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	01/29/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) received treatment and care in accordance with professional standards of practice by:1. Failing to ensure a reassessment was completed for Resident 1 on 4/14/2025 during the day shift (7 a.m. to 3 p.m.) following a change in condition (COC - major decline or improvement in a resident's status that will not resolve without intervention) on 4/13/2025.2. Failing to ensure Resident 1's Medical Doctor 1 (MD 1) was notified that Resident 1 refused to provide a urine sample for a urinary analysis (UA- a laboratory test used to analyze urine levels for possible infections) and a urine culture and sensitivity (C&S- a laboratory test used to identify bacteria or yeast in the urine and determine the most appropriate medication for treatment of an infection). These tests were ordered by MD 1 on 9/18/2025 following a change in condition. These deficient practices had the potential to delay necessary treatment, care and services placing Resident 1 at risk for a decline in overall health status.1. During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 on 10/2/2023, with the most recent readmission on [DATE], with diagnoses that included metabolic encephalopathy (a brain disorder that can cause confusion personality changes and drowsiness), urinary tract infection (UTI- an infection in the bladder [a hollow, muscular organ that stores urine or urinary tract [the body's drainage system designed to produce, store, and remove urine [liquid waste and extra water]), epilepsy, (long term brain disorder causing recurring seizures [sudden, uncontrolled bursts of abnormal electrical activity in the brain]) acute kidney failure (sudden loss of kidney function) and hypertension (HTN- high blood pressure).During a review of Resident 1's Change of Condition form (COC form - a form used by the facility to document changes in resident's condition including actions taken and notification of the physician and responsible party) dated 4/13/2025, the COC form indicated Resident 1 returned to the facility on 4/13/2025 at 4:30 p.m. after being out of the facility. The COC form indicated that Resident 1 had left eye drooping and unequal pupils (a condition where the pupil [the black, circular opening in the center of the iris [colored part of the eye] that controls the amount of light entering the eye is not the same size). The COC form indicated Licensed Vocational Nurse 1 (LVN 1) completed an assessment of Resident 1 and documented that no drooping was observed; the resident had the left eye closed but was able to open it without difficulty and redness of the left eye was noted. During a review of Resident 1's Nursing Progress Note dated 4/14/2025, during the day shift, the Nursing Progress Note did not include documentation of a reassessment following Resident 1's change in condition identified on 4/13/2025.During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition) dated 9/29/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 10/20/2025, the MDS indicated Resident 1's cognition (ability to think and make decisions) was moderately impaired. The (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS further indicated Resident 1 required set-up assistance with oral hygiene, supervision with toileting and personal hygiene and moderate assistance from staff with upper and lower body dressing. During a concurrent interview and record review on 1/29/2026 at 2:05 p.m., with Licensed Vocational Nurse (LVN 2), Resident 1's Nursing Progress Note dated 4/14/2025 was reviewed. LVN 2 stated that when a resident experiences a change in condition, the resident is to be monitored for three (3) days following the change, and a reassessment should be completed during each assigned shift. LVN 2 stated that there was no documented reassessment completed during the day shift regarding Resident 1's COC on 4/13/2025. LVN 2 further stated that a reassessment should have been completed and documented. 2. During a review of Resident 1's COC form dated 9/18/2025, the COC form indicated Resident 1 was assisted into a wheelchair per Resident 1's request and consistent with his (Resident 1) usual routine. The COC form indicated that on 9/18/2025, after eating lunch in the dining room, Resident 1 stated that he (Resident 1) wanted to return to bed and sleep, which was not his (Resident 1) normal pattern. The COC indicated Resident 1 reported increased sleepiness and went to sleep immediately upon returning to bed. The COC indicated MD 1 was notified of the COC and placed a stat (immediately) order for laboratory tests to be completed, including a complete blood count (CBC- a blood test used to evaluate your over health), a comprehensive metabolic panel (CMP- a common, 14-component blood test that checks your body's chemical balance, metabolism and major organ health), Keppra level (a blood test used to measure the level of Keppra [medication used to treat seizures] in the blood stream) and UA along with a urine C&S). During a review of Resident 1's laboratory requisition form dated 9/18/2025, the laboratory requisition form indicated that Resident 1 refused to provide a urine sample, and a UA and urine C&S were not submitted to the laboratory for analysis. During a review of Resident 1's Nursing Progress Note dated 9/18/2025, the Nursing Progress Note indicated that MD 1 was informed of the CBC, CMP, and Keppra level results. However, there was no documentation indicating that MD 1 was informed that Resident 1 did not provide a urinary sample and that the UA and C&S were not completed. During a review of Resident 1's COC form dated 9/22/2025, the COC form indicated that Resident 1 exhibited progressive weakness and increased confusion. The COC form indicated MD 1 was notified and ordered Resident 1 to be transferred to General Acute Care Hospital (GACH) for further evaluation. During a concurrent interview and record review on 1/29/2026 at 3:10 p.m., with the Director of Nursing (DON), Resident 1's Nursing Progress Notes from 4/13/2025 to 4/14/2025 and COC form dated 4/13/2025 were reviewed. The DON stated that following a change in condition, a resident is to be monitored for 72 hours. The DON further stated that the standard of practice is complete a reassessment on each nursing shift, document the reassessment, and notify the MD of any changes in the resident's condition. The DON stated that there was no documented reassessment during the day shift on 4/14/2025 for Resident 1's COC on 4/13/2025. The DON also stated that when an MD orders laboratory test, the MD should be notified of the results, including any refusal by a resident to provide a laboratory specimen (biological sample such as blood or urine collected from a human for analysis, diagnosis or treatment monitoring). The DON stated Resident 1 had a physician order for a UA and C&S on 9/18/2025 however there was no documentation that MD 1 was informed of Resident 1's refusal to provide a urine sample. The DON stated that MD 1 should have been notified of the refusal. When asked if the facility has a policy and procedure (P&P) to ensure reassessments are completed following a COC, the DON stated that the facility does not have and that the current COC policy only addresses notification to the physician. During a review of the facility's P&P titled Requesting, Refusing and/or Discontinuing Care or Treatment last reviewed on 1/15/2026, the P&P indicated that the healthcare practitioner/provider must be notified of refusal of treatment, in a time frame determined by the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's condition and potential serious consequences of the request.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) had accurate information documented on the Change of Condition form (COC form - a form used by the facility to document changes in resident's condition including actions taken and notification of the physician and responsible party) by failing to document the correct time that Resident 1's Medical Doctor (MD) was notified of Resident 1's change of condition on 4/13/2025.This deficient practice had the potential to delay necessary treatment, care and services placing Resident 1 at risk for a decline in overall health status.Findings:1. During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 on 10/2/2023, with the most recent readmission on [DATE], with diagnoses that included metabolic encephalopathy (a brain disorder that can cause confusion personality changes and drowsiness), urinary tract infection (UTI- an infection in the bladder [a hollow, muscular organ that stores urine or urinary tract [the body's drainage system designed to produce, store, and remove urine [liquid waste and extra water]), epilepsy, (long term brain disorder causing recurring seizures [sudden, uncontrolled bursts of abnormal electrical activity in the brain]) acute kidney failure (sudden loss of kidney function) and hypertension (HTN- high blood pressure).During a review of Resident 1's COC form dated 4/13/2025, the COC form indicated Resident 1 returned to the facility on 4/13/2025 at 4:30 p.m. after being out of the facility. The COC form indicated that Resident 1 had left eye drooping and unequal pupils (a condition where the pupil [the black, circular opening in the center of the iris [colored part of the eye] that controls the amount of light entering the eye is not the same size). The COC form indicated Licensed Vocational Nurse 1 (LVN 1) completed an assessment of Resident 1 and documented that no drooping was observed; the resident had the left eye closed but was able to open it without difficulty and redness of the left eye was noted. The COC form, completed by LVN 1, indicated that Resident 1's MD was notified of the change of condition and documented the date and time of the notification as 4/13/2025 at midnight.During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition) dated 9/29/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 10/20/2025, the MDS indicated Resident 1's cognition (ability to think and make decisions) was moderately impaired. The MDS further indicated Resident 1 required set-up assistance with oral hygiene, supervision with toileting and personal hygiene and moderate assistance from staff with upper and lower body dressing. During a concurrent interview and record review on 1/29/2026 at 3:05 p.m., with the Director of Nursing (DON), the COC form dated 4/13/2025 was reviewed. The DON stated that Resident 1's COC form indicated Resident 1 had left eye drooping and unequal pupils. The DON stated that LVN 1 documented the MD was notified on 4/13/2025 at midnight however, this was not correct. The DON stated that LVN 1 should have documented the actual time the MD was called and notified of the COC on the COC form. The DON further stated that information documented on the COC form must be timely and accurate to prevent any delay in resident care. During a review of the facility's policy and procedure (P&P) titled Change in Condition: Notification of last reviewed on 1/15/2026, the P&P indicated The purpose of the facility policy is to ensure residents, family legal representatives, and physicians are informed of changes in the resident's condition.A facility must immediately inform the resident, consult with the Resident's physician and/or nurse practitioner (NP), and notify, consistent with his/her authority.When making notification of above, the facility must ensure that all pertinent information is available and provide upon request (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the physician and or NP. During a review of the facility's P&P titled Charting and Documentation last reviewed on 1/15/2026, the P&P indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the residents medical, physical, functional or psychosocial condition, shall be documented in the resident's medical records. The medical records should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.Documentation in the medical record will be objective, complete and accurate.