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) 35373 (Completion Date 01/19/2024) and 30167 (Completion Date 10/06/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/19/2024 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-2300-1-e, WAC 388-78A-2300-1-e-i, WAC 388-78A-2300-1-e-ii, WAC 388-78A-2300-1, WAC 388-78A-2300

The Department staff who did the on-site verification:
Maria Salas, ALF Complaint Investigator
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

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

Statement of Deficiencies	License #: 1709	Compliance Determination # 30167
Plan of Correction	Woodland Retirement & Assisted Living Community	Completion Date
Page 1 of 4	Licensee: Woodland Retirement & Assisted Living Community LLC	10/06/2023

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 follow-up on 09/22/2023 and 10/06/2023 of:
Woodland Retirement & Assisted Living Community
4532 INTELCO LOOP SE
LACEY, WA 98503

This document references the following SOD dated: 10/06/2023

The following sample was selected for review during the unannounced on-site visit: 9 of 63 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Maria Salas, ALF Complaint Investigator
Celeste Vashey, ALF LTC Licensor
Anissa Bearden, Licensor
Regenia Coleman, ALF NCI CI

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

10/18/2023
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) 10-26-2023 Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(e) Serve nourishing, palatable and attractively served meals adjusted for:

(i) Age, gender and activities, unless medically contraindicated; and

(ii) Individual preferences to the extent reasonably possible.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure palatable and attractive meals were served and accommodated individual preferences for 7 of 7 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, and Resident 7). These failures resulted in all 7 residents not having their choices or preferences honored for meals, not receiving food at acceptable temperatures, and placed all residents at risk of decreased quality of life.

Findings included...

Review of the facility's "Disclosure of Services Required by RCW 18.20.300", undated, showed the facility provided three meals per day, nutritious snacks, and prescribed general low sodium diets. If needed the facility would occasionally prepare food and beverages to the resident and bring them to the resident.

In an observation on 09/22/2023 at 12:45 PM, Resident 4 (R4) and Resident 3 (R3) approached the reception desk to the facility and asked Staff B, Receptionist, who they could talk to about their dining concerns regarding the quality of the food. Staff B stated Staff C, Dining Service Manager, would be the person to talk to but they were not in. R4 stated "the food is horrible! I don't know who the hell the cook is, they must be five years old! It's not good, something has got to be done." R4 expressed concerns that they had been served green beans for the last three days. R4 expressed concerns that the food they received was cold. R4 stated to Staff B that this was not the first time they have expressed concerns about the facility's food. Staff A, Assistant Executive Director, approached R4 and inquired about what their concerns were. R4 expressed concerns that the food they received was cold. R4 expressed concerns about the quality of the fish that was served. Staff A stated they ate at the facility everyday for at least breakfast or lunch and they "don't think it's that bad." Staff A informed R4 that their food should not be served to them cold,

and they would work on getting R4's food hotter.

Record review on 09/22/2023 of the facility's "Complaints and Concerns Binder", undated, showed the last grievance that was reported was from May 2023.

Record review on 09/25/2023 of the facility's "Complaints and Concerns Binder", undated, showed a "Complaint/Concerns Form", dated 09/22/2023, the concerns were taken by Staff A and Staff B. R4 expressed concerns about the temperature of the vegetables being cold and that they were tired of all the French fries and tater tots that were served. The form indicated a check mark that the incident was discussed with the executive director "Staff A". The outcome section had no notes to review. The findings/plan of action section showed that they would discuss R4's concerns with Staff B about the food temperatures and about changing up the starches. The notes on conversation with complainant section had no notes to review. The date resolved section was left blank. The executive director signature was signed by Staff A on 09/22/2023.

In an interview on 09/25/2023 at 10:26 AM, R4 stated they expressed their concerns about the quality of the food to Staff B and Staff A on Friday, 09/22/2023. R4 stated they were regularly served cold food several times a week. R4 expressed concerns about the quality of the corn and green beans that were served. R4 stated they verbally informed facility staff about their concerns. R4 stated they had never been asked to fill out a grievance form regarding their concerns about the quality of the food. R4 stated they expressed concerns about the facility's food quality multiple times within the last few weeks.

In an interview on 09/25/2023 at 10:34 AM, R3 stated they were served cold food all the time. R3 stated when they received cold food from the facility "I just won't eat it." R3 stated they reported their concerns about the food quality and food temperature to the front desk staff. R3 stated often R4 would do majority of the talking but they accompanied R4 when they reported their concerns. R3 stated they have never been asked to fill out a grievance report regarding their concerns.

In an interview on 09/25/2023 at 3:50 PM, Resident 5 (R5), stated the facility brought them all their meals. R5 stated it was the caregiver's responsibility to bring them their meals, but the caregivers had to prioritize resident care which often resulted in them not receiving their lunch until 2:00 PM. R5 stated they regularly received dinner at 4:30 PM, which was a quick turnaround from when they eat lunch. R5 did not think the facility could accommodate bringing them their dinner later due to lack of staffing. R5 stated they filled out what they wanted to eat a week in advance. R5 stated often there were a lot of mistakes to what they ordered and what the facility staff brought them. R5 stated the facility staff brought them breakfast while they were still sleeping. R5 stated if they were given the wrong food item, they do not find out about it until when they wake up which is after the staff have left. R5 stated the day prior they ordered an omelet for breakfast but instead they were served the special which was blueberry pancakes and bacon.

In an interview on 09/25/2023 at 3:50 PM, Resident 6 (R6), stated the facility brought

Statement of Deficiencies	License #: 1709	Compliance Determination # 30167
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them all their meals. R6 stated a lot of the time they had to rewarm the food because the food was brought to them cold. R6 stated they usually ate at different times from when the meal was served which contributed to them needing to reheat their food. R6 was under the impression the facility could not accommodate their request to have their food brought to them at their preferred time. R6 stated they filled out what they wanted to eat a week in advance. R6 stated often there were a lot of mistakes to what they ordered and what the facility staff brought them.

In an interview on 09/22/2023 at 1:12 PM, Resident 1 (R1) stated that the french fries that were served to them for lunch on 09/22/2023 were cold.

In an interview on 09/22/2023 at 3:24 PM, Resident 2 (R2) stated they could not have the green bean salad that was served to them for lunch because it had cottage cheese in it, and they were allergic to dairy. R2 stated the facility staff offered them ice cream and other items they were allergic to despite being made aware of their food allergy. R2 stated the fried potatoes that were served to them were cold. R2 stated they were used to their potatoes being served to them cold.

In an interview on 09/25/2023 at 4:13 PM, Resident 7 (R7) stated the facility had a problem with being able to serve food that was hot.

In an interview on 09/25/2023 at 10:57 AM, Staff C stated residents had expressed concern that the temperature of the foods were served too cold.

This is an uncorrected deficiency previously cited on 06/02/2023.

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) NOV 5, 2023

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

Administrator (or Representative) — Date: 10-26-2023

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodland Retirement & Assisted Living Community
License/Cert.#: 1709
Compliance Determination #: 24456
Investigator: Nancy Mullins
Investigation Date(s): 05/25/2023 through 06/02/2023
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 79377
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Dietary Services- Residents are receiving their food cold, late, and inedible ongoing issues.

Investigation Methods:

Sample:	Total residents: 70 Resident sample size: 15 Closed records sample size:
Observations:	Meal prep and delivery Temp of food served Sample tray
Interviews:	Residents Staff Dietary Manager Director Resident Counsel
Record Reviews:	Menus Approval of menus Resident counsel meetings

Investigation Summary:

1. Observation of meal served at the time of the investigation showed the kitchen staff served food restaurant style to each table. Interviews with residents showed 15 of 15 residents interviewed were not pleased with the meals served. Residents stated food served was cool or cold by the time the meals reached the residents. 7 of 15 residents complained the food did not taste good.
Facility failed practice identified at WAC 388 78A 2300

Conclusion / Action:

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

☐ N/A

STATE OF WASHINGTON
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 05/25/2023 and 05/25/2023 of:

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

This document references the following complaint number(s): 79377

The following sample was selected for review during the unannounced on-site visit: 15 of 70 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Nancy Mullins
Curtis Bruer Jr
Rebecca Kane, Regional Administrator
Jody Just, Field Services Administrator
Shella Scott
Nancy Taylor

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.

Jody Just
Residential Care Services

06/15/2023
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)

6/21/23
Date

WAC 388-78A-2300 Food and nutrition services.

(1) The assisted living facility must:

(e) Serve nourishing, palatable and attractively served meals adjusted for:

(i) Age, gender and activities, unless medically contraindicated; and

(ii) Individual preferences to the extent reasonably possible.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure palatable and attractive meals were served and accommodated individual preferences for 15 of 15 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, and Resident 14, Resident 15). These failures resulted in all 15 residents not having a choice or preference for meals and placed all residents at risk of decreased quality of life.

Findings included...

Review of the facility's "Disclosure Statement (Assisted Living and Memory Care)", undated, showed documentation listed under, "1. Dietary/Food Service The facility provides three nutritious meals are served each day with snacks available seven days a week, including fresh fruit and fresh vegetables. Diets that the facility is not able to provide: Renal, controlled calorie, or controlled carbohydrate diets."

In an observation on 05/25/2023 at 11:10 a.m., accompanied by Staff B, Dietary Manager, showed, kitchen staff in the dining area were serving food onto plates, then placed the plates on a serving tray. The food was placed on the plate then transported uncovered on a large serving tray from the kitchen to the dining room area located across the hallway from the kitchen. Observation showed the kitchen ran out of cauliflower after serving residents on the independent living side. Carrots were substituted for the assisted living residents.

Residents seated at the dining room tables questioned why they did not get the cauliflower they requested on their menu and were told by the server that the kitchen ran out of cauliflower after serving the independent living residents. Observation showed Resident 6 requested butter for their potatoes and by the time the server returned to Resident 6's table, the resident's potatoes were too cold to melt the butter. Resident 6 chose to not eat the meal rather than send the plate back to the kitchen or request another meal.

Resident 6 stated in an interview on 05/25/2023 at 11:30 a.m., that residents talk daily with staff about the food being cold and staff gave the same answers, "we're working on it."

Resident 3 stated in an interview on 05/25/2023 at 11:32 a.m., that food was served cold at the facility. Resident 3 stated residents talked with staff about the food being cold several times. Resident 3 stated, "I just eat it cold."

Observation showed Resident 8 was seated at the table with peers on 05/25/2023 at 11:32 a.m. during lunch and requested to show photos from Resident 15's, Resident Council President, personal cell phone of food items that had been brought to the attention of the Dietary Manager. Resident 8 stated the omelet photo was taken on 05/24/2023 at breakfast because the omelet served was like "rubber." Resident 8 stated residents had complained for two years about the food being served cold and tasting bad. Resident 8 stated the facility had approximately eight different Executive Directors over the past couple years and nothing was ever done about the food complaints.

Resident 4 stated in an interview on 05/25/2023 at 11:34 a.m. during the lunch meal, that dietary staff had been told to not serve tomatoes to Resident 4, but the kitchen continued to serve Resident 4 tomatoes. Resident 4 stated the kitchen placed tomato soup on the resident's tray. Resident 4 also complained about the breakfast served on 05/24/2023. According to Resident 4, the oatmeal was served cold, chunky, and runny. Resident 4 stated the servers were now the cooks and "the servers can't cook."

In a group interview with Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13 and Resident 14 on 05/25/2023 at 11:30 a.m., all residents stated food was served cold at the facility. Residents 1, Resident 3, Resident 14, Resident 13, and Resident 12 stated they ate the food served while other residents would send their cold food back to the kitchen to be warmed in the microwave.

In an interview on 05/25/2023 at 11:40 a.m., Resident 2 stated, "I try to be polite and not send my food back to the kitchen...the cooks have a problem, food does not taste good, and the food is cold." Resident 2 stated the facility had menus that looked okay; however, the food was not good. Resident 2 stated residents often sent food back to be microwaved because the food was cold. Resident 2 stated cold food was an ongoing problem.

In an interview on 05/25/2023 at 11:45 am., Resident 1 stated there was no resident input into what was planned on the menus. Resident 1 stated you eat what's served and food

was often served cold. Resident 1 went on to say the resident spent several years in the military and was taught to eat what was served even if the food was served cold.

In an interview on 05/25/2023 at 1:15 p.m., with Resident 15, Resident Council President, who stated the independent living residents and assisted living residents received the same meals/menus from the same kitchen/cooks. Resident 15 stated every month residents complained about the food being cold and/or the food was not cooked thoroughly enough. Resident 15 stated the Dietary Manager stayed in the kitchen and never came out to the dining areas to see how the residents felt about the meals served.

In an interview on 05/25/2023 at 11:15 a.m., Staff B stated they were aware of the residents' complaints regarding food being cold. Staff B stated they wanted a food cart to transport food from the kitchen to dining room but were told by the facility director the food cart was too expensive to purchase.

In an interview on 05/25/2023 at 11:00 a.m., Staff A, Executive Director, stated that the staff received a complaint from a family member regarding the food and thought the complaint was resolved when the family member reported things were better now. Staff A stated they had only worked at the facility for approximately three months. Staff A stated they were aware of the food complaints and stated this was brought to the Dietary Manager's attention. Staff A gave no explanation why the food was being served cold.

In an interview on 05/25/2023 at 12:15 p.m. Staff E, food server, stated that the independent living residents received their meals first. Staff E stated sometimes the kitchen ran out of food items on the menu before the assisted living facility residents were served their meals. Staff E stated the independent living residents may request extra cauliflower and this shorted the assisted living residents, which required the assisted living residents to receive the substitute vegetable.

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) 10-21-23.

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

Administrator (or Representative) — Date: 10-21-23

Cited WAC	Investigators Comments / Complaints	Expected Outcomes	Action Plan to Address Cited Issues	Responsible Party	Estimated Date of Completion	Actual Date of Completion
CD 24456/ WAC 388-7A-2300	Based on observation interview , and record review the facility failed to ensure palatableand attractive meals were served and accomodated individual preferences for 15 of 15 sampled residents. These failures resulted in 15 of 15 residents not having a choice or preference for meals and placed all residents at risk for decreased quality of life.	The facility's dining services manager will be changing her schedule to ensure attendance and accountability from management is continously being utlizied to ensure staff is serving and cooking food to the proper standards.	Dining Services Manager will be Sun-Mon from 11-7:30 to ensure that lunch and dinner are being prepared and expedited appropriately. This will help put hands and eyes on dinner that is normaly overseen by the manager on duty, will now be overseen by the dining services manager. DSM will work mornings 6-2 Tues-Thurs. This will get hands and eyes on all 3 meals by the DSM. Admin Staff is to assist for the first 30 mins of service rotating by Manager on duty to improve the overall timliness of dining service.	ED/AED/DSM	6/26/2023	