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	04/28/2026

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing staff demonstrated and maintained competency to safely provide care and services in accordance with professional standards, as evidenced by: 1. Facility did not ensue Certified Nursing Assistants (CNAs) maintained a current cardiopulmonary resuscitation ([CPR] an emergency procedure used when a person's breathing or heartbeat stops) certification while working at the facility. 2. Facility did not ensure CNAs were evaluated annually for patient care competencies and skills. 3. Facility did not ensure licensed nurses had a complete competency and evaluation checklist on file. 4. Facility did not ensure Registered Nurse (RN1) was evaluated by competent licensed nurse. 5. Facility did not ensure licensed nurses were competent during a resident emergency. These deficient practices created a risk to resident safety, delayed care, and an inappropriate emergency response. Findings: 1. During a review of Certified Nursing Assistance (CNA) employee files, CNAs employee files indicated 16 CNAs out of 34 CNAs did not have a current CPR certification. During an interview on [DATE] at 2:12 p.m. with Director of Staff Development (DSD), DSD stated the facility did not require CNAs to have a current CPR certification. DSD stated CNAs were hired with a valid CPR certification and they would let it expire because it was not required for them to have it. The DSD stated DSD has not provided any mock codes (a simulated emergency drill designed to replicate a real-life medical emergency, such as cardiac arrest) to employees and there was no documentation in employees' files of last mock codes. During an interview on [DATE] at 2:35 p.m. with DON, the DON stated DON did not know if CNAs were required to be CPR certified. DON stated CNAs should be CPR certified because they work with residents and need to be able help residents in an emergency. The DON stated the risk of CNAs not being CPR certified is it might lead to residents' death. During a review of facility's Job description, titled Certified Nursing Assistant, dated 2024, the job description indicated qualification was to be CPR trained after employment. The Job description indicated CPR certification must be maintained. 2. During a review of CNAs employee files on [DATE], CNAs employee files indicated CNAs had their last competency skills evaluated in 2024. During an interview on [DATE] at 2:33 p.m. with DSD, DSD stated DSD had not completed competency evaluations for CNAs. DSD stated the last completed CNA competency evaluation on file was dated 2024. DSD stated skills competency should be completed annually because it was the method to determine if a CNA was competent to work. During an interview on [DATE] at 2:43 p.m. with DON, the DON stated the DSD was responsible for performing yearly competency evaluations for CNAs. The DON stated it was important to evaluate CNAs competency yearly to make sure they are up to date with their skills. The DON stated if competency evaluations are not performed yearly, there might be a risk of CNAs doing patient care not according to facility's policy and procedures (P&P). 3. During a review of employee files, Licensed Nurse Evaluation, the Licensed Nurse Evaluations (a structured assessment tool or checklist used to measure a nurse's clinical proficiency, competency, and confidence in performing essential tasks) were not complete for one RN and four LVNs. The Licensed Nurse Skill Evaluation did not have evaluator initials, employee's initials, and the date the employee was evaluated. During an interview (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and record review on [DATE] at 2:35 p.m. with DON, five Licensed Nurse Skill Evaluations were reviewed. The Licensed Nurse Skill Evaluations indicated tasks were not dated and had no employee and evaluator initials. The DON stated the Licensed Nurse Skill Evaluation must be filled out with initials and dates for it to be a valid evaluation of skills. The DON stated licensed nurses get evaluated to make sure their skills are up to date and that they have not forgotten their skills. The DON stated she was not aware that Licensed Nurse Skill Evaluations were not completely filled out. 4. During a review of Licensed Nurse Skill Evaluation for Registered Nurse (RN 1), the Licensed Nurse Skill Evaluation indicated RN 1 was evaluated for intravenous therapy ([IV] a way to give fluids, medicine, nutrition, or blood directly into the blood stream through a vein) by an LVN. During an interview and concurrent record review on [DATE] at 2:35 p.m. with DON, Licensed Nurse Skill Evaluation for Registered Nurse (RN 1) was reviewed. Licensed Nurse Skill Evaluation for Registered Nurse indicated RN 1 was evaluated for IV therapy by an LVN. The DON stated LVNs were not allowed to work with IVs because it was out of their scope of practice. The DON stated she had an LVN to help DON perform yearly Licensed Nurse Skill Evaluation because DON needed the help. During a review of facility's job description, titled Director of Clinical Services, dated 2020, the job description indicated the DON was responsible to ensure all nursing personnel received competency training annually. 5. During an interview on [DATE] at 3:58 p.m. with RN 1, RN 1 stated RN 1 was notified by LVN 1 that Resident 1 had low oxygen saturation (a measurement of how much oxygen [a gas essential for life] blood is carrying). RN 1 stated RN 1 did not attempt to check Resident 1's vital signs (measurements of the body's most basic functions to detect or monitor medical problems: body temperature, pulse rate [heart rate], respiration rate [breathing rate], oxygen saturation, and blood pressure). RN 1 stated RN 1 left Resident 1's bedside and went to call 911 (universal emergency telephone number in the United States and Canada, connecting callers to the police, fire, or ambulance services). RN 1 stated RN 1 did not return to Resident 1's room. RN 1 stated RN 1 left LVN 1 in Resident 1's room. RN 1 stated RN 1 did not check Resident 1's vital signs because LVN 1 had checked oxygen saturation and resident's heart rate (number of times heart beats per minute). RN 1 stated RN 1 should have taken full vital signs and delivered oxygen to Resident 1 from five to 10 liters/min (L/min) of oxygen. RN 1 stated RN 1 did not document any vital signs taken before oxygen administration, resident assessments, and vital signs taken after oxygen administration. During an interview on [DATE] at 4:38 with LVN 1, LVN 1 stated Resident 1 did not look good and LVN 1 checked Resident 1's oxygen saturation. LVN 1 stated Resident 1's oxygen saturation was 89 percent (low blood oxygen, below the normal range of 95%-100%) and LVN 1 left Resident 1's bedside to get help. LVN 1 stated LVN 1 left Resident 1's bedside one additional time to get the crash cart (a mobile, locked, and organized cart containing essential emergency medical supplies, medications, and equipment needed to stabilize a resident during a life-threatening crisis, such as cardiac arrest, until emergency medical services [EMS] arrive). LVN 1 stated LVN 1 administered oxygen (refers to medical process of providing extra oxygen to the resident with equipment) to Resident 1 at 2 L/min. LVN 1 stated LVN 1 did not remember if LVN 1 rechecked Resident 1's oxygen saturation. LVN 1 did not increase oxygen administered to Resident 1. LVN 1 stated LVN 1 did not check Resident 1's blood pressure because LVN 1 was busy. LVN 1 stated it was important to check resident's blood pressure because it indicated if oxygen reached to all extremities. LVN 1 stated facility provided walkie talkies (a handheld, portable, battery-operated two-way radio transceiver used for wireless communication) to call for help without leaving resident rooms, LVN1 stated LVN 1 could have used walkie talkie to call for help but instead left resident alone to get help. LVN stated LVN 1 did not document any vital signs taken before oxygen administration, resident assessments, and vital signs taken after oxygen administration. During an interview on [DATE] at 2:09 p.m. with DON, the DON stated during an emergency, the role of an RN was to assess residents and delegate tasks to other staff. The DON stated vital signs had to be taken to set a baseline and to make sure if a resident was stable or unstable. The DON stated during an emergency residents should not be left alone because their heart (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could stop and staff must start CPR. The DON stated staff have walkie talkies that they are supposed to use when there is an emergency. The DON stated she expected licensed nursing staff to reassess resident's vital signs and deliver more oxygen if vital signs have not improved. During a review of facility's P&P, titled Emergency Procedure - Cardiopulmonary Resuscitation, dated [DATE], the P&P indicated the requirement of personnel to have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS). The P&P indicated the facility would provide mock codes (simulation of an actual cardiac arrest) for training purposes. During a review of facility's P&P, titled Oxygen Administration, dated [DATE], the P&P indicated the residents would be assessed before administering oxygen and while resident receive oxygen therapy. The P&P indicated vital signs would be checked and lung sounds. The P&P indicated the date and time of oxygen therapy and the rate of oxygen flow and route would be documented. The P&P indicated all assessment data obtained before, during and after oxygen therapy would be documented.