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	04/22/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the admission Minimum Data Set (MDS - a resident assessment tool) accurately reflected the resident's status for one of four sampled residents (Resident 1). This deficient practice had the potential to result in delayed or inadequate delivery of care and services for Resident 1.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 3/21/2026 with diagnoses that included traumatic subdural hemorrhage (a dangerous collection of blood that forms between the brain's surface and its outer lining), hemiplegia (the severe or complete loss of movement on one side of the body) and hemiparesis (weakness on one entire side of the body [arm, leg, and sometimes face] caused by brain or nervous system injury), and epilepsy (a chronic neurological disorder characterized by recurrent seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]). During a review of Resident 1's History and Physical Examination dated 3/24/2026, the History and Physical Examination indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's admission MDS, dated [DATE], the MDS indicated Resident 1 had the ability to express ideas and wants, as well as the ability to understand others. The MDS also indicated a brief interview for mental status should not be conducted because Resident 1 is rarely/never understood. The MDS also indicated Resident 1 received 51% or more of their total calories through tube feeding (a way of giving medicines and liquids, including liquid foods, through a small tube placed through the nose or mouth into the stomach or small intestine) and averaged 501 cubic centimeter (cc- unit of volume) per day or more of fluid intake through tube feeding. The MDS further indicated Resident 1 had no skin conditions. During a review of Resident 1's Physician's Order Summary Report, the Order Summary Report indicated there was a physician's order, dated 3/21/2026, for a cardiac diet (a heart healthy eating plan designed to lower the risk of cardiovascular disease, manage high blood pressure, and improve cholesterol levels), minced and moist texture, and thin consistency. Resident 1's Order Summary Report also indicated a physician's order, dated 3/21/2026, for Jevity 1.2 (liquid nutrition formula designed for tube feeding or oral feeding that offers 1.2 calories per milliliter (mL - unit of measurement) at 50 mL per bolus (a single, relatively large dose of medication or fluid administered rapidly) via (through) PEG tube (Percutaneous Endoscopic Gastrostomy tube - a medical device inserted through the abdominal wall directly into the stomach to provide long-term nutrition, fluids, and medications), four times a day, in between meals. During a review of Resident 1's 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) Care Conference Notes, dated 4/1/2026, the IDT notes indicated Resident 1 had left and right groin MASD (Moisture-Associated Skin Damage - a general term for inflammation, irritation, or erosion [wearing away] of the skin caused by prolonged exposure to moisture where the skin becomes too wet, softens, and breaks down). During a review of Resident 1's Care Plan Report, from 3/21/2026 to 4/14/2026, the Care Plan Report indicated Resident 1 had a care plan for left groin MASD initiated on 3/22/2026 and a care plan for right groin MASD initiated on 3/22/2026. During an interview on 4/21/2026 at 1:08 p.m., with Certified Nursing (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant 3 (CNA 3), CNA 3 stated Resident 1 was alert but confused and unable to answer questions. During a concurrent interview and record review on 4/22/2026 at 11:55 a.m., with the MDS Coordinator (MDSC), Resident 1's admission MDS dated [DATE] was reviewed. The MDSC stated the admission MDS was completed on 4/1/2026, therefore information for the admission MDS was gathered between the dates of 3/21/2026 to 4/1/2026. The MDSC stated the information was inaccurate for the following sections: Section B - Hearing, Speech and Vision: The admission MDS indicated Resident 1 had the ability to express ideas and wants, as well as the ability to understand others. The MDSC stated Resident 1 did not have the full ability to express ideas and wants and did not have the ability to understand others. Section K - Swallowing/Nutrition Status: The admission MDS indicated Resident 1 received 51% or more of their total calories through tube feeding and averaged 501 cc per day or more of fluid intake through tube feeding. The MDSC stated Resident 1 was receiving less than 51% of their total calories through tube feeding and less than 501cc of fluid intake through tube feeding. Section M - Skin Conditions: The admission MDS indicated Resident 1 did not have any skin conditions. The MDSC stated Resident 1 actually had left and right groin MASD and that should have been reflected in the section. The MDSC stated it is essential to ensure the accuracy of MDS information so the facility can effectively meet residents' needs. The MDSC stated that the MDS and care planning are directly linked, and an accurate MDS is necessary to develop appropriate care plans with relevant goals for the residents. During an interview on 4/22/2026 at 1:23 p.m., with the Director of Nursing (DON), the DON stated that the MDSC had informed her of the inaccuracies in Resident 1's admission MDS dated [DATE]. The DON stated the purpose of the MDS is to obtain an accurate assessment of the resident to ensure the care plan is appropriate. The DON further stated that inaccuracies in the MDS may result in omitted or incorrect care plans, leading to resident needs not being adequately addressed. During a review of the facility's policy and procedure titled, Resident Assessments, last revised on 10/2023, the policy indicated, information in the MDS assessment will consistently reflect information in the progress notes, plan of care and resident observations/interviews. During a review of the facility's policy and procedure titled, Charting and Documentation, last revised on 7/2017, the policy indicated, documentation in the medical record will be objective, complete, and accurate.