WOODWAY INVESTORS LLC
WOODWAY SENIOR LIVING
1712 E MAPLEWOOD Ave
BELLINGHAM, WA 98225

RE: WOODWAY SENIOR LIVING License #2024

Dear Administrator:

The Department completed a follow-up inspection of your assisted living facility on March 12, 2018 for the deficiency or deficiencies cited in the report/s dated January 26, 2018 and found no deficiencies.

The Department staff who did the follow-up inspection:
Josemary Tonn, Licensor

If you have any questions please, contact me at (360) 651-6863.

Sincerely,

[Signature]

Jayne Hill, Field Manager
Region 2, Unit A
Residential Care Services
Residential Care Services
Investigation Summary Report

Provider/Facility: WOODWAY SENIOR LIVING (688424)  Intake ID(s): 3480709
License/Cert. #: AL2024
Investigator: Hochreiter, Robbie  Region/Unit: RCS Region 2/Unit B
Investigation Date(s): 01/11/2018 through 01/26/2018

Complainant Contact Date(s):

Allegations:
Allegations the call light system in the facility does not work well enough to ensure residents get help when they call for it.

Investigation Methods:

- **Sample:** 6 residents, 1 staff member.
- **Observations:** Environment, residents, resident/staff interaction, call light system.
- **Interviews:** Residents, staff, others not associated with the facility.
- **Record Reviews:** Resident records, incident reports, staff record, facility records.

Allegation Summary:
Allegations that the call light system does not work consistently were substantiated. The system was installed when the building was new. Residents have complained about the lights either not working or the staff was not able to turn them off after they were activated. The facility had tried several times to fix them.

Unalleged Violation(s): **Yes**  

Conclusion / Action:  
- **Failed Provider Practice Identified / Citation(s) Written**
- **Failed Provider Practice Not Identified / No Citation Written**

Residential Care Services
Investigation Summary Report

Provider/Facility: WOODWAY SENIOR LIVING (688424)  Intake ID(s): 3478041
License/Cert. #: AL2024
Investigator: Hochreiter, Robbie  Region/Unit: RCS Region 2/Unit B  Investigation Date(s): 01/11/2018 through 01/26/2018

Complainant Contact Date(s):

Allegations:
1. Allegations that there were staff who were unprofessional and gruff with residents, refusing to help with requests.
2. Allegations that a resident recently passed away after a fall.
3. Allegations a resident vomited in the living room and again in his/her room and was not evaluated.

Investigation Methods:
- Sample: 7 residents, 1 staff member.
- Interviews: Residents, staff, others not associated with the facility.
- Observations: Environment, residents, resident/staff interaction.
- Record Reviews: Resident records, incident reports, staff record, facility records.

Allegation Summary:
1. Allegations that there were staff who were unprofessional or gruff with residents could not be substantiated. In interviews with residents, none had complaints about staff. One staff was found to have neglected residents and had been placed on administrative leave. An investigation had not been documented and the allegations had not been reported to the department hotline.
2. Allegations a resident had passed away after a fall were not substantiated. A resident had been deteriorating, attempted to self-transfer and fell. He went to the hospital and then on to rehabilitation.
3. Allegations a resident who vomited several times was not evaluated were not substantiated. The named resident's record contained documentation about the incident. She was monitored through the night and did not have any further episodes.

Unalleged Violation(s): Yes

Conclusion / Action: Failed Provider Practice Identified / Citation(s) Written
Residential Care Services  
Investigation Summary Report

Provider/Facility: WOODWAY SENIOR LIVING (688424)  
Intake ID(s): 3476859
License/Cert. #: AL2024
Investigator: Hochreiter, Robbie  
Region/Unit: RCS Region 2/Unit B  
Investigation Date(s): 01/11/2018 through 01/26/2018
Complainant Contact Date(s):

Allegations:
1. Allegations the housekeeper did not have cleaning supplies.
2. Allegations the facility had 2 washer/dryers that were not able to keep up with all the facility and resident laundry. One dryer was frequently out of service.
3. Allegations the facility had no hand-washing stations other than in the kitchen and a downstairs public restroom.

Investigation Methods:
- **Sample:** 7 residents, 1 staff member.
- **Observations:** Environment, residents, resident/staff interaction.
- **Interviews:** Residents, staff, others not associated with the facility.
- **Record Reviews:** Resident records, incident reports, staff record, facility records.

Allegation Summary:
1. Allegations the housekeeper did not have cleaning supplies were not verified. The housekeeper stated he always had the supplies he needed. He monitored his supplies and when he began to run low, he notified the administrator to order new supplies. The janitor room had adequate amounts of cleaning products.
2. Allegations the facility only had 2 washers and 2 dryers for the entire facility were verified. Allegations one dryer was frequently out of service were verified. Both washers and both dryers were observed to be in working condition at the time of the investigation.
3. Allegations the facility had no hand-washing stations available to staff were not verified. There were bottles of hand sanitizer on the medication carts and gloves available to caregivers and medication technicians. All resident rooms had sinks that were stocked with soap and paper towels.

Unalleged Violation(s): **Yes**

No failed practice related to the allegations identified.
Residential Care Services
Investigation Summary Report

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<th>Provider/Facility:</th>
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| Allegations:              | Allegations a caregiver neglected a resident. |

### Investigation Methods:

- **Sample:** 7 residents, 1 staff member.
- **Interviews:** Residents, staff, others not associated with the facility.

- **Observations:** Environment, residents, resident/staff interaction.
- **Record Reviews:** Resident records, incident reports, staff record, facility records.

### Allegation Summary:

Allegations a named caregiver left a resident sitting in her urine without providing incontinence care were substantiated. Another caregiver gave a written description of the incident to the administrator. The alleged perpetrator was put on administrative leave pending an investigation. The administrator spoke with other caregivers who worked with or after the AP. All staff interviewed by the administrator said it was harder to work with the AP than do everything alone because so much was left undone. The AP remained on administrative leave and was facing termination. The investigation was not documented as required.

### Unalleged Violation(s):


### Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: WOODWAY SENIOR LIVING (688424)  Intake ID(s): 3475546
License/Cert. #: AL2024
Investigator: Hochreiter, Robbie  Region/Unit: RCS Region 2/Unit B
Investigation Date(s): 01/11/2018 through 01/26/2018

Complainant Contact Date(s):

Allegations:
Allegations a named caregiver neglected a resident.

Investigation Methods:
- **Sample:** 7 residents, 1 staff member.
- **Interviews:** Residents, staff, others not associated with the facility.
- **Observations:** Environment, residents, resident/staff interaction.
- **Record Reviews:** Resident records, incident reports, staff record, facility records.

Allegation Summary:
Allegations a named caregiver put a resident to bed in his/her clothing without providing incontinence care were substantiated. Another caregiver gave a written description of the incident to the administrator. The alleged perpetrator was put on administrative leave pending an investigation. The administrator spoke with other caregivers who worked with or after the AP. All staff interviewed by the administrator said it was harder to work with the AP than do everything alone because so much was left undone. The AP remained on administrative leave and was facing termination. The investigation was not documented as required.

Unalleged Violation(s): Yes  No


Conclusion / Action:
- **Failed Provider Practice Identified / Citation(s) Written**
- **Failed Provider Practice Not Identified / No Citation Written**

Residential Care Services
Investigation Summary Report

Provider/Facility: WOODWAY SENIOR LIVING (688424)  Intake ID(s): 3472895
License/Cert. #: AL2024
Investigator: Hochreiter, Robbie  Region/Unit: RCS Region 2/Unit B
Complainant Contact Date(s):

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<th>Date(s)</th>
<th>Investigation Date(s): 01/11/2018 through 01/26/2018</th>
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Allegations:
Allegations a resident fell and no staff came to assist him/her.

Investigation Methods:

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Allegations a resident fell and no staff came to assist him/her.

Allegation Summary:
Allegations a resident was not assisted after she fell could not be substantiated. The named resident stated he/she fell in an area of the building that had no call lights. Another resident walked by and appeared to go for help. When no one came, the resident got up on his/her own. He/she had no injuries. The resident who walked by was observed in a room playing cards with friends and had not gone for help. There were no staff in the area where the resident fell so they were not aware of the fall.

Unalleged Violation(s):  Yes  No

Conclusion / Action:

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No failed practice identified related to the allegations.
You are required to be in compliance at all times with all licensing laws and regulations to maintain your assisted living facility license.

This document references the following complaint numbers: 3472895, 3475546, 3475585, 3476859, 3478041, 3480709
The department has completed data collection for the unannounced on-site complaint investigation on 1/11/2018 and 1/12/2018 of:
WOODWAY SENIOR LIVING
1712 E MAPLEWOOD Ave
BELLINGHAM, WA 98225

The following sample was selected for review during the unannounced on-site complaint investigation: 6 of 56 current residents and 0 former residents.

The department staff that inspected and investigated the assisted living facility:
Robert Hoehreiter, BSN, RN, AFH/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
(360)651-6863

As a result of the on-site complaint investigation 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 I must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative)
Date
WAC 388-78A-2700 Safety measures and disaster preparedness.
(2) The assisted living facility must:
(c) Investigate and document investigative actions and findings for any alleged or suspected neglect or abuse or exploitation, accident or incident jeopardizing or affecting a resident's health or life. The assisted living facility must:
(i) Determine the circumstances of the event;
(ii) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and
(iii) Protect other residents during the course of the investigation.

This requirement was not met as evidenced by:
Based on interviews and record reviews, the facility failed to document an investigation of allegations of neglect of a resident by a caregiver. This failure placed residents at risk of future neglect.

Findings include:

On 1/12/18, record review revealed Staff B was hired on 7/6/17 to work as a caregiver. Two written complaints alleging neglect were found in his employee file.

On 12/15/17, Staff C wrote a complaint about Staff B that said Staff B put Resident 5 to bed for the night without dressing her for bed or changing her soiled incontinence product. She was observed that evening wandering the 1st floor wearing only soiled briefs. In addition, Staff B put Resident 6 to bed fully clothed and in wet briefs. He stated other staff confirmed this was a regular problem with Staff B.

On 12/29/17, Staff D submitted a written complaint about Staff B that said on 12/23/17, Staff B told her he would put out the trash and assist a couple of residents to bed. Staff D found that Staff B had not taken out the trash, and had but Resident 6 to bed in her clothes and soiled briefs. Staff B said Resident 6 refused to allow him to assist her. Resident 6 was said to have been covered in dried feces that was hard to scrub off. Staff D said it was easier to work alone that with Staff B.

The administrator said she had interviewed multiple staff who all said Staff B did not complete his assignments and left residents in soiled clothes and incontinence products. The administrator said Staff B was on administrative leave for the complaints and because e had not followed through on registering to take the Home Care Aide Certification test.

The administrator said she had not completed a written investigation about the allegations of neglect by Staff B.

This is a repeat citation from a full inspection on 10/25/17.
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) 2-1-2018. In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

I understand that to maintain an assisted living facility license, the facility must be in compliance with the licensing laws and regulations at all times.

Administrator (or Representative)  2-1-2018

WAC 388-78A-2630 Reporting abuse and neglect.
(1) The assisted living facility must ensure that each staff person:
(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:
Based on interviews and record reviews, the facility failed to report allegations of neglect of a resident by a caregiver to the department's hotline. This failure placed residents at risk of future neglect.

Findings include:

Record review revealed Staff B was hired as a caregiver on 7/6/17. Two documents alleging neglect were found in his employee file.

On 12/15/17 Staff C submitted written allegations of neglect against Staff B to the administrator. The allegations were that Staff B put Resident 5 to bed without dressing her for bed or changing her soiled incontinence product. Additionally, the complaint alleged Staff B put Resident 6 to bed in her day clothes and wet incontinence product.

On 12/29/17, Staff D submitted a written allegation of neglect against Staff B to the administrator. Staff D said that on 12/23/17, Staff B had told her he would take out the trash and put a couple of residents to bed. Staff D found that Staff B had not taken out the trash. Resident 6 had been put to bed in her day clothes with a soiled brief and the feces had dried on her skin, making it hard to scrub off.

On 1/12/18, the allegations had not been called into the department hotline.
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) 1-21-18. In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

I understand that to maintain an assisted living facility license, the facility must be in compliance with the licensing laws and regulations at all times.

Administrator (or Representative) 2-1-2018

WAC 388-78A-2930 Communication system.

(1) The assisted living facility must:
(a) Provide residents and staff persons with the means to summon on-duty staff assistance:
(i) From resident units;
(ii) From common areas accessible to residents;
(iii) From corridors accessible to residents; and
(iv) For assisted living facilities issued a project number by construction review services on or after September 1, 2004 for construction related to this section, all bathrooms, all toilet rooms, resident living rooms and sleeping rooms.

This requirement was not met as evidenced by:
Based on observations and interviews, the facility failed to repair or replace an old call light system which worked inconsistently causing residents to not know if their call for help was received. This failure placed residents at risk of not receiving help when they need it.

Findings include:

The assisted living facility is licensed to care for 65 residents. 
On 1/12/2018, 56 assisted living residents were living in the facility on 3 floors. 
The administrator stated the call light system was the original system installed when the building was new (1989), and has been worked on several times.

Observation revealed when a resident uses their call light, there is a repeating sound and a light. 
The call light box in the administrator's office signals the resident's call. A message to caregivers and the medication technician goes out over a walkie-talkie. When the caregiver arrives at the resident's room, a message goes over the walkie-talkie requesting the call light be turned off in the administrator's office. Resident interviews revealed the call light does not always turn off
and will continue to sound in the resident's room. There was no way for the resident to call the caregiver when the light was stuck on.

Interviews with residents and staff revealed the call light system did not always work properly.

Resident 1 stated the call lights do not work and the facility was trying to fix them.

Resident 2 said no one comes when she pulls the call light.

Resident 3 said no one comes if you use the call light, you have to go in search of a caregiver if you need help.

**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) 3-1-18. In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

I understand that to maintain an assisted living facility license, the facility must be in compliance with the licensing laws and regulations at all times.

[Signature]
Administrator (or Representative)  
[Date] 2-1-18