

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 03/03/2026
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the comprehensive person-centered care plan for one of three sampled residents (Residents 1) when Certified Nurse Assistant (CNA) 1 failed to use 2 staff persons while transferring (moving a resident from one flat surface to another) Resident 1 with an EZ Stand (a transfer-assist device) according to Resident 1's Care Plan Report (CPR), undated. This failure had the potential for Resident 1 to fall and sustain injuries while being transferred. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on [DATE] with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), muscle wasting and atrophy (loss of muscle tissue), and dementia (a group of thinking and social symptoms that interferes with daily functioning). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 1 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for bathing, dressing, toileting hygiene, oral hygiene, and personal hygiene. During a telephone interview on [DATE] at 12:20 PM with Resident 1's Responsible Party (RR 1), RR 1 stated that on [DATE], while RR 1 was visiting Resident 1 at the facility, CNA 1 used the EZ stand by herself to assist Resident 1 to the bathroom. During a telephone interview on [DATE] at 12:46 PM with CNA 1, CNA 1 stated that on [DATE], around 7:40 PM, CNA 1 used the EZ stand by herself to assist Resident 1 to the bathroom. During a concurrent interview and record review on [DATE] at 9:49 AM with the Director of Nursing (DON), Resident 1's Care Plan Report (CPR), undated, was reviewed. The CPR indicated the facility created a care plan for Resident 1 on [DATE] and revised the care plan on [DATE], related to Resident 1 being at high risk of falling due to confusion and balance problems. The CPR indicated an intervention to prevent Resident 1 from falling was, Use 2-person assist for all transfers with EZ stand. The DON stated the purpose of a care plan was to communicate the interventions staff should use to address a resident's (in general) need. The DON stated interventions created to address a resident's (in general) risk for falling should be followed by staff (in general) to prevent the resident (in general) from falling. The DON stated the DON retrained CNA 1 to use 2 persons when using the EZ Stand following the incident with Resident 1 on [DATE]. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered revised [DATE], 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.</p>

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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