

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER Woodland Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 310 Fourth Street Woodland, WA 98674	

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 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>36368</p> <p>Based on interview and record review, the facility failed to ensure submission of the Payroll Based Journal (PBJ) per the Centers of Medicare and Medicaid (CMS) requirement for 1 of 1 Fiscal Year (FY) Quarter (Q3 2024 [July 1 through August 31, 2024]), reviewed for PBJ submission. This failed practice resulted in CMS having inaccurate data related to nursing home staffing levels which had the potential to impact on the care and services provided to all the residents in the facility.</p> <p>Findings included .</p> <p>Review of the Q3 2024 HPRD Reporting Results FY Quarter 3 2024 (July 1 - August 31) showed: Facility with zero data available.</p> <p>On 04/28/2025 at 2:10 PM, Staff A, Administrator, stated that the facility had not submitted the PBJ to CMS for Quarter 3 2024.</p> <p>Reference WAC 388-97-1090(1)(2)(3)</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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