

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/09/2026
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)		
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medications were administered for 1 of 4 residents (Resident 1) reviewed for medication errors. This failure placed residents at risk for complications and decline in health status. Findings included . Record review of the facilities policy and procedure titled, Admission/re-admission Checklist, undated, documented the facility was to activate/confirm all physician orders in Point Click Care, the facilities electronic medical record. Resident 1 was admitted to the facility on [DATE] at 6:45 pm with diagnosis including nontraumatic subarachnoid hemorrhage, (a type of stroke involving sudden bleeding into the space between the brain and the skull), type 2 diabetes mellitus, (a chronic condition in which the body doesn't produce enough insulin causing elevated blood sugar levels, and essential hypertension (high blood pressure without a single identifiable medical cause). Record review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 04/25/2026, documented Resident 1 had no short-term memory loss and moderately impaired cognitive skills for daily decision making. Record review of Resident 1's nursing progress note, dated 04/25/2026 at 8:24 am, documented, Resident on alert for new admit post brain aneurysm. Resident arrived to the facility yesterday evening. Medications and orders were delayed due to late evening admission. Upon arriving to my shift, the resident had a bad headache and pain in his R [Right] hip rated around 8/10. 10mg (milligrams) PRN (as needed) oxycodone (pain medication) was given as well as the scheduled 1000 mg of Tylenol (pain medication) for the evening that he did not receive per orders. 2 units of insulin (medication to manage blood sugar levels) lispro (sliding scale 206 units of insulin for CBG [capillary blood glucose] and 8 units NPH (evening scheduled) insulin were given per orders. Lidocaine cream applied to painful R hip. Upon reassessment resident voiced relief in both the headache and pain in R hip, although still rated around 3-4/10 on pain scale. Resident calm, polite, and cooperative with care. BP [blood pressure]: 140/64 charted at 0700 [7:00am]. Record review of the Facility Resident Incident Review, Assessment, and Action Report, dated 04/26/2026, documented Resident 1 was not given medications as ordered on the evening of admission on [DATE]. Name of medication(s) and dose(s) that were missed on the evening of admission [DATE]: Irbesartan 300mg, a medication used to treat high blood pressure, give 1 tab at hour of sleep. Clonidine, a medication used to relax blood vessels or calm the central nervous system, 0.1 mg 2 times a day. Evening dose at 9:00 pm. Check blood glucose at 9:00 pm. Metformin HCL ER, a medication used to manage blood sugar levels in Type 2 diabetes, give 1000mg at 9:00 pm. Polyethylene Glycol, a laxative used to treat occasional constipation, give 17 gm (grams) at 9:00 pm. Acetaminophen, a pain medication, give 500 mg 2 tabs at 9:00 pm. Gabapentin, a medication used to treat nerve pain, give 100mg 1 cap at 9:00 pm. Insulin Lispro, a subcutaneous medication used to lower blood glucose, administer according to directions given for sliding scale at 9:00 pm. The Facility Administrative Summary, dated 04/26/2026, documented The Resident Care Manager assigned to Resident 1 failed to follow facility procedure for admissions process of ensuring diagnosis and admissions orders were entered into the medical record prior to his admission which occurred on evening shift. The evening shift Licensed Nurse (LN) assigned to Resident 1 did not initiate the admissions process and did not ask the other unit nurse for guidance or call a Nurse Manager or the (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing Services.Medication Errors: Due to the above failures Resident did not receive his routine medications that should have been administered by the licensed nurse on evening shift. During an interview on 05/12/2026 at 1:00 PM, Staff C, Registered Nurse (RN) and Resident Care Manager (RCM), said Staff D, RN, was a new nurse and a recent new hire to the facility. Staff C said Staff D had completed four weeks of orientation and the admissions process was part of the facility orientation. Staff C said when Staff D was notified of Resident 1's medication errors and questioned as to why the admission process had not been implemented, she said she was unaware it was her responsibility to do so. Staff C said Staff D should have initiated the admission process and if unsure of the process ask another nurse or contact an RCM or the Director of Nursing Services (DNS). During an interview on 05/14/2026 at 9:58 AM, Resident 1's spouse said she was aware that her husband went several hours without his ordered medications. The nurse on duty was new and didn't have a clue about the admissions process. Of more concern to her was the hospital discharging her husband so soon. When she went to visit him the next morning her was wrapped in sheets and blankets shivering and unable to respond to her. She had requested the facility call 911. During an interview on 06/09/2026 at 1:30 PM, Staff E, RN/RCM, said she had been the RCM on duty the day Resident 1 had admitted . Staff E said she had given Staff D report regarding the pending admission. Staff E said she was surprised to hear that the admissions process had not been initiated. Staff E said that to prevent this from happening again she is now completing the order portion of the admission process before going home for the day. During an interview on 06/09/2026 at 2:44 PM, Staff F, RN/RCM, said when expecting an admission on evening shift she gives report to the charge nurse who works 10:00 AM to 6:00 PM. Staff F said it's facility policy to have two nurses present to double check physicians orders before recording them on the medication administration sheet. Staff F said there should be no reason why orders were not verified and noted. During an interview on 06/09/2026 at 4:00 PM, Staff C, RN and Director of Nursing Services, said it was an expectation for nurses to follow admissions procedures when residents were admitted on an evening shift. They know they can call her if they have questions regarding process or need assistance. She said the nurse on duty when Resident 1 was admitted was a new nurse and was probably overwhelmed. The Director of Nursing Services and the RCM's have a process in which they place the admissions orders from the hospital in a queue prior to a resident's actual admit. Once the resident arrived, the nurses were educated to check the queue, verify the orders using two nurses, and then note the orders and order medications from the pharmacy. WAC Reference 388-97-1060[3][k][iii]		