

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  08/20/2025
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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to follow their Policy and Procedures to process a refund for one of four sampled residents (Resident 1) when the resident's share of cost (the amount of money an individual is responsible to pay towards their medical related services, supplies, or equipment before Medi-Cal will begin to pay) was not returned to the family within 60 days upon Resident 1's death. This failure had the potential to result in fiduciary abuse and a violation of Resident 1's rights. Findings: A review of Resident 1's admission Record indicated; Resident 1 was admitted to the facility in 2020 with a diagnoses that included Encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition). The admission Record further indicated Resident 1 was their own responsible party. A review of Resident 1's Minimum Data Set (MDS - an assessment tool used to guide care) Cognitive (having full understanding) Patterns, dated [DATE], indicated Resident 1 had a Brief Interview for Mental Status (a tool to assess a person's full understanding) score of 14 which indicated Resident 1 had full understanding. During an interview with the Business Office Manager (BOM) on [DATE] at 10:57 a.m., the BOM stated the Business Office records indicated \$187.97 was owed to Resident 1's family. The BOM further stated, I didn't know why the money has not been returned. During a concurrent interview and record review with the BOM on [DATE] at 12:17 p.m., the BOM stated, Our policy indicated the money should have been returned to the family within 60 days of Resident 1's death. During an interview with the Administrator (ADM) on [DATE] at 12:32 p.m., the ADM stated, The expectation is that we follow our policy and if the policy says we should have returned the money within 60 days, then we are at fault. During a concurrent interview and record with the ADM and BOM on [DATE] at 12:37 p.m., the ADM and BOM verified Resident 1 expired on [DATE] and as of [DATE], Resident 1's money has not been returned within the 60 days as per there policy. A review of the Business Office records indicated Resident 1 had a Share of Cost overpayment owed back to them of \$187.97 for the month of [DATE]. A review of the Outstanding Account report indicated, the BOM had first corresponded with the complainant on [DATE] at 2:42 p.m. The BOM noted complainant, Asked about refund for Share of Cost. A review of the facility policy titled, A/R Refunds Policy and procedure dated 6/2023 indicated, Overpayments shall be refunded no later than 60 days from when the overpayment was identified, according to CMS 6037-F Final Rule .</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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