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	04/08/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) was properly assessed and monitored upon experiencing a change in condition when:1. Resident 1's oxygen saturation level (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) was not reassessed after oxygen was administered to Resident 1 on [DATE] after Resident 1 was found unresponsive with an O2 sat of 89% (normal O2 sat level for most healthy adults is between 95% and 100%).2. Resident 1's blood pressure (BP) and respiratory/breathing rate (RR) were not assessed on [DATE] when Resident 1 was found unresponsive at 11 pm.These failures resulted in an incomplete assessment of Resident 1 while Resident 1 was experiencing a change in condition and had the potential to result in Resident 1 not receiving rescue breathing and CPR (cardiopulmonary resuscitation, emergency lifesaving procedure, consisting of chest compressions and mouth-to-mouth or mechanical breaths, performed when the heart stops beating or beats ineffectively and/or to restore breathing) immediately and timely.During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on [DATE] with diagnoses which included traumatic subdural hemorrhage (bleeding in the area between the brain and the skull caused by head injury) without loss of consciousness, repeated falls, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and muscle weakness (a lack of muscle strength).During a review of Resident 1's History & Physical (H&P, physician's clinical evaluation and examination of the resident), dated [DATE], the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 1 was dependent (helper does all the effort to complete the activity) on staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 1's Progress Note (PN) titled Incident Note (IN), dated [DATE] and timed at 1:17 am, the IN indicated on [DATE] at 11 pm, the charge nurse (Licensed Vocational Nurse 1 [LVN 1]), noticed that Resident 1 was unresponsive. The IN-indicated staff (unidentified) went to Resident 1's room right away and was unable to arouse Resident 1. The IN indicated Resident 1 was breathing but Resident 1's respiratory/breathing rate (RR) was not documented. The IN indicated Resident 1's temperature was 97.5, Resident 1's pulse was 61 and Resident 1's BP was not taken due to staff (unidentified) rushing to do emergency implementation. The IN indicated Resident 1's blood sugar was assessed, and it was 292. The IN indicated oxygen was administered to Resident 1 for O2 sat of 89% and Resident 1's O2 sat was not assessed after oxygen administration. The IN indicated the paramedics came at 11:07 pm, and after the paramedics assessed Resident 1, the paramedics started CPR on Resident 1. The IN indicated Resident 1's spouse was informed of Resident 1's change in condition and informed that CPR was being performed on Resident 1 by paramedics. The IN indicated the paramedics stopped CPR at 12 am on [DATE] and Resident 1 was pronounced dead.During a review of Resident 1's PN titled eINTERACT SBAR (situation, background, assessment, recommendation - a communication tool used by healthcare workers when there is a change of condition among the residents) Summary for Providers, dated [DATE] and timed at 1:53 am, the (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SBAR indicated on [DATE] at 11 pm Resident 1 was found unresponsive, breathing, with low oxygen saturation level of 89%. The SBAR indicated oxygen was administered to Resident 1 and 911 (emergency number to request the services of the police, fire department, paramedics, ambulance) was called. The SBAR indicated Resident 1's BP and Resident 1's RR were not obtained and the SBAR did not indicate what Resident 1's O2 sat was after oxygen was administered to Resident 1. The SBAR indicated Resident 1's pulse or heart rate was 61 beats per minute and Resident 1's temperature was 97.5 F (Fahrenheit - measure of temperature) on [DATE] at 2:04 am. The SBAR indicated Resident 1's O2 sat on room air was 96% on [DATE] at 1:44 am. The SBAR indicated Resident 1's blood sugar was 292 mg/dl (milligrams [weight measurement] per deciliter [volume measurement]) on [DATE] at 2:05 am. The SBAR indicated Resident 1's primary physician was informed of Resident 1's change in condition on [DATE] at 11:37 pm.During an interview with Registered Nurse 1 (RN 1) on [DATE] at 3:15 pm, RN 1 stated on [DATE] at around 11 pm, All staff (unidentified) were in Resident 1's room, O2 sat was at 89%, I told each staff to get oxygen, nonrebreather mask, called 911 around 11:10 pm and paramedics came right away. RN 1 stated oxygen was given first and because of the commotion staff did not take Resident 1's blood pressure instead took Resident 1's blood sugar.During a telephone interview with the Director of Nursing (DON) on [DATE] at 1:42 pm, the DON stated, Resident 1 was found unresponsive, but breathing with a heart rate of 60, and O2 saturation of 89% at 11 pm on [DATE]. The DON stated the priority, and main focus of the staff (in general) for Resident 1 on [DATE] was to do the ABCs (Airway, Breathing, and Circulation - assessment framework used to identify and treat life-threatening conditions immediately), so oxygen was given by the staff first to Resident 1 and staff also called 911. The DON stated the DON did not know if Resident 1's oxygen saturation went up after Resident 1 received oxygen. The DON reviewed Resident 1's medical record and stated she did not see any O2 saturations documented after staff gave oxygen to Resident 1 on [DATE]. The DON did not know if the oxygen saturation went up or down from the 89% indicated in the SBAR, dated [DATE] and timed at 1:53 am. The DON stated it was important to get a full set of vital signs (Temperature, heart rate/pulse, RR , 02 Sat, BP) and finger stick glucose, if indicated, as part of Resident 1's assessment during a change of condition, but since it was a medical emergency, the priority was to give oxygen to Resident 1 and call 911; no blood pressure was taken because staff were focused on giving oxygen and calling 911.During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, reviewed [DATE], the P&P indicated, Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form.During a review of the SBAR Communication Form, the form indicated, Before Calling MD (Medical Doctor)/NP (Nurse Practitioner)/PA (Physician Assistant): Evaluate the Resident: Complete relevant aspects of the SBAR form below. Check Vital Signs: BP, pulse, and/or apical heart rate, temperature, respiratory rate, oximetry, and finger stick glucose, if indicated.