed pharmacies with new ownership April 2025. The new pharmacy initially had issues with provider prescriptions and the facility resolved the problem in coordination with the family. There were no missed medications noted in the records reviewed. No failed practice identified.
2. Interview and record review showed the NR had meals in the dining room that were often in between activities that also occurred in the dining room that the NR participated in and was not left sitting with his meals. No failed practice identified.
3. The facility monitored the NR's food intake daily with all meals on the Memory Care Unit. The NR has had some weight fluctuation in the last 3 to 6 months. The NR has food preferences and the facility coordinated with the family to assist in the NR's menu selections weekly. The NR's weight is presently stable. The family supplies a dietary supplement. No failed practice identified.

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Conclusion / Action:

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

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