STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055517	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlands Healthcare Center	14966 Terreno DE Flores Lane Los Gatos, CA 95032

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure free from unnecessary psychotropic medication (medications capable of affecting the minds, emotions, and behaviors) for one of three sampled resident (Resident 1) when: 1.There was no documented evidence of non-pharmacological (treatments and strategies that mange health conditions without using medications) approaches attempted before administered psychotropic medication lorazepam (used to treat for anxiety [persistent worry and fear about everyday situations]) to Resident 1;2.There was no documented evidence of side effects monitored for use of lorazepam (an unintended consequence of a medication, may be harmful) for Resident 1;3. There was no documented evidence of episodes of adequate behavior monitored for use of lorazepam for Resident 1. These above failures had the potential to place sampled resident at risk to receive unnecessary psychotropic medication.Findings:1.Review of Resident 1's face sheet (FS: a document that gives resident's information at a quick glance) indicated Resident 1 was admitted to facility on 7/9/2024. Resident 1's diagnoses indicated dementia with anxiety (loss of memory, language, problem solving and thinking abilities interfere with daily living along with irritability, agitation and restlessness).Review of Resident 1's order summary report indicated lorazepam oral concentrate (liquid)1MG (mg: milligram, unit of mass equal to one thousandth of a gram)/ 0.5 ML (ml: milliliter, unit of volume equal to one thousandth of a liter) give 0.25 ml every 6 hours as needed for agitation ., dated 6/28/2025.Review of Resident 1's electronic medication administration record (EMAR: a digital system used in healthcare settings to manage and track administration of medications to residents) for June/2025 indicated Resident 1 received lorazepam as ordered above on 6/28/2025 at 1846 and on 6/29/2025 at 1026.Further review of Resident 1's EMAR for June/2025 indicated there was no documented evidence for non-pharmacological approaches attempted before administered lorazepam on 6/28 and 6/29/2025.2.Review of Resident 1's EMAR for June/2025 indicated there was no documented evidence of monitored for side effects for lorazepam administration.3. Review of Resident 1's EMAR for June/2025 indicated there was no documented evidence for adequate behavior monitored for use of lorazepam.During an interview with facility's director of nursing (DON) on 7/1/2025 at 2:21 p.m., DON confirmed there was no documented evidence of nursing staff attempted non-pharmacological approaches before administered lorazepam, monitored side effects and adequate behavior monitored for use of lorazepam for Resident 1. DON stated license nursing staff should have attempted non-pharmacological interventions, monitored and documented side effects and adequate behavior when administered lorazepam to Resident 1.Review of facility's policy and procedure (P&P) titled, Psychotherapeutic Drug Management, dated 3/2010, the P&P indicated, The nurse shall implement non-drug interventions to modify behavior according to the care plan. Manifestations for the drug i.e. hitting others etc. Documentation shall occur each shift with the number of times this behavior has occurred. Side effects of the drug i.e. drooling, dry mouth, abnormal gait etc. Documentation of side effects shall occur each shift.

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure to notify primary care physician (PCP) for refusal of blood tests (a laboratory analysis of a blood sample used to assess various aspects of resident's health) as ordered by the physician for one of three sampled resident (Resident 1) to meet professional standards.This failure had the potential to affect Resident 1's medical condition and well-being. Findings:Review of Resident 1's face sheet (FS: a document that gives resident's information at a quick glance) indicated, Resident 2 was admitted to facility on 7/9/2024.Review of Resident 1's medical diagnoses included diabetes type 2 (high blood sugar levels), chronic kidney (bean shaped body organ, filters waste and extra fluids from blood to produce urine) disease (a long term condition where the kidneys gradually lose tier ability to function properly), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).Review of Resident 1's order summary report indicated basic metabolic (a blood test that measures several key substances in the blood), CBC (complete blood count) with Diff (differential) (a blood test that measures the number and types of blood cells in the body), iron (a blood test that measures the amount of iron [a mineral found in cell, crucial for various bodily functions] in body), A1C (blood test that measures the average blood sugar level over the past 2-3 months) dated 6/21/2025.Review of laboratory requisitions dated 6/21/2025 at 16:02, 6/23/2025 at 13:02, 6/24/2025 at 12:03 and 6/25/2025 at 9:09 and 18:04 indicated multiple attempts to obtain blood sample for above ordered blood tests.Review of nursing notes during 6/21/2025 to 6/25/2025 indicated there was no documented evidence of Resident 1 refused blood draw for lab tests as ordered above.Review of Resident 1's blood work results indicated there was no documented evidence of above ordered blood test results.During an interview with licensed vocational nurse A (LVN A) on 7/1/2025 at 12:10 p.m., LVN A confirmed there was no documented results for above ordered blood tests for Resident 1. LVN A stated do not recall why blood draw was not done for this resident. LVN A stated possibility resident refused blood work.During an interview with facility's director of nursing (DON) on 7/1/2025 at 2:21 p.m., DON confirmed blood draw for lab tests was not completed. DON stated Resident 1 refused blood draw for lab work several days in a row when attempted by lab staff as indicated per lab requisitions. DON also confirmed license staff did not inform PCP when Resident 1's refused blood draw multiple attempts, unable to get blood test as ordered. DON also confirmed nursing staff did not document when Resident 1 refused blood test as ordered. DON stated license staff should have informed PCP and documented when Resident 1 refused blood draw for testing. Review of facility's policy and procedure (P&P) titled, Requesting, Refusing and /or Discontinuing Care or Treatment, the P&P indicated, Documentation pertaining to a resident's request, discontinuation or refusal of treatment includes at least the following: a. The date and time the care or treatment was attempted;b. The type of care or treatment;c. The resident's response and stated reason(s) for request, discontinuation or refusal;d. The name of the person who attempted to administer the care or treatment;g. The date and time the practitioner was notified as well as the practitioner's response;i. The signature and title of the person recording the data.The healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request.