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

North Creek Assisted Living Community LLC
Vineyard Park at North Creek
1802 192nd St SE
Bothell, WA 98012

RE: Vineyard Park at North Creek # 2742

Dear Administrator:

This document references Compliance Determination 61853 (07/23/2025), which included complaint number(s) 181572.

The Department completed a complaint investigation of your Assisted Living Facility on 07/23/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The department staff who did the inspection and provided consultation:

Hayley Pinkham, ALF Licensor

Consultation:

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

Assisted Living Facility (ALF) failed to notify a primary care physician to get clarification on medications prescribed to a resident in a timely manner. This resulted in a resident going without prescribed eye drops for approximately two weeks.

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:
  - 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.
  - o Send your request to:

Email: RCSIDR@dshs.wa.gov; or
Fax: (360) 725-3225

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 North Creek
License/Cert.#: 2742
Compliance Determination #: 61853
Investigator: Hayley Pinkham
Provider Type: Assisted Living Facility
Intake ID: 181572
Region/Unit #: RCS Region 2 / Unit J
Investigation Date(s): 06/30/2025 through 07/23/2025
Complainant Contact Date(s): 07/23/2025

Allegation(s):

1) The Named Resident (NR) was placed in the Memory Care Unit (MCU) after "false assumptions" by the Assisted Living Facility (ALF) staff.
2) The ALF placed the NR in a room for a two-day emergency respite stay. The room was a model room and not prepared for resident care, accessibility, and the furniture was not safe for the NR. The washer and dryer was not accessible to the NR.
3) The NR's care was neglected, and the NR did not receive ordered medication.
4) The NR was isolated to her room and the ALF did not provide activities or exercise.
5) A male resident entered the NR's room and slept in the NRs bed. The NR was afraid and called for help. no staff responded.
6) The NR became depressed and had suicidal ideation.
7) The NR did not receive a communication system for a week.
8) The fire doors on the MCU were heavy and hard for the NR to open.
9) The ALF is understaffed.
10) The NR was not allowed to dine in the dining room and had to have meals in the room.
11) The NR had difficulty navigating the elevator system in the ALF. The NR ended up in the parking garage due to poor vision and unclear floor identifiers in the elevator.
12) The NR may have had urinary track infection and the ALF would not test the NR.
13) There is no way to reach staff on the MCU by phone and there is no answering service available after hours at the ALF.
14) The NR was dressed in a dirty sweater that was soiled with feces. The staff did not wash the sweater.
15) The NR was not bathed for 3 days and may have developed an urinary track infection from sitting in dirty hygiene pads.
16) The NRs medications were taken away from her from management related no prescriptions on the medication.

Investigation Methods:

Sample:	Total residents: 11 Resident sample size: 1 Closed records sample size: 1
Observations:	Residents

	Activities Resident care equipment Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Maintenance staff
Record Reviews:	Medical records Maintenance logs Facility policies

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Investigation Summary:

1) The NR no longer resides at the ALF. Interview with sampled residents showed no reported concerns for the care and safety at the ALF. Interview and record review showed the NR was reassessed for emerging care needs and placed in MCU for potential safety needs. No failed practice identified.
2) Observation showed the model room was accessible and appropriate for use. Observation did not show the furniture was “unsafe”. Interview showed the NR could use the furniture without difficulty. Observation and interview showed the washer and dryer on the MCU was for staff use only. Washer and dryers in the ALF met accessibility requirements. No failed practice identified.
3) Unable to substantiate the NR care was neglected through interview and record review. Interview and observation of sampled residents did not show concerns for care and/or safety. Interview and record review showed the NR did not receive needed medications. No failed practice identified. See below for investigation summary #16.
4) Interview and record review showed the NR was able to determine activities of choice and the NR preferred to spend time in the room. Observation, interview and record review showed the ALF had space for activities and activities are available to all residents. No failed practice identified.
5) Observation showed the MCU provided care to residents that wander. Interview showed residents are redirected during ambulation and/or exit seeking behavior. Record review showed the Negotiated Service Agreements addressed resident with wandering, requirement of redirection and exit seeking behaviors. No failed practice identified.
6) Interview and record review did not show documented or reported concerns of suicidal Ideation or depression for the NR. No failed practice identified.
7) Interview and record review showed the NR was provided a pendant and the NR was able to use the call light system. Observation showed the ALF staff responded to call lights in a timely manner. No failed practice identified.
8) The reported fire doors were on the ALF portion of the facility. Interview and record review showed the ALF adjusted the speed of closure of the fire door as able to maintain fire door code and safety. Fire doors have been inspected and met code. No observable concerns with the fire doors at the ALF. No failed practice identified.
9) Interview and record review showed the ALF had sufficient staffing levels for a census of 11 residents. No failed practice identified.
10) Interview showed the NR was allowed to have meals in the MCU dining room and received escort assist occasionally to the main dining room. Interview showed the NRs preference was to choose to have breakfast in the room. No failed practice identified.
11) Interview and record review showed the NR went to the parking garage.

Investigative documents and witness statements showed the NR called the fire department from the garage and reported that she “trapped” in the elevator when she was not. Observation of the elevator showed compliance to the American with Disabilities Act (ADA). No failed practice identified.
12) Interview and record review showed the ALF wanted the NR to be seen by a physician for testing. Interview showed the NR was tested. Interview and record review showed the NR did not have a UTI. No failed practice identified.
13) Interview and observation showed the MCU does have a phone available, and the residents are allowed to have a phone in their rooms. Interview and observation showed the ALF has a pager and walkie talkie communication system. No failed practice identified.
14) Interview and record review showed the NR had difficulty with bowels and the NR had dressed self. The dirty sweater was in the laundry to be washed. Interview showed the ALF staff attempted to correct the occurrence and assisted the NR after the “accident”. Observation showed sampled residents in the MCU were clean and well groomed. No failed practice identified.
15) Interview and record review showed the NR did receive shower assist. Interview and record review showed the NR refused shower assist as well. The NR did not have an UTI. No failed practice identified.
16) Interview and record review showed the NR could not safely identify the medications. The ALF reassessed the NR and determined staff assist was necessary. The Negotiated Service Agreement was updated to reflect the NR’s changing condition. Record review showed ALF staff identified the NR had medications that required prescriptions. Record review showed the ALF staff delayed response to the providing physician. The ALF put a plan in place when the delay of medication was identified to continue to adhere to the ALFs medication service policy. Consultation provided to the ALF.

Conclusion / Action:

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