

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2024
NAME OF PROVIDER OR SUPPLIER Woodland Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 678 3rd Street Woodland, CA 95695	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49950</p> <p>Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) was free from abuse when he was struck in the head and chest several times by Resident 2.</p> <p>This failure had the potential to result in serious physical harm.</p> <p>Findings:</p> <p>According to Resident 1's admission record, he was admitted on [DATE] with diagnoses that included Degeneration of Nervous System Due to Alcohol (trouble with balance and body coordination due to chronic alcohol use) and anxiety.</p> <p>A Minimum Data Set (MDS, an assessment tool), dated 4/24/24, indicated Resident 1 had no memory impairment.</p> <p>A nursing note, dated 6/9/24, indicated Resident 1 had been involved in a resident to resident altercation on 6/8/24. The note indicated Resident 1 had been hit in the chest and head area 4-5 times by Resident 2.</p> <p>According to Resident 2's admission record, he was last admitted on [DATE] with diagnoses that included Antiphospholipid Syndrome (a disorder of the immune system that can cause blood clots) and stroke.</p> <p>A MDS, dated [DATE], indicated Resident 1 had no memory impairment.</p> <p>A nursing note, dated 6/9/24, indicated Resident 2 had been involved in a resident to resident altercation on 6/8/24. The note indicated Resident 2 was seen by staff having an altercation with Resident 1.</p> <p>In an interview, on 6/24/24 at 10:43 a.m., Resident 1 stated he was in the smoking area and Resident 2 was trying to bum cigarettes and a lighter from other residents. Resident 1 stated he told Resident 2 to, Knock it off, and Resident 2 began to swing and struck him in the head. Resident 1 denied hitting Resident 2.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview, on 6/24/24 at 10:48 a.m., Resident 2 confirmed he had hit Resident 1 but, stated Resident 1 had hit him first.</p> <p>In an interview, on 6/24/24 at 10:57 a.m., Licensed Nurse 1 (LN 1) stated Resident 1 and Resident 2 had been in an altercation on 6/8/24 around 10 p.m., on the smoking patio. LN 1 stated Resident 2 had a history of aggressive behavior toward other residents, and she had heard cursing between the two and saw Resident 2 punch Resident 1 in the face twice.</p> <p>In an interview, on 6/24/24 at 12:11 p.m., the Social Services Director (SSD) confirmed that there was an altercation between Resident 1 and Resident 2. The SSD agreed that the altercation was abuse regardless of who started the altercation.</p> <p>In an interview, on 6/24/24 at 12:22 p.m., the Director of Nursing (DON) confirmed there had been a resident to resident altercation between Resident 1 and Resident 2 on 6/8/24. The DON agreed that it was abuse when Resident 2 punched Resident 1.</p> <p>A review of the facility's policy titled, Elder/Dependent Adult Abuse, revised 7/17, stipulated, This facility will protect the rights, safety and wellbeing of each resident (regardless of physical or mental condition), for whom we provide care and treatment against any and all forms of physical, verbal, sexual, mental abuse .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>49950</p> <p>Based on interview and record review, the facility failed to ensure an allegation of abuse was reported within the required timeframe for two of four sampled residents (Resident 1 and Resident 2) when an allegation of abuse was not reported to the Department until the following day.</p> <p>This failure to report timely had the potential to compromise resident health and safety.</p> <p>Findings:</p> <p>A review of a facility document, Report Of Suspected Dependent Adult/Elder Abuse , dated 6/8/24 and received by the Department on 6/9/24, indicated an allegation of suspected abuse had been made related to a resident to resident altercation between Resident 1 and Resident 2.</p> <p>In an interview, on 6/24/24 at 12:22 p.m., the Director of Nursing (DON) stated it was the facility's policy to report an allegation of abuse to the Department within 2 hours. The DON 1 confirmed the 6/8/24 allegation had not been reported to the Department until 6/9/24.</p> <p>A review of the facility's policy titled, Elder/Dependent Adult Abuse, revised 7/17, indicated reports of physical abuse would be made within two hours to the Department.</p>