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	03/06/2026

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 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 observation, interview and record review, the facility failed to ensure that the body weight of one of three sampled residents (Resident 1) was accurately documented in the medical record. This deficient practice had the potential to result in delays in care and services for Resident 1, as well as a decreased quality of care and overall health status.Findings: During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted Resident 1 on 3/14/2025 and readmitted on [DATE] with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), bipolar disorder (a chronic mental health condition characterized by intense alternating mood swings between extreme highs and lows), hypotension (low blood pressure). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition) dated 6/19/2025, 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 1/30/2026, the MDS indicated Resident 1's cognition (ability to think and make decisions) was intact. The MDS further indicated Resident 1 was independent with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Weight Summary from 1/8/2026 to 3/3/2026, the Weight Summary indicated the following weights: 159 pounds on 1/8/2026, 159 pounds on 2/9/2026 and 158 pounds on 3/3/2026. During a review of the list of Resident Weights dated 2/28/2026, obtained by Restorative Nursing Attendant 1 (RNA 1) on 2/28/2026, the list of Resident Weights indicated Resident 1's weight as 148 pounds (lbs. - a unit of weight). During an observation on 3/5/2026 at 10:50 a.m., Resident 1 was weighed by Restorative Nursing Attendant 2 (RNA 2), at which time Resident 1's body weight was observed to be 143 lbs. During a concurrent interview and record review on 3/6/2026 at 12:50 p.m., with the Assistant Director of Nursing (ADON), Resident 1's Weight Summary dated 1/8/2026 to 3/3/2026 and along the list of Resident Weights dated 2/28/2026 were reviewed. The ADON stated that Resident 1's Weight Summary form indicated a body weight of 158 lbs. on 3/3/2026, which was entered/documented by the ADON. The ADON confirmed that Resident 1's weight obtained by RNA 1 on 2/28/2026 was 148 lbs. The ADON stated that an incorrect weight was entered into Resident 1's medical record on 3/3/2026 and stated that Resident 1's weight should have been documented as 148 lbs. During an interview on 3/6/2026 at 3:00 p.m., with the Director of Nursing (DON), the DON stated that Resident 1's body weight should have been accurately documented in Resident 1's medical record, reflecting the correct weight of 148 lbs. obtained on 2/28/2026. The DON confirmed that inaccurate documentation has the potential to result in delays in care and services. A review of the facility's policy and procedure (P&P) titled Charting and Documentation last reviewed on 1/15/2026, the P&P indicated All 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 records (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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.Documentation in the medical records will be objective, complete and accurate.