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

12/11/2024

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

RE: Woodway Senior Living # 2563

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 51611 (Completion Date 12/11/2024) and 42808 (Completion Date 09/26/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/11/2024 and found no deficiencies.

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

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:

(b) The resident is relocated to a hospital or other health care facility; or

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(2) The resident or his or her legal representative has the right:

(a) Upon an oral or written request, to access all records pertaining to himself or herself including clinical records within twenty-four hours; and

WAC 388-78A-2430 Resident review of records.

(1) The assisted living facility must assemble all records pertaining to a resident and make them available to a resident within twenty-four hours of the resident's or the resident's representative's request to review the resident's records per RCW 70.129.030 .

The Department staff who did the On Site verification:
Syng To, ALF Complaint Investigator

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
Intake ID: 133242
Compliance Determination #: 42808
Region/Unit #: RCS Region 2 / Unit A
Investigator: Syng To
Investigation Date(s): 06/17/2024 through 09/26/2024
Complainant Contact Date(s): 06/12/2024, 10/08/2024

Allegation(s):

1) The Assisted Living Facility (ALF) did not notify the Named Resident's (NR) guardian for NR's hospitalization and death.
2) The ALF did not provide NR's medical records to their guardian.
3) The ALF staff was asked to forge NR's records.

Investigation Methods:

Sample:	Total residents: 62 Resident sample size: 3 Closed records sample size: 1
Observations:	Facility Residents
Interviews:	Administration Staff Resident's Representative Case Worker
Record Reviews:	Facility records Resident records

Investigation Summary:

Based on interviews and record reviews:
1) Both the ALF Administration and ALF staff stated the NR's guardian was not notified for NR's hospitalization. The ALF Administration stated the ALF was not aware of the NR's death until they received an inquiry from NR's guardian as they did not receive notification from the hospital. Record reviews showed the guardian's contact information was listed as the NR's substitute decision maker, care conference contact, emergency contact, guardian, durable power of attorney and responsible party for financial matters. A citation was issued for noncompliance with WAC 388 78A-2640(1)(b) Reporting significant change in a resident's condition.
2) The ALF Administration stated no medical records request was provided to the NR's guardian. Record reviews showed the ALF received the medical records request. A citation was written for noncompliance with WAC 388-78A-2430(1) Resident review of records.

3) No information for the allegation could be found. Interviewed ALF staff stated they did not have any information or concerns for the NR's records. Reviewed of NR's records showed the documentations were dated, timed, and signed by the ALF personnel. 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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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 06/17/2024 and 06/17/2024 of:

Woodway Senior Living
1712 E Maplewood Ave
Bellingham, WA 98225

This document references the following complaint number(s): 133242

The following sample was selected for review during the unannounced on-site visit: 3 of 62 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Syng To, ALF Complaint Investigator

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.

Residential Care Services

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

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:

(b) The resident is relocated to a hospital or other health care facility; or

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to notify and consult with the resident's representative for 1 of 3 residents (Resident 1) when Resident 1 had a change in health condition and relocated to a hospital. This failure resulted in Resident 1's Representative being unable to participate in medical decisions for Resident 1 while Resident 1 was at the hospital.

Findings included…

Record review of the ALF's policy titled, "Adverse Event Notification", dated May 2018, showed the policy was created to ensure the communication and collaboration for clinically significant events, notification of residents' adverse events was to occur promptly.

Resident 1 was admitted to the ALF on [redacted]/2022 with multiple diagnoses, including [redacted], and [redacted].

On 06/12/2024, at 02:00 PM, Collateral Contact 1 (CC1), Legal Guardian, stated that Resident 1 passed away at the hospital on [redacted]/2024 and they were not notified by the ALF when Resident 1 was sent to the hospital. On [redacted]/2024, they were told by Staff A, Executive Director, that Resident 1 was hospitalized on [redacted]/2024.

Reviewed of Resident 1's face sheet, dated 06/17/2024, showed CC1 was their substitute decision maker, care conference contact, emergency contact, guardian, durable power of attorney and responsible for Resident 1's financial matters.

Reviewed of Resident 1's progress notes dated [redacted]/2024 showed Resident 1 was taken to the hospital due to a medical condition at 06:00 PM.

Reviewed of Resident 1's progress notes dated [redacted]/2024 through 06/04/2024, showed no indication contact was initiated towards CC1, other than the one attempt that was made by Staff B, Med Tech, on [redacted]/2024. Resident 1's progress notes dated [redacted]/2024, showed Resident 1 passed away at the hospital the morning of [redacted]/2024.

On 06/17/2024, 01:29 PM, Staff A, Executive Director, stated that Resident 1 was sent to hospital due to blood coming from the genital area on [redacted]/2024 05:57 PM, and CC1 was not notified before or after Resident 1's hospitalization. Staff A stated Staff B, Medication Technician, called CC1, nobody answered the phone, and Staff B did not leave voicemail or messages to notify CC1 regarding Resident 1's situation. She was not aware of any other facility staff may had called or attempted to make any kind of contact to notify CC1 regarding Resident 1's condition change and hospitalization.

On 06/20/2024, 03:01 PM, Staff B, stated that on [redacted]/2024, they called CC1 to notify them regarding Resident 1's medical condition and hospitalization, but it went straight to voicemail recording. They did not leave a voicemail, and they notified Staff A and Staff C, Nursing Director about the situation and let them follow up.

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

RCW 70.129.030 Notice of rights and services -- Admission of individuals.

(2) The resident or his or her legal representative has the right:

(a) Upon an oral or written request, to access all records pertaining to himself or herself including clinical records within twenty-four hours; and

WAC 388-78A-2430 Resident review of records.

(1) The assisted living facility must assemble all records pertaining to a resident and make them available to a resident within twenty-four hours of the resident's or the resident's representative's request to review the resident's records per RCW 70.129.030 .

This requirement was not met as evidenced by:

Based on interviews and record reviews, the Assisted Living Facility (ALF) failed to release requested medical and personal records for 1 of 3 sampled resident's (Resident 1). This failure resulted in Resident 1's representative not having access to Resident 1's records.

Findings included…

Record review of the ALF's undated policy titled, "Medical Records Release/Disclosure Policy", page 2, showed in the event of a deceased patient, authorization for disclosure of Protected Health Information (PHI) may be made by the legal representative of the decedent's estate or a court appointed administrator. In some cases, family of the deceased may be entitled to copies of the patients record without additional documentation. On page 4, it showed for the release of records of the deceased, the deceased patient's records may be released based on the approval of the patient's personal representative such as an executor, administrator of an estate, or other person who has authority under the state or other law to act on behalf of the deceased individual or their estate. In some cases, if the individual has participated in the patient's care, paying for that care, or is otherwise known to the organization to be the designated representative of the patient, then records may be released upon approval of the Privacy Officer.

Resident 1 was admitted to the ALF on [redacted]/2022 with multiple diagnoses, including [redacted], and [redacted].

Review of Resident 1's medical records showed an assessment, negotiated service agreement, physician order for life-sustaining treatment (POLST) form and progress notes.

On 06/12/2024, 02:00 PM, CC1, stated that on [redacted]/2024 and [redacted]/2024, they called and emailed Staff A, Executive Director, and requested Resident 1's care notes, Physician Orders for Life Sustaining Treatment (POLST) Form, incident report, and they had only received one care note as of 06/12/2024.

Reviewed of Collateral Contact 1's (CC1), Legal Guardian, email communication between CC1 and Staff A dated [redacted]/2024, 05:01 PM, showed CC1 requested from Staff A a copy of Resident 1's past six months of chart notes, any emails (both internal and external) and any other documentation the ALF had on Resident 1. On [redacted]/2024, 03:23 PM, Staff A responded by providing one provider note and explained there were no progress notes in Resident 1's chart between March 24 and the event of last

Wednesday ([redacted]/2024).

On 06/17/2024, 01:29 PM, Staff A stated that the ALF's Medical Records policies for Resident Records was that the request must be made in writing and it had to be made by legally appropriate person who had the right to request them, like guardian or power of attorney. The records were to be sent upon request. CC1 had not requested any medical records after Resident 1 died, the ALF had not provided any records since no request was received from CC1.

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