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	05/09/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 42270 Based on interview and record review it was determined the facility failed to implement policies and procedures for screening potential employees to prevent abuse for 3 of 3 sampled new employees (#s 16, 17, and 18) reviewed for employee screening. This placed residents at risk for abuse. Findings include: The facility's Abuse Screening, Training, Identification, Investigation, Reporting, and Protection policy, dated 8/2024, indicated the screening process for potential employees included: - Contact previous employers requesting employment history to include but not limited to: dates of service, position held, performance history, history of abuse, neglect, misappropriation of resident property, exploitation, or mistreating residents. - Obtain criminal background information. 1. On 5/8/25 at 11:00 AM a random sample of newly hired staff members was reviewed for reference checks with Staff 14 (Human Resources) and Staff 15 (Human Resources Business Partner). Staff 15 stated reference checks were not completed for Staff 16 (CNA), Staff 17 (CNA), and Staff 18 (RN). On 5/8/25 at 3:33 PM Staff 1 (Administrator) acknowledged the new employee reference checks were not completed for Staff 16, Staff 17, and Staff 18 per the facility abuse screening policy. 2. On 5/8/25 at 11:00 AM a random sample of newly hired staff members was reviewed for criminal background checks with Staff 14 (Human Resources) and Staff 15 (Human Resources Business Partner). The review revealed the following: - Staff 16 (CNA) began working in the facility on 2/7/25, but her criminal background check was not started until 5/7/25. - Staff 17 (CNA) began working in the facility on 4/21/25, but her criminal background check was not started until 4/30/25. - Staff 18 (RN) began working in the facility on 4/16/25, but her criminal background check was not started until 5/7/25. (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

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	05/09/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/8/25 at 3:33 PM Staff 1 (Administrator) acknowledged the criminal background checks were not completed for Staff 16, Staff 17, and Staff 18 per the facility abuse screening policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 48830 Based on interview and record review it was determined the facility failed to notify the physician of blood sugar measurements outside of parameters for 1 of 5 sampled residents (#4) reviewed for medications. This placed residents at risk for diabetic complications. Findings include: Resident 4 was admitted to the facility in 2020 with diagnoses including diabetes and dementia. A 4/11/25 physician order indicated staff were to check Resident 4's CBG (blood sugar measurement) level three times a day and to notify the physician for a CBG level less than 70 or greater than 350. A review of the 4/2025 Diabetic Administration Record revealed the following occurrences of a CBG greater than 350: -4/16/25 at 12:00 PM, CBG was 379. -4/29/25 at 12:00 PM, CBG was 442. -4/29/25 at 5:30 PM, CBG was 427. -4/30/25 at 12:00 PM, CBG was 368. No documentation was found in Resident 4's clinical record to indicate the physician was notified of the elevated CBGs. On 5/9/25 at 12:26 PM Staff 18 (RN) stated she did not notify the physician as Resident 4's CBG was not over 450. On 5/9/25 at 12:29 PM Staff 2 (DNS) acknowledged staff were not notifying the physician due to the belief it was not needed unless Resident 4's CBG was over 450.