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	05/04/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess and complete the fall risk factors in the Nursing Documentation Evaluation for three of five sampled residents (Resident 1, Resident 2, and Resident 3).This deficient practice had the potential to place the residents at increased risk for injury related to falls.Findings:a. During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 on 3/21/2026 with diagnoses that included traumatic brain injury (TBI - a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head), epilepsy (a brain condition that causes people to have repeated, unexpected seizures [a sudden, temporary surge of abnormal electrical activity in the brain that disrupts its normal function]), anemia (a condition where the body does not have enough healthy red blood cells), dementia (a progressive state of decline in mental abilities), and history of falling.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/24/2026, the MDS indicated that Resident 1's cognition (ability to think, reason, and function) was severely impaired. The MDS further indicated that Resident 1 was dependent on staff with Activities of Daily Living (ADLs - activities such as bathing, dressing and toileting a person performs daily) except eating which required maximal assistance.During a review of Resident 1's Change in Condition (COC - an acute, abnormal alteration in a resident's physical or mental baseline) Evaluation form dated 4/7/2026 timed at 5:10 a.m., the COC Evaluation form indicated that staff found Resident 1 lying on the floor next to bed; Resident 1 was unable to state what happened but upon assessment Resident 1 had stated that Resident 1wanted to be assisted to the bathroom. Resident 1 had minimal bleeding on the right lower lip. Resident 1's Transfer Form dated 4/7/2026 indicated that the facility transferred Resident 1 to general acute care hospital 1 (GACH 1) on 4/7/2026 at 8:57 a.m. due to the fall.During a review of Resident 1's Fall Risk Factor in the Nursing Documentation Evaluation dated 3/21/2026, the Nursing Documentation Evaluation indicated check marks for history of falls within the last six (6) months, poor safety judgement, and impaired balance. However, the following fall risk factors: disorientated/confused, predisposing disease or injury, requires assist for toileting, or unsteady gait (a person's particular manner, style, or pattern of walking or running) were left unchecked and blank.During a concurrent interview and record review on 5/1/2026 at 3:32 p.m., with the Director of Nursing (DON), the DON reviewed Resident 1's Fall Risk Factor in the Nursing Documentation Evaluation dated 3/21/2026 and stated that the following fall risk factors: disorientated/confused, predisposing disease or injury, requires assist for toileting, or unsteady gait were not marked. The DON stated the assessment was not completed accurately or its entirety.b. During a review of Resident 2's admission Record, the admission Record indicated that the facility originally admitted Resident 2 on 3/8/2019 and readmitted on [DATE] with diagnoses that included disorders of bone density and structures, lumbar vertebra (lower backbone) compression fracture (when part of a vertebra, or the vertebral body, collapses), dementia, and history of falling.During a review of Resident 2's MDS dated [DATE], the MDS indicated that Resident 2's cognition was severely impaired. The MDS further indicated that Resident 2 required supervision or touching assistance on (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff with oral, toileting and personal hygiene, shower and bathe self, dressing, bed mobility (movement), and transfer.During a review of Resident 2's COC Evaluation form dated 4/22/2026 timed at 2:06 a.m., the COC Evaluation form indicated that Certified Nursing Assistant 4 (CNA 4) heard a loud sound coming from Resident 2's room. Upon entering the room to check on Resident 2, CNA 4 observed Resident 2 lying on the floor outside the restroom. Resident 2 was noted to have minimal bleeding to the right side of the face with an abrasion (a superficial injury where skin is scraped or rubbed off) and a laceration (a torn or jagged wound in the skin or soft body tissue) to the right index finger (the finger located immediately next to the thumb). Resident 2's Transfer Form dated 4/22/2026 indicated that the facility transferred Resident 2 to GACH 1 on 4/22/2026 at 6:30 a.m. following the fall.During a review of Resident 2's COC Evaluation form dated 4/26/2026 timed 3:40 p.m., the COC Evaluation form indicated that Resident 2's chair alarm activated and Resident 1 was found lying on the floor on the resident's left side of the wheelchair. During a review of Resident 2's Fall Risk Factor in the Nursing Documentation Evaluation dated 4/22/2026, the Nursing Documentation Evaluation indicated check marks for disorientated/confused, poor safety judgement, predisposing disease or injury, and requires assist for toileting. However, the following fall risk factors: history of falls in the last 6 months, impaired balance, or unsteady gait were left unchecked and blank.During a concurrent interview and record review on 5/1/2026 at 4:01 p.m., with the DON, the DON reviewed Resident 2's Fall Risk Factor in the Nursing Documentation Evaluation dated 4/22/2026 and stated that the DON did not mark the fall risk factor for history of falls within the last 6 months, despite the COC Evaluation form (dated 4/22/2026) indicating a fall incident on the same date. The DON stated the actual fall incident that occurred on 4/22/2026 was not included in the assessment because the incident occurred on the day the assessment was completed. c. During a review of Resident 3's admission Record, the admission Record indicated that the facility originally admitted Resident 3 on 8/29/2023 and readmitted on [DATE] with diagnoses that included hemiplegia (total paralysis [loss of ability to move part or all of the body] of the arm, leg, and trunk on the same side of the body) and hemiparesis (paralysis or weakness on one side of the body) following cerebral infarction (known as stroke, loss of blood flow to a part of the brain resulting in damage to brain tissue), abnormality of gait and mobility, left femur (thigh bone) fracture (broken bone), epilepsy, and history of falling.During a review of Resident 3's MDS dated [DATE], the MDS indicated that Resident 3's cognition was severely impaired. The MDS further indicated that Resident 3 required maximal assistance on staff with toileting hygiene, shower and bathe self, dressing, and moderate assistance with bed mobility and transfer.During a review of Resident 3's COC Evaluation form dated 4/27/2026 timed at 12:56 p.m., the COC Evaluation form indicated that at 1 p.m., staff heard Resident 3 calling for help and was found sitting on the floor next to the resident bed.During a review of Resident 3's Fall Risk Factor in the Nursing Documentation Evaluation dated 4/27/2026, the Nursing Documentation Evaluation indicated check marks for poor safety judgement, impaired balance, predisposing disease or injury, and requires assist for toileting. However, the following fall risk factors: history of falls within the last 6 months, disorientated/confused, or unsteady gait were left unchecked and blank.During a concurrent interview and record review on 5/1/2026 at 4:14 p.m., with the DON, the DON reviewed Resident 3's Fall Risk Factor in the Nursing Documentation Evaluation dated 4/27/2026 and stated that the DON did not mark the fall risk factor for history of falls within the last 6 months, despite the COC Evaluation form (dated 4/27/2026) indicating a fall incident on the same date. The DON stated the assessment was completed incorrectly and incompletely and stated that inaccurate or incomplete assessments could prevent the facility from developing and implementing appropriate care plans to reduce residents' risk for falls. During a review of the facility's policy and procedures (P&P) titled, Fall Risk Assessment last reviewed 1/15/2026, the P&P indicated, The nursing staff, in conjunction the attending physician, consultant pharmacist, therapy staff, and other, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls.During a review of the facility's P&P titled, Fall Management last reviewed 1/15/2026, the P&P indicated, To reduce risk falls and minimize the actual occurrence of falls. Patient experiencing a fall will receive appropriate care and investigation of the cause. If patient falls. Interdisciplinary (combining two or more academic, scientific, or artistic fields into one activity, study, or project) to review post Fall.