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	09/08/2025

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's attending physician documented a resident's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) within 72 hours following admission for one of three sampled residents (Resident 1).This deficient practice had the potential for inconsistent care coordination due to incomplete medical records for Resident 1.Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility readmitted Resident 1 on 8/26/2025 with diagnoses that included other toxic encephalopathy (a broad term for any brain disease that alters brain function or structure), sepsis (a life-threatening blood infection), and pneumonia (an infection/inflammation in the lungs). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 8/27/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the sense) was severely impaired. The MDS indicated Resident 1 substantial/maximal assistance required from staff with eating, oral hygiene, toileting hygiene and personal hygiene.During a concurrent interview and record review on 9/5/2025 at 12:56 p.m., with the Director of Nursing (DON), reviewed Resident 1's medical records in regards to H&Ps. The DON stated that Resident 1 was readmitted on [DATE] and Resident 1's H&P was not completed until 9/1/2025, six days after readmission.During a follow-up interview on 9/8/2025 at 11:58 a.m., with the DON, the DON stated that residents' H&Ps should be completed and signed within 72 hours of initial admission and/or readmission. The DON stated that residents' H&Ps are important because it is the provider's baseline assessment by the facility's physician and it is a document where staff can reference the H&P for the residents' plan of care. During an interview on 9/8/2025 at 5:54 p.m., with the Nurse Practitioner (NP), the NP stated that the NP was not able to complete Resident 1's H&P timely because she has been behind on completing her notes because she has a lot of residents to see. The NP stated that she would not be able to finish her notes on the day of the visit and would complete and sign H&Ps at a later date. The NP further stated that she (the NP) is aware that she needs to complete and sign the H&P on the same day of her visit with the residents. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, reviewed date 1/16/2025, the policy indicated services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) regarding the resident's condition and response to care. During a review of the facility's P&P titled, Physicians Visits, reviewed date 1/16/2025, the policy indicated the attending physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a nutritional supplement drink per physician's order for one of three sampled residents (Resident 1).This deficient practice had the potential for Resident 1 to receive insufficient food intake which could result in weight loss and malnutrition (lack of sufficient nutrients in the body).Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility readmitted Resident 1 on 8/26/2025 with diagnoses that included other toxic encephalopathy (a broad term for any brain disease that alters brain function or structure), sepsis (a life-threatening blood infection), and pneumonia (an infection/inflammation in the lungs).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 8/27/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the sense) was severely impaired. The MDS indicated Resident 1 substantial/maximal assistance required from staff with eating, oral hygiene, toileting hygiene and personal hygiene.During a review of Resident 1's Order Summary Report, the Order Summary Report indicated an order for regular diet, pureed texture (a texture modified diet that consists of smooth, moist foods that are easy to swallow, food with soft pudding like consistency), thin consistency, nutritional supplement drink one (1) bottle with meals, breakfast and lunch, ordered 8/26/2025.During a review of Resident 1's care plan (a document that summarizes a resident's needs, goals, and care/treatment) for resident is at nutritional risk, revised on 8/27/2025, the care plan indicated an intervention for nutritional supplement drink with meals breakfast and lunch for supplement.During a review of Resident 1's Nutritional assessment dated [DATE] timed 12:09 p.m., the Nutritional Assessment indicated nutritional supplement drink twice a day with meals with breakfast and lunch to provide additional calories and protein.During an observation on 9/5/2024 at 12:45 p.m., in Resident 1's room, observed Resident 1's lunch tray. Observed no nutritional supplement drink on Resident 1's lunch tray.During an interview on 9/5/2025 at 2:58 p.m., with the Assistant Dietary Supervisor (ADS), the ADS stated that nutritional supplement drinks are not provided by the kitchen and are given to residents by nursing staff.During an interview on 9/5/2025 at 3:10 p.m., with the Director of Nursing (DON), the DON stated that certified nursing assistants will ask the charge nurses for the nutritional supplement drink to provide to residents.During an interview on 9/5/2025 at 3:15 p.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated that he (CNA 1) did not provide a nutritional supplement drink to Resident 1 because CNA 1 did not assist Resident 1 with lunch. CNA 1 stated that he did not provide a nutritional supplement drink for breakfast.During an interview on 9/5/2025 at 3:18 p.m., with Restorative Nursing Assistant (RNA 1), RNA 1 stated that she (RNA 1) assisted Resident 1 with lunch. RNA 1 continued to state that RNA 1 did not provide Resident 1 with a nutritional supplement drink during lunch or breakfast.During an interview on 9/5/2025 at 4:30 p.m., with the DON, the DON stated that nutritional supplement drinks should have been provided to Resident 1 because it is a physician's order.During a review of the facility's policy and procedure (P&P), Therapeutic Diets, last reviewed 1/16/2025, the policy indicated the therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care in accordance with his or her goals and preferences.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide two of three sampled residents (Resident 1 and Resident 2) with meals that accommodated their food preferences.This deficient practice had the potential to result in decreased meal intake which could lead to weight loss and malnutrition (lack of sufficient nutrients in the body).Findings:a. During a review of Resident 1's admission Record, the admission Record indicated the facility readmitted Resident 1 on 8/26/2025 with diagnoses that included other toxic encephalopathy (a broad term for any brain disease that alters brain function or structure), sepsis (a life-threatening blood infection), and pneumonia (an infection/inflammation in the lungs).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 8/27/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the sense) was severely impaired. The MDS indicated Resident 1 substantial/maximal assistance required from staff with eating, oral hygiene, toileting hygiene and personal hygiene.During a review of Resident 1's Order Summary Report, the Order Summary Report indicated an order for regular diet, pureed texture (a texture modified diet that consists of smooth, moist foods that are easy to swallow, food with soft pudding like consistency), thin consistency, nutritional supplement drink one (1) bottle with meals, breakfast and lunch, ordered 8/26/2025.During a review of Resident 1's care plan (a document that summarizes a resident's needs, goals, and care/treatment) for resident is at nutritional risk, revised on 8/27/2025, the care plan indicated an intervention to honor food preferences within meal plan. During a review of Resident 1's Dietary Profile dated 7/10/2025 timed 4:31 p.m., the Dietary Profile indicated Resident 1 likes mashed potato for lunch and dinner. Preferences noted on meal ticket.During a review of Resident 1's noon meal ticket dated Friday 9/5/2025, the meal ticket indicated: orange juice, Italian baked fish, herb baked potatoes, mashed potatoes, green beans, bread/margarine, white cake/chocolate icing, ice cream, pudding, and water.During a concurrent observation, interview, and record review on 9/5/2025 at 12:15 p.m., with the Assistant Dietary Supervisor (ADS), observed Resident 1's lunch tray which contained pureed Italian baked fish, pureed herbed baked potatoes, pureed green beans, pureed bread with margarine, pureed white cake with chocolate icing, ice cream, pudding, and water. The ADS reviewed Resident 1's noon meal ticket and stated that the mashed potatoes were not served. The ADS stated that Resident 1 should have been served mashed potatoes because mashed potatoes are Resident 1's preference and was printed on the meal ticket.b. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 7/16/2025 with diagnosis that included encephalopathy (a medical condition characterized by a disturbance in brain function that causes changes in mental state, behavior, and cognitive abilities), dysphagia (difficulty swallowing), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had severe cognitive impairment. The MDS indicated Resident 2 required setup and clean-up assistance with eating and oral hygiene and required supervision or touching assistance with staff with toileting and personal hygiene.During a review of Resident 2's Order Summary Report, the Order Summary Report indicated an order for regular diet, regular texture, thin consistency, ordered 11/4/2024. During a review of Resident 2's Dietary Profile dated 7/15/2025 timed 8:33 p.m., the Dietary Profile indicated coffee with all meals.During a review of Resident 2's noon meal ticket dated Friday 9/8/2025, the meal ticket indicated: baked ziti, tossed salad/dressing, garlic bread, strawberry poke cake, lemonade, and coffee. During an observation on 9/8/2025 at 12:50 p.m., in Resident 2's room, observed Resident 2's lunch meal tray. Observed no coffee on Resident 2's lunch meal tray.During an interview on 9/8/2025 at 12:55 p.m., with Resident 2, in Resident 2's room, Resident 2 stated that Resident 2 is missing his coffee.During a concurrent observation, interview, and record review on 9/8/2025 at 12:56 p.m., with the Director of Staff Development (DSD), reviewed Resident 2's noon meal ticket. Observed Resident 2's lunch meal tray and the DSD stated that Resident 2 is missing his coffee.During an interview on 9/8/2025 at 1:10 p.m., with the Director of Nursing (DON), the DON stated all meal tickets should be followed because the facility should be following residents' preferences. The DON stated it is the residents' right.During an interview on 9/8/2025 at 5:00 p.m., with the Registered Dietician (RD), the RD stated that it is important to honor residents' dietary preferences and follow residents' meal tickets because following preferences and meal ticket will help in increasing oral intake. The RD stated if the facility does not follow residents' preferences and/or meal ticket, there is a