STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056066	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident 1 received prescribed medications in a timely manner as ordered by the physician for one of three sampled residents. This deficient practice had the potential to result in the delay of medication administration for Resident 1. Findings: A review of the Resident 1's Admission Record indicated an admission date of [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Physicians Orders, dated 6/18/2020, indicated the resident was to receive [MEDICATION NAME] Patch 5%, (medicine used to numb pain), apply to affected area topically, one time a day for pain. A review of the Resident 1's Medication Administration Record [REDACTED]. Resident 1 had the medication administered on 6/18/2020 and not on 6/17/2020. During a telephone interview and a concurrent record review with Assistant Director of Nursing (ADON), on 8/26/2020, at 11:34 a.m., the ADON stated Resident 1 was admitted to the facility on [DATE] late at night. The ADON stated [MEDICATION NAME] Patch 5% Patch was not given to Resident 1 because the medication was not available on 6/17/20. The ADON stated the charge nurses should have made a follow up call to the pharmacy regarding the delivery of medications on that date. A review of the facility's Proof of Delivery record indicated Resident 1's medication, [MEDICATION NAME] Patch 5%., was shipped on 6/18/2020. The medication's received date was 6/18/2020 at 12:41 p.m. The facility policy and procedure titled New Orders for Non-Controlled Medications, dated 3/1/2011, indicated the Center will communicate new medication orders to the pharmacy in accordance with pharmacy guidelines and state/federal regulation.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to implement infection control practices by failing to place used gloves in the proper receptacle after use. These deficient practices has the potential for the spread of infection and cross contamination among residents. Findings: During an observation of the entrance of Resident 1's room, on 7/7/2020, at 9:35 a.m., an isolation cart was observed in front of Resident 1's door with a pair of gloves turned inside out. During a concurrent interview with the Director of Nursing (DON), she confirmed that a pair of dirty gloves were on top of the isolation cart. The DON stated the gloves were used. The DON stated the used gloves should be disposed in a trash can after it was used by staff. The facility's policy titled Standard Precautions, dated 11/15/10, indicated the purpose was to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. The policy further indicated to discard single use items promptly.

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