STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056066	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Care Center	7120 Corbin Ave. Reseda, CA 91335

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review, the facility failed to ensure that a grievance filed by one of three sampled residents (Resident 1) was documented and filed in the facility grievance log. This deficient practice had the potential to affect the residents' quality of life and the provision of care. Findings: During a review of Resident 1's Admission Record indicated that Resident 1 was originally admitted to the facility on [DATE] with diagnoses that included type two (2) diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) with diabetic neuropathy (a type of nerve damage that can occur with diabetes), and atrial fibrillation (an irregular, often rapid heart rhythm). During a review of Resident 1's History and Physical dated 3/8/2024 indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 5/8/2024, indicated Resident 1's cognitive (relating to the mental process involved in knowing, learning, and understanding things) skills for daily living was intact. The MDS indicated that Resident 1 required setup or clean-up assistance from staff with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 1 required supervision or touch assistance with toileting hygiene, shower or bathing, and lower body dressing. During a review of Resident 2's Admission Record indicated that Resident 2 was originally admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, atrial fibrillation, and heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs). During a review of Resident 2's History and Physical dated 1/15/2024 indicated Resident 2 has the capacity to understand and make decisions. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/29/2024 at 8:45 a.m. with Resident 1, Resident 1 stated that Resident 1 has complained to several facility staff regarding her (Resident 1) roommate (Resident 2) and the roommate's son visiting inside the room until 10:30 p.m. to 11:00 p.m. at night. Resident 1 stated that she (Resident 1) is unable to rest because Resident 2 and her (Resident 2) son are loud. During a concurrent interview and record review on 7/29/2024 at 11:20 a.m., with Social Services Designee 1 (SSD 1), SSD 1 stated that on 7/19/2024, during the stand up meeting (a short, daily facility staff meeting to communicate and address resident concerns), she (SSD 1) was made aware of Resident 1's grievance regarding Resident 2 and Resident 2's son visiting late into the night. SSD 1 reviewed the facility's grievance log for 7/2024 and stated that there were no documented grievances from Resident 1 for 7/2024. SSD 1 stated that she (SSD 1) did not document Resident 1's grievance on a grievance form. SSD 1 further stated that she (SSD 1) did not document Resident 1's grievance on the facility's grievance log because she (SSD 1) did not have time. SSD 1 stated that she (SSD 1) should have documented Resident 1's grievance on the facility's grievance form and logged the grievance in the facility's grievance log so that the facility can keep track of all grievance. During an interview on 7/29/2024 at 1:33 p.m. with the Social Services Director (SSD), the SSD stated that once a grievance is received, the grievance should then be documented on the facility's grievance form. SSD stated that once the facility grievance form is completed, that form is then placed in the facility's grievance log. SSD stated that it is importance to log grievances on the facility's grievance log because it will inform the facility on when the grievance was received, help the facility can track all grievances, and ensure timely resolutions. The SSD continued to state that the facility has 72 hours to resolve a grievance. During a review of the facility's policy and procedure titled, Grievances/ Complaints, Recording and Investigation, last reviewed 1/11/2024, the policy indicated that grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance (s). Under policy and interpretation and implementation: 3. The assigned facility staff will record and maintain all grievances and complaints on the Resident Grievance Complaint Log.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 39550 Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan (a written course of action that helps a resident achieve outcomes that improve their quality of life) for one of three sampled residents (Resident 3), who made an allegation of financial abuse. This deficient practice had the potential to negatively affect the delivery of care and services to Resident 3. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated the facility admitted Resident 3 on 12/30/2024 with diagnoses that included metabolic encephalopathy (a problem in the brain that is caused by a chemical imbalance in the blood), dementia (a group of thinking and social symptoms that interferes with daily functioning), rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood), cachexia (a general state of ill health involving great weight loss and muscle loss), and a history of falling. During a review of Resident 3's Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 7/5/2024, the MDS indicated that Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. During a review of Resident 3's Change in Condition (COC) Evaluation document dated 7/21/2021 at 12:00 p. m., the COC indicated that two (2) police officers arrived at the facility due to an allegation of financial abuse. During an interview and concurrent record review with Registered Nurse Supervisor (RNS) on 7/30/2024 at 11:23 a.m., reviewed Resident 3's care plans from 6/2024 to 7/30/2024. RNS stated that there was no documentation found that a care plan specific to the allegation of financial abuse was developed for Resident 3. RNS stated that a care plan specific to financial abuse should have been developed because the specific care plans will have specific interventions for Resident 3 to assist the facility staff on how to protect Resident 3 from financial abuse. When asked who was responsible for initiating Resident 3's care plan specific for financial abuse, RNS stated the Minimum Data Set department is responsible. During an interview with Minimum Data Set Nurse 2 (MDSN 2) on 7/30/2024 at 2:28 p.m., MDSN 2 stated that following a change of condition (COC) in a resident, a care plan should be initiated specific to the change of condition. MDSN 2 stated that immediately after a COC is documented the care plan related to the specific COC should have been initiated. MDSN 2 stated that a care plan is important to initiate because a care plan is a personalized plan of care to target a residents' issue and is based on a specific concern. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled Care Plan Comprehensive, review date 1/11/2024, indicated an individualized comprehensive care plan that includes measurable objectives and timetabled to meet the resident's medical, physical, mental, and psychosocial needs shall be developed for each resident.