STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

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

RE: Vineyard Park of Bremerton License # 2695

Dear Administrator:

This letter addresses Compliance Determination(s) 81060 (Completion Date 07/24/2026) and 76789 (Completion Date 06/18/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/24/2026 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-2120-1, WAC 388-78A-2120-2-a, WAC 388-78A-2120-3-a, WAC 388-78A-2120-4

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

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit D
Residential Care Services

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Vineyard Park of Bremerton **Provider Type:** Assisted Living Facility

License/Cert.#: 2695
Intake ID: 222524
Compliance Determination #: 76789
Region/Unit #: RCS Region 3 / Unit D
Investigator: Shelley Neeleman
Investigation Date(s): 05/01/2026 through 06/18/2026
Complainant Contact Date(s):

Allegation(s):
Quality of Care and Treatment – Neglect:
Administration/Personnel:
Nursing Services:
Resident/Patient/Client Assessment:
1) The named resident went to the hospital for an infected wound on the bottom of the foot. The facility neglected to identify the wound and neglected to perform any wound care, which may result in a partial foot [redacted].

Investigation Methods:

Sample:	Total residents: 78 Resident sample size: 4 Closed records sample size:
Observations:	General environment Residents Resident rooms Staff Staff to Resident interactions Staffing levels
Interviews:	Staff Residents Family
Record Reviews:	Resident Characteristic Roster Face Sheets Service Plans Progress Notes Incident Reports Statement from Facility RN, dated 05/01/2026 Medication Administration Records AL Assessment Home Health Certification and Plan of Care CenterWell Home Health Client Coordination Note Reports Wounds-Skin Integrity Policy, revised 10.7.2020

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Investigation Summary:

1) Based on observation, there was no indication of a lack of staffing or a lack of care and services.

Based on interviews and record review, the named resident was receiving wound care services from a home health agency for leg wounds. The home health nurse noted a new wound (a diabetic ulcer) on the bottom of the named resident's right foot on 04/24/2026 and bandaged the wound.

Facility staff did not become aware of the named resident's pressure ulcer until [redacted] 2026, when the named resident exhibited symptoms of an infection, and the home health nurse contacted emergency services to have the named resident sent to the hospital for evaluation and treatment. The facility was informed by hospital staff that the named resident required a partial [redacted] of his right foot. The facility failed to identify the named resident's new skin issue and did not monitor or treat the named resident's wound. This failure placed the named resident at risk for unmet care needs and harm.

The facility did not meet regulatory requirements as outlined in WAC 388-78A-2120(1)(2)(a)(3)(a)(4).

Conclusion / Action:

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

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STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
PO Box 99250, Lakewood, WA 98496

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 05/01/2026 of:

Vineyard Park of Bremerton
2707 Clare Ave
Bremerton, WA 98310

This document references the following complaint number(s): 222524

The following sample was selected for review during the unannounced on-site visit: 4 of 78 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Shelley Neeleman, ALF Complaint Investigator

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit D
PO Box 99250
Lakewood, WA 98496

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Statement of Deficiencies	License #: 2695	Compliance Determination #76789
Plan of Correction	Vineyard Park of Bremerton	Completion Date
Page 2 of 4	Licensee: Laurel Glen ALC LLC	06/18/2026

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.

Laurie Anderson — Residential Care Services

06/23/2026 — 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.

[signature] — Administrator (or Representative)

06/24/2026 — Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(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

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor 1 of 3 sampled resident's (Resident 1 [R1]) well-being and take appropriate actions for the resident's changing needs. This failure placed R1 at risk for unmet care needs and at risk for potential harm.

Findings included...

Record review of the facility's policy titled, "Wounds-Skin Integrity", revised 10/07/2020, showed it was the policy of CarePartners Senior Living to assist each resident with maintaining healthy skin integrity as per assessed need. When providing hands-on ADL [Activities of Daily Living] assistance, staff will monitor and report any indication of altered skin integrity to [Licensed Nurse (LN)] for evaluation.

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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.

Laurie Anderson
Residential Care Services

06/23/2026
Date

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Administrator (or Representative)

Date

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This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to monitor 1 of 3 sampled resident's (Resident 1 [R1]) well-being and take appropriate actions for the resident's changing needs. This failure placed R1 at risk for unmet care needs and at risk for potential harm.

Findings included...

Record review of the facility's policy titled, "Wounds-Skin Integrity", revised 10/07/2020, showed it was the policy of CarePartners Senior Living to assist each resident with maintaining healthy skin integrity as per assessed need. When providing hands-on ADL [Activities of Daily Living] assistance, staff will monitor and report any indication of altered skin integrity to [Licensed Nurse (LN)] for evaluation.

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Record review of R1's Wound Record Report from CenterWell Home Health (CenterWell), dated 04/24/2026, showed that a diabetic ulcer (an open sore that primarily develops on the feet or legs of a person with a chronic condition where the body is unable to control high and low blood sugar levels) was identified on R1's right foot near the smallest, outermost toe. The CenterWell nurse bandaged the wound and provided directions for staff to adjust or reinforce the wound dressing if it became dislodged.

Record review of R1's Service Plan Report, initiated 01/24/2025, showed that R1's skin may be dry, thin, and bruise easily. The plan showed R1 was able to independently apply lotion and protect skin. The plan showed that staff were to observe R1's skin and notify LN of any red, raised, discolored, or open areas.

Record review of R1's Medication Administration Record (MAR), Schedule for April 2026, showed an order for "daily foot checks", and to "apply moisturizing cream to feet" daily. The MAR showed that every day in April of 2026 was signed off as "administered" by a staff member except days 04/24/2026, 04/25/2026, 04/28/2026, 04/29/2026, and 04/30/2026. The MAR showed the code "RA" or "Resident Not Found" on 04/24/2026, the code "O" or "Other" on 04/25/2026, and the code "RH" or "Resident Hospitalized" from [redacted]/2026 through [redacted]/2026.

Record review of R1's Progress Note, dated 04/25/2026 at 1:26 a.m., showed that at 8:30 a.m., R1 had pale skin, was shivering, and reported feeling weak and cold.

Record review of R1's Progress Note (Order type), dated 04/25/2026 at 6:55 p.m., showed that R1 had a bandage on their foot for a wound. The note showed that staff did not apply lotion on this date.

Record review of R1's Incident Description (ID), dated [redacted]2026 at 10:00 a.m., showed that on [redacted]2026 the CenterWell nurse observed a new wound on the bottom of R1's right foot. There was no documentation that showed the CenterWell nurse reported the wound to facility staff. The ID showed that on [redacted]2026 at approximately 10:00 a.m., the CenterWell nurse called Emergency Medical Technicians (EMTs) to evaluate R1. R1 was awake and reported seeing people on the rooftop, a new symptom for R1. R1 was transported to the hospital.

Review of R1's undated records showed no documentation that staff reported any altered skin integrity for R1 to nursing staff, as directed in R1's Service Plan. There was no documentation that staff checked R1's wound dressing to ensure it remained secure, as directed by the CenterWell nurse.

Record review of R1's Progress Note, dated [redacted]2026 at 2:57 p.m., showed that R1 was scheduled for surgery on 05/04/2026 for a partial [redacted] of the right foot due to a significant infection in the wound of R1's right foot.

During an interview on 05/01/2026 at 1:58 p.m., Staff A, the Executive Director (ED), stated that residents at the facility with wounds were all managed by CenterWell Home Health. Staff A stated that while staff provided care, they would observe residents for

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Statement of Deficiencies	License #: 2695	Compliance Determination # 76789
Plan of Correction	Vineyard Park of Bremerton	Completion Date
Page 4 of 4	Licensee: Laurel Glen ALC LLC	06/18/2026

skin issues and report any skin issues to the Resident Care Coordinator (RCC). Facility care staff also conducted skin checks twice weekly and documented skin issues on the facility skin check form for the RCC and facility nurse to review. Staff A stated that when a new skin issue was identified, the resident was placed on alert monitoring for the RCC and facility nurse to monitor.

During an interview on 05/21/2026 at 3:57 p.m., Staff B, the Resident Care Coordinator, stated that CenterWell visited R1 on 04/24/2026. Staff B stated that CenterWell did not leave any notes from that visit with staff. Staff B stated that staff were unaware of the foot wound when R1 exhibited symptoms of infection. Staff B stated that on 04/25/2026, a dressing was observed on R1's right foot. Staff B stated that this was when staff first noticed the wound.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Vineyard Park of Bremerton is or will be in compliance with this law and / or regulation on (Date) 07/10/2026 .

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

[signature] 06/24/2026

Administrator (or Representative) Date

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skin issues and report any skin issues to the Resident Care Coordinator (RCC). Facility care staff also conducted skin checks twice weekly and documented skin issues on the facility skin check form for the RCC and facility nurse to review. Staff A stated that when a new skin issue was identified, the resident was placed on alert monitoring for the RCC and facility nurse to monitor.

During an interview on 05/21/2026 at 3:57 p.m., Staff B, the Resident Care Coordinator, stated that CenterWell visited R1 on 04/24/2026. Staff B stated that CenterWell did not leave any notes from that visit with staff. Staff B stated that staff were unaware of the foot wound when R1 exhibited symptoms of infection. Staff B stated that on 04/25/2026, a dressing was observed on R1's right foot. Staff B stated that this was when staff first noticed the wound.

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I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Vineyard Park of Bremerton is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date

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June 26, 2026

Laurie Anderson, Field Manager

RCS Region 3, Unit D

P.O. Box 99250

Lakewood, WA 98496

RE: Vineyard Park of Bremerton– License 2695 Plan of Correction

2707 Clare Ave Bremerton, WA 98310

Dear Laurie Anderson,

Please find the plan of corrections for the investigation and citation:

WAC 388-78A-2120 Monitoring residents' well-being- wound/skin integrity

- Date of correction 7/10/2026
- Skin checks are being done weekly or daily if needed for resident's diabetic or with skin issues.
- Resident Care Coordinator will complete skin check form and notify doctor of any skin issues and coordinate with outside providers for plan of care.
- Staff have been re-trained by Administrator:

  - On 6/18/26 staff were in-serviced by Administrator and Resident Care Coordinator on skin integrity, observing skin during ADLs, monitoring and completing skin check forms for skin issues. Staff have also reviewed WAC 388-78A-2020, WAC 388-78A-2120.

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

Sincerely,

Bobbie Cruz, Administrator

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