STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Woodland Retirement & Assisted Living Community LLC
Woodland Retirement & Assisted Living Community
3425 Boone Rd SE
SALEM, OR 97317

RE: Woodland Retirement & Assisted Living Community License # 1709

Dear Administrator:

This letter addresses Compliance Determination(s) 31708 (Completion Date 10/26/2023) and 27801 (Completion Date 08/10/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/26/2023 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-2640-2, WAC 388-78A-2640-2-a, WAC 388-78A-2640-2-b, WAC 388-78A-2160

The Department staff who did the on-site verification:
Phan Pham, Nurse Surveyor

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, Field Manager
Region 3, Unit E
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodland Retirement & Assisted Living Community
License/Cert.#: 1709
Compliance Determination #: 27801
Investigator: Phan Pham
Provider Type: Assisted Living Facility
Intake ID: 90154
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 08/09/2023 through 08/10/2023
Complainant Contact Date(s):

Allegation(s):
Quality of care - Named resident fell and sustained injury to her head.

Investigation Methods:

Sample:	Total residents: 61 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents, environment, staff interactions with residents, staff members providing care and services, infection control practice, and safety measures.
Interviews:	Residents, staff members, administrative and member not associated with the facility.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:
An investigation was conducted, and allegation identified in the intake related to fall with injury, care and services were reviewed. The assisted living facility failed to ensure staff members provided care and services in accordance with the negotiated service agreement to prevent the resident from fallen. Additional residents reviewed for care, services and safety had no concerns.

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: Woodland Retirement & Assisted Living Community
License/Cert.#: 1709
Compliance Determination #: 27801
Investigator: Phan Pham
Provider Type: Assisted Living Facility
Intake ID: 92024
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 08/09/2023 through 08/10/2023
Complainant Contact Date(s):

Allegation(s):

Quality of care - Named resident fell and sustained a hip fracture. Named resident was admitted to the facility and the assisted living facility did not report the Named resident's case manager.

Investigation Methods:

Sample:	Total residents: 61 Resident sample size: 4 Closed records sample size: 0
Observations:	Residents, environment, staff interactions with residents, staff members providing care and services, infection control practice, and safety measures.
Interviews:	Residents, staff members, administrative and member not associated with the facility.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:

An investigation was conducted, and allegation identified in the intake related to fall with fracture, care and services were reviewed. The assisted living facility failed to ensure staff notify the resident’s case manager when the resident was admitted to the hospital. Additional residents reviewed for care, services and safety had no concerns.

Conclusion / Action:

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

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 08/09/2023, 08/09/2023 and 08/09/2023 of:

Woodland Retirement & Assisted Living Community
4532 INTELCO LOOP SE
LACEY, WA 98503

This document references the following complaint number(s): 90154, 92024

The following sample was selected for review during the unannounced on-site visit: 4 of 61 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Nurse Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Cory Cisneros
Residential Care Services

08/15/2023
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) 9-7-23 Date

WAC 388-78A-2640 Reporting significant change in a resident's condition.

(2) The assisted living facility must notify any agency responsible for paying for the resident's care and services as soon as possible whenever:

(a) The resident is relocated to a hospital or other health care facility; or

(b) The resident dies.

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to ensure staff notify the resident's case manager when the resident was admitted to the hospital for a hip surgery for one of two sampled residents (Resident 1) reviewed. This failure placed the resident at risk for not receiving the necessary care and treatment.

Findings included...

Review of Resident 1's (R1) face sheet showed the resident was admitted to the facility on [redacted]/2023 with diagnoses including [redacted].

Review of R1's negotiated service agreement, dated 02/27/2023, documented R1 was dependent on staff members for assistance with her toileting needs, dressing and transfer. R1 was able to communicate her needs and use her call pendant to summon staff for assistance. R1 was out of the facility during the investigation.

Review of an incident investigation, dated [redacted]/2023 at 9:50 PM, showed R1 was found on the floor in her bathroom. R1 reported she had attempted to transfer and to finish getting dressed when she fell. R1 complained of hip pain. R1 was transported to the hospital and diagnosed with [redacted].

During an interview on [redacted]/2023 at 10:32 AM, Collateral Contact 1, Resident 1's representative, stated R1 had a hip surgery and was still in the hospital as of [redacted]/2023. Collateral Contact 1 said R1 was to be discharged to a skill nursing facility for rehabilitation when she was discharged from the hospital.

Review of Department Records showed R1 was a [redacted] client with an assigned case manager. Review of Department Records of case notes from the case manager, dated 07/15/2023 through 08/15/2023, showed the facility did not report R1's hospitalization to the case manager.

During an interview on 08/09/2023 at 2:34 PM, Staff A, Assisted Living Director, said she was responsible for reporting and did not know the resident's case manager needed to be notified.

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, Woodland Retirement & Assisted Living Community is or will be in compliance with this law and / or regulation on (Date) 9-24-23 .

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

Administrator (or Representative) — Date: 9.7.23

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on interview and record, the assisted living facility failed to ensure staff members provided care and services in accordance with the negotiated service agreement for one of four sampled residents (Resident 1) reviewed. This failure resulted in a fall with injury and placed the resident at risk for sustaining additional avoidable injuries.

Findings included...

Review of Resident 1's (R1) face sheet showed the resident was admitted to the facility on [redacted]/2023 with diagnoses including [redacted].

Review of R1's negotiated service agreement, dated 02/27/2023, documented R1 was dependent on staff members for assistance with her toileting needs, dressing and transfers. R1 was able to communicate her needs and use her call pendant to summon staff for assistance.

R1 was out of the facility during the investigation.

Review of an incident investigation, dated 07/08/2023 at 10:15 PM, showed R1 was found on the floor in her bathroom, between the toilet and the dresser. R1 was undressed from her waist down. R1 reported she had fallen at 9:00 PM on 07/08/2023. R1 stated she had called for assistance, and no one came. The investigation concluded that the evening shift staff members had assisted R1 to the toilet at approximately 9:30 PM on 07/08/2023. The staff members did not return to assist R1 until the night shift staff checked on the resident around 10:15 PM and found R1 had fallen. R1 sustained a bump to the back of her head when she attempted to transfer without the assistance of staff members.

During an interview on 08/09/2023 at 11:05 AM, Staff B, Caregiver, stated R1 required staff members to assist her with dressing, toileting and transfer. Staff B said all care staff members were responsible for ensuring the resident's care were being met. Staff B stated the resident's service agreement had the necessary care and services information the resident required, and staff members assigned to assist the resident were supposed to follow the service agreement.

During an interview on 08/09/2023 at 11:19 AM, Staff A, Assistant Living Director, said all care staff members were responsible for assisting residents and ensuring services were being provided. Staff A stated the staff members that assisted R1 to the toilet were responsible for assisting the resident back to bed. Staff A said she would verbally inform staff members when changes were made to the resident's service agreement. Staff A stated she routinely observed staff members assisting residents with care and services when she was on the floor to ensure staff members perform tasks safely and the service agreements were being followed.

This is a recurring deficiency previously cited on 09/16/2021.

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, Woodland Retirement & Assisted Living Community is or will be in compliance with this law and / or regulation on (Date) 9-24-23 .

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

Administrator (or Representative) — Date: 9.7.23