

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  01/08/2026
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to follow-up and cancel a resident's transportation for a cancelled appointment for one of five sampled residents (Resident 1). This deficient practice resulted in Resident 1 being transported to an appointment that was cancelled. 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 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 11/3/2025, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) 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 Nursing Progress Note dated 12/19/2025 timed at 11:52 p.m. documented by Registered Nurse 2 (RN 2), the Nursing Progress Note indicated Resident 1's Responsible Party (RP 1) requested to cancel the urology (branch of medicine concerned with the urinary system) appointment scheduled on 12/22/2025 at 11:30 a.m. During a review of Resident 1's Nursing Progress Note dated 12/22/2025 timed at 3:04 p.m., the Nursing Progress Note indicated that Resident 1 left for his appointment at 10:20 a.m. and returned at 12 p.m. stating that RP 1 might have cancelled the appointment. During a concurrent interview and record review on 1/8/2026 at 3:15 p.m., with the Director of Nursing (DON), reviewed Resident 1's Nursing Progress Note dated 12/19/2025 timed 11:52 p.m. The DON stated that RP 1 requested to cancel the appointment scheduled on 12/22/2025, but Resident 1 left the facility on [DATE] at 10:20 a.m. for their appointment then found out it had been cancelled when Resident 1 arrived at the clinic. The DON stated Resident 1 returned to the facility without seeing a urologist, and there was no documentation regarding cancelling Resident 1's transportation by the facility staff. During an interview on 1/8/2026 at 3:45 p.m., with the Social Services Director (SSD), the SSD stated that Resident 1's appointment was scheduled for 12/22/2025 at 11:30 a.m. but RP 1 had requested for Resident 1's appointment to be cancelled on Friday night 12/19/2025 at 11:52 p.m. The SSD stated the nursing staff did not inform the Social Services Department to follow up regarding Resident 1's cancelled appointment. The SSD stated Resident 1 left the facility on [DATE] at 10:30 a.m. and went to the clinic for the cancelled appointment and travelled for no reason. During a concurrent interview and record review on 1/8/2026 at 4:02 p.m., with Registered Nurse 2 (RN 2), reviewed Resident 1's progress notes and the facility's communication log used to communicate with facility staff. RN 2 stated RP 1 asked to cancel Resident 1's appointment that was scheduled for 12/22/2025. RN 2 stated that RN 2 documented on the communication log so the morning staff can follow up and</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>was not able to give a verbal endorsement to the next shift. During a concurrent interview and record review on 1/8/2026 at 4:50 p.m., with the DON, reviewed the communication log documented by RN 2 on 12/19/2025 at 11:52 p.m. The DON verified by stating that RN 1's documentation indicated a communication to the morning supervisor to cancel Resident 1's appointment for 12/22/2025 for 11:30 a.m. which was requested by RP 1. The DON stated the morning nurse on 12/22/2025 did not follow up to cancel Resident 1's transportation. During a review of the facility's policy and procedure (P&amp;P) titled, Transportation, Social Services, last reviewed on 1/16/2025, the P&amp;P indicated, Our facility shall help arrange transportation for residents as needed.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide pharmaceutical services to meet the needs for one of five sampled residents (Resident 2) by failing to: 1. Ensure Licensed Vocational Nurse 2 (LVN 2) administered methocarbamol (a prescription muscle relaxant used to relieve pain and discomfort from muscle spasms [or cramp, when a muscle suddenly and forcefully tightens up on its own, often feeling like a painful knot or twitch]) and gabapentin (used to treat nerve pain) in a timely manner per the physician's order for the scheduled dose at 9 a.m. and 1 p.m. for Resident 2. 2. Ensure the licensed nurses removed Resident 2's lidocaine external patch (a sticky, flexible pad placed on the skin to help relieve minor aches and pain) four (4) percent (% - unit of medication strength), or lidocaine 4% patch, as per the physician's order. 3. Ensure Registered Nurse 1 (RN 1) clarified the frequency of lidocaine 4% patch with Resident 2's physician upon admission on [DATE]. These deficient practices had the potential to result in worsening symptoms and pain and negatively affected the delivery of care and services to Resident 2. Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 12/22/2025 with diagnoses that included multiple fractures (broken bones) of right-side ribs, wedge compression fracture (WCF - collapsing the bone in the front of the spine and leaving the back of the same bone unchanged) of second lumbar vertebra (the five large, strong bones that make up the lower back and labeled Lumbar 1 [L1] to L5), and history of falling. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 12/25/2025, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was intact. The MDS further indicated that Resident 2 required moderate staff assistance for toileting hygiene, shower, upper/lower body dressing, bed mobility (movement), and transfer. During a review of Resident 2's Order Summary Report dated 12/22/2025, the Order Summary Report indicated the following orders:- Admit Resident 2 to the facility under Primary Care Physician 1 (PCP 1)'s care. Order Date: 12/22/2025- Methocarbamol oral tablet 500 milligram (mg - a unit of measurement): Give one (1) tablet by mouth three times a day for muscle spasm. Order Date: 12/22/2025.- Gabapentin capsule 100 mg: Give 100 mg by mouth three times a day for neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). Order Date: 12/22/2025.- Lidocaine 4% patch, apply to right chest area, ribs topically one time a day for pain management and remove per schedule. Order Date: 12/22/2025. a. During a review of Resident 2's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) Administration History, the MAR Administration History (MAR audit records) for methocarbamol oral tablet 500 mg, the MAR Administration History indicated the following:- On 12/24/2025, methocarbamol oral tablet 500 mg was scheduled for 9 a.m., but was administered at 12:07 p.m., and documented at 12:09 p.m.- On 12/24/2025, methocarbamol oral tablet 500 mg was scheduled for 1 p.m., but was administered at 2:42 p.m., and documented at 2:42 p.m. During a review of Resident 2's MAR Administration History for gabapentin 100 mg, the MAR Administration History indicated the following:- On 12/24/2025, gabapentin 100 mg was scheduled for 9 a.m., but was administered at 12:07 p.m., and documented at 12:09 p.m.- On 12/24/2025, gabapentin 100 mg was scheduled for 1 p.m., but was administered at 2:42 p.m., and documented at 2:42 p.m. During a concurrent phone interview and record review on 1/7/2026 at 2:59 p.m., with LVN 2, reviewed Resident 2's MAR Administration History for methocarbamol and gabapentin documented by LVN 2 on 12/24/2025 timed at 12:09 p.m. and 2:42 p.m. LVN 2 stated that LVN 2 documented after giving each resident their medications and was</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 - Some</p>	<p>a bit late to pass the medications in a timely manner on that day (12/24/2025). LVN 2 stated some medications were given out of the window time frame for medication administration, which was one hour before and one hour after the scheduled medication time. LVN 2 further stated the two medication administrations of methocarbamol and gabapentin were administered too close, with the first administration of both medications at 12:07 p.m. for the scheduled 9 a.m. dose, and the second administration of both medications at 2:42 p.m. for the scheduled 1 p.m. dose. LVN 2 stated LVN 2 monitored for side effects due to administering the medications too close. During a concurrent interview and record review on 1/8/2026 at 2:24 p.m., with the Director of Nursing (DON), reviewed Resident 2's physician orders and MAR Administration History for methocarbamol and gabapentin documented by LVN 2 on 12/24/2025 timed at 12:09 p.m. and 2:42 p.m. The DON stated that if LVN 2 administered the scheduled 9 a.m. dose at 12:07 p.m. and the scheduled 1 p.m. dose at 2:42 p.m., LVN 2 did not administer the medications in a timely manner per the physician orders, and the two medication administration times were too close to each other and there was a possibility for side effects to occur. During a review of the facility's policy and procedure (P&amp;P) titled, Administering Medications, last reviewed on 1/16/2025, the P&amp;P indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). b. During a concurrent interview and record review on 1/8/2026 at 12:06 p.m., with LVN 4, reviewed Resident 2's MAR Administration History and progress notes for the lidocaine 4% patch scheduled on 12/26/2025 at 9 a.m. LVN 4 stated that LVN 4 could remember the observation after checking her notes. LVN 4 stated that LVN 4 observed the old lidocaine 4% patch that was supposed to be removed on 12/25/2025 by the 3 p.m.-11 p.m. shift nurse, still on Resident 2's back of the lower lumbar area on 12/26/2025. LVN 4 stated Resident 2 was upset and refused to have a new lidocaine 4% patch on 12/26/2025, and documented NN meaning 'no medications and see nurses' notes'. During a concurrent interview and record review on 1/8/2026 at 2:17 p.m., with the DON, reviewed Resident 2's physician orders and MAR Administration History for lidocaine 4% patch scheduled on 12/26/2025 at 9 a.m. The DON stated that Resident 2's lidocaine 4% patch was supposed to be removed daily at 9 p.m. by the 3 p.m.-11 p.m. shift nurses. The DON further stated that the resident could have side effects from the overdose of lidocaine 4% patch if not removed per the physician orders. During a review of Resident 2's General Acute Care Hospital 1 (GACH 1) Inpatient Discharge Instructions provided by GACH 1 on 12/22/2025 to the facility, the Inpatient Discharge Instructions indicated the lidocaine 4% patch should be removed after eight (8) to 12 hours. During a review of the facility's P&amp;P titled, Administering Medications, last reviewed on 1/16/2025, the P&amp;P indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. c. During a review of Resident 2's GACH 1 Inpatient Discharge Instructions provided by GACH 1 on 12/22/2025 to the facility, the Inpatient Discharge Instructions indicated to apply one lidocaine 4% patch to affected area twice daily, duration for seven (7) days, and the next dose was on 12/22/2025 at 8 p.m. During a concurrent interview and record review on 1/8/2026 at 3:30 p.m., with RN 1 and the DON, reviewed Resident 2's GACH 1 Inpatient Discharge Instructions, admission orders dated 12/22/2025, Nursing Documentation Evaluation dated 12/22/2025, and the progress notes. When RN 1 was asked how RN 1 verified Resident 2's admission orders with the physician on 12/22/2025, RN 1 stated that RN 1 called the physician and followed GACH 1's Inpatient Discharge Instructions. When RN 1 was asked how RN 1 verified the lidocaine 4% patch order that indicated twice daily administration per Resident 2's GACH 1 Inpatient Discharge Instructions, RN 1 stated RN 1 carried over the order as once daily upon admission on</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 - Some</p>	<p>[DATE]. RN 1 stated RN 1 could not recall how they verified Resident 2's lidocaine 4% patch order and if RN 1 mentioned once daily or twice daily to the physician. During a concurrent phone interview and record review on 1/8/2026 at 4:58 p.m., with Primary Care Physician 1 (PCP 1), PCP 1 stated that he (PCP 1) received a phone call from the nurse to verify new admission orders for Resident 2. PCP 1 stated PCP 1 did not change lidocaine 4% patch from twice daily to once daily and the facility should follow Resident 2's GACH 1's Inpatient Discharge Instructions. During a review of the facility's P&amp;P titled, admission Notes, last reviewed on 1/16/2025, the P&amp;P indicated, When a resident is admitted to the nursing unit, the admitting nurse is to ensure the following information (as each may apply) is in the nurses' notes, admission form, or other appropriate place, as designated by facility protocol. The time the attending physician was notified of the resident's admission. Orders to be verified and carried out.</p>		