STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385150	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodside Post Acute	301 Ridings Avenue Molalla, OR 97038

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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42222 Based on observation, interview and record review it was determined the facility failed to provide care and assistance to prevent accidents for 1 of 5 sampled residents (#1) reviewed for accidents. This placed residents at risk for unmet care needs. Findings include: Resident 1 was admitted to the facility in 10/2024 with diagnoses including traumatic brain injury and anxiety disorder. Resident 1's MDS 5-Day assessment dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment. Resident 1's revised Care Plan dated 11/11/24 revealed she/he was at risk for falls related to her/his immobility. Care plan interventions were to anticipate and meet needs, educate and remind the resident to call for assistance with all transfers and to provide verbal cues for assistance. On 1/31/25 the facility submitted a report to the State Agency which revealed Resident 1 was found with her/his legs hanging off the bed. Resident 1's left leg was observed lying on the baseboard heater and Staff 4 (CNA) immediately placed the resident's legs back on her/his bed. Staff 4 observed redness and what appeared to be a burn on the resident's leg. Staff 3 (LPN) was notified and provided care to the wound. Resident 1 was unable to tell staff what happened due to her/his confusion. On 2/4/25 at 12:30 PM, Staff 3 stated she was the nurse on duty the day of the incident on 1/31/25. She stated in late afternoon, Staff 4 informed her he had found the resident with her/his legs dangling off the bed touching the heating unit which resulted in a burn on the resident's leg. She immediately went to the resident's room and observed the resident's bed was really close to the heating unit, approximately 1 to 2 feet away. She told Staff 4 that was too close to the heating unit and they moved the bed away from it. Staff 3 stated she examined Resident 1's lower left leg and noted the skin was red, slightly peeled and the wound appeared to be a burn. Staff 3 treated the wound, bandaged it and stated the resident was fine, was conversing and seemed okay. She stated she did not observe any other objects around the resident's bed that could have caused the injury and in her opinion the wound appeared to be a burn. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385150	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodside Post Acute	301 Ridings Avenue Molalla, OR 97038

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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/25 at 1:34 PM, Staff 5 (CNA) stated he was familiar with Resident 1 and the resident frequently tried to get out of bed. He stated care plan interventions were to offer to get the resident up and in her/his wheelchair and to make sure no objects were around or blocking the bed due to Resident 1's fall risk. He stated the resident moved her/his legs around frequently. On 2/4/25 at 1:40 PM, Staff 6 (Housekeeping) stated she was familiar with Resident 1 and she/he frequently swung her/his legs off the bed. She stated residents' beds were supposed to be 3 feet away from the heaters. On 2/4/25 at 2:00 PM, Staff 7 (CNA) stated she was familiar with Resident 1 and she/he was a wiggle worm, frequently wiggled around in the bed and staff frequently did checks on her/him. She stated she had not heard of any incidents of this type in the year and a half she had worked at the facility. On 2/4/25 at 2:25 PM, Staff 4 stated he was Resident 1's assigned CNA on 1/31/25, and heard the resident calling for help. Staff 4 went into Resident 1's room and observed her/him in bed, with both legs off the bed and her/his hands holding onto the bed rail. Staff 4 stated he observed the resident's lower left leg was lying on the top of the heating unit and Resident 1 acted like she/he was in pain, saying help me. Staff 4 moved the resident's legs onto the bed, observed the injury on the leg and immediately left to find Staff 3, who was in another resident room. When Staff 3 was available, she and Staff 4 went back to Resident 1's room and Staff 4 stated he observed the skin on the lower left leg peeling back a little. Staff 4 stated the skin touching the heating unit was where the injury was and he did not observe any other objects between the resident's bed and the heating unit which could have caused the injury. Staff 4 stated the resident's bed was close to the heating unit and demonstrated the distance of approximately 1 foot between the heating unit and the resident's bed. Staff 4 did not recall how long the resident's bed had been near the heating unit. On 2/4/25 at 3:40 PM, Staff 2 (DNS) stated she had provided wound care to Resident 1 earlier in the afternoon and the wound's measurements were 4.5 cm long and 2.4 cm wide. The resident reported no pain during the wound care. Observations were made of Resident 1 on 2/4/25 from 11:00 AM through 4:00 PM. Resident 1 was observed in bed with a bandage on her/his lower left leg but was not interviewed due to her/his confusion. Random audits were completed on 2/4/25 of baseboard heaters throughout the day with Staff 8 (Maintenance Director). An infrared heat detector was utilized to obtain temperatures, which were found to be under 120 degrees Fahrenheit. Resident 1's heating unit was very warm to the touch on the top of the unit. Staff 8 stated he completed weekly audits of the heating units and provided reports that confirmed his weekly audits. On 2/5/24 at 4:00 PM, Staff 1 (Administrator) and Staff 2 (DNS) were informed of the findings of the investigation and provided no additional information.