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

10/01/2025

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) 66432 (Completion Date 10/01/2025) and 59276 (Completion Date 07/01/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 10/01/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(4) Take appropriate action in response to each resident's changing needs.

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;

(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.

The Department staff who did the On Site verification:
Pamela Horlick, NCI RN Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse 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 #: 59276
Investigator: Pamela Horlick
Investigation Date(s): 05/08/2025 through 07/01/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 177030
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

Resident/Patient/Client Neglect: Report of resident being found to have open sores after discharging from facility.

Investigation Methods:

Sample:	Total residents: 49 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members Business office manager
Record Reviews:	State reporting log Hospital records Medical records Facility policies Adult Family Home Progress notes Assessments Doctor Notes Progress Notes Temporary Care Plans (TCP's) Wound log

Investigation Summary:

Resident/Patient/Client Neglect: Based on interview and record review, the facility failed to monitor wounds once the facility became aware of wounds that developed. 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 05/08/2025 of:

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

This document references the following complaint number(s): 177030

The following sample was selected for review during the unannounced on-site visit: 3 of 49 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

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.

Clinton Fridley
Residential Care Services

07/10/2025
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)

7/11/2025
Date

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(1) Observe each resident consistent with his or her assessed needs and negotiated service agreement;

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to take appropriate action to address a resident's changing needs when pressure wounds were discovered for 1 of 3 residents [Resident 1 (R1)]. This failure resulted in the deterioration of one pressure sore and another not being monitored consistently and placed resident at risk for further deteriorating skin integrity and pain.

Findings included...

Record review of the facility's policy titled, "Alert Charting," dated 06/01/2023, showed that staff are responsible to make sure residents are placed on alert when appropriate and that at least one chart note entry, identified as related to alert charting, is recorded each shift for each resident named on the alert charting log, in general residents on alert status will remain on alert for 72 hours unless otherwise directed by management.

Record review of R1's document titled, "Resident Service Plan," dated 12/24/2024, showed that staff were to provide physical assist with bathing and were to observe for any skin issues and report to the assisted living director (ALD)/ registered nurse (RN) for further evaluation.

Review of R1's record titled, "Quarterly Licensed Nurse Evaluation Summary," dated 01/18/2025, showed diagnoses to include [redacted]. Requires one staff person for assistance with showers, toileting and dressing and there were no skin issues identified at time of eval.

Review of charting notes for R1, dated 04/06/2025 at 11:54AM by Staff D, MT, documented, "multiple sores present on both buttocks. Cleaned and changed. Resident has been denying care regularly."

Review of charting notes for R1, as of 04/08/2025, showed no documentation facility staff reported the identified skin breakdown, noted on 04/06/2025, to the family representative or health care provider and no documentation showing staff placed R1 on alert charting for the identified skin breakdown.

Review of charting notes for R1, dated 04/09/2025 at 3:19PM by Staff B, Registered Nurse (RN), documented, "RN Change of condition: res wounds to buttocks are assessed by this RN, 5 pressure areas of multiple stages including unstageable are noted to bilat inner buttocks. Staff reports resident is frequently incontinent and sits in recliner most of the day. Scant amount of drainage notes. Staff to continue to encourage repositioning and check and change frequently. Res placed on alert, PCP [primary care provider] faxed for orders for desitin [barrier cream] and home health wound care referral. Family notified. TCP [temporary care plan]."

Review of R1 record titled, "Wound Assessments," dated 04/09/2025 by Staff B, RN, documented an unstageable pressure wound to back right buttock, acquired on 04/06/2025 at 11:48AM, measuring 1.8 centimeters (cm) by 0.9 cm by 0.1 cm, with a small amount of sanguineous (bloody or contains blood) drainage, and the wound bed contained necrotic (dead tissue that is typically black, dry, and leathery) tissue and slough (dead tissue that is usually yellow or white) was noted.

Review of R1 record titled, "Wound Assessments," dated 04/09/2025 by Staff B, RN, documented a non-healing stage three pressure wound (a deep wound that penetrates through the skin's top layers into the fatty tissue beneath, creating a crater-like appearance) to the lower back center, acquired on 03/30/2025 at 5:58AM, scant sanguineous drainage, and the wound bed contained slough with notes saying the facility requested orders and that home health wound care referral was requested and faxed to the PCP. No documentation of measurements noted. R1's facility records

revealed that the last assessment of this wound was performed on 03/31/2025 by Staff C, Regional Nurse Consultant, it was measured and described as being superficial without signs of infection.

Review of R1's charting notes for 04/10/2025, 04/12/2025 and 04/13/2025 showed no documentation regarding the wounds documented on 04/09/2025 in the facility document titled, "Wound Assessments."

Review of R1's charting notes for 04/14/2025 at 3:18PM, Staff E, MT, documented, "General chart note: second referral request faxed to provider for wound care."

Review of charting notes for R1, dated [redacted]/2025 at 5:17PM by Staff B, RN, notes that R1 discharged to an AFH and family reported PCP was aware of wounds and will be working with coordinating wound care specialty to take over in AFH.

In an interview on 05/08/2025 at 2:57PM, Staff B, RN, stated that they were first made aware of R1's wounds on 04/09/2025 and did not know when the wounds started and was under the impression that other people were aware of the wounds prior to Staff B's employment with the facility. Staff B assessed the wounds on 04/09/2025 and stated their initial reaction to R1's wounds were "there is no way this is brand new" and that there were five pressure sores in multiple stages, the wounds were extensive and they placed R1 on alert charting and documented on the wound log the same day.

In an interview on 05/09/2025 at 1:04PM, Staff C, RNC, stated the wound note on 04/09/2025 is the same wound mentioned in the charting notes dated 04/06/2025 and stated the wound on R1's bottom was a pressure sore because it was the bottom. Staff C was asked if the R1's PCP was made aware of the wounds on 04/06/2025, they stated no, the PCP was made aware on 04/09/2025. Staff C was asked if Staff B, RN, should have been notified sooner of the wounds, they stated yes. Staff C stated Staff D should have notified the nurse, done an occurrence report, notified family and the doctor. Staff C stated nobody was notified on 04/06/2025, they were notified on 04/09/2025. Staff C was asked if the care of the wound was delayed, they stated it was.

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) 8/24/25
8/15/25 - KR 60.

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

KR 7/10/2025

Administrator (or Representative) Date

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;

(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 report a significant change in the resident's condition to the resident's representative and physician for 1 of 3 residents (Resident 1 [R1]). This failure resulted in the residents' representative, physician not being consulted regarding the change of condition and a delay of care for the resident and placed them at risk for worsening of the condition and treatment not being implemented timely.

Findings included...

Record review of the facility's policy titled, "BSL HS 101: Skin Monitoring," revised on 09/12/2023, showed that caregivers, medication technicians (MT)/qualified medical administration person (QMAP) will, once a skin issue is observed, make an occurrence report, doctor and family notifications and add the issue to the skin log.

Record review of the facility's undated policy titled, "Occurrence Reporting Policy," showed that notifications will be generally made within the shift the event and/or

awareness of the event occurred, and the following people should be notified: resident's physician, family/responsible party, and the facility administrator or their designee.

Review of R1's undated document titled, "Resident Data Sheet," showed that the resident had both a financial and healthcare power of attorney (POA) and moved into the ALF on [redacted] 2024.

Record review of R1's document titled, "Resident Service Plan," dated 12/24/2024, showed that staff were to provide physical assist with bathing and were to observe for any skin issues and report to the assisted living director (ALD)/ registered nurse (RN) for further evaluation.

Review of R1's record titled, "Quarterly Licensed Nurse Evaluation Summary," dated 01/18/2025, showed diagnoses to include [redacted]. Requires one staff person for assistance with showers, toileting and dressing and there were no skin issues identified at time of evaluation.

Review of R1 record titled, "Wound Assessments," dated 03/31/2025 by Staff C, Regional Nurse Consultant (RNC), documented a new skin issue to the lower back center, acquired on 03/30/2025 at 5:58AM, no drainage noted, two areas noted: first one measured 4.0 centimeters (cm) by 2.5 cm by 0.2 cm and the second one measured 3.0 cm by 2.0 cm by 0.2 cm and was covered with a border dressing, the areas were described as superficial, without any signs or symptoms of infection.

Review of R1 record titled, "Resident Temporary Care Plan," (TCP) dated 03/31/2025, documented a new issue of skin breakdown and the place on the document for who was notified of the issue, relationship to the resident and date/time of the notification was blank.

Review of charting notes for R1, dated 04/06/2025 at 11:54AM by Staff D, MT, documented, "multiple sores present on both buttocks."

Review of charting notes and other facility records provided for R1, as of 04/08/2025, showed no documentation that facility staff reported the identified skin breakdowns, noted on 03/29/2025 and 04/06/2025, to the family representative or health care provider.

In an interview on 05/09/2025 at 1:04PM, Staff C, RNC, stated that the wound note on 04/09/2025 was the same wound mentioned in the charting notes dated 04/06/2025 and stated the wound on R1's bottom was a pressure sore because it was the bottom. Staff C was asked if the R1's PCP was made aware of the wounds on 04/06/2025, they stated no, the PCP was made aware on 04/09/2025. Staff C was asked if Staff B, RN,

should have been notified sooner of the wounds, they stated yes. Staff C was asked if an occurrence report was completed, they stated probably not. Staff C stated Staff D should have notified the nurse, done an occurrence report, notified family and the doctor. Staff C stated nobody was notified on 04/08/2025, they were notified on 04/09/2025. Staff C was asked if the care of the wound was delayed, they stated it was. Staff C stated the doctor was faxed on 04/09/2025 but no response was received until 04/13/2025. Staff C was asked if the doctor should have been called since no response was received back, they stated in their opinion, yes.

In an interview on 05/13/2025 at 3:25PM, Collateral Contact 1 (CC1) stated they hadn't been made aware of the wounds until 04/09/2025. CC1 stated they were stage 3 when R1 moved out of the facility on [redacted] 2025.

This is a recurring deficiency previously cited on 10/24/2023.

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) 8/24/25
8/15/25 - KR ED

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

Administrator (or Representative) 7/11/2025 Date