

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Woods Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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.  (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Woods Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility staff failed to inform one of one sampled resident's (Resident 1) doctor of Resident 1's low blood pressure (BP - the force of blood pushing against the artery walls as the heart pumps around the body) reading on 12/4/2025 when Resident 1 was admitted to the facility. This deficient practice had the potential to lead to further complications such as dizziness, confusion, and physical injury to Resident 1. Cross Reference F689 Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including atrial fibrillation (an irregular heartbeat in which the upper chambers of the heart [the atria] beat inconsistently and rapidly) and hypertension (high BP - when one's blood pushes too forcefully against the artery walls.) During a review of Resident 1's Progress Notes (PN), dated 12/4/2025, the PN indicated Resident 1 was admitted to the facility via ambulance at 5:18 PM and the initial vital signs indicated a pulse of 82 beats per minute and a BP of 64/40 millimeters of mercury (mm/Hg - standard unit for measurement of BP). The PN indicated at 10:30 PM, Resident 1 was found on the floor after having slipped off the bed onto the floor while attempting to use the urinal located on the right side of the bed. During a review of Resident 1's Situation, Background, Assessment and Recommendation (SBAR, structured communication framework that helps teams share information about the condition of a resident) Communication Form, dated 12/4/2025, the SBAR form indicated at 10:30 PM, Resident 1 was found on the floor of Resident 1's room perpendicular to Resident 1's bed. The SBAR form indicated Resident 1 had attempted to use the urinal located on the right side of Resident 1's bed and Resident 1 slipped onto the floor. The SBAR form indicated at the time of the fall, Resident 1's BP was 65/41 mm/Hg. During a review of Resident 1's Glasgow Coma Scale Assessment Flow Sheet (GCS, a score used to measure an individual's level of consciousness based on three kinds of behavior: eye movement, speech and other body motions) dated from 12/4/2025 to 12/8/2025. Resident 1's BP was taken every 15 minutes after the fall from 10:30 PM to 11:30 PM as follows: 10:30 PM: 64/40 mm/Hg 10:45 PM: 80/40 mm/Hg 11:00 PM: 90/40 mm/Hg 11:15 PM: 100/70 mm/Hg 11:30 PM: 97/80 mm/Hg During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/14/2025, the MDS indicated Resident 1 had intact cognition (ability to understand and process information) and required moderate assistance (helper does less than half the effort) to come to a standing position from sitting in a chair or on the side of the bed and substantial assistance (helper does more than half the effort) for toileting hygiene. During an interview on 12/17/2025 at 2:35 PM with Resident 1, Resident 1 stated a normal BP reading for Resident 1 was about 117/ 87 mm/Hg. Resident 1 stated Resident 1 did not recall feeling dizzy before the fall and did not have a clear memory of how the fall happened. Resident 1 stated sometimes when turning to the right side, the whole room appeared to spin. Resident 1 stated Resident 1 had slid off the right side of the bed while attempting to use the urinal located on the right side of the bed. During an interview on 12/18/2025 at 9:20 AM with Certified Nurse Assistant (CNA) 2, CNA 2 stated a BP reading of 65/40 mm/Hg was considered low BP. CNA 2 stated CNA 2 needed to report the low BP to the nurse right away because the resident's condition could change very quickly and lead to other complications including dizziness and potentially higher risk of falls. During an interview on 12/18/2025 at 9:40 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated if a resident's BP was 65/40 mm/Hg, LVN 1 would check the BP again manually, elevate the resident's feet to encourage blood flow, and inform the doctor. LVN 1 stated LVN 1 would check the BP manually to ensure it was not a mechanical error with the machine. LVN 1 stated if the resident stated they were feeling okay, LVN 1 would still recheck the BP. LVN 1 stated low BP could lead to delirium and dizziness. LVN 1 stated if the staff were unable to reach the doctor, they informed the Director of Nursing (DON) and Registered Nurse (RN) supervisor. During an interview on 12/18/2025 at 11:48 AM with LVN 4, LVN 4 recalled Resident 1 had an approximate BP of 64/40 mm/Hg upon admission on [DATE]. LVN 4 stated a normal BP was about 120/80 mm/Hg and Resident 1's BP was considered low. LVN 4 stated Resident 1 did not appear to have any symptoms of low BP such as paleness or disorientation. LVN 4 stated LVN 4 sent a picture of Resident 1's medications to Resident 1's doctor when Resident 1 was admitted to the facility for medication reconciliation purposes. LVN 4 stated LVN 4 did not discuss/report Resident 1's vital signs [low BP] to Resident 1's doctor. LVN 4 stated LVN 4 did not speak to the doctor about Resident 1's low BP due to feeling overwhelmed by admitting a second resident just ten minutes after Resident 1 arrived [was admitted] to the facility on [DATE]. LVN 4 stated Resident 1 had a fall</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Woods Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2025
NAME OF PROVIDER OR SUPPLIER  Woods Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility staff failed to implement interventions to reduce the risk for falls for one of three sampled residents (Resident 1), who was at high risk for falls, when Resident 1 was admitted to the facility on [DATE] with low blood pressure (a condition in which the force of blood pushing against the artery walls is too low). This deficient practice potentially led Resident 1 to slide off Resident 1's bed onto the floor on 12/4/2025 while attempting to stand to use the urinal. This deficient practice had the potential to result in injury and a physical decline to Resident 1. Cross Reference F684 Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including atrial fibrillation (an irregular heartbeat in which the upper chambers of the heart [the atria] beat inconsistently and rapidly) and hypertension (high blood pressure - when a person's blood pushes too forcefully against the artery walls). During a review of Resident 1's Fall Risk Evaluation (FRE), dated 12/4/2025, the FRE indicated Resident 1 had balance problems while standing. The FRE indicated Resident 1 experienced 1 to 2 falls in the past 3 months. The FRE indicated a resident was considered a high risk for potential falls if the total score was 10 or greater. During a review of Resident 1's Progress Notes (PN), dated 12/4/2025, timed at 6:23 PM, the PN indicated Resident 1's FRE score was 13. During a review of Resident 1's Situation, Background, Assessment and Recommendation (SBAR, structured communication framework that helps teams share information about the condition of a resident) Communication Form, dated 12/4/2025, the SBAR form indicated at 10:30 PM, Resident 1 was found on the floor of Resident 1's room perpendicular to Resident 1's bed. The SBAR form indicated Resident 1 had attempted to use the urinal located on the right side of the bed and slipped onto the floor. The SBAR form indicated at the time of the fall, Resident 1's blood pressure was 65/41 millimeters of mercury (mm/Hg - standard unit for measurement blood pressure). During a review of Resident 1's Glasgow Coma Scale Assessment Flow Sheet (GCS, a score used to measure an individual's level of consciousness based on three kinds of behavior: eye movement, speech and other body motions) dated from 12/4/2025 to 12/8/2025. The GCS indicated Resident 1's blood pressure was taken every 15 minutes after the fall from 10:30 PM to 11:30 PM and readings indicated: 10:30 PM: 64/40 mm/Hg 10:45 PM: 80/40 mm/Hg 11:00 PM: 90/40 mm/Hg 11:15 PM: 100/70 mm/Hg 11:30 PM: 97/80 mm/Hg During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/14/2025, the MDS indicated Resident 1 had intact cognition (ability to understand and process information) and required moderate assistance (helper does less than half the effort) to come to a standing position from sitting in a chair or on the side of the bed and needed substantial assistance (helper does more than half the effort) for toileting hygiene. During an interview on 12/17/2025 at 2:35 PM with Resident 1, Resident 1 stated a normal blood pressure reading for Resident 1 was about 117/ 87 mm/Hg. Resident 1 stated Resident 1 did not recall feeling dizzy before the fall but did not have a clear memory of how the fall happened. Resident 1 stated sometimes when turning to the right side, the whole room appeared to spin. Resident 1 stated Resident 1 had slid off the right side of the bed while attempting to use the urinal located on the right side of the bed. During an interview on 12/18/2025 at 11:48 AM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated Resident 1 was admitted to the facility on [DATE] at approximately 5:18 PM. LVN 4 stated LVN 4 was aware Resident 1 was a fall risk upon admission because Resident 1 had on a yellow bracelet that indicated Fall Risk from the general acute care hospital (GACH). LVN 4 stated, on 12/4/2025, Resident 1's initial blood pressure was taken around 6:30 PM and measured 64/40 mm/Hg. LVN 4 stated a value of 64/40 mm/Hg was considered low blood pressure, but Resident 1 did not have any symptoms of low blood pressure such as paleness or dizziness and was able to communicate with LVN 4. LVN 4 stated LVN 4 did not communicate Resident 1's low blood pressure to Resident 1's doctor. LVN 4 stated in general, low blood pressure could make a resident (in general) a higher risk for falls. During an interview on 12/18/2025 at 12:18 PM with the Director of Nursing (DON), the DON stated there were many factors that could have contributed to Resident 1's fall on 12/4/2025. The DON stated Resident 1 blood pressure was not stable and Resident 1 should have been monitored [before Resident 1's fall] and Resident 1's doctor should have been informed [of Resident 1's low blood pressure to receive adequate interventions]. The DON stated in general, low blood pressure could increase the risk of falls. The DON stated there was no documented evidence in Resident 1's PNs indicating Resident 1's doctor was notified of Resident 1's low blood pressure on 12/4/2025. During a review of the facility's policy and</p>		