

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/25/2026
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)		
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. Based on interview and record review, the facility failed to ensure nursing staff implemented and documented the required 72-hour monitoring (closely observing and evaluating a resident for three days after something important changes in their health) following a change in condition for two of four sampled residents (Resident 2 and Resident 3). This failure had the potential to delay the identification of a worsening clinical condition, timely physician notification and the implementation of necessary interventions. a. During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted Resident 2 on 1/27/2023 and readmitted the resident on 3/10/2026 with diagnoses that included, but were not limited to, subluxation (a joint is partially out of place but not completely dislocated) of C4/C5 cervical vertebrae (the seven bones in the neck that support the head and protect the spinal cord), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN- high blood pressure). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 4/20/2026, the MDS indicated Resident 2's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) skills for daily decision making were intact. The MDS further indicated Resident 2 was independent with oral hygiene, toileting and personal hygiene, upper and lower body dressing, and eating. The MDS also indicated Resident 2 needed supervision with showering or bathing. During a review of Resident 2's Care Plan (CP) initiated on 6/12/2026, the CP indicated Resident 2 reported that a CNA (Certified Nursing Assistant) hit the roommate. The CP further indicated Resident 2 was to be monitored for psychosocial distress (refers to the emotional, mental, and social suffering a resident experiences when struggling to cope with their health, environment, or losses). b. During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted Resident 3 on 4/20/2022 and readmitted the resident on 3/19/2026 with diagnoses that included, but were not limited to, encounter for palliative care (specialized medical care that focuses on improving the quality of life for people with serious illnesses), Parkinson's disease (a condition that affects the brain and makes it harder to control body movements) without dyskinesia (uncontrolled, involuntary movements that a person cannot stop), acute kidney failure (the kidneys suddenly stop working properly over a short period of time, usually hours to days), and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 5/25/2026, the MDS indicated Resident 3's cognitive skills for daily decision-making were severely impaired. The MDS further indicated Resident 3 was dependent on staff for oral hygiene, toileting and personal hygiene, upper and lower body dressing, showering, and eating. During a review of Resident 3's Care Plan (CP) initiated on 6/12/2026, the CP indicated Resident 3 was at risk for psychosocial distress due to a roommate who claimed a CNA hit the resident. The CP intervention indicated Resident 3 was to be monitored for signs and symptoms of psychosocial distress and to offer support as indicated. During a concurrent interview and record review on 6/25/2026 at 1:00 p.m., with the Director of Nursing (DON), Resident 2's and Resident 3's Licensed Nurse Progress Notes from 6/12/2026 through 6/15/2026 were reviewed. The Licensed Nurse Progress Notes did not (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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(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	indicate the required 72-hour monitoring was implemented and documented by the licensed nurse. The DON stated there was no documentation in the Licensed Nurse Progress Notes indicating Resident 2 and Resident 3 were monitored for 72 hours following their (Resident 2 and Resident 3) change in condition. The DON further stated licensed nurses should perform and document 72-hour monitoring of residents following a change in condition to facilitate early identification of a declining health status and ensure timely physician notification for appropriate treatment. During an interview on 6/25/2026 at 3:08 p.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated it is important to monitor residents after a change in condition to identify signs of decline and determine whether reevaluation by the physician is needed. LVN 3 further stated that monitoring residents after a change in condition promotes resident safety. During a review of the facility's policy and procedure (P&P) titled, Acute Condition Changes - Clinical Protocol last revised on 1/15/2026, the P&P indicated, The staff will monitor and document the resident/patient's progress and responses to treatment, and the physician will adjust treatment accordingly.		