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

11/21/2025

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) 69125 (Completion Date 11/21/2025) and 65602 (Completion Date 09/25/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 11/21/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(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 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

The Department staff who did the On Site verification:
Celeste Vashey, ALF LTC Licensor

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

Sincerely,

Clinton Fridley RN

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 #: 65602
Investigator: Anissa Bearden
Investigation Date(s): 09/16/2025 through 09/25/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 191620
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
allegation staff member was rough with a resident during personal care that cause injury on resident leg.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Resident rooms Staff to resident interactions Dining
Interviews:	Residents Nursing staff Administrative Staff
Record Reviews:	Facility policies Personnel files Incident investigation State reporting log Medical records Hospital records

Investigation Summary:
after interview and record review, the facility failed to have a Washington state Name and Date of Birth background check on the employee that had alleged been rough with the resident causing a skin impairment to the residents leg. This was failed practice.

Conclusion / Action:

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

☐ N/A

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodland Retirement & Assisted Living Community
License/Cert.#: 1709
Compliance Determination #: 65602
Investigator: Anissa Bearden
Investigation Date(s): 09/16/2025 through 09/25/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 194104
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):
allegation resident has compression fracture to upper back from falls.

Investigation Methods:

Sample:	Total residents: 51 Resident sample size: 3 Closed records sample size: 1
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions
Interviews:	Nursing staff Residents Identified resident
Record Reviews:	Medical records Hospital records State reporting log Incident investigation Facility policies

Investigation Summary:
after interview and record review, the facility failed to a qualified assessor or nurse complete a change of condition assessment on a resident that had three fall within 2 week period that resulted in 3 emergency department visits with new orders for pain medications, increase assistance with activities of daily living needs, that no longer aligns with the residents current service plan. failed practice.

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 09/16/2025 and 09/24/2025 of:

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

This document references the following complaint number(s): 190981, 191620, 188754, 194104, 194879

The following sample was selected for review during the unannounced on-site visit: 3 of 51 current residents and 1 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.

Clinton Fridley
Residential Care Services

10/07/2025
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)

10/10/25
Date

WAC 388-78A-2462 Background checks Who is required to have.

(2) The assisted living facility must ensure that the administrator and all caregivers employed directly or by contract after January 7, 2012 have the following background checks:

(a) A Washington state name and date of birth background check; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a Washington State Name and Date of Birth Background Check was completed for 1 of 3 sampled staff (Staff B). This failure resulted in all residents at risk for being cared for by a staff member with an unknown background history.

Findings included...

Record review of Resident 1's (R1's) occurrence report, dated 08/20/2025, showed R1 reported that a caregiver removed their compression stocking last night was "rough". R1 stated that the caregiver had grabbed their right leg and "yanked" the compression sock off that hurt them and caused redness and small bruise.

In an interview on 09/16/2025 at 12:26 PM, Staff E, Regional Nurse Consultant, stated they followed up with R1 regarding the reported incident. Staff E stated R1 reported the employee that was rough with them was a staff member with tattoos that was identified as Staff B, who worked from 2:00 PM until 10:00 PM on 08/19/2025.

On 09/16/2025 at 9:35 AM, the Department requested Staff B's employee file for

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Residential Care Services

Date

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Administrator (or Representative)

Date

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Findings included…

Record review of Resident 1's (R1's) occurrence report, dated 08/20/2025, showed R1 reported that a caregiver removed their compression stocking last night was "rough". R1 stated that the caregiver had grabbed their right leg and "yanked" the compression sock off that hurt them and caused redness and small bruise.

In an interview on 09/16/2025 at 12:26 PM, Staff E, Regional Nurse Consultant, stated they followed up with R1 regarding the reported incident. Staff E stated R1 reported the employee that was rough with them was a staff member with tattoos that was identified as Staff B, who worked from 2:00 PM until 10:00 PM on 08/19/2025.

On 09/16/2025 at 9:35 AM, the Department requested Staff B's employee file for

review.

Record review of Staff B's welcome letter, dated 07/17/2025, showed Staff B's employment start date for the facility was on 07/17/2025.

In an interview on 09/16/2025 at 10:40 AM, Staff A, Executive Director, stated the facility did not have an employee file for Staff B as they transferred from the sister facility next to them. Staff A only had one document for Staff B's employee file that was the welcome letter of employment. At 10:56 AM, Staff A stated the facility did not have any background checks completed for Staff B. Staff A acknowledged that Staff B should have a Washington State Name and Date of Birth background check completed upon hire at the facility.

This is a recurring deficiency previously cited on 09/11/2023 and 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) 11/8/25 .

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

Administrator (or Representative) — Date: 10/10/25

WAC 388-78A-2100 Ongoing assessments.

(2) The assisted living facility must:

(a) Complete a full assessment addressing the elements set forth in WAC 388-78A-2090 for each resident at least annually;

(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 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

review.

Record review of Staff B's welcome letter, dated 07/17/2025, showed Staff B's employment start date for the facility was on 07/17/2025.

In an interview on 09/16/2025 at 10:40 AM, Staff A, Executive Director, stated the facility did not have an employee file for Staff B as they transferred from the sister facility next to them. Staff A only had one document for Staff B's employee file that was the welcome letter of employment. At 10:56 AM, Staff A stated the facility did not have any background checks completed for Staff B. Staff A acknowledged that Staff B should have a Washington State Name and Date of Birth background check completed upon hire at the facility.

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_____ _____
Administrator (or Representative) Date

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(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 ;

(ii) When the resident's negotiated service agreement no longer addresses the resident's current needs and preferences;

(iii) When the resident has an injury requiring the intervention of a practitioner.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to complete an ongoing assessment focused on residents identified problems, a change of condition, and when they had an injury requiring practitioner intervention for 1 of 3 sampled residents (Resident 2 [R2]). This failure placed R2 at risk for unmet care needs by staff untrained of the most updated care and service needs for the residents.

Findings included…

Record review of the facility's health service manual, dated 04/02/2025, documented when a change of conditions was noted with a resident, the community would maintain an effective system of communicating changes and the registered nurse/licensed nurse would complete an assessment and oversight. Significant change of condition meant a major deviation from the most recent evaluation that may affect multiple areas of functioning or health that was not expected to be short term and imposes significant risk to the residents.

Record review of R2's resident service plan, dated 07/15/2025, revealed an admission date of [redacted]/2025 and that R2 was independent with transfers, dressing, personal hygiene needs, toileting, medication management, ambulation with use of a cane, and not considered a fall risk.

Record review of R2's temporary care plan (TCP), dated 08/31/2025, showed R2 was found lying on their back near the front door of their apartment. R2 was transported to the emergency department for further evaluation related to discomfort. The TCP showed it was signed by Staff C, Medication Aide, with no other documented reviews by the registered nurse or a licensed nurse.

Record review of the emergency department after visit summary, dated 08/31/2025, showed R2 was evaluated related to hip pain and recent multiple falls and was diagnosed with [redacted]. R2 was given pain medications when they were at the emergency department and instructions to follow up with their primary care physician.

Record review of R2's chart note, dated 08/31/2025 at 3:11 PM, showed R2 had an unwitnessed fall and was sent to the hospital for further evaluation for complaints of 9 out of 10 pain in the hip.

Record review of R2's charting note, dated 09/01/2025 at 1:33 PM, showed R2 complained of pain to their left side lower rib and hip area. R2 remained in bed and attempted to get up out of bed with staff assistance and was only able to sit in the wheelchair for a short amount of time before needing to lay back down. R2's power of attorney was called about R2's condition and the power of attorney told the staff to remind R2 to take Tylenol for the pain. R2 required one person assistance from staff

with toileting, transfers, activities of daily living needs (ADL), and changing.

Record review of R2's TCP, dated 09/05/2025, showed R2 had an unwitnessed non injury fall when they tried to self-transfer from bed to the wheelchair. The TCP was completed by Staff D, Medication Aide, with no other documented reviews by the registered nurse or a licensed nurse.

Record review of the emergency department after visit summary, dated 09/05/2025, showed R2 was evaluated related to fall and was diagnosed with [redacted]. R2 had blood work done and was sent with instructions to follow up with their primary care physician in one day.

Record review of R2's chart note, dated 09/05/2025 at 2:41 PM, showed R2 was found sitting upright on the ground. R2 complained of back pain and was sent to the emergency department for further evaluation. R2 continued to require one-person assistance with all ADL's and transfers.

Record review of R2's chart note, dated 09/08/2025 at 1:32 PM, showed R2 complained of pain to their left hip and lower rib areas. R2 remained in bed or sitting in wheelchair and required one-person full assistance with ADL's from care staff.

Record review of R2's after visit summary, dated 09/09/2025, showed R2 had a compression fracture (broken bone) in their thoracic spine (upper part of the back and spine area) that was contributing to their left side pain and chest bruising. R2 was to treat their pain with Tylenol (medication to help relieve pain and discomfort), cold packs on and off for 20 minutes and lidocaine patches (medicated patches to help with pain and discomfort). R2's scans showed they had a long-term small blood clot to their left lung that was unable to be treated with blood thinners related to R2's frequent falling. R2 was to follow up with primary care physician that week.

Record review of R2's TCP, dated 09/09/2025, showed R2 was sent out to the emergency department for chest pain. Staff were to provide R2 full assistance with transfers, toileting, dressing, escorts to meals in wheelchair, and stand by assistance with walker for short ambulation. The TCP was signed by Staff D with no other documented reviews by the registered nurse or a licensed nurse.

Record review of R2's chart note, dated 09/09/2025 at 2:14 PM, showed R2 was sent out to the emergency department that morning for complaints of severe chest pain. R2 returned to the facility that afternoon with diagnosis of [redacted]. R2 was to treat the pain with Tylenol, cold packs, and lidocaine patches. Staff to continue to assist R2 with ADL's, dressing, transfers, and escort in wheelchair.

Record review of R2's chart note, dated 09/12/2025 at 12:37 PM, showed R2 continued

to require full assistance from staff with ADL's.

On 09/18/2025 at 10:09 AM, the Department requested to review R2 last nursing assessment.

Record review of an email sent to the Department on 09/18/2025 at 4:46 PM, showed R2 did not take any medications and confirmed with R2's power of attorney that R2 did not take medications. The facility had just hired a nurse that started on 09/15/2025. Staff E, Regional Nurse Consultant, oversees multiple facilities within the corporation and has been behind on the nursing assessment for the residents at the facility. There were no assessments provided that were completed prior to 09/16/2025.

Record review of R2's charting notes, dated 08/31/2025 through 09/16/2025, showed there was no change of condition assessment completed by a qualified assessor, registered nurse, or licensed nurse documented.

In an interview on 09/24/2025 at 12:50 PM, Staff A, Executive Director, stated the current assessment for R2 as of 09/16/2025 was their pre-admission assessment that was dated 05/21/2025. Staff A stated Staff E was responsible to complete change of condition assessments for residents that required one for the facility when the facility did not have a permanent nurse. Staff A acknowledged that a change of condition assessment was not completed on R2 that required three emergency department visits, new medication orders for pain management, and a significant change in needing assistance from care staff for their ADL's.

This is a recurring deficiency previously cited on 04/19/2024.

Plan/Attestation Statement

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

Administrator (or Representative) 10/10/25 Date

to require full assistance from staff with ADL's.

On 09/18/2025 at 10:09 AM, the Department requested to review R2 last nursing assessment.

Record review of an email sent to the Department on 09/18/2025 at 4:46 PM, showed R2 did not take any medications and confirmed with R2's power of attorney that R2 did not take medications. The facility had just hired a nurse that started on 09/15/2025. Staff E, Regional Nurse Consultant, oversees multiple facilities within the corporation and has been behind on the nursing assessment for the residents at the facility. There were no assessments provided that were completed prior to 09/16/2025.

Record review of R2's charting notes, dated 08/31/2025 through 09/16/2025, showed there was no change of condition assessment completed by a qualified assessor, registered nurse, or licensed nurse documented.

In an interview on 09/24/2025 at 12:50 PM, Staff A, Executive Director, stated the current assessment for R2 as of 09/16/2025 was their pre-admission assessment that was dated 05/21/2025. Staff A stated Staff E was responsible to complete change of condition assessments for residents that required one for the facility when the facility did not have a permanent nurse. Staff A acknowledged that a change of condition assessment was not completed on R2 that required three emergency department visits, new medication orders for pain management, and a significant change in needing assistance from care staff for their ADL's.

This is a recurring deficiency previously cited on 04/19/2024.

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Administrator (or Representative) Date