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	07/24/2025

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to timely administer CPR for 1 of 3 sampled residents (#1) reviewed for CPR. This failure, determined to be an immediate jeopardy situation, resulted in Resident 1 receiving emergency CPR 13 to 20 minutes after Resident 1 was found unresponsive. This placed all residents at risk for not receiving timely CPR and constituted substandard quality of care. Findings include: The facility's [DATE] Policy and Procedure on Code Status and CPR stated in the event of a medical emergency where a resident is observed not breathing a staff member should initiate the following steps: - Call for help and bring crash cart to the area;- First CPR responder will verify code status of the resident in the EHR;- If the resident is full code, CPR will be initiated and 911 will be called. CPR will be continued until EMTs arrive to take over CPR.Resident 1 was admitted to the facility in 7/2025, with diagnoses including hemiparesis and tracheostomy. Resident 1's POLST status was identified as Full Code, which required CPR. Resident 1's [DATE] Care Plan identified the resident was at risk for complications of hypoxia related to acute and chronic respiratory failure, which included altered levels of consciousness.The facility's Investigation Report indicated that on [DATE] at around 9:30 AM, staff noticed Resident 1 was non-responsive and sought assistance from nursing. The nurse on scene indicated a response time of 10 to 20 minutes after the resident's initial assessment. Resident 1 was identified to be a full code status. The nurse's delay in initiating CPR resulted in an extensive delay of immediate lifesaving treatment for Resident 1. Per Resident 1's Progress Note dated [DATE] at 11:04 AM, Staff 5 (CNA) noted between 9:20 and 9:30 AM, Resident 1 was unresponsive to physical and verbal stimulation and reported the concern to Staff 4 (LPN). Staff 4, upon examination, declared Resident 1 dead at 9:33 AM. Staff 4 contacted Staff 2 (DNS) between 9:35 AM to 9:40 AM for further instruction, and from 9:40-9:45 AM, Staff 2 instructed Staff 4 to gather DNR status, start CPR, and call EMS. On [DATE] at 1:20 PM, Staff 4 (LPN) stated he did not initiate CPR lifesaving services due to his belief that the resident was already deceased . Staff 4 stated he determined Resident 1 deceased as of 9:33 AM due to the resident's lack of physical or verbal stimulation and yellowing of the skin near the resident's face. Staff 4 stated that around 9:42 AM, he received instructions from Staff 2 to check Resident 1's code status and initiate CPR. Staff 4 confirmed he began initiating CPR between 13 and 20 minutes after receiving direction from Staff 2 (DNS). Staff 4 further confirmed he did not call a Code Blue and did not check on Resident 1's code status because he declared Resident 1 had passed away. On [DATE] at 1:57 PM, Staff 5 (CNA) stated he was the care staff member who discovered Resident 1 was nonresponsive and had called for immediate assistance. Staff 5 stated he had noticed Resident 1 looked yellow and was nonresponsive. Staff 5 reported to Staff 4 of the event and further stated Code Blue and CPR was not initiated as Staff 4 believed Resident 1 was dead. Staff 5 stated he saw Resident 1 still conscious around 8:40 AM with no signs of concern. On [DATE] at 2:50 PM, Staff 6 (LPN) stated she was the additional nurse called to the emergency. Staff 6 stated at least 10 minutes or longer had passed between the time Resident 1 was assessed to when CPR services had begun. Staff 6 stated a Code Blue had not been called, but Staff 6 had contacted 911 for emergency services. On [DATE] at 3:07 PM, Staff 2 (DNS) stated that around 9:30 AM, Staff 4 contacted Staff 2 to request if law enforcement or if family needed to be contacted as Resident 1 had been determined by Staff 4 to be deceased . Staff 2 requested Staff 4 to begin CPR services after Resident 1's code status was determined. On [DATE] at 1:30 PM, Staff 1 (Administrator) confirmed the facility did not initiate CPR services in a timely manner to Resident 1. On [DATE] at 4:06 PM, the facility was notified of the Immediate Jeopardy (IJ) situation and immediacy removal plan was requested. On [DATE] at 5:19 PM, the facility submitted an acceptable immediacy removal plan.The deficient practice was identified as Past Noncompliance based on the following:On [DATE], the deficient practice was identified by the facility to be corrected when the facility completed a root causes analysis of the incident and determined there was a delay in initiating and conducting CPR. The Plan of Correction included:Re-educating LNs on the process of verifying code status, including POLST or physician orders when residents were observed with no pulse or respirations. All LNs were reeducated before their oncoming shift including float and agency LNs on emergency response.Medical records conducted audits on all new residents for a signed POLST or physician's order to determine resident's status until substantial compliance was met. Daily audits were immediately implemented to ensure proper initiation of emergency CPR services were provided during mock code blue for all shifts with no deficient practice found.