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	03/18/2026

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review it was determined the facility failed to investigate allegations of sexual abuse for 3 of 3 sampled residents (#s 102, 103, and 108) reviewed for allegations of sexual abuse. This placed all residents at risk for sexual abuse and constituted substandard quality of care. A determination was made that the facility's noncompliance placed Residents 102, 103, and 108 in immediate jeopardy, beginning on 3/17/26.On 3/17/26 at 2:12 PM, Staff 14, Staff 15 (Regional Directors of Clinical Service), and Staff 2 (DNS) were notified of the immediate jeopardy (IJ) situation and provided a copy of the IJ template related to the facility's failure to investigate allegations of sexual abuse. Findings include: Resident 105 was admitted to the facility in 2025 with diagnoses including stroke affecting the non-dominant side, and depression. Resident 105's 11/2025 MDS indicated the resident was cognitively intact and used a wheelchair for mobility.1. Resident 102 was admitted to the facility in 2025 with diagnoses including cognitive loss related to pathological development (cognitive status equal to a young child), legal blindness, and non-verbal communication.On 3/4/26 at 9:55 AM, Staff 11 (Anonymous Complainant) reported that a night shift CNA placed Resident 102 on Alert Charting as they believed Resident 105 had performed or attempted to perform sexual acts on Resident 102. Staff 11 believed this due to Resident 102's briefs being ripped open; the resident was crying and did not want her/his brief changed. Staff 11 said Resident 105 was placed on alert for inappropriate behavior, the incident was reported to facility management, and no investigation was completed.On 3/9/26 at 2:21 PM, Staff 8 (CNA) stated she was not happy that no action was taken by management when they were told about Resident 102's brief being torn and the resident did not want to be touched or have her/his brief changed. Staff 8 stated she told the Nurse and spoke to the Human Resources department, Staff 2 (DNS) and Staff 1 (Administrator). Staff 8 said she reported Resident 105 was being sexually inappropriate and had attempted sexual behaviors with multiple residents.On 3/11/26 at 8:03 AM, Staff 7 (Social Service Director) stated she was aware of Resident 105's behaviors and the possible sexual contact with Resident 102. Staff 7 stated Staff 1 was aware of this incident of potential abuse.On 3/11/26 at 11:10 AM, Staff 6 (Social Service Director) stated she was told about the incident involving Resident 102 during a morning meeting attended by Staff 1 and Staff 2.On 3/10/26 at 10:30 AM and 3/11/26 at 12:11 PM, Staff 1 stated he had spoken to staff and believed the incident with Resident 102 and Resident 105 was based assumptions by other staff and no investigation was completed.2. Resident 103 was admitted to the facility in 2019 with diagnoses including Alzheimer's Disease and Parkinson's Disease.On 3/4/26 at 9:55 AM, Staff 11 (Anonymous Complainant) reported Resident 105 attempted to put Resident 103 into a shower room to do sexual acts with Resident 103, but a staff member intervened. Staff 11 stated she did not witness the incident but had spoken to Resident 103 after the incident, who stated Resident 105 was sick and made bad comments to her/him. Staff 11 stated the incident was reported to management and no investigation was completed.On 3/9/26 at 2:21 PM, Staff 8 (CNA) stated she spoke to the human resources department, Staff 2 (DNS) and Staff 1 (Administrator) and informed them that Resident 105 was being sexually inappropriate and attempted to instigate sexual behaviors with multiple residents. Staff 8 stated Resident 105's behavior included attempting to take a resident into a shower room to unclothe the resident.On 3/11/26 at 11:10 AM, Staff 6 (Social (continued on next page)

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

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Service Director) stated she was told by staff that Resident 105 attempted to video Resident 103 and stated Resident 105 wanted to kiss Resident 103 and get her/him into a shower room. Staff 6 confirmed she had reported the incident to Staff 1.On 3/10/26 at 10:30 AM and 3/11/26 at 12:11 PM, Staff 1 stated he was aware of the incident with Resident 103 and Resident 105 and stated no investigation was completed.3. Resident 108 was admitted to the facility in 2025 with diagnoses including Huntington's Disease (neurodegenerative disorder which progressively affects movement, cognition and mental health), and dementia.On 3/4/26 at 9:55 AM and 3/9/26 at 1:13 PM, Staff 11 (Anonymous Complainant) stated on 2/28/26 they observed Resident 105 telling Resident 108 to take off her/his shirt and made gestures for Resident 108 to remove her/his shirt. Staff 11 stated they completed a written statement and gave it to Staff 12 (LPN/Unit Manager).On 3/11/26 at 8:03 AM, Staff 9 (CNA) stated Resident 105 had behaviors with multiple residents. Staff 9 state he heard from another staff that Resident 105, along with other residents, were laughing, and encouraging Resident 108 to take her/his top off. Staff 9 state he had observed Resident 105 rubbing the backs of other residents more physically than was appropriate, which he reported to the nurse.On 3/11/2026 at 11:10 AM, Staff 6 (Social Service Director) stated she was told in the morning by Staff 2 that Resident 105 was verbalizing a desire to marry Resident 108. Staff 6 stated she was made aware by an unnamed staff member that Resident 108 was removing her/his top while Resident 105 was in the dining room with her/his phone. Staff 6 stated she spoke to Resident 105 who did admit to her/his behaviors and stated, it was innocent, and she informed Staff 1 of the incident.On 3/10/26 at 10:30 AM and 3/11/26 at 12:11 PM, Staff 1 stated he was aware of Resident 108 removing her/his top. Staff 1 stated there was no investigation completed for the incident involving Resident 108 removing her/his shirt while Resident 105 was in the dining room.On 3/17/26 at 3:18 PM, the facility submitted an acceptable IJ Removal Plan, which included the following:-Resident 102, 103, and 108 received head to toe skin assessments completed by RCMs with no observed findings.-Resident 105 was placed on one-to-one observations pending investigations.-Staff 1 (Administrator) and Staff 2 (DNS) were re-educated of the facility's abuse policy, reporting and thorough investigations.-Social Services to interview all interviewable residents regarding abuse.-Nurses will complete a head-to-toe assessment on all non-interviewable residents.-All staff, including agency staff, will be re-educated on the facility's abuse policy and reporting.The immediate jeopardy was removed on 3/18/26 at 3:08 PM when surveyors verified implementation of the facility's IJ Removal Plan. Following the removal of the immediacy, noncompliance remained at isolated without actual harm that is not IJ.

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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. Based on interview and record review the facility failed to ensure care plan interventions were followed for transfers for 1 of 3 sampled residents (#107) reviewed for falls. This placed residents at risk for injury and falls. Findings include:Resident 107 admitted to the facility in 2/2026 with diagnoses including multiple sclerosis. Resident 107's 2/25/26 ADL Care Plan indicated Resident 7 was dependent on two staff members for transfer and to utilize a Hoyer (mechanical) lift. A 3/9/26 Facility Reported Incident indicated Resident 107 reported she/he was transferred by Staff 3 (CNA) on 2/28/26 without the use of the Hoyer lift. Resident 107 reported right flank pain and was assessed to have no visible injury. Resident 107's 3/10/26 x-ray indicated no rib fractures or dislocation was noted. On 3/10/26 at 10:40 AM, Resident 107 stated Staff 3 gave her/him a giant bear hug and made several attempts to transfer the resident from the chair to the bed. Resident 107 stated the transfer caused three broken ribs. On 3/10/26 at 11:21 AM, Staff 3 stated she completed a stand-pivot transfer with Resident 107 and verified she had not read Resident 107's care plan. On 3/10/26 at 11:50 AM, Staff 1 (Administrator) stated on 2/28/26 Staff 3 completed a stand-pivot transfer with Resident 107 when the resident was care planned to be a Hoyer lift transfer by two staff members.

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor. Based on interview and record review it was determined the facility failed to ensure rehabilitative services were provided for 1 of 3 sampled residents (#107) reviewed for rehabilitation services. This placed residents at risk for a decline in range of motion. Findings include:Resident 107 admitted to the facility in 2/2026 with diagnoses including multiple sclerosis. Resident 107's 2/24/26 admission Orders included an order for physical therapy and occupational therapy.Review of Resident 107's clinical record found no documented evidence Resident 107 received therapy as ordered.On 3/11/26 at 10:58 AM, Resident 107 stated she/he had not received therapy since her/his admission.On 3/11/26 at 10:40 AM, Staff 2 (Director of Rehabilitation) stated Resident 107 had not received any therapy services from her/his date of admission through 3/11/26. Staff 2 verified Resident 107's admission Orders included orders for physical therapy and occupational therapy.