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) 35372 (Completion Date 02/07/2024) and 29262 (Completion Date 10/24/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/07/2024 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-2610-2-f, WAC 388-78A-2640-1, WAC 388-78A-2640-1-a, WAC 388-78A-2640-1-b, WAC 388-78A-2640-1-c, WAC 388-78A-2640-3, WAC 388-78A-2640-3-a, WAC 388-78A-2640-3-b

The Department staff who did the on-site verification:
Anissa Bearden, Licensor

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 #: 29262
Investigator: Anissa Bearden
Investigation Date(s): 09/08/2023 through 10/24/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 97341
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
allegation of the facility not reporting to the department that facility had a communicable disease outbreak.

Investigation Methods:

Sample:	Total residents: 61 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Resident care equipment
Interviews:	Nursing staff administrative staff
Record Reviews:	Medical records State reporting log Facility policies

Investigation Summary:
After observation, interview, and record review the facility did not report to complaint resolution unit when a resident tested positive with a infection communicable disease and the local health department declared the facility in an outbreak status. The facility failed to complete a focused assessment on a resident and notify the physician when they had a change of condition and resulted with a hospitalization and death. failed practice identified.
Facility failed to monitor residents well being and have a respiratory protection program developed. Citations were addressed with the full inspection follow up CD 30128.

Conclusion / Action:

☒ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Statement of Deficiencies	License #: 1709	Compliance Determination # 29262
Plan of Correction	Woodland Retirement & Assisted Living Community	Completion Date
Page 1 of 9	Licensee: Woodland Retirement & Assisted Living Community LLC	10/24/2023

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 09/08/2023 and 10/11/2023 of:

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

This document references the following complaint number(s): 97341

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:

Anissa Bearden, Licensor

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

11/01/2023
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) 11·01·2023 Date

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to report an infectious disease outbreak to the Complaint Resolution Unit (CRU). This failure placed 61 of 61 residents and 48 staff members, and visitors at risk of being infected and continue the spread of COVID-19 (Corona Virus Disease 2019-an infectious disease caused by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, sore throat, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death) during a COVID-19 outbreak.

Findings included...

Record review of the document titled, "Guidance Framework for Responding to COVID-19 in Long Term Care Facilities", undated, under the section "Identification of a positive case", showed the facility was to notify their licensor immediately.

Record review of the "Assisted Living Facility Guidebook, Partners in Protection", dated February 2018, under the section, "Appendix D other reporting requirements for assisted living facilities", showed communicable disease outbreak would be reported to the Department of Health (DOH) and Social Services hotline. Under the section titled, "reporting guidelines for Assisted Living Facilities", showed communicable disease outbreak was required to be reported to the Local Health Department" and the Department of Social and Health Services CRU hotline number.

Record review of the facility's letter, titled, "Public Health and Social Services Department", dated 09/01/2023, showed they were reported that the facility had two residents positive with COVID-19. A single facility acquired case in a resident or three or more epidemiologically linked cases within healthcare personnel within a facility designates an outbreak. The public health was placing the facility under public health monitoring and declared an outbreak. Under the section titled, "identification of a positive case", showed the facility was to notify their licensor immediately.

Record review of the facility's letter, titled, "Public Health and Social Services Department", dated 09/06/2023, showed they were reported that the facility had three staff members positive with COVID-19. A single facility acquired case in a resident or three or more epidemiologically linked cases within healthcare personnel within a facility designates an

outbreak. The public health was placing the facility under public health monitoring and declared an outbreak. Under the section titled, "identification of a positive case", showed the facility was to notify their licensor immediately.

Record review of the facilities, "Community COVID-19 Infection Control Policy; Washington", revised date 04/21/2023, under section titled, "revised: outbreak response", showed an outbreak was defined as either or, one probable or confirmed case of COVID-19 among residents and/or staff or three or more cases of illness compatible with COVID-19 in residents with onset of 72 hours. The facility would report positive COVID-19 cases to the state licensing agency (CRU) as well as their local health department.

Record review of the Departments database for dates 08/28/2023 through 09/08/2023, showed there were no reported positive COVID-19 resident cases or that the facility reported the infectious communicable disease outbreak.

Record review of the facility untitled document, undated, showed Resident 1 (R1), and Resident 2 (R2) tested positive for COVID-19 on 08/28/2023.

In an observation on 09/08/2023 at 10:57 AM, Staff E, Receptionist was observed to be wearing an N95 respirator mask.

In an interview and observation on 09/08/2023 at 11AM, Staff C, Registered Nurse, stated they needed to put on their N95 respirator. Staff C stated there were five residents positive with COVID-19 within the facility.

In an interview on 09/08/2023 at 11:08 AM, Staff C stated the first positive COVID-19 resident case was on 08/28/2023. Staff C stated R1 and R2 were a couple and were the first ones to test positive with COVID-19. Staff C stated Resident 3 (R3) tested positive for COVID-19 on 08/31/2023. Staff C stated they called Staff F, Registered Nurse Director of Nursing Corporate, for guidance. Staff C stated they were directed to call the DOH to report the positive COVID-19 cases. Staff C stated they contacted the local health department on 09/01/2023. Staff C stated they believed that Staff D, Assisted Living Director, had reported the COVID-19 outbreak to CRU.

In an interview on 09/08/2023 at 12:22 PM, Staff D stated they called and reported the positive COVID-19 resident cases to the DOH public health department.

In an observation on 09/08/2023 at 12:42 PM, Resident 3 and Resident 4's (R4) entry door to their apartment was a posted sign that showed they were on isolation precautions for 14 days. The sign instructed anyone that was entering the room to wear the appropriate PPE.

In an interview on 09/08/2023 at 1:27 PM, Staff D stated they only reported the positive COVID-19 cases to the DOH public health department. Staff D stated they understood that an outbreak for the facility needed to be four to five positive residents.

In an interview on 09/08/2023 at 1:37 PM, Staff C stated the were not aware they needed to report to CRU when the facility was declared in an outbreak status.

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) Dec 1, 2023

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

Administrator (or Representative) — Date: NOV 3, 2023

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

(1) The assisted living facility must consult with the resident's representative, the resident's physician, and other individual(s) designated by the resident as soon as possible whenever:

(a) There is a significant change in the resident's condition;

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

(c) The resident dies.

(3) Whenever the conditions in subsection (1) or (2) of this section occur, the assisted living facility must document in the resident's records:

(a) The date and time each individual was contacted; and

(b) The individual's relationship to the resident.

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to notify a resident's physician when there was a significant change of condition for 1 of 3 sampled residents (Resident 4). This failure resulted in the physician being unaware of the decline in condition in the resident, unable to provide medical guidance and delayed the treatment for Resident 4. Another Resident called 911 for Resident 4 and Resident 4 was transferred to the hospital where they passed away.

Findings included...

Record review of the facility's policy, titled, "Communication with Resident's Physician", dated 10/11/2023, showed the facility would keep each resident's primary care physician informed of any changes in condition.

Record review of the facility's policy, titled, "Change of Condition", dated 07/2009, showed the facility's expectation that a resident change of condition would be evaluated with appropriate notification, documentation, and service plan updates. A significant change of condition was one that caused a major deviation in the resident's health or functional

abilities. When a significant change of condition was noted by staff the follow would be completed that included notifying the executive director and/or resident care coordinator, notify the Registered Nurse (RN) to receive appropriate monitoring instructions for that resident, place the resident on alert charting and document in the progress note the observation of the resident's condition, that the RN was notified, what the RN's monitoring instructions were and the residents vitals signs. The service plan would be added that resident had a change of condition that showed what the staff were to monitor with the resident, what care to provide, and when to re-notify the RN. The resident's physician would be notified and follow any additional orders the physician may have given. The RN would assess and document on the resident the next community visit.

Record review of the Mayo Clinic article titled, "Treating COVID-19 at home: Care tips for you and others", dated 05/25/2023, showed treatment for COVID-19 was aimed at relieving symptoms that included rest, fluids, and pain relievers. The person that was positive with COVID-19 should be watched for signs and symptoms that were getting worse. If symptoms were getting worse call the provider(physician). If the person with COVID-19 has emergency warning signs, get medical attention right away. Call 9-1-1 or your local emergency number if you notify any emergency signs that included trouble breathing, persistent chest pain or pressure, new confusion, trouble staying awake, pale, gray, or blue-colored skin, lips or nail beds-depending on skin tone. The list did not include all symptoms. Call the provider if the person with COVID-19 had any other severe symptoms.

Record review of the facility's health services manual document titled, "change of condition/monitoring and temporary care plans", dated 08/27/2020, showed as changes were noted, the community would maintain an effective system of communicating changes, providing additional monitoring respective to the change and the RN assessment and oversight. As a change of condition were observed the following system would apply that included the physician and responsible party notifications would take place as applicable to the resident and the nature of the change and nurses would complete a full or focused assessments applicable to the noted changes.

Record review of the facility's "Medication technician and QMAP training module 7", dated 05/01/2023, under the section "first aid and emergency situations", showed if in doubt about whether a situation should be considered an emergency, call 9-1-1 and determine need for assistance from outside the facility. Staff shall know that only the resident, a physician, or a person with legal authority to make health care decisions can decide whether to accept or decline emergency medical treatment for a resident. In an emergency that required a treatment decision and documentation of legal authority for that decision was not in a resident's record, staff shall oversee the process to transfer the resident outside the facility for evaluation and treatment.

Record review of Resident 4's (R4) quarterly licensed nurse evaluation summary, dated 06/23/2023, showed R4 moved into the facility on [redacted]/2022. R4 was alert and oriented to person, place, and time with mild forgetfulness. There was no functional change. R4 had a change with the need for an increased assistance with showering. R4 was able to make personal dietary choices. R4 didn't have any significant weight loss or weight gain and was able to consume adequate intake. R4 self-administered all medications. The assessment

was completed by Staff C, Registered Nurse.

Record review of R4's Resident Service Plan, dated 06/20/2023, showed R4 had multiple medical diagnoses that included [redacted] and [redacted] and [redacted] R4 wanted to be resuscitated (attempt to make heartbeat if found without a heartbeat). R4 walked with a four-wheel walker for short distances and used a wheelchair that R4's spouse pushed them in. R4 did not require staff support with mobility. R4 was not at risk for falls or had a pattern of falls. R4 was not at risk for weight loss. R4's spouse escorted R4 to the dining room for all meals and did not require meal trays. R4 was able to make all their nutritional choices independently. R4 could dress themselves and R4's spouse helped when R4 could not do it themselves. R4 did not experience any bowel or bladder incontinence (ones inability to control urine or bowel from coming out of body). R4 was independent with all of their toileting needs.

Record review of R4's charting note, dated 09/01/2023 at 1:49 PM, showed R4 was found lying face down on the ground in their apartment bathroom on their stomach. R4 required staff assistance to get them up and into the wheelchair. R4 reported that their legs gave out while they stood at the bathroom sink and fell to the ground. Staff reminded R4 and R4's spouse to call for assistance when they needed help with activities of daily living (ADL's).

Record review of R4's charting note, dated 09/02/2023 at 6:13 PM, showed R4 tested positive with COVID-19 (Corona Virus Disease 2019-an infectious disease caused by a virus causing respiratory illness with symptoms including cough, fever, new or worsening malaise, sore throat, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death). R4 experienced weakness to the right side of their body and body weakness.

Record review of R4's charting note, dated 09/02/2023 at 6:37 PM, showed R4 felt weak, experienced back pain and hot/cold flashes. R4 was pale and sweaty.

Record review of R4's charting note, dated 09/03/2023 at 11:14 AM, showed R4 experienced slight weakness and required assistance with ambulation.

Record review of R4's charting note, dated 09/04/2023 at 3:30 AM, showed R4 was weak and required help with transfers.

Record review of R4's charting note, dated 09/04/2023 at 9:58 PM, showed R4 continued to test positive with COVID-19. R4 was still not feeling well and stayed in bed all day.

Record review of R4's charting note, dated 09/05/2023 at 9:12 PM, showed R4 continued to cough, experience sore throat, body aches, and reported feeling weak.

Record review of R4's charting note, dated 09/06/2023 at 1:20 AM, showed R4 had a difficult time talking. R4 requested assistance to change their brief. R4 experienced difficulty with turning when they were in bed when staff assisted to help clean up R4. R4 continued to be really weak from their sickness.

Record review of R4's charting note, dated 09/06/2023 at 1:26 PM, showed R4 complained of an increase in weakness. R4 was not able to perform their ADL's without staff assistance. R4's cold like symptoms had an increase with shortness of breath. Medication technician would report to the RN.

Record review of R4's charting note, dated 09/06/2023 at 4:09 PM, showed R4 continued to test positive for COVID-19. R4 continued to experience cold symptoms and shortness of breath. Medication technician reported to the RN that R4 still appeared very sick.

Record review of R4's charting note, dated 09/08/2023 at 11:06 AM, showed Staff C, RN, documented a late entry for a change of condition assessment completed on 09/06/2023 at 5 PM. Staff C's change of condition assessment, showed R4 continued to have symptoms of COVID. R4 stated they were not feeling better at all. R4's spouse stated R4 was having some hallucinations. There was no notification to the physician documented.

Record review of R4's charting note, dated 09/08/2023 at 12:05 PM, showed Staff C documented a late entry for a change of condition assessment completed on 09/01/2023 at 11:06 AM. Staff C change of condition assessment showed they responded to an all staff call. R4 had become weak and fell in their apartment. R4's spouse had tested positive with COVID-19. R4 was tested that afternoon again and tested positive for COVID-19. R4 would be provided meal trays. R4 would be rounded on to monitor their symptoms. There were no further focused assessment details about R4's condition related to their fall and testing positive for COVID-19 for review. There was no notification to the physician documented.

Record review on [redacted]/2023 of R4's medical chart showed there were no notifications to R4's physician for review that R4 was continuing to decline and had experienced shortness of breath.

In an interview on [redacted]/2023 at 10:32 AM, R3 stated R4 was not eating and required a lot of assistance with getting up out of bed and to the bathroom. R3 stated R4 was not eating and was drinking only 12 to 14 ounces of water a day. R3 stated R4 did not have the strength to take their medications. R3 stated none of the staff offered to send R4 out to the hospital for further evaluation. R3 stated they were given the guidance to send R4 to the hospital when they called the consulting nurse through their health insurance company. R3 called 911 for R4 based on the consulting nurse from the insurance company's recommendation. R3 stated the hospital physician called at 10 PM that night and told them that R4 was critically ill. R4 stated at 12 AM the physician had called back and reported that R3 was not expected to live through the night. R3 stated R4 had passed away an hour after that last call. R3 stated none of the medical staff at the facility offered

or encouraged R4 to be sent to the hospital for further evaluation.

In an interview on [redacted]/2023 at 4:29 PM, Staff G, Medication Technician, stated R4 was really weak and looked like they needed to go to the emergency room. Staff G stated R4 had a hard time moving and R4's pulse was high and not normal. Staff G stated they reported R4's condition to Staff C. Staff G stated they had to have two people to turn R4 in bed. Staff G stated R4 was not able to use the bathroom and required staff to change their briefs and was incontinent of urine. Staff G stated R4's briefs were not that wet.

In an interview on 09/26/2023 at 11:31 AM, Staff C stated they checked the residents alert chartings daily to review of any changes with the residents they were to know.

In an interview on 09/26/2023 at 12:18 PM, Staff H, Mediation Technician, stated any change with the residents are faxed or communicated to the resident's physician. Staff H stated once the fax was replied and sent back from the physician, it would be filed under medication orders in the residents hard medical chart.

In an interview on [redacted]/2023 at 1:55 PM, Staff H, stated if a resident complained of shortness of breath or had a change of condition they would call and inform Staff C.

In an interview on 09/26/2023 at 12:28 PM, Staff C stated they document in the residents charting notes their assessments. Staff C stated they would have them identified as "RN change of condition". Staff C stated R4 required R3 to assist more with R4's care needs. Staff D, Assisted Living Director, stated staff were assisting R4 with transfers and using the bathroom with one person assistance. Staff C stated they did not check R4's vital signs. Staff C stated they did not check R4's oxygen saturations. Staff C stated they should have checked R4's oxygen saturations. Staff C stated they were unsure if R4 had been eating or drinking fluids throughout the day. Staff C stated their assessments of R4 were documented in R4's charting notes.

In an interview on 10/11/2023 at 11:39 AM, Staff I, Regional Director of Operations, stated they would send any resident out to the hospital if they had experienced any significant changes, or the staff would contact 9-1-1 for further medical evaluation for a resident. Staff I stated more could have been done for R4.

In an interview on 10/26/2023 at 11:15 AM, Staff J, Executive Director, stated staff were required to notify the resident's physician with any changes from the residents baseline behavior and activities of daily living function.

Plan/Attestation Statement

Statement of Deficiencies	License #: 1709	Compliance Determination # 29262
Plan of Correction	Woodland Retirement & Assisted Living Community	Completion Date
Page 9 of 9	Licensee: Woodland Retirement & Assisted Living Community LLC	10/24/2023

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) Dec 5, 2023

Wells 11.3.23

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

Administrator (or Representative)

NOV 3 2023
Date