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

12/06/2024

Woodland Village Operations LLC
Woodland Village
2020 A St SE Ste 101
Auburn, WA 98002

RE: Woodland Village # 2512

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 51324 (Completion Date 12/06/2024) and 45334 (Completion Date 08/19/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/06/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

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:

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

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

This document was prepared by Residential Care Services for the Locator website.

(2) The assisted living facility must:

(d) Provide all resident care and services according to current acceptable standards for infection control;

The Department staff who did the On Site verification:

Celeste Vashey, ALF LTC Licensor
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

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodland Village
Provider Type: Assisted Living Facility
License/Cert.#: 2512
Compliance Determination #: 45334
Intake ID: 141251
Investigator: Celeste Vashey
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 08/08/2024 through 08/19/2024
Complainant Contact Date(s):

Allegation(s):
Concerns for residents safety of their environment and care and services provided at the facility.

Investigation Methods:

Sample:	Total residents: 47 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents
Record Reviews:	Medical records State reporting log Incident investigation Facility policies

Investigation Summary:
Based on observation, interview, and record review failed practice had been identified in regards to WAC 388 78A 3090 1AD and WAC 388 78A 2100 2II

Conclusion / Action:

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

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodland Village
Provider Type: Assisted Living Facility
License/Cert.#: 2512
Compliance Determination #: 45334
Intake ID: 141193
Investigator: Celeste Vashey
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 08/08/2024 through 08/19/2024
Complainant Contact Date(s):

Allegation(s):
The facility reported the COVID-19 outbreak that occured within the facility.

Investigation Methods:

Sample:
Total residents: 47
Resident sample size: 3
Closed records sample size: 0

Observations:
Identified resident
Residents
Activities
Dining
Resident care equipment
Resident rooms
Staff to resident interactions

Interviews:
Identified resident
Nursing staff
Residents
Family members

Record Reviews:
Medical records
Incident investigation
Facility policies

Investigation Summary:
Based on observation, interview, and record review failed practice had been identified related to WAC 388 78A 2610 12D.

Conclusion / Action:

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

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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
Plan of Correction
Page 1 of 14

License #: 2512
Woodland Village
Licensee: Woodland Village Operations LLC

Compliance Determination # 45334
Completion Date
08/19/2024

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 08/08/2024 and 08/19/2024 of:

Woodland Village
2100 SW Woodland Circle
Chehalis, WA 98532

This document references the following complaint number(s): 141251, 141193

The following sample was selected for review during the unannounced on-site visit: 3 of 47 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Celeste Vashey, ALF LTC 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

08/27/2024
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.

This document was prepared by Residential Care Services for the Locator website.

Statement of Deficiencies
Plan of Correction
Page 2 of 14

License #: 2512
Woodland Village
Licensee: Woodland Village Operations LLC

Compliance Determination # 45334
Completion Date
08/19/2024

Administrator (or Representative)

09/10/2024
Date

WAC 388-78A-3090 Maintenance and housekeeping.

(1) The assisted living facility must:

(a) Provide a safe, sanitary and well-maintained environment for residents;

(d) Ensure each resident or staff person maintains the resident's quarters in a safe and sanitary condition consistent with the negotiated service agreement.

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to provide a safe, sanitary, and well-maintained environment for 1 of 3 areas within the facility (Resident 1[R1]'s room). This failure placed R1 at risk to have a diminished quality of life due to unsafe, unsanitary, and unmaintained living conditions.

Findings included...

Record review of R1's "Negotiated Service Agreement (NSA)", dated 08/18/2023, showed, R1 could make themselves understood and were able to understand others. R1's trash, bathroom, and room were cleaned once weekly. The document was signed by a community representative and R1 on 01/18/2024.

Record review of R1's "Unusual Occurrence Report", dated 07/22/2024, showed R1 had fallen in their room next to their desk. R1 had been walking and reported they slipped. The yes box had been checked under the clutter on floor section, phone cords/tv cords lying around, and poor lighting. The surrounding area section showed the area had been cluttered. R1 was not observed to wear socks or shoes. R1 was not observed to use their assistive device. The facility care staff noted R1's room was a mess, so the facility caregiver picked up the room to prevent tripping hazards. The prevention of future similar incidents/NSA section showed when facility staff saw clutter, they were to encourage resident to clean up the clutter. The facility staff would clean as needed to prevent a fall. The housekeeping staff cleaned weekly to assist with room clutter. The facility staff would advise the resident to wear nonskid footwear when they saw R1 barefoot or in just socks. The document was signed by Staff B, Resident Care Director, on 07/24/2024.

In an interview on 08/07/2024 at 2:13 PM, Collateral Contact 1 (CC1), said when they visited R1, their electronic bicycle had blocked their apartment entrance. CC1 said when they were present, R1 tried to move their electronic bicycle and lost their balance. CC1 said they had to brace R1 up against the wall to prevent a fall. CC1 said R1 could not

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use and maneuver their walker inside of their apartment.

In an observation and interview on 08/08/2024 at 10:43 AM, R1's kitchenette area had a trash bag hanging off the cabinets drawer's handle. On the counters were multiple containers of cat treats, empty cups, and cups with liquids. R1's glasses were on top of the refrigerator. R1 said "hmmm" and had been observed to pick up their glasses and put them on. R1 had another pair of glasses hanging on the kitchenette's cabinets drawer's handle. R1's room showed there was a tricycle to the far-right side of the room. The tricycle was placed after the bathroom and took up R1's living room and bedroom space. To get to R1's sitting desk and bed R1 had to move around the tricycle and walk in between the narrow pathway. R1's four wheeled walker had been used to prop open R1's bathroom door. Inside of R1's bathroom was a bicycle that had been propped against the wall. Inside of the bathroom showed the cats litterbox in the corner. The bathroom sink cabinet had a trash bag hanging off the drawer's handle. There was a Swiffer mop and broom on the ground. There was what appeared to be a gait belt (safety device that helped people with mobility issues move and prevent falls) hanging in the shower. R1 was not able to identify what the item was inside of their shower. R1's living room showed a swivel chair and 1 of 5 legs were missing a wheel. R1 was observed sitting in the chair and said it was unstable. R1's bed had been placed to where the left side of the bed almost touched the wall. On the left side of the bed there was a standing lamp with a long metal bar without the lamp shade attached. The lamp had two spots of duct tape wrapped around the bar. One of the duct tape spots had wire sticking out of it. The right side of R1's bed showed there was a shoe rack and a box with a variety of household tools that impeded R1's ability to exit from the right side of their bed. On the floor there were books, paper notebooks, a helmet, laundry detergent pods, Lysol disinfectant spray, and two vacuums. In the corner of R1's room was a rolled-up mattress pad. R1 said they ordered the mattress pad but didn't think it would fit on their bed. R1 reported housekeeping came in once weekly to help them clean. There was a towel observed to be on the ground in the narrow pathway in between the tricycle and the kitchen. R1 had been observed wearing one sock on one foot and nothing on the other. R1 stepped on the towel and lost their footing. R1's arms had been observed to fly into the air as they attempted to regain their balance. R1's cane had been inside of their bathroom next to the door. R1 said they had been looking for it. R1 said the bicycle in the bathroom was motorized. R1 said they used both of their bicycles that were inside of their room. R1 acknowledged their room had tripping hazards inside of it. R1 said they almost forgot how to walk. R1 put out their right arm and there were multiple bright red marks on the outer part of R1's arm. By R1's elbow it appeared the skin had somehow rubbed off as there was open flesh. R1 said they fell and caught themselves against the wall. R1 was unable to clarify when they almost fell and received the wound on their arm. R1 said their arm burned and they were going to put cortisone (medicated cream) on it. The inside of R1's right arm was noted to have a multicolored bruise on it by the bend of their elbow. R1 said they were always falling, and the facility staff were tired of hearing from them. R1 said when they reported falls, they were encouraged to go to the hospital. R1 said they did not want to go to the hospital because they did not have anyone to watch their cat.

In an interview on 08/08/2024 at 11:20 AM, Staff C, Caregiver, said they were in R1's room earlier in the day to take their trash out. Staff C said that R1's room had been crowded. Staff C acknowledged R1 had multiple bicycles inside of their room that could be a tripping hazard.

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In an interview on 08/08/2024 at 11:27 AM, Staff D, Caregiver said they covered a shift and did not often work with R1. Staff D said R1's room had tripping hazards. Staff D said R1 got mad at facility staff if they tried to clean their room. Staff D said at one point they left R1's room because R1 started screaming when Staff D tried to clean it. Staff D was unsure if R1 getting upset when staff cleaned their room had been incorporated into R1's NSA. Staff D said to their knowledge housekeeping cleaned R1's room today 08/08/2024 or the day prior on 08/07/2024. Staff D said the facility staff could clean R1's room and the following day it would be messy. Staff D did not think the bicycles inside of R1's room had been a safety hazard as they thought R1 could maneuver around them.

In an interview on 08/08/2024 at 12:50 PM, Staff B acknowledged R1 had three falls in the month of July. Staff B said the falls were associated with R1 not wearing socks or shoes and losing their footing. Staff B said facility staff encouraged R1 to wear socks and shoes to prevent falls. Staff B said R1 had a lot of clutter inside of their room. Staff B said housekeeping staff tried to help R1 declutter but R1 had been resistive to help. Staff B said the facility interventions should be in incorporated into R1's NSA.

Record review of R1's NSA, dated 08/18/2023, showed it did not address R1's resistance to care and services.

In an interview on 08/08/2024 at 1:55 PM, Staff A said they had cleaned and organized R1's room and the next day it would be unkept. Staff A said R1 would not allow the facility staff to remove items from their room. Staff A said it had been a surprise when R1 ordered their bicycle and it had got delivered to the facility. Staff A confirmed R1 rode their bicycles. Staff A confirmed R1 being resistive to care and services from the facility were not incorporated into R1's care plan.

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 Village is or will be in compliance with this law and / or regulation on (Date) October 3rd, 2024

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

Administrator (or Representative)

08/30/2024
Date

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

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related issues:

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review the facility failed to complete on going assessments for 1 of 3 sampled residents (Resident 1[R1]). This failure placed R1 at risk for unmet care needs and staff not having the most updated and accurate care and services the resident required.

Findings included...

Record review of the facility's policy, titled, "Assessments, Ongoing/Change in Condition Assessments", dated 11/14/2017, showed ongoing assessments were full assessments completed annually to ensure that each resident's condition were monitored to identify physical, mental, emotional, and health status changes in a timely manner. Change in condition assessments occurred when a significant changed in a resident's condition that resulted in a change in a resident's physical, mental, or psychosocial status. The Resident Care Director or licensed practical nurse would complete a change of condition assessment within a reasonable timeframe after a resident demonstrated an injury that required the intervention of a practitioner, a change in behavior or mental status, unplanned weight change, and whenever a residents negotiated service agreement no longer addressed the resident's current needs and preferences.

Record review of R1's "Resident Assessment", dated 08/17/2023, showed R1 had been independent with mobility, a checked mark box indicated R1 used a cane. The history of falls section showed R1 had a fall two weeks ago. R1 had been independent with transfers. R1 had been independent with bed mobility. There was an unchecked box in the section that showed "safety device assessment to be completed if side rail, transfer pole, and/or trapeze bar used." The speech and communication section showed R1 could make themselves understood and were able to understand others. R1 had been oriented to person, place, and time. The housekeeping staff were responsible to empty residents' trash, clean R1's bathroom, and clean R1's room once weekly on Wednesday's.

Record review of R1's "Negotiated Service Agreement", dated 08/18/2023, showed, R1 used a walker when they ambulated. Under bed mobility it showed R1 used half or a quarter side rail. R1 was able to make themselves understood and were able to understand others. R1's trash, bathroom, and room were cleaned once weekly. The document was signed by a community representative and R1 on 01/16/2024.

Record review of R1's "Unusual Occurrence Report", dated 07/01/2024, showed a random customer came to the bus and reported that R1 had fell and they picked R1 up. R1 had not reported the fall. The prevention of future similar incidents/NSA (negotiated

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service agreement) section showed facility staff were to encourage R1 to use their walker versus a cart. The Document was signed by Staff B, Resident Care Director on 07/03/2024.

Record review of R1's "Unusual Occurrence Report", dated 07/22/2024, showed R1 had fallen in their room next to their desk. R1 had been walking and reported they slipped. The yes box had been checked under the clutter on floor section, phone cords/tv cords lying around, and poor lighting. The surrounding area section showed the area had been cluttered. R1 was not observed to wear socks or shoes. R1 was not observed to use their assistive device. The facility care staff noted R1's room was a mess, so caregiver picked up the room to prevent another tripping hazard. The prevention of future similar incidents/NSA section showed when facility staff saw clutter, they were to encourage resident to clean up the clutter. The facility staff would clean as needed to prevent a fall. The housekeeping staff cleaned weekly to assist with room clutter. The facility staff would advise the resident to wear nonskid footwear when they saw R1 barefoot or in just socks. The document was signed by Staff B on 07/24/2024.

Record review of R1's "Unusual Occurrence Report", dated 07/27/2024, showed R1 fell in the elevator, got themselves up, and went back to their room. A concerned visitor reported the fall to the facility office staff. The prevention of future similar incidents/NSA section showed R1 had not used their walker at the time of the fall. The facility staff were to remind R1 to use their walker if they saw R1 without it. Physical therapy had been ordered for R1. The document was signed by Staff B on 08/01/2024.

Record review of R1's "Resident Notes", dated 07/03/2024, showed Staff B wrote R1 had a witnessed fall at Walmart on 07/01/2024 at approximately 11:50 AM. R1 had tripped over the edge of the rolled-up carpet in front of the store. R1 had been helped up by other customers in the store as the facility staff did not witness the fall. R1 had not reported the fall to facility staff. A customer came to the bus and informed facility staff. R1 had used a grocery cart instead of their walker. R1 would be encouraged to use their walker more when outside of the facility.

Record review of R1's "Resident Notes", dated 07/24/2024, showed Staff B wrote R1 had a non injury fall on 07/22/2024. The facility care staff had walked by and heard R1 fell. R1 did not have socks or shoes on. R1's apartment had been cluttered. R1 refused to let facility staff help them put on socks or shoes. The facility staff cleaned R1's apartment to prevent R1 from tripping again. Staff B wrote facility staff would help declutter R1's apartment as needed to prevent tripping and routine housekeeping would clean up cluttered area as well.

Record review of R1's "Resident Notes", dated 08/01/2024, showed Staff B wrote R1 had a non injury fall on 07/27/2024 in the elevator and got themselves back up. The facility staff were made aware from a concerned visitor that had reported they witnessed the fall. Staff B wrote R1 was a poor historian, and they were unsure of what caused them to fall. R1's Medical Doctor referred R1 to physical therapy.

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In an interview on 08/07/2024 at 2:13 PM, Collateral Contact 1 (CC1), said R1 had not been able to start on home health services because after they completed a cognitive evaluation it was determined R1 would not be able to retain the content. CC1 said R1 had not been able to repeat three words back to them. CC1 said to start services R1 would need another individual to be taught the information to reiterate back to R1 as needed. CC1 said when they visited R1, their electronic bicycle had blocked their apartment entrance. CC1 said when they were present R1 tried to move their electronic bicycle and lost their balance. CC1 said they had to brace R1 up against the wall to prevent a fall. CC1 said R1 would not be able to use and maneuver their walker inside of their apartment.

In an observation and interview on 08/08/2024 at 10:43 AM, R1's room showed there was a tricycle to the far-right side of the room. The tricycle was placed after the bathroom and took up R1's living room and bedroom space. To get to R1's sitting desk and bed R1 had to move around the tricycle and walk in between the narrow pathway. R1's four wheeled walker had been used to prop open R1's bathroom door. Inside of R1's bathroom was a bicycle that had been propped against the wall. R1's living room area showed a swivel chair and 1 of 5 legs were missing a wheel. R1 was observed sitting in the chair and said it was unstable. R1's bed had been placed to where the left side of the bed almost touched the wall. R1 was able to exit their bed from the left side. On the left side of the wall there was one horizontal grab bar and one vertical grab bar attached to the wall. R1 said they used the grab bars to assist them getting out of bed. At the end of R1's bed had a rail attached to half the bed. R1 said they used the rail to assist them getting out of bed. The right side of R1's bed showed there was a shoe rack and a box with a variety of household tools that impeded R1's ability to exit from the right side of their bed. In the corner of R1's room was a rolled-up mattress pad. R1 said they ordered the mattress pad but didn't think it would fit on their bed. R1 said they needed home health because they almost forgot how to walk. R1 put out their right arm and there were multiple bright red marks on the outer part of R1's arm. By R1's elbow it appeared the skin had somehow rubbed off as there was open flesh. R1 said they fell and caught themselves against the wall. R1 was unable to clarify when they almost fell and received the wound on their arm. R1 said their arm burned and they were going to put cortisone (medicated cream) on it. The inside of R1's right arm was noted to have a multicolored bruise on it by the bend of their elbow. R1 said they were always falling, and the facility staff were tired of hearing from them. R1 said when they reported falls, they were encouraged to go to the hospital. R1 said they did not want to go to the hospital because they did not have anyone to watch their cat. R1 said home health was supposed to start on Monday but they did not show. R1 mentioned a concern that their insurance did not pay for the home health service on time. There was a towel observed to be on the ground in the narrow pathway in between the tricycle and the kitchen. R1 had been observed wearing one sock on one foot and nothing on the other. R1 stepped on the towel and lost their footing. R1's arms had been observed to fly into the air as they attempted to regain their balance. R1's cane had been inside of their bathroom behind next to the door. R1 said they had been looking for it. R1 said the bicycle in the bathroom was motorized. R1 said they used both of their bicycles that were observed inside of the room. R1 acknowledged their room had tripping hazards inside of it.

In an interview on 08/08/2024 at 11:20 AM, Staff C, Caregiver, said R1 did not have memory impairments that they were aware of. Staff C said they had not been notified that R1 had any recent falls. Staff C said they were in R1's room earlier in the day to

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take their trash out. Staff C said that R1's room had been crowded. Staff C acknowledged R1 had multiple bicycles inside of their room that could be a tripping hazard.

In an interview on 08/08/2024 at 11:27 AM, Staff D, Caregiver said they covered a shift and did not often work with R1. Staff D said they provided R1 their medications. Staff D had knowledge about R1's fall that took place inside of the elevator. Staff D said R1's room had tripping hazards. Staff D said R1 got mad at facility staff if they tried to clean their room. Staff D said at one point they left R1's room because R1 started screaming when Staff D tried to clean it. Staff D was unsure if R1 getting upset when staff cleaned their room had been incorporated into R1's NSA. Staff D said to their knowledge housekeeping cleaned R1's room today 08/08/2024 or the day prior on 08/07/2024. Staff D said the facility staff could clean R1's room and the following day it would be messy. Staff D did not think the bicycles inside of R1's room had been a safety hazard as they thought R1 could maneuver around them.

In an interview on 08/08/2024 at 12:50 PM, Staff B acknowledged R1 had 3 falls in the month of July. Staff B noted the fall that took place outside of the facility at the store where a witness informed the facility staff R1 fell. Staff B said the other falls were associated with R1 not wearing socks or shoes and losing their footing. Staff B said facility staff encouraged R1 to wear socks and shoes to prevent falls. Staff B said R1 had a lot of clutter inside of their room. Staff B said housekeeping staff tried to help R1 declutter but R1 had been resistive to help. Staff B said the facility interventions should be in incorporated into R1's NSA. Staff B said they had to check R1's temporary service plan to see how often the facility staff attempted interventions.

In an interview on 08/08/2024 at 1:55 PM, Staff B confirmed R1's "Resident Assessment", review date 08/17/2023 was the most updated assessment for R1. Staff B confirmed they did not complete a new assessment after R1's 3 reported falls in July. Staff B confirmed R1's "NSA", dated 08/18/2023 was the most updated care plan for R1. Staff A, Executive Director, and Staff B said R1 refused the facility staff interventions. Staff A said they had cleaned and organized R1's room and the next day it would be unkept. Staff A said R1 would not allow the facility staff to remove items from their room. Staff A said it had been a surprise when R1 ordered their bicycle and it had got delivered to the facility. Staff A confirmed R1 rode their bicycles. Staff A confirmed R1 being resistive to care and services from the facility was not incorporated into R1's care plan. Staff B said the facility did not have a temporary service plan to review after R1's falls. Staff A said R1 did have a temporary service plan as they would use that to determine if another assessment was needed. Staff A said the facility created a temporary service plan for R1, but they refused all the services. Staff B did not have knowledge R1 had active wounds on their right arm.

Record review of R1's records showed there was no documented temporary service plan provided to review for R1 related to their falls on 07/01/2024, 07/22/2024, and 07/27/2024.

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Statement of Deficiencies Plan of Correction Page 9 of 14	License #: 2512 Woodland Village Licensee: Woodland Village Operations LLC	Compliance Determination # 45334 Completion Date 08/19/2024

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 Village is or will be in compliance with this law and / or regulation on (Date) October 30, 2024

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

Administrator (or Representative) 08/30/2024 Date

WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure all staff were fit tested for an N95 respirator (a device worn over the mouth and nose or entire face that prevents inhalation of dust, smoke, and other substances) for 2 of 3 Staff (Staff E and Staff F). The facility failed to ensure 2 of 2 facility staff (Staff C and Staff D) doffed (took off) PPE (personal protective equipment) accurately. This placed 47 of 47 residents and 55 staff at risk of a spread of an infectious disease.

Findings included...

WAC 296-842-14005 "Provide medical evaluations.
Medical Evaluation Process
Step 1: Identify employees who need medical evaluations AND determine the frequency of evaluations from Table 7. Include employees who:
(a) Are required to use respirators; or
Step 6: Obtain a written recommendation from the LHCP that contains only the following medical information:
(a) Whether or not the employee is medically able to use the respirator;
(b) Any limitations of respirator use for the employee;
(c) What future medical evaluations, if any, are needed;
(d) A statement that the employee has been provided a copy of the written recommendation"

WAC 296-842-15005
"Conduct fit testing.

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(1) Provide, at no cost to the employee, fit tests for ALL tight fitting respirators on the following schedule:
(a) Before employees are assigned duties that may require the use of respirators;
(b) At least every twelve months after initial testing;"

WAC 296-842-12010
"Keep respirator program records
(1) A written copy of the current respirator program must be kept by the employer.
(2) Keep each employee's current fit test record, if fit testing is conducted, until the next fit test is administered. Fit test records must include:
(a) Employee name;
(b) Test date;
(c) Type of fit-test performed;
(d) Description (type, manufacturer, model, style, and size) of the respirator tested;
(e) Results of fit tests, for example, for quantitative fit tests include the overall fit factor AND a print out, or other recording of the test.
(3) Keep training records that include employees' names and the dates trained.
(4) Keep written recommendations from the LHCP.
Reference: See chapter 296-802 WAC, Employee medical and exposure records, for additional requirements that apply to medical records.
(5) You must allow affected employees and their representatives to examine and copy records required by this section."

Record review of the document titled, ""L&I (Labor and Industries) and Department of Health (DOH) Respirator and Person Protection Equipment (PPE) guidance for Long Term Care: Employer responsiblities for respiratory protection program and provision of PPE", dated 03/30/2021, showed, "The Long-term care facilities (LTCF) are required to provide initial fit tests for each Health Care Worker (HCW) with the same model, style, and size respirator (N-95) that the HCW will be required to wear for protection against the COVID-19 [Corona Virus Disease 2019-a respiratory illness] and other airborne hazards. COVID-19 is 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. A "Fit test" is a procedure that tests the seal between the respirator's face piece and the HCW's face. It includes a medical evaluation and is completed by someone who is trained to fit test which takes a minimum of 15-20 minutes." The "fit test" is to be completed every 12 months."

Record review of the Department of Health document titled, "Respiratory Protection Program for Long-Term Care Facilities", undated, showed "providing your workforce with respiratory protection against respiratory hazards, such as the virus that causes COVID-19, is a safety standard regulated and enforced by the Washington Department

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of Labor and Industries (L&I). Employers have an obligation to protect their employees from hazards in the workplace (General Duty WAC 296-126-094). In healthcare facilities, the tight-fitting disposable 'N95' respirator is a commonly used for respiratory protection. Respirator fit testing ensures that tight-fitting respirators seal properly and helps protect employees from exposure to airborne particles such as viruses and bacteria. Keep your employees safe and working by getting them fit tested and ready to properly use a respirator."

Record review of the Department of Health document titled, "Taking PPE (personal protective equipment) Off", dated "August 2023", showed facility staff were to take their gowns and gloves off near the exit door and sanitize their hands before exiting. The facility staff were to remove eye protection, sanitize their hands, remove their respirator, and sanitize their hands before putting on another surgical face mask or respirator.

Record review of the Dear Provider (DP) Letter, dated 04/30/2021, ALF# 2021-024, titled, "Employer Responsibilities for Respiratory Protection Program and Provision of Personal Protective Equipment (PPE)", directed LTCF's under WAC 296-842-12005 to develop and maintain a respirator program which included initial fit testing and providing staff with their fit tested respirator.

Record review of the dear provider letter number 2023-014, dated 03/30/2023, showed that the Secretary of Health announced the order that required wearing a face covering in long term care facilities had ended on 04/03/2023. Despite that the order had ended the individuals in long-term care facilities, including residents, staff, and visitors, were required to continue to follow the Department of Health (DOH) and Centers of Disease Control and Prevention (CDC) guidance. Respiratory Protection Program (RPP) requirements were not changed by the ending of the Secretary of Health's order, nor would they change when the federal public health emergency ended on 05/11/2023. Staff would still be required to wear N95 respirators around individuals with suspected or confirmed COVID-19, and an RPP was required anytime a respirator was used in a long-term care facility. An RPP must include medical clearance, fit testing, training, written policies, and documentation.

Record review of the facility's policy titled, "Personal Protective Equipment" undated, showed employees were responsible to properly wear PPE. Employees would be trained on how to properly doff and wear PPE. N95 respirators would be worn when entering rooms in isolation and other activity that involved close contact with potentially infected people. A medical evaluation/clearance would be needed to determine if the use was physically fit to wear a respirator. Fit testing would be needed to determine which respirator model/size provided the proper fit to the user.

Record review of the facility's policy titled, "Respiratory Protection Program", undated, showed use of respirators at the facility were to protect against COVID-19 and other airborne diseases. The employees who were included in the program included certified nursing assistants, registered nurses, and caregivers. Every employee who needed to wear a respirator would complete a medical evaluation. All employees designated to

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use respirators would be fit tested in accordance with state and federal guidance. Respirator training included how to properly inspect, put on, seal check, use, and remove the respirator. Under record keeping showed a copy of the medical evaluation and latest fit testing results would be kept in the employee's personnel file.

Record review of the facility's untitled document, dated 08/04/2024 – 08/17/2024, showed Staff E, Caregiver, worked 08/04/2024 and 08/05/2024. Staff E had been scheduled to work 08/09/2024 – 08/12/2024, 08/16/2024 – 08/17/2024. Staff F, Caregiver, worked 08/07/2024 – 08/08/2024. Staff F had been scheduled to work 08/09/2024 – 08/10/2024 and 8/14/2024 – 08/17/2024.

Record review of the facility's document titled, "Meeting", dated 05/30/2024 showed fit testing had been reviewed during the meeting. Staff E had not been listed as a facility staff member in attendance.

Record review of the facility's document titled, "Meeting", dated 06/27/2024, showed compliance review had been reviewed during the meeting. Staff E and Staff F had not been listed as facility staff members in attendance.

Record review of the facility's document titled, "Meeting", dated 07/24/2024, showed regulatory requirements had been reviewed during the meeting. Staff E and Staff F had not been listed as facility staff members in attendance.

Medical Clearances/Fit Testing

Record review of the facility's, "Employee Hire Date", dated 08/08/2024, showed Staff E, Caregiver was hired on 05/02/2024.

Record review of Staff E, "Respirator Medical Clearance" dated 05/05/2024, showed Staff E had been medically cleared for unrestricted respirator use on 05/05/2024.

There were no records provided to review to show that Staff E had been fit tested to use a respirator.

Record review of the facility's, "Employee Hire Date", dated 08/08/2024, showed Staff F, Caregiver was hired on 06/26/2024.

There were no records provided to review to show that Staff F had a completed medical clearance and had been fit tested to use a respirator.

In an interview on 08/08/2024 at 11:45 AM, Staff A, Executive Director, said Staff E did

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not have their completed respirator fit test to review. Staff A said Staff F did not have their completed medical clearance or respirator fit test to review. Staff A said Staff F had been verbally reminded multiple times they needed to come to the facility during the day since they worked the night shift to complete the needed records. Staff A said Staff F had not attended facility all staff meetings where the facility reviewed medical clearance and fit testing requirements. Staff A said Staff E and Staff F had been on the schedule while the facility was in COVID-19 outbreak status.

Doffing PPE

In an interview on 08/08/2024 at 11:12 AM, Staff C, Caregiver, said when they entered a COVID-19 positive residents' room they wore a respirator, googles, a gown, and gloves while inside of the room. Staff C said when they doffed PPE, they took all of the PPE off inside of the COVID-19 positive residents' room and threw the items away in the resident's trash can. Staff C said they entered the hallway without any PPE.

In an observation on 08/08/2024 at 11:26 AM, Staff C had been observed outside of Resident 2 (R2)'s doorway. Outside of R2's doorway showed a tray of PPE available for the facility staff to use. Staff C had been wearing a surgical face mask. R2 opened their door and Staff C said they wanted to check in on R2. Staff C had been an arm's length away from R2. R2 said they were okay. Staff C reminded R2 the importance of quarantining inside of their room. R2 said they did not have intentions of leaving their room at this time.

In an interview on 08/08/2024 at 11:27 AM, Staff D, Caregiver said when they entered a COVID-19 positive residents' room they wore a respirator, googles, a gown, and gloves while inside of the room. Staff D said when they doffed PPE, they took all of the PPE off inside of the COVID-19 positive residents' room and threw the items away in the resident's trash can. Staff D said they entered the hallway without any PPE.

In an interview on 08/08/2024 at 10:30 AM, Staff A said when the facility staff had to go into a COVID-19 resident room before they exited, they would strip off their PPE and put it inside of the trash can located on the inside of the COVID-19 residents' door. Staff A confirmed there was only one trash can available on the inside of the resident's door facility staff could use.

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 Village is or will be in compliance with this law and / or regulation on (Date) October 31, 2024.

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

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Statement of Deficiencies Plan of Correction Page 14 of 14	License #: 2512 Woodland Village Licensee: Woodland Village Operations LLC	Compliance Determination # 45334 Completion Date 08/19/2024

Administrator (or Representative)

08/30/2024
Date

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