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	03/04/2025

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on interview and record review, the facility failed to: 1. Ensure a discharge summary with a complete reconciliation of medications (a process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over-the-counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care) was provided upon discharge to the residents or responsible party (RP) for three of three sampled residents (Resident 1, Resident 3, and Resident 4) by failing to document what post-discharge medications the residents were to take and were provided and the amount of medications provided. 2. Ensure a discharge summary included information to monitor for bleeding signs related to taking apixaban (anticoagulant- medication used to treat and prevent blood clots [gel-like clumps of blood]) and Plavix (medication used to prevent blood clots) upon being discharged home for one of three sampled residents (Resident 1). These deficient practices had the potential to result in an unsafe discharge and for the residents and their RP to be unaware of what medications are needed to be continued after being discharged from the facility and the residents' continuity of care. Findings: 1. a. During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 to the facility on [DATE] with diagnoses including cerebral infarction (a serious medical condition that occurs when blood flow to the brain is blocked, leading to brain cell death). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 2/14/2025, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact, and the resident needed maximum assistance from staff with toileting hygiene, upper/lower body dressing, bed mobility (movement) and transfer. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following physician orders: (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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Last coverage day of insurance was 2/27/2025 and discharged to custodial care on 2/28/2025; Order Date: 2/25/2025. - Discharge home per resident request; Order Date: 2/28/2025. During a review of Resident 1's Discharge Plan Documentation (DPD) signed 2/28/2025, the DPD indicated Resident 1 was discharged home. The DPD further indicated the following: - Medication changes and/or discontinuations: Summarize medication changes and/or discontinuations during stay include medication names and reason for D/C (discontinue) or change - if no changes or D/C document no changes during stay: See medication list. During a concurrent interview and record review on 3/4/2025 at 1:35 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 1's DPD signed 2/28/2025 and Resident 1's Order Summary Report. The ADON stated that the facility was utilizing Resident 1's Order Summary Report as a medication list for when Resident 1 was being discharged home. The ADON further stated that Licensed Vocational Nurse 2 (LVN 2) completed Resident 1's DPD, and the medication list indicated that some medications were marked but could not tell what medications or how many pills were released to Resident 1 and/or family upon leaving the facility on 2/28/2025. During a phone interview on 3/4/2025 at 1:47 p.m., with LVN 2, LVN 2 stated that LVN 2 filled out Resident 1's DPD signed 2/28/2025 and documented on the DPD form to see the medication list, but LVN 2 did not complete the medication list. LVN 2 stated that a Registered Nurse (RN) supervisor or a charge nurse will count the released medications upon a resident being discharged home and then should document the released medications with amount of medication released. During a concurrent interview and record review on 3/4/2025 at 3:50 p.m., with Director of Nursing (DON), reviewed Resident 1's DPD signed 2/28/2025 and Resident 1's Order Summary Report. When the DON was asked if Resident 1's DPD with the medication list was completed as a reconciliation of medication prior to discharging home, the DON stated that the nursing staff did not document how many pills were released and just placed marks on the Order Summary Report without any further information for Resident 1 upon being discharged home. 1. b. During a review of Resident 3's Admission Record, the Admission Record indicated the facility originally admitted Resident 3 to the facility on [DATE] and readmitted the resident on 10/14/2024 with diagnoses including diabetes mellitus (DM- a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 3's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was intact, and the resident needed supervision or touching assistance from staff with toileting hygiene, lower body dressing, and transfer. During a review of Resident 3's Order Summary Report, the Order Summary Report indicated a physician order to discharge home on 2/14/2025 with home health services (HHS); Order Date: 2/13/2025. During a review of Resident 3's DPD signed 2/14/2025, the DPD indicated Resident 3 was discharged . The DPD further indicated the following: (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Medication changes and/or discontinuations: Summarize medication changes and/or discontinuations during stay include medication names and reason for D/C or change - if no changes or D/C document no changes during stay: See attached medication list and provided left over medications. During a concurrent interview and record review on 3/4/2025 at 2:22 p.m., with LVN 3, reviewed Resident 3's DPD signed 2/14/2025. LVN 3 stated since RN 1 completed Resident 3's DPD signed 2/14/2025, RN 1 should count the released medications with the amount released and document the amount on the medication list. When LVN 3 was asked in general how many days of medication supply should be provided to a resident upon being discharged home, LVN 3 stated that the facility instructs the residents to follow up with their primary care physician and make an appointment in a week, so a minimum of five-to-seven-day supply of medications should be provided. LVN 3 further stated that if a resident is left with only two days of prescribed medications to take home and was not able to make an appointment to have their prescription refilled, the resident might end up in the hospital. During a concurrent interview and record review on 3/4/2025 at 3:06 p.m., with RN 1, reviewed Resident 3's DPD signed 2/14/2025 and Resident 3's Order Summary Report. RN 1 stated that Resident 3 was discharged home on 2/14/2025 and Resident 3's DPD was completed by RN 1. RN 1 stated the discharge medications were not marked or counted for the released medications on the form, so RN 1 could not tell that what medications or how many pills Resident 3 was discharged home with. During a concurrent interview and record review on 3/4/2025 at 3:20 p.m., with the DON, reviewed Resident 3's DPD signed 2/14/2025 and Resident 3's Order Summary Report. The DON stated that Resident 3's medications list did not indicate what medications and/or how many medications were released to the resident/family upon being discharged home. 1. c. During a review of Resident 4's Admission Record, the Admission Record indicated the facility originally admitted Resident 4 to the facility on [DATE] and readmitted the resident on 12/14/2024 with diagnoses including multiple sclerosis (MS - a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord). During a review of Resident 4's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was intact, and the resident was independent for activities of daily living (ADLs- activities related to personal care). During a review of Resident 4's Order Summary Report, the Order Summary Report indicated the following physician order: - May discharge on 2/12/2025 with HHS; Order Date: 2/11/2025. During a review of Resident 4's DPD signed 2/12/2025, the DPD indicated Resident 4 was discharged home. The DPD further indicated the following: - Medication changes and/or discontinuations: Summarize medication changes and/or discontinuations during stay include medication names and reason for D/C or change - if no changes or D/C document no changes during stay: See attached medication list and provided left over medications. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/4/2025 at 3:02 p.m., with RN 1, reviewed Resident 4's DPD signed 2/12/2025. RN 1 stated there were no copies of the discharge medication list and was unable to locate the documents that indicated the facility provided a reconciliation medication list to Resident 4 upon being discharged home. During a concurrent interview and record review on 3/4/2025 at 3:20 p.m., with the DON, reviewed Resident 4's DPD signed 2/12/2025. The DON stated there was no medication list for Resident 4 left in the closed records. 2. During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 to the facility on [DATE] with diagnoses including cerebral infarction. During a review of Resident 1's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was intact, and the resident needed maximum assistance from staff with toileting hygiene, upper/lower body dressing, bed mobility and transfer. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following physician orders: - Last coverage day of insurance was 2/27/2025 and discharged to custodial care on 2/28/2025; Order Date: 2/25/2025. - Discharge home per resident request; Order Date: 2/28/2025. - Apixaban five (5) milligram (mg- metric unit of measurement), give one tablet by mouth two times a day for deep vein thrombosis (DVT - a blood clot in a deep vein) prophylaxis (an attempt to prevent disease). - Plavix 75 mg, give one tablet by mouth one time a day for prophylaxis until 3/9/2025. During a review of Resident 1's DPD signed 2/28/2025, the DPD indicated Resident 1 was discharged home. During a phone interview on 3/4/2025 at 1:47 p.m., with LVN 2, when LVN 2 was asked if LVN 2 explained to Resident 1 and/or family to monitor for bleeding as a side effect (an expected and known effect of a drug that is not the intended therapeutic outcome) due to taking apixaban and Plavix, LVN 2 stated LVN 2 did not explain to Resident 1 or their family about monitoring for bleeding. During a concurrent interview and record review on 3/4/2025 at 2:50 p.m., with RN 1, reviewed Resident 1's DPD signed 2/28/2025 and nursing progress notes on the day of discharge 2/28/2025. When RN 1 was asked if the nursing staff informed Resident 1 or family to monitor for any bleeding signs related to taking apixaban and Plavix, RN 1 stated that there was no documentation that indicated Resident 1, or their family was informed to monitor for bleeding signs at home. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/4/2025 at 3:50 p.m., with the DON, reviewed Resident 1's DPD signed 2/28/2025. When the DON was asked if the nursing staff explained to Resident 1 or their family to monitor for any bleeding signs related to taking apixaban and Plavix upon being discharged home, the DON stated that there was no documentation on the DPD and was unable to provide documentation if the discharging nursing staff educated Resident 1 and/or their family to monitor for any bleeding signs. During a review of the facility's policy and procedure (P&P) titled, Transfer or Discharge, Preparing a Resident for, last reviewed on 1/16/2025, the P&P indicated, Resident will be prepared in advance for discharge Nursing Services is responsible for . Preparing the discharge summary and post-discharge plan; Preparing the medications to be discharged with the resident (as permitted by law); Providing the resident or representative (sponsor) with required documents (i.e., Discharge Summary and Plan) Completing discharge note in the medical record.