STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

07/16/2026

North Creek Assisted Living Community LLC
Vineyard Park at North Creek

,

RE: Vineyard Park at North Creek # 2742

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 80218 (Completion Date 07/16/2026) and 76969 (Completion Date 05/27/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/16/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
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:

(5) Appropriate behavioral interventions, if needed;

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

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

WAC 388-78A-2250 Alteration of medications. The assisted living facility must generally provide medications in the form they are prescribed when administering medications or providing medication assistance to a resident. The assisted living facility may provide medications in an altered form consistent with the following:

(1) Alteration includes, but is not limited to, crushing tablets, cutting tablets in half, opening capsules, mixing powdered medications with foods or liquids, or mixing tablets or capsules with foods or liquids.

(2) Residents must be aware that the medication is being altered or added to their food.

(3) A pharmacist or other practitioner practicing within their scope of practice must determine that it is safe to alter a medication.

(4) If the medication is altered, documentation of the appropriateness of the alteration must be on the prescription container, or in the resident's record.

The Department staff who did the On Site verification:
Hayley Pinkham, ALF Licensor

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

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Vineyard Park at North Creek
License/Cert.#: 2742
Compliance Determination #: 76969
Investigator: Hayley Pinkham
Investigation Date(s): 05/06/2026 through 05/27/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 223116
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):

1) The Named Resident 1 (NR1) is entering the Named Resident 2's (NR2) apartment and will not leave the NR2 alone. The NR2 had to leave the room and the NR2 has been crying. The Assisted Living Facility (ALF) staff "promises" to keep NR1 out of NR2's apartment.

Investigation Methods:

Sample:	Total residents: 55 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions Dining
Interviews:	Identified resident Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records

Investigation Summary:

1) Interview with the NR1 showed the NR1 was disturbed and distressed by the interactions with NR2. The NR2 did not want to participate in an interview. Observation showed the NR2 aggressively interacted with the NR1 and attempted multiple times to enter the NR1's apartment without staff intervention. Record review showed the ALF did not document needed interventions in the NR1 and NR2's Negotiated Service Agreement to limited behaviors or interactions. Findings of deficient practice. See Statement of Deficiency dated 05/27/2026.

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

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 North Creek
License/Cert.#: 2742
Compliance Determination #: 76969
Investigator: Hayley Pinkham
Investigation Date(s): 05/06/2026 through 05/27/2026
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 221165
Region/Unit #: RCS Region 2 / Unit J

Allegation(s):

1) The Named Resident 1 (NR1) pushed the Named Resident 2 (NR2) down to the ground with the apartment door. The NR2 sustained an injury to the head.

Investigation Methods:

Sample:	Total residents: 55 Resident sample size: 4 Closed records sample size:
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Identified staff Nursing staff Family members
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1) Interview with the NR1 showed the NR1 denied the altercation with the NR2 but reported aggressive statements regarding private space and interactions with others. Interview with the NR2 showed the NR2 could not recall the interactions and reported feeling safe at the Assisted Living Facility (ALF). The ALF investigated the altercation, sought medical treatment for the NR2 and reported the altercation to the department. Record review showed the ALF did not document needed interventions in the NR1‘s negotiated Service Agreement to address the NR1’s aggressive behaviors or negative interactions with other residents. Findings of deficient practice. See Statement of Deficiency dated 05/27/2026.

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

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
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

Statement of Deficiencies	License #: 2742	Compliance Determination # 76969
Plan of Correction	Vineyard Park at North Creek	Completion Date
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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 05/06/2026 of:

Vineyard Park at North Creek
1802 192nd St SE
Bothell, WA 98012

This document references the following complaint number(s): 223116, 221165, 220100

The following sample was selected for review during the unannounced on-site visit: 4 of 55 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Hayley Pinkham, ALF Licensor

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 2 , Unit J
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

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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.

Janice Seigen
Residential Care Services

5/28/2026
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)

5/3/2026
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:

(5) Appropriate behavioral interventions, if needed;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to ensure the Negotiated Service Agreement (NSA) for 3 of 3 sampled residents (Resident 1, 2 and 3) were developed to include the residents' behavioral concerns and required interventions. This placed Resident 1, 2, and 3 at risk of harm from not receiving assistance during behavioral concerns.

Findings included...

Resident 1 and Resident 2

Record review of an Assessment, dated 01/17/2026, showed the ALF admitted Resident 1 on [redacted]/2026 with a diagnosis of [redacted].

Record review of an Assessment, dated 04/21/2026, showed the ALF admitted Resident 2 on [redacted]/2026 with a diagnosis of [redacted].

In interview, on 05/05/2026 at 5:01 PM, Collateral Contact 1 (CC1 – Resident 1's Legal

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Representative) stated that there were issues in the facility with Resident 2's behavior and how it affected Resident 1. CC1 stated Resident 2 has been obsessed with Resident 1, following her and not leaving her alone, entering her room without permission, and getting aggressive when redirected. CC1 stated Resident 1 did not feel safe and is, "about to have a nervous breakdown" due to Resident 2's behavior. CC1 stated she had spoken to Staff A (Administrator) on several occasions regarding this situation. CC1 stated Staff A said she would institute care staff to re- direct and separate Resident 1 and Resident 2 and assist with escorting Resident 1 to their apartment and securing Resident 1's door by locking.

Observation, on 05/06/2026 at 12:16 PM, showed when Resident 1 entered the dining room for lunch, Resident 2 was observed immediately waving Resident 1 down. Resident 1 turned away from Resident 2. Resident 2 followed Resident 1 and sat down at the same table. Resident 1 shifted her body away from Resident 2. The care staff did not attempt to redirect or separate Resident 2 from Resident 1.

Observation, on 05/06/2026 at 1:07 PM, showed when Resident 1 was leaving the dining room with Resident 2 following closely behind. The care staff were observed going to stand and walk in between Resident 1 and Resident 2. While Resident 1 was leaving the dining room, Resident 2 attempted on multiple occasions to reach out and touch Resident 1, becoming verbally and physically aggressive to the care staff and stating, "get your ass out of the way." The care staff assisted Resident 1 to her apartment and secured Resident 1 behind the locked door.

Observation, on 05/06/2026 at 1:12 PM, showed Resident 2 approached Resident 1's apartment door and shook the apartment door handle attempting to enter. Observed Resident 2 in the vicinity of Resident 1's apartment door for approximately five minutes, shaking the doorknob and attempting to enter Resident 1's apartment four times. There were no care staff in the vicinity, and no care staff escorted Resident 2 away from the area after securing Resident 1 in their apartment.

Review of Resident 1's NSA, dated 01/21/2026, showed there was no indication as to whether Resident 1 required assist with escort to their apartment and assist with unlocking and locking their apartment door. The NSA showed there was no indication that Resident 1's contact with Resident 2 was to be limited.

Review of Resident 2's NSA, dated 04/23/2026, showed there was no information regarding their obsessive and aggressive behaviors, no plan on how to manage those behaviors and no interventions in place to keep Resident 1 safe from Resident 2.

In interview on 05/19/2026 at 3;13 PM, Staff A, (Administrator), stated the interventions for assistance with escort and limiting contact between Resident 1 and Resident 2, "absolutely" should be addressed on the NSA.

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Resident 3

Record review of an Assessment, dated 03/11/2026, showed the ALF admitted Resident 3 on [redacted]/2026 with a diagnosis of [redacted].

Record review of an Incident Investigation Summary, dated 04/11/2026, showed Resident 3 pushed a resident down to the floor with their apartment door when they mistakenly attempted to enter Resident 3's apartment. The Summary showed the resident hit with the door sustained injuries.

Record review of a Progress Note (PN), dated 05/01/2026, showed Resident 3 was placed on alert monitoring for increased verbal aggression and threatening behaviors toward other residents, including ongoing conflict with a specific resident. The PN showed that staff must closely monitor interactions and prevent contact between the two residents. The PN showed, "If escalation occurred, staff were to immediately separate and redirect Resident 3 to their room or calmly talk with them and redirect by engaging in conversation about topics they love." PN showed staff must maintain increased supervision in common areas and communicate across every shift. The PN was repeated verbatim on 05/01/2026 through 05/05/2026.

Review of Resident 3's NSA, dated 03/12/2026, showed there was no indication that Resident 3 had a history of physical and verbal aggression towards residents in Resident 3's personal space. The NSA did not include interventions for care staff to manage Resident 3's behaviors.

In interview on 05/19/2026 at 3:13 PM, Staff A stated Resident 3's behaviors should be addressed on their NSA. Staff A confirmed interventions had not been documented in the contents of Resident 1, Resident 2 and Resident 3's NSA.

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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 at North Creek is or will be in compliance with this law and / or regulation on (Date) 6/30/2026

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

Administrator (or Representative) 6/3/2026 Date

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure they evaluated for any significance or outcome and notified the physician when 1 of 1 resident (Resident 3) refused their medications on multiple occasions. This failure resulted in Resident 3 not having necessary medical follow-up when they missed multiple doses of prescribed medications.

Findings included...

Record review of the ALF's undated policy titled Medications, showed the ALF was to document resident's refusal or inability to take medication according to the prescription and notify the prescriber if indicated.

Review of the website www.drugs.com showed quetiapine was an atypical antipsychotic used to treat several types of mental health disorders. Quetiapine should be taken

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exactly as prescribed. Quetiapine should not be stopped suddenly, as mental health conditions may get worse, or could cause unpleasant symptoms (such as trouble sleeping, nausea and vomiting). Follow doctor's instructions before stopping quetiapine.

Review of the website www.drugs.com showed amlodipine tablets are indicated for the treatment of hypertension, to lower blood pressure. Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and myocardial infarctions.

Review of the website www.drugs.com showed famotidine is a histamine-2 blocker that works by decreasing the amount of acid the stomach produces. Famotidine is used to treat and prevent ulcers in the stomach and intestines. Famotidine also treats gastroesophageal reflux disease (GERD) and other conditions in which acid backs up from the stomach into the esophagus, causing heartburn.

Record review of a Face Sheet showed the ALF admitted Resident 3 on [redacted]/2026 with a diagnosis of [redacted] Review of a Negotiated Service Agreement (NSA), dated 03/12/2026, showed Resident 3 required facility staff assistance of some or all medications per physician orders.

Record review of hospital Discharge Summary, dated [redacted]/2026, showed Resident 3 had physician's orders for the following routine medications: amlodipine 2.5 milligrams (mg) tablet, take one tablet every day; quetiapine 25 mg tablet, take one tablet in the evening; famotidine 10 mg tablet, take one tablet two times a day; multivitamin with minerals, one tablet every day; vitamin B12 (supplement)1000 micrograms (mcg), take one tablet every day; vitamin D3 (supplement)10 mcg, take one tablet every day.

Record review of the March, April, and May 2026 Medication Administration Record (MAR), on 05/18/2026, showed Resident 3 refused his amlodipine, quetiapine, famotidine and vitamins on 59 occasions.

Record review showed the ALF had no documentation that Resident 3 was evaluated for any significance or outcome of refusing his medications. There was no documentation the ALF notified Resident 3's physician of refusing ordered medications.

In interview, on 05/19/2026 3:13 PM, Staff A (Administrator) stated the ALF did not have documented evidence that the primary care physician was notified of Resident 3's refusal of medication.

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

Administrator (or Representative) 6/3/2026 Date

WAC 388-78A-2250 Alteration of medications. The assisted living facility must generally provide medications in the form they are prescribed when administering medications or providing medication assistance to a resident. The assisted living facility may provide medications in an altered form consistent with the following:

(1) Alteration includes, but is not limited to, crushing tablets, cutting tablets in half, opening capsules, mixing powdered medications with foods or liquids, or mixing tablets or capsules with foods or liquids.

(2) Residents must be aware that the medication is being altered or added to their food.

(3) A pharmacist or other practitioner practicing within their scope of practice must determine that it is safe to alter a medication.

(4) If the medication is altered, documentation of the appropriateness of the alteration must be on the prescription container, or in the resident's record.

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure an appropriate practitioner had documented and prescribed if a medication could be altered for 1 of 1 resident (Resident 3) prior to mixing medication with a liquid. This failure resulted in Resident 3 receiving prescribed medication in an altered form without an order.

Findings included...

Record review of an undated Face Sheet showed the ALF admitted Resident 3 on [redacted]/2026 with a diagnosis of [redacted]. Review of a Negotiated Service Agreement (NSA), dated 03/12/2026, showed Resident 3 required facility staff assistance of some or all medications per physician orders.

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Record review of Discharge Summary from a hospital stay, dated [redacted]/2026, showed Resident 3's was prescribed quetiapine (an atypical antipsychotic used to treat several types of mental health disorders) 25 milligram (mg) tablet, take 1/2 tablet three times a day as needed for anxiety and agitation. The Discharge Summary did not include instructions or approval for altering.

Record review of a Progress Note (PN), dated 03/19/2026, showed Resident 3 received their quetiapine. The PN showed Staff B (Medication Technician), provided Resident 3's quetiapine "via soda."

Record review of a PN, dated 03/22/2026, showed Resident 3 received their quetiapine "inside the soda." Staff B documented "we are mindful that he [Resident 3] does not taste the medication."

Record review of Resident 3's, March 2026 "Medication Administration Record" (MAR), on 05/18/2026, showed no instructions or orders to alter medications.

In interview, on 05/19/2026 3:13 PM, Staff A (Administrator) confirmed that altered medications needed to have a physician's order.

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