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	12/15/2025

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

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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 ensure one of three sampled residents (Resident 1) received care and services in accordance with professional standards of practice by failing to administer Resident 1's midrodrine (medication to treat low blood pressure [hypotension]) as prescribed by the physician.This deficient practice resulted in the omission of midodrine which could have resulted in Resident 1 experiencing a hypotensive (low blood pressure) episode.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 3/24/2025 and readmitted Resident 1 on 6/1/2025 with diagnoses including Parkinson's disease (a brain disorder that slowly worsens over time, mainly affecting movement due to a lack of dopamine, a chemical messenger for smooth motion) without dyskinesia (involuntary, erratic, and uncontrollable body movements, ranging from subtle twitches to wild flinging or repetitive grimaces, often affecting the face, or limbs) and hypotension. During a review of Resident 1's History & Physical (H&P) dated 6/19/2025, the H&P indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 11/3/2025, the MDS indicated the resident had intact cognition (the mental process involved in knowing, learning, and understanding things). The MDS indicated Resident 1 was independent 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 dated 9/24/2025 for midrodrine hydrochloride (HCl) Oral Tablet. The order indicated to give 10 milligrams (mg-units of measurement) by mouth three times a day related to hypotension, hold if SBP (systolic blood pressure-the top number in a blood pressure reading) is greater than 150. During a concurrent interview and record review on 12/15/2025 at 2:26 p.m. with the MDS Nurse (MDSN), Resident 1's Medication Administration Record (MAR, a report detailing the medication administered to a resident by the licensed nurses) dated 11/2025 was reviewed. The MDSN stated that Resident 1 did not receive midrodrine on 11/30/2025 at 7:30 a.m. when the resident's blood pressure was 150/89 mg/dl (milligrams per deciliter - unit for measuring substance concentration in blood). The MDSN stated Resident 1's blood pressure was within the prescribed parameters (a set of defined limits) of administering Resident 1's midrodrine and it should have been administered. The MDSN stated all medications should be given per physician's order. During a concurrent interview and interview on 12/15/2025 at 2:35 p.m., with Licensed Vocational Nurse 2 (LVN 2), Resident 1's MAR dated 11/2025 was reviewed. LVN 2 stated that she did not administer Resident 1's midrodrine because she did not want Resident 1's blood pressure to go higher since midrodrine increases blood pressure. LVN 2 stated she should have given midodrine to Resident 1 as prescribed by the physician; failure to give the medication could have resulted in an episode of hypotension. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, with review date 1/16/2025, the P&P indicated medications are administered in a safe and timely manner, and as prescribed. The director of nursing services supervises and directs all personnel who administer without unnecessary interruptions. Medications are administered in accordance with the prescriber orders, including any required time frame.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure a bottle of ketoconazole 2% shampoo (used to treat a variety of infections caused by fungus or yeast) was secured in a medication cart and not left unattended on top of a toilet in a resident shared restroom for one of three sampled restrooms. This deficient practice had the potential for unauthorized use of the medication, which could result in a negative impact to the health, and well-being of residents and increases the risk of contamination.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 3/24/2025 and readmitted Resident 1 on 6/1/2025 with diagnoses including Parkinson's disease (a brain disorder that slowly worsens over time, mainly affecting movement due to a lack of dopamine, a chemical messenger for smooth motion) without dyskinesia (involuntary, erratic, and uncontrollable body movements, ranging from subtle twitches to wild flinging or repetitive grimaces, often affecting the face, or limbs) and hypotension. During a review of Resident 1's History & Physical (H&P) dated 6/19/2025, the H&P indicated Resident has the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 11/3/2025, the MDS indicated the resident had intact cognition (the mental process involved in knowing, learning, and understanding things). The MDS indicated Resident 1 was independent 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 dated 11/29/2025 for ketoconazole external shampoo 2%, apply to scalp topically every day shift on Wednesday and Saturday for seborrheic dermatitis (a common, long-term skin condition causing red, itchy, flaky patches with greasy scales, stubborn dandruff on the scalp, face, chest, and other oily areas) for 30 days, use shampoo on bath days and rinse thoroughly. During an observation on 12/15/2025 at 12:28 p.m., in Resident 1's shared restroom, observed a bottle of ketoconazole 2% shampoo on top of the toilet, unattended. During a concurrent observation and interview on 12/15/2025 at 12:45 p.m. with Treatment Nurse 1 (TN 1), in Resident 1's shared restroom, observed a bottle of ketoconazole 2% shampoo on top of the toilet, unattended. TN 1 stated that Resident 1's bottle of ketoconazole 2% shampoo should be stored in the treatment cart. TN 1 stated that Resident 1's bottle of ketoconazole 2% shampoo should be stored in the treatment cart because ketoconazole is a type of treatment medication and all medications should be stored in a locked cart for resident safety. During a review of the facility's policy and procedure (P&P) titled Storage of Medications, reviewed 1/16/2025, the P&P indicated the facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperatures, light and humidity controls. Only persons authorized to prepare and administer medications have access. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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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 - Some	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 - Some	Based on interview and record reviewed, the facility failed to maintain accurate medical records in accordance with accepted professional standards and practices for one of three sampled residents (Resident 3), by failing to ensure Licensed Vocational Nurse 2 (LVN 2) did not falsify blood pressure entries in Resident 3's Medication Administration Record (MAR, a report detailing the medication administered to a resident by the licensed nurses) on 12/1/2025, 12/8/2025, 12/9/2025, 12/12/2025, and 12/15/2025. This deficient practice had the potential to affect appropriate medication administration due to the inaccurate blood pressure documentation in Resident 3's medical record. Findings: During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted Resident 3 on 4/11/2025 and readmitted the resident on 11/19/2025 with diagnoses including heart failure (the heart cannot pump enough blood and oxygen to meet the body's needs), cardiomegaly (an enlarged heart, meaning the heart muscle is thicker or stretched out, making it harder to pump blood effectively), and essential hypertension (high blood pressure). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 11/21/2025, the MDS indicated the resident had severe cognitive (the mental process involved in knowing, learning, and understanding things) impairment. The MDS indicated Resident 3 required substantial/maximal assistance with eating, and is dependent with staff on oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 3's Order Summary Report, the Order Summary Report indicated an order dated 9/12/2025 for diltiazem (medication that treats high blood pressure and angina [chest pain]) tablet 30 milligrams (mg- unit of measurement), give 1 tablet by mouth three times a day for hypertension hold for SBP (Systolic Blood Pressure-the top number in a blood pressure reading) less than 110. During a concurrent interview and record review on 12/15/2025 at 3:23 p.m. with LVN 2, Resident 3's Medication Administration Record (MAR- a report detailing the medication administered to a resident by the licensed nurses) for 12/2025 was reviewed. LVN 2 stated that prior to the administration of a blood pressure medication, the resident's blood pressure should be taken and documented in the MAR. LVN 2 stated that she documented Resident 1's blood pressures on the MAR for the following days: 12/1/2025 at 9 a.m.112/59 millimeters of mercury (mmHg - is a unit of pressure)12/1/2025 at 1p.m. 112/59 mmHg12/8/2025 at 9 a.m.125/76 mmHg12/8/2025 at 1 p.m. 125/76 mmHg12/9/2025 at 9 a.m.122/76 mmHg12/9/2025 at 1 p.m. 122/76 mmHg12/12/2025 at 9 a.m. 124/72 mmHg12/12/2025 at 1 p.m. 124/72 mmHg12/15/2025 at 9 a.m. 106/78 mmHg12/15/2025 at 1 p.m. 106/78 mmHgLVN stated she took Resident 3's blood pressures at 1 p.m. on 12/1/2025, 12/8/2025, 12/9/205, 12/12/2025, and 12/15/2025, however, she did not document Resident 1's actual blood pressure readings. LVN 2 was unable to provide documented evidence of blood pressures taken at 1:00 p.m. on 12/1/2025, 12/8/2025, 12/9/2025, 12/12/2025, and 12/15/2025. LVN 2 stated that instead of documenting Resident 3's actual blood pressures at 1:00 p.m. on 12/1/2025, 12/8/2025, 12/9/2025, 12/12/2025, and 12/15/2025, she copied the blood pressures taken at 9 a.m. on 12/1/2025, 12/8/2025, 12/9/2025, 12/12/2025, and 12/15/2025 and documented these blood pressures for 1 p.m. on 12/1/2025, 12/8/2025, 12/9/2025, 12/12/2025, and 12/15/2025. LVN 2 stated she did not document the actual blood pressure at 1:00 p.m. on 12/1/2025, 12/8/2025, 12/9/2025, 12/12/2025, and 12/15/2025 because the facility was too fast-paced and that she had too many residents to document on. LVN 2 stated that because she willfully documented inaccurate blood pressure results in Resident 3's MAR, LVN 2 stated that it is falsification of documentation. During an interview on 12/15/2025 at 4:15 p.m. with the Director of Nursing (DON,) the DON stated that staff are to document blood pressure readings in real time. The DON stated that because LVN 2 knowingly and willfully documented inaccurate blood pressure results that LVN 2 did not take at the specific time, LVN 2 falsified Resident 3's blood pressure documentation. The DON further stated that it is important to document blood pressure reading accurately to enable staff to monitor and evaluate the effectiveness of the blood pressure medication. During a review of the facility's policy and procedure (P&P) titled Charting and Documentation, reviewed on 1/16/2025, the P&P 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 disciplinary team regarding the resident's condition and response to care. Documentation of procedures and treatments will include care specific details, including: c. the assessment data and/or any unusual findings obtained during the procedure/treatment. During a review of the facility's P&P titled Nursing Documentation, reviewed on