STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

Sapphire at Woodway, LLC
Woodway Senior Living
1712 E Maplewood Ave
Bellingham, WA 98225

RE: Woodway Senior Living License # 2563

Dear Administrator:

This letter addresses Compliance Determination(s) 45556 (Completion Date 08/13/2024) and 40877 (Completion Date 07/09/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/13/2024 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-2660-1, RCW 70.129.050.1

The Department staff who did the on-site verification:
Judith Mellon, RN, Licensor

If you have any questions, please contact me at (360)651-6846.

Sincerely,

Kimberley Ripley, Field Manager
Region 2, Unit A
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Woodway Senior Living
Provider Type: Assisted Living Facility
License/Cert.#: 2563
Compliance Determination #: 40877
Intake ID: 129249
Investigator: Judith Mellon
Region/Unit #: RCS Region 2 / Unit A
Investigation Date(s): 05/06/2024 through 07/09/2024
Complainant Contact Date(s): 06/21/2024

Allegation(s):

1) A Named Resident's (NR) family members were not contacted and potentially violated HIPPA laws letting strangers in on details of the NR's death and did not contact family members.
2) The elevator was consistently out of order.
3) The NR had passed away. The NR had fallen forward and his legs were stuck under the wheelchair.
4) The facility toilets are not ADA compliant.
5) There is a concern on how the facility handled CPR.
6) Phone messages were left for the Assisted Living Facility (ALF), and no one responded to family.
7) The water fountain was out of order on the first floor of the facility.
8) There was a worn spot on the floor where the NR may have tripped on and fell.
9) A named person living nearby had stated that an unidentified Resident had tripped in the middle of the road, fell and the person helped get the unnamed Resident up and get them back to the facility.

Investigation Methods:

Sample:	Total residents: 67 Resident sample size: 0 Closed records sample size: 1
Observations:	Resident living quarters, staff response to resident care needs, facility bathrooms/toilets including adaptive equipment, elevator
Interviews:	Executive Director, Health and Wellness Director / Registered Nurse, Regional Nurse, Medication Technician, Resident Care Coordinators, Residents
Record Reviews:	Named Resident's medical records including face sheet, negotiated service agreement and assessments, facility investigation report

Investigation Summary:

1) The NR medical records identified the NR as their own power-of-attorney. The ALF's nurse stated information had been provided to the person listed on the NR’s old

information sheet and that the old information sheet was not the updated one, with current information. Failed practice was identified. A citation was issued for Washington Administrative Code 388-78A-2660 (1) Resident rights reference RCW 70.129.050 (1) Privacy and confidentiality of personal and medical records.
2) The elevator was previously not working, and repairs were made. The elevator was observed to work. No failed practice was identified.
3 & 5) Facility staff reported the NR was unresponsive in front of the TV stand with an unlocked wheelchair nearby. 911 was notified, CPR was initiated by facility staff and continued by emergency medical responders. No failed practice was identified.
4) The NR had a bedside commode and Staff stated the NR did not use the apartment's bathroom. Public restrooms on the ALF's first floor were provided for Visitors. ALF apartment bathrooms were observed and had safety handrails around the commodes and toilet seat risers for resident use. Staff stated residents were assessed for adaptive commodes, seat risers when needed. ALF Residents deny any concerns regarding the available commodes. No failed practice was identified.
6) The facility stated that they were unaware of phone messages not being responded to and had a meeting with family members of the NR. No failed practice was identified.
7) Facility Staff reported the water fountain was not working secondary to a prior COVID-19 outbreak. Staff reported while working with the local health authority during COVID-19, the fountain had been disconnected to prevent the spread of COVID-19. The Staff reported keeping the fountain off was to prevent infections of residents, staff and visitors. The facility reported all residents have access to water. No failed practice was identified.
8) The NR's apartment had a worn area observed on the floor. Facility staff reported the NR was unresponsive in front of the TV stand with an unlocked wheelchair nearby. The wheelchair and the NR were not near the worn area. No failed practice was identified.
9) Not able to substantiate. No returned calls from the Named Friend. ALF Staff reported not aware of any recent falls. No failed practice was 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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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

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 05/06/2024 and 06/06/2024 of:

Woodway Senior Living
1712 E Maplewood Ave
Bellingham, WA 98225

This document references the following complaint number(s): 129249

The following sample was selected for review during the unannounced on-site visit: 0 of 67 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Judith Mellon, RN, Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit A
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Kim Ripley
Residential Care Services

07/09/2024
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.

Administrator (or Representative) Date

RCW 70.129.050 Privacy and confidentiality of personal and medical records. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility to provide a private room for each resident however, a resident cannot be prohibited by the facility from meeting with guests in his or her bedroom if no roommates object.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interviews and record reviews the Assisted Living Facility (ALF) failed to maintain privacy and confidentiality for 1 of 1 deceased resident's (Resident 1) medical record. This failure resulted in a violation of the Health Insurance Portability and Accountability Act (HIPPA) rules and regulations, which protects individually identifiable health information.

Findings included…

The U.S. Department of Health and Human Services website showed that the HIPPA Privacy Rule protects most "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or medium, whether electronic, on paper, or oral. The Privacy Rule calls this information protected health information (PHI)2 (health information that can identify an individual).

Resident 1 was admitted to the ALF on [redacted]/2017 with multiple medical diagnoses including [redacted] and [redacted]. The resident record showed Resident 1 passed away on [redacted]/2024.

The negotiated service agreement (NSA) dated 06/13/2023 showed Resident 1 was independent with activities of daily living and ambulation.

On 05/06/2024 at 8:09 AM, Collateral Contact 1 (CC1), Anonymous stated that Staff A, Health and Wellness Director, had explained to CC1 that a female person, who identified as a family member, had requested medical information about Resident 1. CC1 stated that the

details of Resident 1's medical incident were reviewed with that person.

On 05/06/2024 at 2:52 PM, Staff A stated that Resident 1 was their own power-of-attorney and had two face sheets that listed emergency contacts. Staff A stated that a female person had been in the facility, stated they were family and spoke with Staff about Resident 1's medical information. Staff A stated that information was provided to the female person listed on the old face sheet.

On 05/06/2024 at 8:09 AM, CC1 stated that Resident 1 was their own Power-of-Attorney. CC1 stated Resident 1's information on the face sheet was updated a while ago and that the person listed on the face sheet was not Resident 1's Power-of-Attorney and should not have received any medical related information.

Review of Resident 1's medical record showed the Resident had two face sheets. The primary emergency contact information had been updated on the face sheet forms and the emergency contact changed from a female person to a male person.

Review of the ALF's incident report for Resident 1 showed a female emergency contact was notified, as was listed on the Resident 1's older face sheet when Resident 1 had a medical change in condition.

In an interview on 06/05/2024 at 1:45 PM, Staff B, Regional Registered Nurse stated that the Staff had used the old face sheet to notify the emergency contact. They had two and they just had pulled the old one.

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, Woodway Senior Living is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Administrator (or Representative) Date