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

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

RE: Woodland Village License # 2512

Dear Administrator:

This letter addresses Compliance Determination(s) 51159 (Completion Date 12/06/2024) and 46629 (Completion Date 09/24/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/06/2024 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2600-1-b, WAC 388-78A-2600-2-i

The Department staff who did the on-site verification:
Celeste Vashey, ALF LTC 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

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodland Village
Provider Type: Assisted Living Facility
License/Cert.#: 2512
Compliance Determination #: 46629
Intake ID: 136884
Investigator: Pamela Horlick
Region/Unit #: RCS Region 3 / Unit E
Investigation Date(s): 09/04/2024 through 09/24/2024
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Report of resident representative being denied requested documents from the facility.
2. Injury of Unknown Origin: Report of a resident being found with a bruise on their eyelid and family not being notified.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 3 Closed records sample size: 0
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members
Record Reviews:	State reporting log Incident investigation Facility policies Care Plans Progress Notes TSP Face Sheet Characteristic Roster Supervisor Investigation

Investigation Summary:

1. Resident representative not concerned any longer regarding not being provided requested documentation. No failed practice identified.
2. Facility failed to monitor resident and contact residents representative after resident sustained injury from unknown origin. Failed Practice Identified.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2512	Compliance Determination # 46629
Plan of Correction	Woodland Village	Completion Date
Page 1 of 4	Licensee: Woodland Village Operations LLC	09/24/2024

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 09/04/2024 and 09/04/2024 of:

Woodland Village
2100 SW Woodland Circle
Chehalis, WA 98532

This document references the following complaint number(s): 136884

The following sample was selected for review during the unannounced on-site visit: 3 of 45 current residents and 0 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.

Cory Cisneros
Residential Care Services

09/30/2024
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.

Statement of Deficiencies	License #: 2512	Compliance Determination # 46629
Plan of Correction	Woodland Village	Completion Date
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Administrator (or Representative)

10/03/2024

Date

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(b) Provide the necessary care and services for residents, including those with special needs;

(2) The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

(i) To supervise and monitor residents, including accounting for residents who leave the premises;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to implement policies and procedures to monitor a resident and notify the family after an incident occurred for 1 of 3 residents, (Resident 1 [R1]). This failure placed R1's family at risk of being unaware of a potential injury and placed the resident at risk for unidentified care needs.

Findings included...

Record review of facility policy, titled, "Incident Report Policy," undated, stated, "Purpose: To inform the licensed nurse and the Executive Director of an unusual occurrence involving a resident receiving services in a Village Concepts managed community...An unusual event is any unexpected occurrence involving a resident, which caused and injury or had the potential for causing an injury...Procedure: The person that witnesses or hears of an unusual event concerning a resident will complete all aspects of the Unusual Occurrence form and Resident Alert form...Notify the appropriate people of the occurrence (Physician, family/guardian, ED [executive director], RCD [resident care director], Case worker)...Place the resident on alert and any other interventions as directed by the RCD/LN [Licensed Nurse]."

Record review of facility policy, titled, "Temporary Service Plans & Alert Charting Guidelines," dated 08/08/2022, showed, "This procedure outlines the process to address residents additional support due to a change in condition, hospitalization, etc. outside the negotiations service plan. Additional services may include monitoring, ADL assistance, housekeeping, or laundry services, etc...The care Director(s) and Executive Directors are responsible for implementing this policy...These parties are responsible for ensuring that all involved staff adhere to these policies." Under section, "Alert Charting: General Guidelines," it showed, "Alert Charting is appropriate under the conditions

outlined in this operating procedure...Alert charting is generally used to address conditions that are generally expected to be resolved in 4 days or less. If monitoring exceeds 4 days, consideration of a TSP should be initiated, or a new NSA generated accordingly."

Review of R1's face sheet, dated 11/07/2023, showed that R1 was admitted to the facility on [redacted]/2021.

Review of Department Records showed that a report was made on 07/01/2024, that showed R1 had bruising on their right eye, brow, and eyelid.

Record review of facility document titled, "Unusual Occurrence Report," showed "Date of Discovery" was 06/27/2024 at 7:00AM. Under "Describe what happened" it stated, "black eye was noticed the other day but looks worse and spread." Under notifications showed the RCD (Resident Care Director) was notified on 06/29/2024, Executive Director was notified on 06/29/2024, and R1's Primary Care Physician was notified in person on 06/28/2024. Family was not notified. Document was completed by Staff C, Medication Technician, on 06/29/2024, signed by the RCD and ED on 06/30/2024.

Record review of R1's progress note, dated 06/30/2024, showed staff reported a small thin purplish bruise on R1's right eye lid on 06/27/2024 at 0700. R1 stated they "didn't know they had a bruise to the eyelid." Staff reported observation to ED and RCD. Staff monitored R1 on 06/28/2024. Hospice notified and observed residents eye on 06/28/2024 per outside provider note. Family visit on 06/29/2024 and was concerned about the bruising to the right eye. The bruising had increased in size covering eyelid and outer edges of right eye. Due to family concerns and bruise to face, the findings were reported to the Department. There was no previous progress note entries on 06/29/2024, 06/28/2024, or 06/27/2024 indicating that a bruise to the eyelid was observed.

Record review of outside provider notes, dated 06/28/2024, showed the hospice nurse documented R1 was "noted to have bruising to right eye and no one seemed to know how."

Record review of document titled, "Temporary Service Plan," dated 06/30/2024, showed the "Reason for Temporary Services or Change to NSA," was for "Bruising of right eyelid." Start date to monitor was 06/30/2024 through 07/07/2024.

In an interview on 09/03/2024 at 3:30 PM, Collateral Contact 1 (CC1), R1's representative, was asked what they knew of the injury on R1, they stated while R1 was in memory care, they observed R1 to have a facial injury on their eye. CC1 stated it was black and blue and nobody reported it to them. CC1 stated they found out that the injury happened 2-3 days prior their visit to the facility on 06/29/2024.

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In an interview on 09/04/2024 at 2:09 PM, Staff D, Medication Technician, was asked what they would do if they found a resident to have an injury of unknown origin, they stated they would put them on alert to monitor them and let the next shift know what happened so that they were aware. Staff D stated they would report it to their supervisor, nurse and notify family and the resident's doctor. Staff D was asked if they would notify the family and doctor for a bruise, they stated, yes definitely.

In an interview on 09/04/2024 at 1:56 PM, Staff C, Medication Technician, was asked what they would do if they found a resident with an injury of unknown origin, they stated, they would put them on alert to do daily vitals and to assess whether the injury was getting better. Staff C was asked how long they would put them on alert for, they stated 4-5 days. Staff C stated they would fill out an unusual occurrence report documenting the details of the incident. Staff C was asked who they would notify, they stated the nurse, the family, and they would fax the doctor about the injury. Staff C was asked if they would notify family of a resident if there was a bruise or bump on the head, they stated yes. Staff C was asked if the family of R1 was notified of the injury, they stated no. Staff C stated they reported it to Staff B, Nurse and to Staff A, Executive Director.

In an interview on 09/04/2024 at 3:23 PM, Staff A, was asked what the expectation of staff was when a resident was found with an injury of unknown origin, they stated, staff were to report it to them and to Staff B, start an occurrence report, place them on alert and they were to notify the doctor and the family of the resident. Staff A was asked if they notified the family of R1 of the injury, they stated, the person who does the unusual occurrence report would have notified the family and they would have done the unusual occurrence report when the injury was discovered. Staff A was asked, if the injury was discovered on 06/27/2024 per the unusual occurrence report, would family have been notified on 06/27/2024, staff A stated yes. Staff A stated the family of R1 was not notified of the injury and they should have been notified by the end of the shift or by the end of the day.

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) ~~November 11th 2024~~ November 8th, 2024

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

Administrator (or Representative) — Date: 10/03/2024