STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505232	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Convalescent Center	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)
F 0689 Level of Harm - 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** Based on observation, interview, and record review, the facility failed to ensure a safe transfer during the use of a mechanical (hoyer) lift for 1 of 4 residents (Resident 1) reviewed for accident hazards. Resident 1 experienced harm when the hoyer lift sling detached during a mechanical lift transfer resulting in a fall; the resident sustained injuries to the head, rib fractures, and fractures of the lumbar vertebra (spine) that required hospital evaluation and treatment. Findings included.Record review of the facility policy and procedure revised in July 2017, and reviewed on 12/15/2025, titled, Lifting Machine, Using a Mechanical, documented the following: Steps in the Procedure:12. Attach sling straps to sling bar, according to manufacturer's instructions.a. Ensure the sling is securely attached to the clips and that it is properly balanced.b. Check to make sure the resident's head, neck and back are supported.c. Before resident is lifted, double check the security of the sling attachment.d. Examine all hooks, clips or fasteners.e. Check the stability of the straps.f. Ensure that the sling bar is securely attached and sound. Resident 1 was admitted to the facility on [DATE] with multiple diagnoses including osteoarthritis (a degenerative joint disease caused by a breakdown of protective cartilage, leading to pain, stiffness, and reduction in mobility), spondylosis of cervical and thoracic regions of the spine (a wearing of the vertebral disks of the neck and mid spine), and Alzheimer's Disease (a progressive, incurable brain disorder). The Minimum Data Set, an assessment tool, dated 02/28/2026, documented Resident 1's cognitive skills for daily decision making was severely impaired. Record review of Resident 1's care plan, dated 06/04/2025, showed Resident 1 required the assistance of two people during hoyer lift transfers.Record review of an incident report for Resident 1, dated 02/19/2026, showed Resident 1 was being transferred by two Certified Nursing Assistants (CNA's) when a corner of the hoyer sling she was being transferred in became disengaged from the hoyer lift and she fell approximately four feet to the ground landing on her buttocks, bouncing, and then falling backward striking her head on the leg of the hoyer lift. Record review of Resident 1's hospital records, dated 02/19/2026, showed as a result of the fall from the hoyer sling, Resident 1 sustained an abrasion to the back of head, fractures of the 6th, 7th, 8th, and 10th ribs, and fractures of the 1st and 2nd lumbar vertebra (largest vertebra at the base of the spinal cord which support the rest of the spine and withstand body weight and movement). On 02/24/2026, at 3:00 PM, Staff D, Certified Nursing Assistant (CNA), said she and another CNA were present during the transfer when Resident 1 fell. They were attempting to get her up for dinner. They had placed the sling beneath her and attached the loops at each corner of the sling top and bottom to the mechanical (Hoyer) lift. They had just raised her off the bed and had gotten her in the space between the bed and wheelchair when the bottom left corner of the sling came loose from the lift and Resident 1 dropped to the floor. Record review of an email from Staff C, Registered Nurse (RN), dated 02/26/2026 at 7:30 PM, showed Staff C said that after research the facility had decided to replace all the hoyer slings and each resident who required transfers using hoyer lifts would have their own slings labeled with their names. On 03/27/2026, at 2:39 PM, Staff F, Licensed Practical Nurse (LPN), said she was called to Resident 1's room by one of the CNA's present when Resident 1 fell. Staff D said when she entered the room, she first assessed (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
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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 0689 Level of Harm - Actual harm Residents Affected - Few	the resident, then when looking at the Hoyer lift, she noted one of the loops of the sling had become disengaged. The CNA's told her when they raised Resident 1 from the bed everything had been fine. It wasn't until they had moved her from the bed toward the wheelchair that the sling had come undone. Staff F said she had assessed the sling after the incident, and it had looked like it was in good condition. Staff F had taken the Hoyer lift and sling used to transfer Resident 1 out of rotation until it could be assessed by the Maintenance Department. On 03/27/2026, at 3:07 PM, Staff E, CNA, said when she and Staff D had transferred Resident 1 on the evening of the fall, the loops of the sling were securely fastened. We had barely lifted her up and off the bed when the bottom left loop became disconnected and she fell. We were really shocked and couldn't figure out what happened. We are all on hyper alert now. Especially with the slings because a lot of the slings are old. We are now examining the slings every time we use one and the Hoyer lifts too. We're looking at the little metal disks now too to make sure they're not loose. We look at this each time now. In an observation and interview on 03/27/2026 at 3:50 PM, Staff D, CNA, demonstrated how she and a co-worker attached the Hoyer sling to the Hoyer lift prior to Resident 1's fall. Staff D said she remembered hearing the sling loops click into place, but she thinks one of the round metal disks might have been a little loose. Staff D said there has been a lot of training since the incident, and all new slings are being ordered. On 03/30/2026, at 1:56 PM, Staff G, Maintenance Director, said the mechanical lifts and slings were inspected monthly. He said there was a new policy in place where each resident will have their own slings. They will be labeled and dated for specific residents and new slings will be ordered each year. Record review of monthly maintenance logs for hoyer slings and lifts for January through December of 2025 and January, February, and March of 2026 showed no concerns noted with slings or lifts. On 03/30/2026, at 4:30 PM, Staff B, Director of Nursing Services, said the facility had expected a citation as Resident 1's fall from the Hoyer sling resulted in injury. While they don't know exactly how this occurred, they were doing everything they can to prevent recurrence and harm to other residents. Reference WAC 388-97-1060[3][g]