

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER Woodland Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>Based on interview, and record reviews, the facility failed to manage a resident's pain by failing to administer his scheduled pain medication as ordered by the physician for one of three sample residents (Resident 1).</p> <p>This deficient practice had the potential to negatively affect Resident 1's psychosocial wellbeing and quality of life.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record (face sheet), the admission Record indicated that the facility admitted the resident on 6/13/2025, with diagnoses including type two diabetes mellitus (DM2-a disorder characterized by difficulty in blood sugar control and poor wound healing), displayed fracture (when the broken ends of the bone are no longer aligned) of second cervical vertebra (the neck area of your spine), and abrasion (a superficial wound caused by rubbing or scraping the skin) of scalp (the skin covering the head).</p> <p>During a review of Resident 1's Nursing Documentation Evaluation form dated 6/13/2025, the Nursing Evaluation form indicated that the resident was alert and oriented to time, place, and person and was able to communicate his needs with clear speech.</p> <p>During a review of Resident 1's physician Order Summary Report (physician order) dated 6/13/2025, the Order Summary Report indicated to administer oxycodone-acetaminophen (a medication to relieve moderate to severe pain) oral tablet 7.5-325 milligrams (mg-a unit of measure of mass), give one (1) tablet by mouth three times a day for pain management.</p> <p>During a review of Resident 1's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 6/13/2025-6/14/2025, the MAR indicated that Licensed Vocational Nurse 3 (LVN 3) administered oxycodone-acetaminophen oral tablet 7.5-325 mg to Resident 1 on 6/14/2025 at 6:00 a.m.</p> <p>During a review of Resident 1's Nursing Progress Notes dated 6/14/2025 at 9:39 a.m., the Nursing Progress notes indicated that at 9:11 a.m., a charge nurse reported that Resident 1 had packed his belongings and wanted to leave the facility. Resident 1 stated that he (Resident 1) was promised a lot of things including assistance with having his car towed to General Acute Care Hospital 1 (GACH 1). The Nursing Progress notes further indicated that Resident 1 left the facility Against Medical Advice (AMA- a situation where a patient leaves a healthcare facility or refuses treatment despite the recommendation of their healthcare provider).</p> <p>(continued on next page)</p>

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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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 6/17/2025 at 11:37 a.m. with Resident 1, Resident 1 stated that he was admitted to the facility on the afternoon of 6/13/2025, and he left the facility on the morning 6/14/2025. Resident 1 stated that he left the facility because he did not receive any pain medications, the bed was uncomfortable, and his breakfast was cold. Resident 1 stated that the facility staff only offered Tylenol for his pain which does not work for him. Resident 1 stated that he did not receive oxycodone 7.5-325 mg while in the facility.</p> <p>During a concurrent interview and record review on 6/17/2025 at 11:43 a.m. with Registered Nurse 2 (RN 2), Resident 1's MAR for June 2025 was reviewed. RN 2 stated that on 6/14/2025 at 6:00 a.m., LVN 3 documented that she administered oxycodone-acetaminophen oral tablet 7.5-325 mg to Resident 1.</p> <p>During a concurrent observation and interview on 6/17/2025 at 12: 51 p.m., with Licensed Vocational Nurse 2 (LVN 2), Resident 1's oxycodone-acetaminophen bubble pack (a medication packaging system that contains individual doses of medication per bubble), and Antibiotic and Controlled Drug (medications which have a potential for abuse and may also lead to physical or psychological dependence) Record for June 2025 were reviewed. LVN 2 stated that Resident 1's oxycodone-acetaminophen oral tablet 7.5-325 mg bubble pack is intact and contains 30 tablets. LVN 2 stated that Resident 1's Antibiotic and Controlled Drug Record also indicated that the count for oxycodone-acetaminophen 7.5-325 mg tablets is 30. LVN 2 stated that based on this information, Resident 1 did not receive any oxycodone 7.5-325 mg from his bubble pack. LVN 2 further stated that there are no oxycodone-acetaminophen 7.5-325 mg tablets in the facility's Emergency Medication Kit (E-Kit- contains a limited supply of medications for use during emergencies when regular pharmacy services are unavailable) either.</p> <p>During an interview on 6/17/2025 at 1:55 p.m., with LVN 3, LVN 3 stated that on 6/13/2025, she (LVN 3) worked at the facility from 11p.m. to 7a.m. and she was assigned to Resident 1. LVN 3 stated that Resident 1 did not report any pain during her shift. LVN 3 stated that Resident 1's physician ordered to administer oxycodone 7.5-325 mg to the resident three times a day for pain management. LVN 3 stated that she did not administer Resident 1's oxycodone-acetaminophen that was prescribed by his physician to be administered on 6/14/2025 at 6:00 a.m. LVN 3 stated that she accidentally documented that she administered oxycodone-acetaminophen 7.5-325 mg to Resident 1 on 6/14/2025 at 6:00 a.m. LVN 3 stated that while she was in Resident 1's room in the early morning of 6/14/2025, she (LVN 3) had to leave Resident 1's room to tend to another resident. LVN 3 stated that she must have documented by mistake when she was in a rush leaving Resident 1's room. LVN 3 stated that she should have administered pain medication to Resident 1 as ordered by his physician. LVN 3 stated that the potential outcome of not administering pain medication as ordered by the physician is increased pain and discomfort for the resident.</p> <p>During an interview on 6/17/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON stated that licensed staff are required to administer medication to residents as ordered by their physicians. The DON stated that licensed staff are responsible to assess all residents for pain and administer pain medications as ordered by their physicians. The DON stated that Resident 1's oxycodone-acetaminophen 7.5-325 mg bubble pack is intact and contains 30 tablets. The DON stated that LVN 3 did not administer Resident 1's oxycodone scheduled for administration on 6/14/2025 at 6:00 a.m. The DON stated that LVN 3 made an incorrect and inaccurate documentation that she administered the medication in Resident 1's MAR. The DON stated that the potential outcome of not administering a resident's scheduled pain medication as ordered by the physician is increased pain and harm to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedures (P&P) titled Pain Management, last reviewed on 1/16/2025, the P&P indicated that at a minimum daily, residents will be evaluated for the presence of pain by making an inquiry of the resident or by observing for signs of pain. If pain medications are given, document on the back of the MAR or on the PRN (as needed) pain management flow sheet. Residents receiving interventions for pain will be monitored for the effectiveness and side effects in providing pain relief. Document non-pharmacological interventions and effectiveness, effectiveness of PRN pain medications, ineffectiveness of routine or PRN medications including interventions, follow ups and physician notifications.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interview, and record review, the facility failed to accurately provide pharmaceutical services to one of three sampled residents (Resident 1) by failing to:</p> <ol style="list-style-type: none"> Administer oxycodone-acetaminophen (a medication to relieve moderate to severe pain) oral tablet 7.5-325 milligrams (mg-a unit of measurement of mass) to Resident 1 on 6/14/2025 at 6:00 a.m., as prescribed by the physician. Ensure LVN 3 did not document administration of oxycodone-acetaminophen oral tablet 7.5-325 mg on 6/14/2025 at 6:00 a.m in Resident 1's Medication Administration Record when it had not been given. <p>These deficient practices had the potential for harm to the resident due to inaccurate records of narcotic use; and increased the risk of controlled drug diversion.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s admission Record (face sheet), the admission record indicated that the facility admitted the resident on 6/13/2025, with diagnoses including type two diabetes mellitus (DM2-a disorder characterized by difficulty in blood sugar control and poor wound healing), displayed fracture (when the broken ends of the bone are no longer aligned) of second cervical vertebra (the neck area of your spine), and abrasion (a superficial wound caused by rubbing or scraping the skin) of scalp (the skin covering the head).</p> <p>During a review of Resident 1 ' s Nursing Documentation Evaluation form dated 6/13/2025, the Nursing Evaluation form indicated that the resident was alert and oriented to time, place, and person and was able to communicate his needs with clear speech.</p> <p>During a review of Resident 1 ' s physician Order Summary Report (physician order) dated 6/13/2025, the Order Summary report indicated to administer oxycodone-acetaminophen (a medication to relieve moderate to severe pain) oral tablet 7.5-325 mg, give one (1) tablet by mouth three times a day for pain management.</p> <p>During a review of Resident 1 ' s Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 6/13/2025-6/14/2025, the MAR indicated that Licensed Vocational Nurse 3 (LVN 3) administered oxycodone-acetaminophen oral tablet 7.5-325 mg to Resident 1 on 6/14/2025 at 6:00 a.m.</p> <p>During a review of Resident 1 ' s Nursing Progress Notes dated 6/14/2025 at 9:39 a.m., the Nursing Progress notes indicated that at 9:11 a.m., Resident 1 left the facility Against Medical Advice (AMA- a situation where a patient leaves a healthcare facility or refuses treatment despite the recommendation of their healthcare provider).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 6/17/2025 at 11:37 a.m. with Resident 1, Resident 1 stated that he was admitted to the facility in the afternoon of 6/13/2025, and he left the facility in the morning 6/14/2025. Resident 1 stated that he left the facility because he did not receive any pain medications, the bed was uncomfortable, and his breakfast was cold. Resident 1 stated that the facility staff only offered Tylenol for his pain which does not work for him. Resident 1 stated that he did not receive oxycodone 7.5-325 mg while in the facility.</p> <p>During a concurrent interview and record review on 6/17/2025 at 11:43 a.m. with Registered Nurse 2 (RN 2), Resident 1's MAR for June 2025 was reviewed. RN 2 stated that on 6/14/2025 at 6:00 a.m., LVN 3 documented that she administered oxycodone-acetaminophen oral tablet 7.5-325 mg to Resident 1.</p> <p>During a concurrent observation and interview on 6/17/2025 at 12: 51 p.m., with Licensed Vocational Nurse 2 (LVN 2), Resident 1's oxycodone-acetaminophen bubble pack (a medication packaging system that contains individual doses of medication per bubble), and Antibiotic and Controlled Drug (medications which have a potential for abuse and may also lead to physical or psychological dependence) Record for June 2025 were reviewed. LVN 2 stated that Resident 1's oxycodone-acetaminophen oral tablet 7.5-325 mg bubble pack is intact and contains 30 tablets. LVN 2 stated that Resident 1's Antibiotic and Controlled Drug Record also indicated that the count for oxycodone-acetaminophen 7.5-325 mg tablets is 30. LVN 2 stated that based on this information, Resident 1 did not receive any oxycodone 7.5-325 mg from his bubble pack. LVN 2 further stated that there are no oxycodone-acetaminophen 7.5-325 mg tablets in the facility's Emergency Medication Kit (E-Kit- contains a limited supply of medications for use during emergencies when regular pharmacy services are unavailable) either.</p> <p>During an interview on 6/17/2025 at 1:55 p.m., with LVN 3, LVN 3 stated that on 6/13/2025, she (LVN 3) worked at the facility from 11p.m. to 7a.m. and she was assigned to Resident 1. LVN 3 stated that Resident 1 did not report any pain during her shift. LVN 3 stated that Resident 1's physician ordered to administer oxycodone 7.5-325 mg to the resident three times a day for pain management. LVN 3 stated that she did not administer Resident 1's oxycodone-acetaminophen that was prescribed by his physician to be administered on 6/14/2025 at 6:00 a.m. LVN 3 stated that she accidentally documented that she administered oxycodone-acetaminophen 7.5-325 mg to Resident 1 on 6/14/2025 at 6:00 a.m. LVN 3 stated that while she was in Resident 1's room in the early morning of 6/14/2025, she (LVN 3) had to leave Resident 1's room to tend to another resident. LVN 3 stated that she must have documented by mistake when she was in a rush leaving Resident 1's room. LVN 3 stated that she should have administered pain medication to Resident 1 as ordered by his physician. LVN 3 stated that the potential outcome of not administering pain medication as ordered by the physician is increased pain and discomfort for the resident.</p> <p>During an interview on 6/17/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON stated that licensed staff are required to administer medication to residents as ordered by their physicians. The DON stated that licensed staff are responsible to document accurately and timely in the resident's medical record when they administer medications. The DON stated that Resident 1's oxycodone-acetaminophen 7.5-325 mg bubble pack is intact and contains 30 tablets. The DON stated that LVN 3 did not administer Resident 1's oxycodone scheduled for administration on 6/14/2025 at 6:00 a.m. The DON stated that LVN 3 made an incorrect and inaccurate documentation that she administered the medication in Resident 1's MAR. The DON stated that the potential outcome of not administering a resident's scheduled pain medication as ordered by the physician is increased pain and harm to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedures (P&P) titled Administering medications, last reviewed on 1/16/2025, the P&P indicated that medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour before and after of their prescribed time, unless otherwise specified. If a drug is withheld, refused, or given at a time other than the scheduled tie, the individual administering the medication shall document accordingly. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next dose.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on interview and record review, the facility failed to maintain accurate medical records in accordance with the accepted professional standards for one of three sampled residents (Resident 1) when on 6/14/2025, Licensed Vocational Nurse 3 (LVN 3) documented in the Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) that she administered Resident 1's pain medication when it had not been given.</p> <p>This deficient practice placed the resident at risk of not receiving appropriate care due to inaccurate medical care information.</p> <p>Findings:</p> <p>During a review of Resident 1's admission Record (face sheet), the admission Record indicated that the facility admitted the resident on 6/13/2025, with diagnoses including type two diabetes mellitus (DM2-a disorder characterized by difficulty in blood sugar control and poor wound healing), displayed fracture (when the broken ends of the bone are no longer aligned) of second cervical vertebra (the neck area of your spine), and abrasion (a superficial wound caused by rubbing or scraping the skin) of scalp (the skin covering the head).</p> <p>During a review of Resident 1's Nursing Documentation Evaluation form dated 6/13/2025, the Nursing Evaluation form indicated that the resident was alert and oriented to time, place, and person and was able to communicate his needs with clear speech.</p> <p>During a review of Resident 1's physician Order Summary Report (physician order) dated 6/13/2025, the Order Summary Report indicated to administer oxycodone-acetaminophen (a medication to relieve moderate to severe pain) oral tablet 7.5-325 milligrams (mg-a unit of measure of mass), give one (1) tablet by mouth three times a day for pain management.</p> <p>During a review of Resident 1's Medication Administration Record for 6/13/2025-6/14/2025, the MAR indicated that Licensed Vocational Nurse 3 (LVN 3) administered oxycodone-acetaminophen oral tablet 7.5-325 mg to Resident 1 on 6/14/2025 at 6:00 a.m.</p> <p>During a telephone interview on 6/17/2025 at 11:37 a.m. with Resident 1, Resident 1 stated that he was admitted to the facility in the afternoon of 6/13/2025, and he left the facility in the morning of 6/14/2025. Resident 1 stated that he left the facility because he did not receive any pain medications, the bed was uncomfortable, and his breakfast was cold. Resident 1 stated that the facility staff only offered Tylenol for his pain which does not work for him. Resident 1 stated that he did not receive oxycodone 7.5-325 mg while in the facility.</p> <p>During a concurrent interview and record review on 6/17/2025 at 11:43 a.m. with Registered Nurse 2 (RN 2), Resident 1's MAR for June 2025 was reviewed. RN 2 stated that on 6/14/2025 at 6:00 a.m., LVN 3 documented that she administered oxycodone-acetaminophen oral tablet 7.5-325 mg to Resident 1.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 6/17/2025 at 12: 51 p.m., with Licensed Vocational Nurse 2 (LVN 2), Resident 1`s oxycodone-acetaminophen bubble pack (a medication packaging system that contains individual doses of medication per bubble), and Antibiotic and Controlled Drug (medications which have a potential for abuse and may also lead to physical or psychological dependence) Record for June 2025 were reviewed. LVN 2 stated that Resident 1`s oxycodone-acetaminophen oral tablet 7.5-325 mg bubble pack is intact and contains 30 tablets. LVN 2 stated that Resident 1`s Antibiotic and Controlled Drug Record also indicated that the count for oxycodone-acetaminophen 7.5-325 mg tablets is 30. LVN 2 stated that based on this information, Resident 1 did not receive any oxycodone 7.5-325 mg from his bubble pack. LVN 2 further stated that there are no oxycodone-acetaminophen 7.5-325 mg tablets in the facility`s Emergency Medication Kit (E-Kit- contains a limited supply of medications for use during emergencies when regular pharmacy services are unavailable) either.</p> <p>During an interview on 6/17/2025 at 1:55 p.m., with LVN 3, LVN 3 stated that on 6/13/2025, she (LVN 3) worked at the facility from 11 p.m. to 7 a.m., and she was assigned to Resident 1. LVN 3 stated that Resident 1 did not report any pain during her shift. LVN 3 stated that she accidentally documented that she administered oxycodone-acetaminophen 7.5-325 mg to Resident 1 on 6/14/2025 at 6:00 a.m. LVN 3 stated that while she was in Resident 1`s room in the early morning of 6/14/2025, she (LVN 3) had to leave Resident 1`s room to tend to another resident. LVN 3 stated that she must have documented by mistake when she was in a rush leaving Resident 1`s room. LVN 3 stated that she should not have documented that she administered pain medication to Resident 1 when in fact she did not provide him with any medication. LVN 3 stated that the potential outcome of documenting that a medication was administered to a resident when it was not is incorrect and inaccurate medical records.</p> <p>During an interview on 6/17/2025 at 2:30 p.m., with the Director of Nursing (DON), the DON stated licensed staff are required to administer medication to residents as ordered by their physicians. The DON stated licensed staff are responsible to document accurately and timely in the resident`s medical record when they administer medications. The DON stated that LVN 3 did not administer Resident 1`s oxycodone scheduled for administration on 6/14/2025 at 6:00 a.m. The DON stated that LVN 3 made an incorrect and inaccurate documentation that she administered the medication in Resident 1`s MAR. The DON stated that the potential outcome of documenting that a medication was administered to a resident when it was not, is inaccurate medical records and creating confusion among staff in providing appropriate care to the resident.</p> <p>During a review of the facility`s Policy and Procedures (P&P) titled Nursing Documentation, last reviewed on 1/16/2025, the P&P indicated that the purpose of this policy is to communicate patient`s status and provide complete, comprehensive and accessible accounting of care and monitoring provided. Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident`s condition, situation, and complexity. Documentation for subsequent and/or routine care and procedures may be completed by exception or the use of checklist, flow charts, or other documentation tools. Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion as outlines by other policies and procedures.</p> <p>During a review of the facility`s Policy and Procedures (P&P) titled Administering Medications, last reviewed on 1/16/2025, the P&P indicated that if a drug is withheld, refused, or given at a time other than the scheduled tie, the individual administering the medication shall document accordingly.</p>		