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	08/22/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to notify a resident's physician regarding a resident's Systane (used to relieve burning, irritation, and discomfort caused by dry eyes) night ophthalmic (relating to the eyes) gel not being available and not being administered for one of four sampled residents (Resident 1). This deficient practice had the potential to result in worsening symptoms and negatively affect the delivery of care and services to Resident 1.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 3/24/2025 and readmitted the resident on 6/12/2025 with diagnoses that included Parkinson's disease (a movement disorder of the nervous system that worsens over time), hypotension (low blood pressure), and bipolar disorder (mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/5/2025, the MDS indicated Resident 1 was able to make self-understood and understand others, and Resident 1's cognition (ability to think and make decisions) was intact. The MDS further indicated that Resident 1 was independent for activities of daily livings (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Order Summary Report dated 8/19/2025, the Order Summary Report indicated the physician ordered to instill (to introduce a liquid substance slowly and drop by drop into a specific body cavity or surface) Systane night ophthalmic gel 0.3%, one drop in both eyes at bedtime for dry eyes.During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 8/2025, the MAR indicated that Licensed Vocational Nurse 1 (LVN 1) did not administer Systane to Resident 1's eyes on 8/19/2025 and 8/20/2025 at 9 p.m.During a concurrent interview and record review on 8/21/2025 at 4:53 p.m. , with LVN 1, reviewed Resident 1's MAR for 8/2025. LVN 1 stated Resident 1's Systane was not delivered on 8/19/2025 and 8/20/2025, and Resident 1's Systane was still not available on that day, 8/21/2025. LVN 1 stated LVN 1 was going to contact the pharmacy to find out how long it would take to be delivered. When LVN 1 was asked if LVN 1 notified Resident 1's physician that Resident 1's Systane was not available and was not administered to Resident 1's eyes on 8/19/2025 and 8/20/2025, LVN 1 stated that she (LVN 1) did not inform Resident 1's physician yet. During a concurrent interview and record review on 8/21/2025 at 4:59 p.m., with the Director of Nursing (DON), reviewed Resident 1's MAR for 8/2025 for Systane. The DON stated that if any medications were not delivered from the pharmacy and the facility was not able to administer the medications to the residents, the license nurses should notify the residents' physician for unavailability of medication because a physician might have a different plan of care if the physician knew the ordered medications were not available.During a review of the facility's policy and procedure (P&P) titled, Guidelines for Notifying Physicians of Clinical Problems, last reviewed on 1/16/2025, the policy indicated, The charge nurse or supervisor should contact the attending physician at any time if they feel a clinical situation requires immediate discussion and management.Non-immediate Notification Situations. However, do not wait if there is concern or reason to believe that the situation requires more urgent discussion.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for one of four sampled residents (Resident 1) by failing to accurately document Resident 1's blood pressure (BP - a measure of how well blood circulates through your arteries [pathway that carries blood away from the heart]).This deficient practice placed the resident at risk of not receiving appropriate care due to inaccurate resident medical care information and the potential to result in confusion in the care and services for Resident 1.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 3/24/2025 and readmitted the resident on 6/12/2025 with diagnoses that included Parkinson's disease (a movement disorder of the nervous system that worsens over time), hypotension (low blood pressure), and bipolar disorder (mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/5/2025, the MDS indicated Resident 1 was able to make self-understood and understand others, and Resident 1's cognition (ability to think and make decisions) was intact. The MDS further indicated that Resident 1 was independent for activities of daily livings (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 1's Order Summary Report dated 8/21/2025, the Order Summary Report indicated the following orders:- Record standing BP, again after three (3) minutes. Standing BP at 10 a.m., 12:30 p.m., and 5:30 p.m., three times a day. Order date: 3/26/2025.- Midodrine hydrochloride (used to treat the symptoms of low BP caused by a changing position or standing), give 10 milligram (mg- unit of measurement) by mouth three times a day related to hypotension (low blood pressure), hold for systolic BP (SBP - the first number in a blood pressure reading, which measures the pressure in the arteries when the heart beats) greater than 120, call the physician immediately if SBP is less than 90. Order date 8/7/2025. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 8/2025, the MAR indicated the following:- On 8/1/2025 at 5 p.m., Resident 1's standing BP was 66/58 millimeters of mercury (mmHg- unit of measurement for BP).- On 8/8/2025 at 5 p.m., Resident 1's standing BP was 53/39 mmHg. During a review of Resident 1's Weights and Vitals Summary, the Weights and Vitals Summary indicated the following:- On 8/8/2025, Resident 1's sitting BP was 80/56 mmHg at 8:44 p.m., Resident 1's standing BP was 53/39 mmHg at 8:45 p.m., and Resident 1's sitting BP was 80/56 mmHg at 8:46 p.m. During a concurrent phone interview and record review on 8/21/2025 at 3:50 p.m., with Licensed Vocational Nurse 2 (LVN 2), reviewed Resident 1's Weights and Vitals Summary. Informed LVN 2 that LVN 2 documented Resident 1's BPs on 8/8/2025 was 80/56 mmHg at 8:44 p.m., 53/39 mmHg at 8:45 p.m., and 80/56 mmHg at 8:46 p.m. LVN 2 stated that Resident 1's BPs were not that low and entered the wrong readings mistakenly, but LVN 2 did not know how to correct it by striking out the documentation and was so busy to correct Resident 1's BP readings on that day (8/8/2025). LVN 2 further stated that Resident 1 took midodrine to elevate low BPs, but still if Resident 1's BPs were that low then LVN 2 should call the physician to notify about Resident 1's low BPs but Resident 1 never had any episodes of SBP below 90.During a concurrent interview and record review on 8/21/2025 at 4:26 p.m., with the Director of Nursing (DON), reviewed Resident 1's Weights and Vitals Summary. The DON stated that LVN 2 should correct the wrong data entered, and if they do not know how to correct it, then LVN 2 should ask an RN supervisor or other licensed nurses. The DON stated if licensed nurses do not correct the data entered mistakenly in a timely manner, especially BP readings, it would make the staff confused regarding a resident's condition or the services delivered. During a concurrent phone interview and record review on 8/22/2025 at 3:56 p.m., with LVN 2, reviewed Resident 1's MAR dated 8/2025. Informed LVN 2 that LVN 2 documented that Resident 1's standing BP was 66/58 mmHg on 8/1/2025 at 5 p.m. LVN 2 stated that Resident 1's SBP was never lower than 90 and it was entered mistakenly. LVN 2 was unable to recall Resident 1's BP on 8/1/2025 but if it was that low, LVN 2 should initiate a Change of Condition (COC - any significant, sudden deviation from a resident's normal physical, mental, cognitive, or functional status) and notify the physician. LVN 2 stated Resident 1's low BP was entered mistakenly and LVN 2 did not learn how to correct in the MAR. During a review of the facility's policy and procedure (P&P) titled, Blood Pressure, Measuring, last reviewed on 1/16/2025, the policy indicated, Hypotension is defined as blood pressure less than 100/60 millimeters of mercury. Nurse should review if there are any medications ordered for hypotension and administer as ordered. Recheck blood pressure then