STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056083	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woods Health Services	2600 A Street LA Verne, CA 91750

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of three sampled resident (Residents 1) by failing to ensure Resident 1's care plan's interventions included a treatment order to cover Resident 1's left hip wound. This failure had the potential result in unmet individualized needs for Resident 1 and the potential to affect the resident's physical and psychosocial well-being. (Cross Reference F684 and F842) Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 2/18/2025 with diagnoses including acute osteomyelitis (bone infection) of the left femur (thigh bone), infection and inflammatory reaction due to internal left hip prosthesis (artificial body part), and dysphagia (difficulty swallowing foods or liquids). During a review of Resident 1's History and Physical (H&P), dated 2/19/2025, the H&P indicated Resident 1 had a healing wound on the left hip. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/25/2025, the MDS indicated Resident 1 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene and dressing. The MDS indicated Resident 1 required partial/moderate (helper does less than half the effort) from staff for oral and personal hygiene. The MDS indicated Resident 1 had a surgical wound. The MDS indicated Resident 1 required surgical wound care. During an interview on 5/15/2025 at 3:25 p.m. with Registered Nurse (RN) 1, RN 1 confirmed Resident 1 was admitted to the facility with a surgical wound. RN 1 stated RN 1 did not get a treatment order for Resident 1's surgical wound. During a concurrent interview and record review on 5/19/2025 at 10:21 a.m. with the Director of Nursing (DON), Resident 1's untitled care plan, initiated on 2/19/2025, was reviewed. The care plan indicated Resident 1 was at risk for infection. The care plan did not include a treatment order to cover Resident 1's left hip wound until 4/16/2025. The DON stated all residents (in general) who had wounds needed their care plan to include a wound treatment order. (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, .Care Plans, Comprehensive Person-Centered, revised March 2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated, The comprehensive, person-centered care plan: a. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . b. reflects currently recognized standards of practice for problem areas and conditions.

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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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received wound (an injury to living tissue caused by a cut) care and treatment in accordance with the facility's Policies and Procedures (P&P) titled, admission Assessment and Follow Up: Role of the Nurse, when: a. Registered Nurse (RN) 1 failed to conduct a complete wound assessment (a thorough examination of both the wound itself and the resident's overall health to understand the wound's status, identify any factors hindering healing, and develop an effective treatment plan) and document Resident 1's left hip surgical wound (a cut through the skin made during surgery [a procedure to remove or repair a part of the body]) upon admission to the facility on 2/18/2025. b. RN 1 failed to obtain a treatment order for Resident 1's left hip surgical wound upon admission on [DATE]. The facility did not obtain the treatment order until 2/28/2025. c. Licensed Vocational Nurse (LVN) 3 and LVN 4 failed to carry out (implement) the treatment order for Resident 1's left hip surgical wound on 4/13/2025, 4/14/2025, and 4/15/2025. These failures resulted in an infection (the invasion and growth of germs/bacteria [a microorganism (an organism that can be seen only through a microscope such as bacteria), especially one which causes disease] in the body) to Resident 1's left hip surgical wound. Resident 1 was transferred to General Acute Care Hospital (GACH) 2 where Resident 1 received treatment for the infected (contaminated with harmful organisms such as bacteria) left hip surgical wound on 4/25/2025. (Cross Reference F656 and F842) Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 2/18/2025 with diagnoses including acute (sudden) osteomyelitis (bone infection) of the left femur (thigh bone), infection and inflammatory reaction due to internal left hip prosthesis (artificial body part), and dysphagia (difficulty swallowing foods or liquids). The AR indicated Resident 1 was discharged to GACH 2 on 4/25/2025. During a review of Resident 1's History and Physical (H&P), dated 2/19/2025, the H&P indicated Resident 1 had a healing wound on the left hip. During a review of Resident 1's Interdisciplinary Team [IDT, a team of health care professions who work together to establish plans of care for residents] Conference Record (IDT Record), dated2/24/2025, the IDT Record indicated Resident 1 was admitted to the facility following left wound care and osteomyelitis. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated2/25/2025, the MDS indicated Resident 1's cognitive skills (ability to make daily decisions) were intact. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene and dressing. The MDS indicated Resident 1 required partial/moderate (helper does less than half the effort) assistance from staff for oral and personal hygiene. The MDS indicated Resident 1 had a surgical wound and required surgical wound care. During a review of Resident 1's Emergency Department Reports (EDR), dated 4/25/2025, the EDR indicated Resident 1 was transferred to GACH 2's Emergency Department on 4/25/2025 due to increased swelling and drainage (the process of removing excess water and moisture from an area) on Resident 1's left hip wound for one week (specific dates were not indicated). The EDR indicated Resident 1's left hip wound was noted to have erythema (redness of the skin), tenderness (sensitivity to pain), and drainage. The EDR indicated Resident 1's left hip surgical wound was infected. The EDR indicated Resident 1 was given Zosyn (antibiotic medication used to treat infections) via intravenous piggyback (IVPB, a method of administering medication through an IV [IV, a soft flexible tube placed inside a vein, usually in the hand or arm and used to give a person medicine or fluids line]). The EDR indicated Resident 1 was admitted to the telemetry unit (a unit in the hospital dedicated to patients who require monitoring of the heart) at GACH 2 on 4/25/2025. During a review of Resident 1's GACH 2 Laboratory Report (LR, a document that conveys the methods, results, and conclusions of a testing sample of a substance from the body), dated 4/25/2025, the LR indicated a lab culture (a laboratory test to identify the presence and type of microorganisms, aiding in diagnosing infections) was collected from Resident 1's wound on Resident 1's left hip on 4/25/2025. The LR indicated Resident 1's wound contained staphylococcus aureus (bacteria that can cause wound infections). During a review of Resident 1's GACH 2 Progress Notes (PN), signed 4/27/2025, the PN indicated Resident 1 had a severely infected left arthroplasty (a surgical procedure to replace part of the hip joint with a prosthetic implant). The PN indicated Resident 1 admitted to GACH 2 with developing skin breakdown over Resident 1's left hip flap (healthy skin and tissue that is partly detached and moved to cover a nearby wound). During a review of Resident 1's GACH 2 Infectious Disease Progress Note (IDPN), signed 4/28/2025, the IDPN indicated Resident 1's left hip surgical wound was infected. The IDPN indicated Resident 1 was receiving Meropenem (antibiotic medication used to treat infections caused by bacteria) and Vancomycin (powerful antibiotic medication used to treat a variety of serious bacterial infections) via IV. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/14/2025 at 12:01 p.m. with Resident 1's Representative (RR) 1, RR 1 stated Resident 1 fell in 2022 (do not recall exact dates) and broke Resident 1's left hip at RR 1's home. RR 1 stated Resident 1 had surgery for the broken left hip, but the surgery was not successful. RR 1 stated Resident 1 underwent multiple surgeries and Resident 1's latest surgery was on 11/11/2024. RR 1 stated the surgery on 11/11/2024 left Resident 1 with a gaping (split open) surgical wound from Resident 1's left knee to the left hip. RR 1 stated Resident 1 received wound care treatment for Resident 1's left hip surgical wound and the wound was healing while Resident 1 resided at GACH 1. RR 1 stated Resident 1's left hip surgical wound was treated and kept covered with a bandage (a strip of material used to bind a wound) while at GACH 1. RR 1 stated Resident 1 was transferred from GACH 1 to the facility on 2/18/2025. RR 1 stated Resident 1's left hip surgical wound needed daily care for the wound to continue to heal. RR 1 stated RR 1 had to fight with facility staff (unable to identify) to take care of Resident1's left hip surgical wound. RR 1 stated on one occasion; facility staff (unable to identify) had not changed Resident 1's wound bandage for 2 days (unable to recall the dates). RR 1 stated on 4/17/2025, Resident 1's left hip wound had drainage and a foul (bad) smell. RR 1 stated RR 1 sent a picture of Resident 1's left hip surgical wound to MD 1 on 4/17/2025 and RR 1 told MD 1 the wound looked worse (bad/poorer). RR 1 stated MD 1 replied to continue with wound care. RR 1 stated RR 1 wanted a second opinion so RR 1 went to Resident 1's Surgeon (MD 2) and showed MD 2 pictures of Resident 1's left hip surgical wound on 4/23/2025. RR 1 stated MD 2 informed RR 1 that Resident 1's left hip surgical wound was infected. RR 1 stated RR 1informed MD 1 that Resident 1's left hip surgical wound was infected, and MD 1 agreed to transfer Resident 1 to GACH 2 where MD 2 could treat Resident 1's infected wound. RR 1 stated Resident 1's left hip surgical wound became infected because the facility did not give Resident 1 the right wound care and treatment. During a concurrent interview and record review on 5/15/2025 at 9:31 a.m. with the Director of Nursing (DON), Resident 1's Order Details (OD), dated 2/28/2025 and 4/16/2025 were reviewed. The OD, dated 2/28/2025 indicated MD 1 ordered, Change dressing to left hip with abdominal pad (ABD, pad used to absorb fluid from wounds), secure with paper tape in the evening [daily] and change as needed if becomes saturated. The treatment was to be done every evening. The OD, dated 4/16/2025 indicated MD 1 ordered a wound consultation and [wound] treatment. The DON stated when residents (in general) were admitted to the facility, a [licensed] nurse (in general) assessed the resident (in general). The DON stated when the resident had a surgical wound, the admitting nurse carried out the wound treatment orders from the sending facility. The DON stated if Resident 1 did not have wound treatment orders, the admitting nurse (RN 1) needed to obtain an order from MD 1or the surgeon (MD 2). The DON stated when Resident 1 was admitted with a surgical wound, a wound consultation needed to be obtained to ensure assessment and treatment of the wound by the Wound Care Specialist (WCS). The DON stated Resident 1 was admitted to the facility on [DATE] but the facility did not get a treatment order for Resident 1's left hip surgical wound until 2/28/2025 (10 days after Resident 1's admission). The DON stated a wound consultation was not obtained for Resident 1 until 4/16/2025. The DON stated on 4/16/2025, Licensed Vocational Nurse (LVN) 1 informed the DON the treatment order for Resident 1's left hip surgical wound was not carried out [by LVN 3 and LVN 4] on 4/13/2025, 4/14/2025, and 4/15/2025. The DON stated the treatment orders were not carried out on those days (4/13/2025, 4/14/2025, and 4/15/2025). The DON stated RN 1 possibly missed Resident 1's admission surgical wound assessment (on 2/18/2025) because the assessment was not found in Resident 1's medical record. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 5/15/2025 at 12:01 p.m. with LVN 2, Resident 1's Medication Administration Record (MAR) for the month of April 2025 was reviewed. The MAR indicated to cleanse Resident 1's wound with Normal Saline (NS, salt solution), pat dry, cover with ABD pad and secure with paper tape. The MAR dated 4/13/2025, 4/14/2025 and 4/15/2025 were left blank (no staff initial indicated the wound treatment was done on these dates). LVN 2 stated on 4/16/2025 at around 8:20 a.m., the WCS was in Resident 1's room changing Resident 1's left hip surgical wound dressing and was there to teach RR 1 how to perform dressing changes for Resident 1. LVN 2 stated LVN 2 saw the old dressing on Resident 1's left hip surgical wound was dated 4/12/2025, indicating the dressing was last changed on 4/12/2025 (indicating staff did not change Resident 1's dressing on 4/13/2025, 4/14/2025, and 4/15/2025). During a concurrent interview and record review on 5/15/2025 at 3:25 p.m. with RN 1, Resident 1's Clinical admission (CA), dated 2/18/2025 was reviewed. The CA did not indicate Resident 1 had a left hip surgical wound and the area indicating surgical wounds was left blank. RN 1 stated Resident 1 was admitted to the facility with a left hip surgical wound. RN 1 stated the left hip surgical wound was dry and did not look infected on admission. RN 1 stated when Resident 1 was admitted to the facility with a wound, RN 1 (the admitting nurse) needed to document Resident 1' s wound assessment in the CA. RN1 stated RN 1 did not measure Resident 1's left hip surgical wound. RN 1 stated a wound assessments needed to be documented so the condition of the wound could be monitored. RN 1 stated RN 1did not obtain a treatment order, upon Resident 1's admission to the facility on 2/18/2025, from MD 1 for Resident 1's left hip surgical wound. RN 1 stated RN 1 did not feel a need for it due to Resident 1's wound bed (the base of floor of a wound) looking dry and no scab (dry rough protective crust that forms over a cut or wound during healing) over the wound. RN 1 stated RN 1 did not think Resident 1's wound needed a dressing over the wound (uncovered). During a telephone interview on 5/15/2025 at 4:02 p.m. with the WCS, the WCS stated the first time the WCS saw Resident 1 was on 4/16/2025. The WCS stated on 4/16/2025, the WCS saw Resident1's left hip surgical wound dressing was not changed for several days (4/13/2025, 4/14/2025, and4/15/2025). The WCS stated the WCS saw Resident 1 one more time on 4/23/2025 [the wound was fragile and discolored]. The WCS stated facility staff (unable to identify) were not consistent in treating Resident 1's left hip surgical wound. The WCS stated there should have been a treatment order for Resident 1's left hip surgical wound from the first day Resident 1 arrived at the facility (on 2/18/2025). The WCS stated a wound bed needed to have some measure of moisture to promote healing. The WCS stated Resident 1's wound should not be left uncovered (without the ABD pad) (left uncovered since 2/18/2025 to 2/28/2025) until it [the wound] was fully closed. The WCS stated since there was no treatment order for Resident 1's left hip surgical wound until 2/28/2025 (10 days after Resident 1's admission), and facility staff were inconsistent in following the treatment orders after 2/28/2025, the facility could have caused Resident 1's wound to become infected. The WCS stated when Resident 1's left hip surgical wound was left uncovered, microorganisms and/or bodily fluids could have caused the wound to become infected. During an interview on 5/19/2025 at 10:49 a.m. with the Infection Preventionist (IP), the IP stated when Resident 1 was admitted to the facility with a surgical wound, the facility should ensure there was a treatment order for Resident 1's wound. The IP stated when Resident 1's wound had a wound bed, the wound should be kept covered to prevent germs (bacteria) from linens and blankets from touching the wound bed (transferring bacteria from the linens and blankets to the wound bed). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 5/19/2025 at 10:49 a.m. with MD 1, MD 1 stated Resident 1 was admitted to the facility from GACH 1 with an open surgical wound. MD 1 stated there should have been a treatment order for Resident 1's left hip surgical wound upon Resident 1's admission to the facility (on 2/18/2025). MD 1 stated MD 1 sent Resident 1 to GACH 2 (on 4/25/2025) because Resident 1's left hip surgical wound was not healing. During a review of the facility's P&P titled, admission Assessment and Follow Up: Role of the Nurse, revised September 2012, the P&P indicated, The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, . The P&P indicated, Conduct an admission assessment (history and physical), including: .A summary of the individual's recent medical history, including hospitalizations, acute illnesses, and overall status prior to admission Relevant medical, social, and family history .A list of active medical diagnoses and patient problems . Current medication and treatments. The P&P indicated, Conduct a physical assessment, including the skin. The P&P indicated, Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. The P&P indicated, The following information should be recorded in the resident's medical record: . All relevant assessment data obtained during the procedure. During a review of the facility's P&P titled, Charting and Documentation, revised July 2017, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview and record review, the facility failed to maintain a complete and accurate medical record for one of three sampled resident (Resident 1) when: a. Registered Nurse (RN) 1 failed to document Resident 1's left hip wound upon admission to the facility on 2/18/2025. b. Facility staff (in general) failed to document the description of Resident 1's left hip wound on 3/19/2025, 3/26/2025, 4/9/2025, and 4/16/2025. These failures resulted in Resident 1's medical record containing inaccurate and incomplete information. (Cross Reference F656 and F684) Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 2/18/2025 with diagnoses including acute osteomyelitis (bone infection) of the left femur (thigh bone), infection and inflammatory reaction due to internal left hip prosthesis (artificial body part), and dysphagia (difficulty swallowing foods or liquids). During a review of Resident 1's History and Physical (H&P), dated 2/19/2025, the H&P indicated Resident 1 had a healing wound on the left hip. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/25/2025, the MDS indicated Resident 1 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting hygiene and dressing. The MDS indicated Resident 1 required partial/moderate (helper does less than half the effort) from staff for oral and personal hygiene. The MDS indicated Resident 1 had a surgical wound. The MDS indicated Resident 1 required surgical wound care. During a concurrent interview and record review on 5/15/2025 at 3:25 p.m. with RN 1, Resident 1's Clinical admission (CA), dated 2/18/2025 was reviewed. The CA did not indicate Resident 1 had a surgical wound or describe Resident 1's surgical wound. RN 1 confirmed Resident 1 was admitted to the facility with a surgical wound. RN 1 stated when residents (in general) are admitted with wounds, the admitting nurse should document in the CA the description of the wound including the measurements of the wound. RN 1 stated the wound assessment needed to be documented in the CA so the condition of the wound could be monitored. During a concurrent interview and record review on 5/19/2025 at 10:26 a.m. with the DON, Resident 1's Long Term Care Evaluation (LTC Eval) dated 3/19/2025, 3/26/2025, 4/9/2025, and 4/16/2025 were reviewed. The LTC Evals failed to indicate Resident 1 had a surgical wound on the left hip. The DON stated facility staff (in general) should have documented the surgical wound with descriptions and measurements of the wound on the LTC Evals. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation, revised July 2017, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.