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

10/22/2024

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

RE: Woodland Retirement & Assisted Living Community # 1709

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 49100 (Completion Date 10/22/2024) and 39908 (Completion Date 04/19/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/22/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

WAC 388-78A-3170 Circumstances that may result in enforcement remedies.

(1) The department is authorized to impose enforcement remedies described in WAC 388-78A-3160 if any person described in subsection (2) of this section is found by the department to have:

(l) Knowingly or with reason to know, made false statements of material fact in the application for the license or the renewal of the license or any data attached thereto, or in any matter under investigation by the department;

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

The Department staff who did the On Site verification:

Paul Aube, ALF NCI

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 #: 39908
Investigator: Paul Aube
Provider Type: Assisted Living Facility
Intake ID: 127177
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 04/17/2024 through 04/19/2024
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Public report of uncredentialled staff working in the facility, and long call light wait times.
2. Fraud/False Billing: Public report of financial exploitation of residents, and facility falsifying documentation to avoid State fines.

Investigation Methods:

Sample:	Total residents: 63 Resident sample size: 2 Closed records sample size: 0
Observations:	Identified resident Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Management
Record Reviews:	Disclosure of Services Incident investigation Facility policies Personnel files Staff Schedules Staff Training Resident Medication Administration Records Resident Progress Notes Resident Care Plans Resident Nursing Assessments

Investigation Summary:

1. Quality of Care/Treatment: After interview, unable to substantiate claims of long call

light wait times. Review of staff Credentials showed facility staff to have worked under expired license, and to have administered medications without proper Nurse Delegation training. Failed practice identified.
2. Fraud/False Billing: Unable to substantiate claims regarding financial exploitation. Review of records showed facility failed to complete a nursing assessment timely, accurately, and knowingly made false statements regarding accuracy and completion of their nurse assessment during a matter under investigation by the Department. Failed practice identified.

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 04/17/2024 and 04/19/2024 of:

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

This document references the following complaint number(s): 125703, 127216, 127177

The following sample was selected for review during the unannounced on-site visit: 2 of 63 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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

05/01/2024
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.

Krysta Kendall, Representing Jennifer Hills

Administrator (or Representative) Date 5/2/24

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(b) Complete an assessment specifically focused on a resident's identified problems and related issues:

(i) Consistent with the resident's change of condition as specified in WAC 388-78A-2120 ;

This requirement was not met as evidenced by:

Based on interview, and record review the facility failed to ensure resident Assessments were completed timely, and failed to ensure that it was consistent with the resident's change of condition for 1 of 2 residents reviewed, (Resident 1 [R1]). These failures placed all residents who were assessed by the Nurse at risk for unmet care needs and injury.

Findings included...

In an interview on 04/17/2024 at 1:21PM, Staff B, the Regional Nurse Consultant, was asked at which times a new Nursing Assessment would be completed for a resident. Staff B stated, "A new assessment would be completed before move-in, and again when they come in; we will complete it again withing the first 14 days. We do it again quarterly, and for a change in condition." Staff B was asked about resident changes in condition, and within what time frame the Nursing Assessment should be completed. Staff B stated, "Immediately, within the first 24 hours, and it is performed by the RN [Registered Nurse]."

Review of R1's face sheet showed that the resident was admitted to the facility [redacted]/2018.

Review of R1's Temporary Care Plan, dated 03/28/2024, under "Describe the situation" it stated, "Resident RTF [Return to Facility] this evening from ER [Emergency Room]. Resident was diagnosed with [redacted]. [R1] has been requiring more hands-on assist. Resident has been showing signs of weakness." Under the section titled, "What interventions/additional services will be provided" it stated, "Resident to be a 2-person assist with gait belt. Resident to be assisted with all ADL's [Activities of Daily Living] including transfers and toileting, as well as frequent checks. Observe for reaction to antibiotics, cont[inued] UTI symptoms, meal tray service."

Review of R1's Progress Notes, under the category titled "RN Change of Condition", dated 03/28/2024 at 11:46AM, stated, "RN went to resident room to do assessment for RTF... When I arrived, resident was in WC (Wheelchair) and said [they] needed help toileting. At this time care staff arrived to help with resident. [They] [were] a 3-person assist onto the

toilet."

Review of a Progress Note for R1, dated 03/29/2024 at 9:12AM, it stated, "Staff are to assist with all ADL's while resident is feeling weak and is a three person assist for safety as [they] [are] unable to bare weight." In another "RN Change of Condition" Progress Note, dated 03/29/2024 at 10:08AM, it stated, "Resident has had a change in baseline and is a 3-person assist. Resident was able to help prior to hospital admit but can no longer bear weight on [their] legs."

Review of a Progress Note for R1, dated 03/30/2024 at 2:42AM, stated, "Resident was assisted to bed at 10:15PM by one [evening] caregiver, and the [nightshift] caregiver."

Review of a Progress Note for R1, dated 03/31/2024 at 2:09PM, stated, "Resident is alert and oriented at this time with continued complaint of arm pain and weakness in the legs. Resident is not able to bare weight and is a 2-3 person assist with gait belt at this time."

Review of a Progress Note for R1, dated 04/06/2024 at 3:43PM, stated, "Resident also required a 3-person transfer multiple times, due to safety reasons."

Review of a Progress Note for R1, dated 04/08/2024 at 6:13AM, stated, "…resident is needing a lot of help while standing and is sometimes a three people help when trying to do a transfer."

Review of a Progress Note for R1, dated 04/15/2024 at 3:24AM, stated, "RETURN TO FACILITY. Resident was going out for some fresh air and went around a chair, but [their] wheelchair clipped the chair and resident had fallen over…Resident was taken in [to the hospital] and returned to us around 1:30AM. Resident cannot walk."

Review of a Progress Note for R1, dated 04/15/2024 at 1:07PM, stated, "Resident has daily routine coming down in the dining room with assistant escort due to scooter is broken."

Review of a Progress Note for R1 dated 04/16/2024 at 1:33PM, stated, "Resident has been able to call for staff when needed and has continued with routine. Assistance in manual wheelchair due to motorized chair being broken in the fall… Resident has restricted ROM [Range of Motion] and continues to not be able to bare weight at this time."

Review of a Progress Note for R1, dated 04/16/2024 at 3:30PM, stated, "Resident is on alert due to [fall] RTF. Resident is very sore and is saying [they] can't stand at all and needs many people."

Review of R1's most recent Nursing Assessment showed that it was completed on 04/16/2024. Under the "Orientation/Memory/Cognitive" section it stated, "Alert and

Oriented x 3 (Person, Place, and Time), able to make needs known and direct care." Under the section titled, "Mobility/Ambulation/Safe Resident Handling" it stated "Mobility has not changed compared to previous status. [R1] has steady gait using a 4WW (Four Wheel Walker) but mainly uses motorized wheelchair to and from meals and activities. Under the "Activities of Daily Living" section, it stated, "1-person SBA (Stand-By Assist) for showers and dressing for safety."

In an interview with Staff B on 04/17/2024 at 1:17PM, Staff B was shown R1's Nursing Assessment completed on 04/16/2024. Staff B was asked if it was their signature on the page and if they were the Nurse that completed the Nursing Assessment. Staff B confirmed that it was their signature. Staff B was shown R1's Temporary Care Plan, and then asked how they made the determination that R1 had a "steady gait using a 4WW" while the Temporary Care Plan stated "Resident to be a 2-person assist with gait belt. Resident to be assisted with all ADL's (Activities of Daily Living) including transfers and toileting." Staff B stated that they were not aware of the Temporary Care Plan and stated that the floor staff did not show it to them. Staff B then stated that the Temporary Care Plan was completed by a Medication Aide, and not an RN (Registered Nurse). Staff B was then shown the numerous Progress Notes for R1, which all stated R1 was a 2-3 person assist with transfers, and that they have difficulty bearing weight. Staff B was again asked how they can make the determination that R1 had a "steady gait using a 4WW." Staff B stated that they cannot speak to the written progress notes and stated, "Residents can change throughout the day." Staff B stated that they can only speak to their own assessment. Staff B stated that during their assessment they determined R1 to be able to walk with the 4WW. Staff B was asked how they assessed R1, and how they determined that R1 was able to walk with the 4WW. Staff B stated, "I walked with [them]." Staff B was asked what R1 would report if they were interviewed and asked if they were assessed and walked with Staff B. Staff B stated that R1 would verify it. Staff B then stated that residents who have dementia are not often able to accurately recall events and say what happened. Staff B was notified that there was no diagnosis of [redacted] for R1, and that per the Nursing Assessment that they completed, R1 was documented as Alert and Oriented x 3. Staff B agreed this was true. Staff B then re-affirmed that what was written on the Nursing assessment was accurate. Staff B stated that the R1 used a 4WW to ambulate and that they primarily used a motorized scooter mainly to get around. Staff B was asked if they were aware that R1's scooter was broken during their fall on 04/15/2024. Staff B stated, "No, I was not aware of that." Staff B again re-iterated the accuracy of their assessment and stated, "I am basing it on what I saw. I saw that [they] transferred. [They] [were] not a 2-person assist when I did my assessment."

Review of a Progress Note for R1, written by Staff B on 04/15/2024 at 2:23PM, it stated, "This RN went to resident for routine skin/wound assessment of lodged [injured] left/right ankle." Further review of this note showed only documentation on R1's wounds, and no documentation on attempts to assess R1's mobility and attempts of ambulation with R1.

During an interview with R1 on 04/17/2024 at 3:04PM, R1 was asked if the nurse came to assess their ability to walk on 04/16/2024, or 04/15/2024. R1 shook their head and stated, "No." R1 was notified of Department Representative intent to validate the claims made by Staff B, who stated that they assessed R1's ability to walk, and walked alongside them while they used the 4WW. R1 stated, "No that did not happen. [They] [are] lying to you. I don't know why. And frankly, that makes me kind of mad that [they] would tell you

that." R1 was asked if they were able to ambulate at all on their own using the 4WW. R1 stated, "I can't even stand by myself, let alone walk." R1 was asked if they required 2-persons to ambulate. R1 stated, "I can bear weight, with the two gals on each side of me with that belt on, but then my knees start to buckle."

In an interview with Staff A, the covering Assistant Executive Director, on 04/16/2024 at 3:26PM, Staff A was asked if a normal part of a nursing assessment should include complete review of the resident record, including any active Temporary Care Plans in place, and all resident progress notes. Staff A responded, "Absolutely."

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) 6/3/2024 .

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

Krysta Henderson, Representing Jennifer Hills — 5/2/24

Administrator (or Representative) — Date

WAC 388-78A-3170 Circumstances that may result in enforcement remedies.

(1) The department is authorized to impose enforcement remedies described in WAC 388-78A-3160 if any person described in subsection (2) of this section is found by the department to have:

(l) Knowingly or with reason to know, made false statements of material fact in the application for the license or the renewal of the license or any data attached thereto, or in any matter under investigation by the department;

This requirement was not met as evidenced by:

Based on interview and Record Review, the facility representative knowingly made false statements to the Department during a matter under investigation regarding 1 of 2 Nursing Assessments reviewed. This failure resulted in Resident 1 having an inaccurate assessment, and placed all residents who were to be assessed by the Nurse at risk for inaccurate assessments, unmet care needs, and decreased quality of life.

Findings included...

Review of Department Records showed a reported complaint for the facility, dated 04/16/2024, that stated, "[there is] suspicion of...[the facility] falsifying documents in order to avoid state fines."

that." R1 was asked if they were able to ambulate at all on their own using the 4WW. R1 stated, "I can't even stand by myself, let alone walk." R1 was asked if they required 2-persons to ambulate. R1 stated, "I can bear weight, with the two gals on each side of me with that belt on, but then my knees start to buckle."

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Krysta Kendall, Representing Jennifer Hills — 5/2/24

Administrator (or Representative) — Date

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(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

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(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

(3) The assisted living facility must ensure that all nursing services, including nursing supervision, assessments, and delegation, are provided in accordance with applicable statutes and rules, including, but not limited to:

(c) Chapter 246-840 WAC, Practical and registered nursing;

This requirement was not met as evidenced by:

Based on interview, and record review, the facility failed to ensure staff had the required nurse delegation training and documentation by the Registered Nurse (RN) Delegator for 1 of 2 sampled residents (Resident 2 [R2]) who were receiving nurse delegated services. The facility failed to verify 1 of 2 sampled staff member's (Staff C) credentials and trainings for qualification prior to administering nurse delegated tasks. These failures placed all residents receiving RN delegated services at risk for harm and injury due to untrained, unqualified, and unsupervised care staff.

Findings included...

"WAC 246-840-930 Criteria for delegation.
...(8) Verify that the nursing assistant or home care aide: (a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction; (b) Has completed both the basic caregiver training and core delegation training before performing any delegated task; (c) Has evidence as required by the Department of Social and Health Services of successful completion of nurse delegation core training; (d) Has evidence as required by the Department of Social and Health Services of successful completion of nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client; and (e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions. (9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision. (11) Document in the patient's record the rationale for delegating or not delegating nursing tasks. (12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes: (a) The rationale for delegating the nursing task; (b) The delegated nursing task is specific to one patient and is not transferable to another patient; (c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide; (d) The nature of the condition requiring treatment and purpose of the delegated nursing task; (e) A clear description of the procedure or steps to follow to perform the task; (f) The predictable outcomes of the nursing task and how to effectively deal with them; (g) The risks of the treatment; (h) The interactions of prescribed medications; (i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services. (l) Document teaching done and a return demonstration, or other method for verification of competency; and (m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks and may be more frequent. (16) The registered nurse delegator evaluates the patient's responses to

the delegated nursing care and to any modification of the nursing components of the patient's plan of care. (17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems. (18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment. (19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days."

Review of the Washington State Department of Social and Health Services 2024 training document titled, "Community Nurse Delegation Orientation," it showed the following:
• All long-term care workers (LTCW) must have active home care aide certified credential, or active nursing assistance certified, or active nursing assistance registered credential with completed basic core training.
• All LTCW must have nurse delegation core training certificate or transcripts and nurse delegation with special focus on diabetes certificate or transcript to administer insulin.
• All LTCW must have active credentials with Department of Health (DOH) to be delegated.

Review of Department Records showed a complaint dated 04/16/2024 that stated, "[Resident's] safety being jeopardized by allowing non-delegated staff to give insulins. Their safety is being compromised due to the facility allowing untrained staff to pass [medications] to residents."

During an interview with Former Staff 1 (FS1), the former facility RN (Registered Nurse) Delegator on 04/17/2024 at 1:44PM, FS1 stated, "On Friday, (04/12/2024) I did not delegate to anyone that day. They were short staffed and needed someone to work. They grabbed [Staff C] who had been scheduled to work as a caregiver, to work as a Med Aide [Medication Aide]. I do not believe that [Staff C] had an active license, but even if [they] did, [they] [were] not delegated." FS1 stated that R2 was on insulin, and they were so new to the facility that nurse delegation was not yet set up for them. FS1 then stated on 04/12/2024 that Staff C administered insulin to R2 without proper nurse delegation.

Review of an undated Offer Letter from facility showed Staff C was hired to work at the facility on 04/08/2024 as a Caregiver.

Review of the facility staff schedule for 04/12/2024 showed that for the afternoon shift, Staff C was listed to work as "Care/Training."

Review of R2's face sheet showed that the resident was admitted to the facility on [redacted]/2024.

Review of R2's Medication Administration Record (MAR) for 04/12/2024 showed an active order for:
• "Humalog Kwikpen [medication to treat blood glucose levels]... 'staff are to check [blood glucose] and administer insulin subcutaneously per sliding scale before meals and at bedtime. Record injection site and rotate sites with every injection.'**THIS IS A DELEGATED TASK TO BE PERFORMED BY DELEGATED STAFF ONLY**" Review of administration times for the 4:00PM and 7:00PM doses on 04/12/2024 showed that the doses were signed off and administered by Staff C.

• "Insulin Glargine [medication to treat blood glucose levels]... 'inject 17 units subcutaneously 2 times daily, record injection site and rotate sites.'**THIS IS A DELEGATED TASK TO BE PERFORMED BY DELEGATED STAFF ONLY**" Review of administration times for the 7:00PM dose on 04/12/2024 showed was signed off and administered by Staff C.

On 04/19/2024 at 2:45PM, the Department requested the facility to provide Credential Information and licensure, including all Nurse Delegation training and documentation of Staff C for Department review. At 5:43PM, the Department Representative received notice from Staff A, the covering Assistant Executive Director, which stated, "Staff C has informed me [they] [have] a pending NAR (Nursing Assistant Registration). As for delegations, we do not have current delegations for [Staff C]."

According to the Department of Health "Application Status" document, last reviewed on 10/10/2023, it stated, "A "pending" status means the review process is underway... Remember: You may not work until we issue your credential for some credential types."

Review of Department of Health Provider Credential records on 04/17/2024 show Staff C had a Credential Type of "Nursing Assistant Registration," with a Credential Status of "EXPIRED." Review of the Expiration Date for Staff C's credentials showed that it expired on 02/18/2024.

This is a recurring deficiency previously cited on 10/26/2023 and 07/10/2023.

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) 6/3/24 .

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

Krystal Kendall, Representing Jennifer Hills

Administrator (or Representative) Date 5/2/24

Review of R2's Medication Administration Record (MAR) for 04/12/2024 showed an active order for:
• "Humalog Kwikpen [medication to treat blood glucose levels]... 'staff are to check [blood glucose] and administer insulin subcutaneously per sliding scale before meals and at bedtime. Record injection site and rotate sites with every injection.'**THIS IS A DELEGATED TASK TO BE PERFORMED BY DELEGATED STAFF ONLY**" Review of administration times for the 4:00PM and 7:00PM doses on 04/12/2024 showed that the doses were signed off and administered by Staff C.

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According to the Department of Health "Application Status" document, last reviewed on 10/10/2023, it stated, "A "pending" status means the review process is underway… Remember: You may not work until we issue your credential for some credential types."

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

_____ _____

Administrator (or Representative) Date