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	05/05/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to promptly notify the physician of a change in condition for one (1) of three (3) sampled residents (Resident 1) when Resident 1's new onset buttocks pain following a fall on 4/23/2026 was not communicated to Resident 1's primary physician.This deficient practice had the potential to delay further assessment, timely diagnostic evaluation, and timely interventions related to the resident's change in condition and possible injury.Cross reference F689 and F684During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 3/24/2026, with diagnoses including displaced bimalleolar fracture of right lower leg, subsequent encounter for closed fracture with routine healing (broken bones on both sides of the right ankle/lower leg that were out of place, currently healing normally after treatment), unspecified abnormalities of gait and mobility (difficulty walking, balancing, or moving safely), and generalized muscle weakness.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 3/31/2026, the MDS indicated Resident 1's cognition (the ability to think and process information) was intact. The MDS indicated Resident 1 required substantial/maximum assistance (helper does more than half the effort to complete the activity) for showering/bathing, lower body dressing, and with mobility (moving around in bed, transferring in and out of chair/bed, and to sit to stand).During a review of a Change in Condition Evaluation (CCE), with an effective date of 4/23/2026 and timed at 9:29 AM, the CCE indicated Resident 1 had a fall. The CCE indicated CNA (unidentified) called Charge Nurse (unidentified) into Resident 1's room and upon arrival at resident 1's room, the Charge Nurse found Resident 1 sitting in an upright position (on the floor).During a review of Resident 1's Progress Notes (PN), dated 4/23/2026, the PN indicated Resident 1 was administered Hydrocodone-Acetaminophen (a narcotic pain medication used to treat moderate to severe pain) oral tablet 5-325 milligrams (mg-a unit of measurement used to show the amount or strength of medication) at 12 PM, due to Resident 1's complaint of pain on a numeric pain scale (a rating system where the resident rates pain from zero (0) to ten (10), with 0 meaning no pain and 10 meaning the worst pain possible) rating of 7/10 to the right ankle and buttocks.During a review of Resident 1's Medication Administration Record (MAR), dated 4/23/2026, the MAR indicated that Resident 1 was administered Hydrocodone-Acetaminophen oral tablet 5-325 mg at 12 PM. The MAR indicated the physician's order was to give Resident 1 Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth every four (4) hours as needed for moderate (4-6) to severe (7-10) pain and to hold if respiration rate less than twelve (12).During a review of Resident 1's Post Fall Assessment (PFA), dated 4/23/2026 and timed at 2:24 PM, the PFA indicated Resident 1 had a fall on 4/23/2026 at 9:15 AM and Resident 1 required two (2) person assistance with transfers. The PFA indicated Resident 1's physician and family/responsible party were notified of Resident 1's fall on 4/23/2026. The PFA also indicated Resident 1's pain rating was 0/10.During a review of Resident 1's Interdisciplinary Team Conference Record (ITCR), dated 4/24/2026, the ITCR indicated the Interdisciplinary Team (IDT, a team of professionals from various disciplines who work in collaboration to address the resident's care) discussed Resident 1's fall incident which occurred on 4/23/2026 during the stand-up meeting (brief meeting to discuss resident status updates and resident care coordination), with no injury (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified at that time. The ITCR indicated Licensed Vocational Nurse 1 (LVN 1) documented on 4/23/2026 at 9:15 AM that Certified Nursing Assistant 2 (CNA 2) called the Charge Nurse (LVN 1) into Resident 1's room. Upon LVN 1's arrival in Resident 1's room, Resident 1 was observed sitting upright (on the floor). Assessment findings indicated Resident 1 was able to move the upper and lower left extremities with the right boot (a medical device worn to immobilize and protect the foot or ankle after surgery or an injury) in place. Vital (measurements of the body's basic functions, such as heart rate, breathing rate, blood pressure, and temperature) were stable. Equal hand grips were noted, and the resident was assisted into a wheelchair with a two-person assist. Resident 1's primary physician (MD 1) was notified of the fall and neurological checks (neurological exam, a check of how well the brain, nerves, and muscles work often performed after a suspected head injury) were initiated. Resident 1's family member (FM 1) was also notified. The ITCR also indicated according to CNA 1's statement, Resident 1 had just had a shower and was transported back to the room in a shower chair due to a scheduled beauty salon appointment. CNA 1 stated the plastic bag placed on Resident 1's right boot to prevent the boot from getting wet was removed and the floor was wiped dry prior to asking Resident 1 to stand so Resident 1's bottom could be dried. The shower chair brakes were locked when Resident 1 stood. The resident stood with assistance from CNA 1 and was supported on Resident 1's right side while bearing weight on the left foot due to non-weight-bearing (NWB-unable to put weight on the affected foot/leg) orders to the right foot. CNA 1 stated the incident occurred quickly and Resident 1 slipped while CNA 1 attempted to lower the resident safely to the floor. The resident landed on the buttocks and reportedly lightly hit the head on the shower chair. CNA 1 called for assistance from CNA 2, who was at the nurses' station at the time, and then notified LVN 1. LVN 1 assessed Resident 1 and with CNA 2, assisted the resident back into the wheelchair. Documentation indicated there was no change in level of consciousness (alertness and awareness) and Resident 1 denied pain at that time.During an interview and concurrent record review on 5/5/2026 at 11:15 AM with Registered Nurse (RN) 1, Resident 1's MAR, PN, PFA, and CCE were reviewed. RN 1 stated Resident 1's medical records revealed Resident 1 had received Hydrocodone-Acetaminophen 5-325 mg on 4/23/2026 for complaint of 7/10 right ankle and buttocks pain following the fall. RN 1 stated that further review failed to reveal documentation the physician was notified of the Resident 1's new onset buttocks pain following the fall. RN 1 stated that new onset pain following a fall should be assessed and reported to the physician, as it had indicated a change in condition or possible injury requiring further evaluation and intervention. RN 1 stated that failure to notify Resident 1's physician of Resident 1's new onset buttocks pain following the fall resulted in delayed medical evaluation, delayed early diagnostic testing, and delayed timely treatment of a possible injury following Resident 1's fall.During an interview on 5/5/2026 at 4:05 PM, with the Director of Nursing (DON), the DON stated Resident 1's new onset pain following the fall should have been immediately assessed and promptly reported to the physician, as it represented a significant change in condition and potential injury requiring timely evaluation and intervention. During a review of the facility's Policy and Procedures (P&P) titled, Woods Health Services - Change in a Resident's Condition or Status, reviewed 7/31/2025, the P&P indicated the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The P&P indicated, The nurse will notify the resident's attending physician or physician on call when there has been an accident or incident involving the resident and.significant change in the resident's physical/emotional/mental condition.A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions and.requires interdisciplinary review and/or revision of the care plan.During a review of the facility's P&P titled, Pain - Clinical Protocol, revised dated 3/2018, the P&P indicated the nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition, and when there is onset of new pain or worsening of existing pain. During a review of the facility's P&P titled, Woods Health Service - Pain Assessment and Management, revised dated 3/2020, the P&P indicated to:Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary with the pain management program.Report the following information to the physician or practitioner: Significant changes in the level of the resident's pain.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide cardiopulmonary resuscitation (CPR, emergency lifesaving procedure, consisting of chest compressions and manual or mechanical breaths, performed when the heart stops beating or beats ineffectively and/or to restore breathing) to one of three sampled residents (Resident 3) in accordance with the facility's Policy and Procedure (P&P) titled Emergency Procedure- Cardiopulmonary Resuscitation, dated [DATE], when: 1. Rescue breaths were not provided to Resident 3 on [DATE] at 12:35 PM. 2. An artificial manual breathing unit (Ambu bag, a handheld medical device used to manually force air or oxygen into a person's lungs) and a non-rebreather oxygen mask (a medical device used in emergencies to deliver high concentrations of oxygen) were available for use in the facility's emergency cart on [DATE] 12:35 PM. These deficient practices resulted in an inadequate emergency lifesaving response for Resident 3 and placed other residents in the facility at risk for inadequate emergency care.During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included myocardial infarction ([heart attack] occurs when a blood clot blocks blood flow to the heart) and cerebral infarction (pathological process that results in an area of necrotic tissue in the brain caused by disrupted blood supply and restricted oxygen supply). During a review of Resident 3's History and Physical Examination (H&P, physician clinical evaluation and examination of the resident), dated [DATE], the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Nursing Progress Notes (NPN), dated [DATE] and timed at 1:44 PM, the NPN indicated on [DATE] at 12:35 PM, Certified Nursing Assistant (CNA) 3 entered Resident 3's room and found Resident 3 unresponsive. The NPN indicated Licensed Vocational Nurse (LVN) 2 found Resident 3 unresponsive and LVN 2 assessed for respirations and they were absent. The NPN indicated LVN 2 assessed Resident 3's carotid pulse (rhythmic heartbeat felt by pressing fingers against the carotid artery in the neck) and it was non-palpable (unable to be felt), and LVN 2 initiated CPR. The NPN indicated at 12:40 PM rescue breaths were administered to Resident 3 via an Ambu bag from the emergency cart (crash cart). Resident 3's Minimum Data Set (MDS - a resident assessment tool) was unavailable on [DATE] because Resident 3 had only been admitted to the facility on [DATE]. During an interview on [DATE] at 11:08 a.m. with LVN 2, LVN 2 stated LVN 2 entered Resident 3's room and Resident 3 was cold to touch and Resident 3's skin color was gray. LVN 2 stated when LVN 2 entered Resident 3's room, CNA 3 was providing chest compressions (a lifesaving emergency procedure used when a person's heart stops beating; a rhythmic, downward pressure on the center of the chest to manually pump blood to vital organs). LVN 2 stated LVN 2 checked Resident 3's left carotid pulse and left radial pulse (heartbeat felt by pressing the radial artery against the wrist bone) and they were both absent. LVN 2 stated LVN 2 started CPR with 30 chest compressions. LVN 2 stated LVN 2 did not provide rescue breaths ([mouth-to-mouth resuscitation] a first-aid technique where a rescuer breathes directly into an unresponsive person's mouth to deliver oxygen to their lungs) because LVN 2 did not have an artificial AMBU bag or a mouth cover. LVN 2 stated LVN 2 was supposed to provide mouth-to-mouth rescue breaths but only with a mouth cover and LVN 2 did not have one at that time. During an interview on [DATE] at 1:12 p.m. with LVN 3, LVN 3 stated LVN 3 entered Resident 3's room and saw LVN 2 doing chest compressions. LVN 3 stated Resident 3 looked pale and had no pulse. LVN 3 stated LVN 3 relieved LVN 2 from performing CPR, LVN 3 performed 30 chest compressions and did not perform rescue breathing. LVN 3 stated LVN 3 performed more than five rounds of chest compressions. LVN 3 stated LVN 3 did not provide rescue breaths because LVN 3 did not have an Ambu bag. LVN 3 stated the emergency cart did not have an Ambu bag. During an interview on [DATE] at 1:50 p.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated CNA 3 found Resident 3 pale in color, with no pulse and CNA 3 started chest (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	compressions. CNA 3 stated CNA 3 performed chest compressions but did not perform rescue breathing. CNA 3 stated rescue breaths were not provided to Resident 3 because nursing staff (in general) did not have an Ambu bag or a mouth cover. CNA 3 stated CNA 3 was relieved from performing chest compressions by LVN 2. During an interview on [DATE] at 3:40 p.m. with Registered Nurse (RN) 1, RN 1 stated RN 1 entered Resident 3's room and saw nursing staff (LVN 2 and LVN 3) performing CPR. RN 1 stated an emergency cart was in the room and the CPR backboard was still on the emergency cart. RN 1 stated RN 1 asked nursing staff to put the backboard under Resident 3's torso to facilitate CPR. RN 1 stated Resident 3 was on oxygen via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) and RN 1 increased oxygen to 6 liters per minute (l/min). RN 1 stated Resident 3 had a nasal cannula because the emergency cart did not have a non-rebreather oxygen mask. RN 1 stated RN 1 left the room to get an Ambu bag because the emergency cart did not have one. RN 1 stated RN 1 checked if Resident 3 had a pulse and Resident 3 did not have a pulse. RN 1 stated Resident 3 did not have a blood pressure cuff (a medical device, placed around arm, inflated to temporarily stop blood flow, then slowly deflated while pressure changes are recorded) on and RN 1 asked someone to get one. RN 1 checked residents' blood pressure (measuring the maximum pressure exerted against artery walls when the heart contracts and pushes blood out) and it was 80/50 (low blood pressure, it may indicate that brain and vital organs are not receiving enough blood flow). RN 1 stated RN 1 delivered 2 rescue breaths with Ambu bag after the 30 chest compressions. RN 1 stated nursing staff had not provided Resident 3 any rescue breaths only chest compressions. RN 1 stated Resident 3 did not have a blood pressure cuff on or a pulse oximeter (medical device that measures heart rate and how much oxygen the blood has) during CPR and did not know how resident vital signs were monitored. RN 1 stated it was important to provide rescue breathing because it helped expand lungs between chest compressions. RN 1 stated if rescue breathing was not delivered to a resident there was a risk of not providing proper oxygenation to resident and blood circulation to the resident during CPR. During an interview on [DATE] at 3:58 p.m. with the Director of Nursing (DON), the DON stated nursing staff were required to check residents' vital signs and provide 30 chest compression and 2 rescue breaths during CPR. The DON stated nursing staff (in general) must use an Ambu bag to deliver rescue breaths to prevent the spread of infection. The DON stated nursing staff were required to provide rescue breaths by mouth-to-mouth resuscitation (a first-aid technique where a rescuer breathes directly into an unresponsive person's mouth to deliver oxygen to their lungs) before emergency cart arrived in the room. The DON stated CPR should not be performed without a backboard. The DON stated a backboard must be placed under resident's torso during CPR for CPR to be effective to residents. DON stated the risk of performing CPR without a backboard was resident would not receive the correct recoil (the natural expansion of the chest wall after a compression during CPR) from chest compression. During a review of facility's Policy and Procedure (P&P) titled Emergency Procedure-Cardiopulmonary Resuscitation, dated [DATE], the P&P indicated the facility must maintain equipment and supplies necessary for CPR/BLS in the facility. The P&P indicated if an individual was found unresponsive, staff must check for breathing and pulse, and staff would initiate basic life support (BLS) sequence of events. The P&P indicated after 30 chest compressions, 2 breaths must be provided via Ambu bag or manually with a CPR shield (mouth cover). The P&P further indicated, Trained rescuers should also provide ventilations with a compression-ventilation ratio of 30:2.

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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. Based on interview and record review, the facility failed to provide necessary care and services to one (1) of three (3) sampled residents (Resident 1) when:A. Licensed Nurses failed to assess and accurately document Resident 1's pain status following a fall on 4/23/2026.B. Resident 1's new onset buttocks pain following a fall on 4/23/2026 was not communicated to Resident 1's primary physician.These deficient practices had the potential to result in inaccurate pain assessment, delayed recognition of worsening conditions or injury, and ineffective pain management interventions for Resident 1.Cross reference F580 and F689During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 3/24/2026, with diagnoses including displaced bimalleolar fracture of right lower leg, subsequent encounter for closed fracture with routine healing (broken bones on both sides of the right ankle/lower leg that were out of place, currently healing normally after treatment), unspecified abnormalities of gait and mobility (difficulty walking, balancing, or moving safely), and generalized muscle weakness.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 3/31/2026, the MDS indicated Resident 1's cognition (the ability to think and process information) was intact. The MDS indicated Resident 1 required substantial/maximum assistance (helper does more than half the effort to complete the activity) for showering/bathing, lower body dressing, and with mobility (moving around in bed, transferring in and out of chair/bed, and to sit to stand).During a review of a Change in Condition Evaluation (CCE), with an effective date of 4/23/2026 and timed at 9:29 AM, the CCE indicated Resident 1 had a fall. The CCE indicated CNA (unidentified) called Charge Nurse (unidentified) into Resident 1's room and upon arrival at resident 1's room, the Charge Nurse found Resident 1 sitting in an upright position (on the floor).During a review of Resident 1's Glasgow Coma Scale (a tool used to measure a person's alertness and level of consciousness by checking their eye, speech, and movement responses) Assessment Flowsheet (GCSAF), dated 4/23/2026, the GCSAF indicated Resident 1's numeric pain scale rating (a rating system where the resident rates pain from zero (0) to ten (10), with 0 meaning no pain and 10 meaning the worst pain possible) was 0/10 at 11:20 AM.During a review of Resident 1's Daily Skilled Charting (DSC), dated 4/23/2026, the DSC indicated that Resident 1's numeric pain scale rating was 7/10 at 12:00 PM.During a review of Resident 1's Progress Notes (PN), dated 4/23/2026, the PN indicated Resident 1 was administered Hydrocodone-Acetaminophen (a narcotic pain medication used to treat moderate to severe pain) oral tablet 5-325 milligrams (mg-a unit of measurement used to show the amount or strength of medication) at 12 PM, due to Resident 1's complaint of pain rating of 7/10 to the right ankle and buttocks.During a review of Resident 1's Medication Administration Record (MAR), dated 4/23/2026, the MAR indicated that Resident 1 was administered Hydrocodone-Acetaminophen oral tablet 5-325 mg at 12 PM. The MAR indicated the physician's order was to give Resident 1 Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth every four (4) hours as needed for moderate (4-6) to severe (7-10) pain and to hold if respiration rate less than twelve (12).During a review of Resident 1's GCSAF, dated 4/23/2026, the GCSAF indicated that Resident 1's numeric pain scale rating was 0/10 at 12:20 PM.During a review of Resident 1's Post Fall Assessment (PFA), dated 4/23/2026 and timed at 2:24 PM, the PFA indicated Resident 1 had a fall on 4/23/2026 at 9:15 AM and Resident 1 required two (2) person assistance with transfers. The PFA indicated Resident 1's physician and family/responsible party were notified of Resident 1's fall on 4/23/2026. The PFA also indicated Resident 1's pain rating was 0/10.During a review of Resident 1's Interdisciplinary Team Conference Record (ITCR), dated 4/24/2026, the ITCR indicated the Interdisciplinary Team (IDT, a team of professionals from various disciplines who work in collaboration to address the resident's care) discussed Resident 1's fall incident which occurred on 4/23/2026 during the stand-up meeting (brief meeting to discuss resident status updates and resident care coordination), with no injury identified at that time. The ITCR indicated Licensed Vocational Nurse 1 (LVN 1) documented on 4/23/2026 at 9:15 AM that Certified Nursing Assistant 2 (CNA 2) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called the Charge Nurse (LVN 1) into Resident 1's room. Upon LVN 1's arrival in Resident 1's room, Resident 1 was observed sitting upright (on the floor). Assessment findings indicated Resident 1 was able to move the upper and lower left extremities with the right boot (a medical device worn to immobilize and protect the foot or ankle after surgery or an injury) in place. Vital signs (measurements of the body's basic functions, such as heart rate, breathing rate, blood pressure, and temperature) were stable. Equal hand grips were noted, and the resident was assisted into a wheelchair with a two-person assist. Documentation indicated there was no change in Resident 1's level of consciousness (alertness and awareness) and Resident 1 denied pain at that time. Resident 1's primary physician (MD 1) was notified of the fall and neurological checks (neurological exam, a check of how well the brain, nerves, and muscles work often performed after a suspected head injury) were initiated. Resident 1's family member (FM 1) was also notified. The ITCR also indicated according to CNA 1's statement, Resident 1 had just had a shower and was transported back to the room in a shower chair due to a scheduled beauty salon appointment. CNA 1 stated the plastic bag placed on Resident 1's right boot to prevent the boot from getting wet was removed and the floor was wiped dry prior to asking Resident 1 to stand so Resident 1's bottom could be dried. The shower chair brakes were locked when Resident 1 stood. The resident stood with assistance from CNA 1 and was supported on Resident 1's right side while bearing weight on the left foot due to non-weight-bearing (NWB-unable to put weight on the affected foot/leg) orders to the right foot. CNA 1 stated the incident occurred quickly and Resident 1 slipped while CNA 1 attempted to lower the resident safely to the floor. The resident landed on the buttocks and reportedly lightly hit the head on the shower chair. CNA 1 called for assistance from CNA 2, who was at the nurses' station at the time, and then notified LVN 1. LVN 1 assessed Resident 1 and with CNA 2, assisted the resident back into the wheelchair.During an interview and concurrent record review on 5/5/2026 at 11:15 AM with Registered Nurse (RN) 1, Resident 1's GCSAF, DSC, MAR, PN, PFA, and CCE were reviewed. RN 1 stated Resident 1's records which were reviewed revealed repeated documentation of 0/10 pain assessments following the fall. However, the PN dated 4/23/2026 and timed at 12:30 PM documented administration of Hydrocodone-Acetaminophen oral tablet 5-325 mg to Resident 1 for complaint of 7/10 right ankle and buttocks pain. RN 1 stated pain documentation should accurately reflect the resident's pain complaints, location of pain, and reassessment findings. RN 1 further stated inconsistent pain documentation could make it difficult to accurately monitor the resident's pain status, evaluate effectiveness of interventions, and identify changes in the resident's condition following the fall.During an interview on 5/5/2026 at 4:05 PM, with the Director of Nursing (DON), the DON stated Resident 1's new onset pain following the fall should have been immediately assessed and promptly reported to the physician, as it represented a significant change in condition and potential injury requiring timely evaluation and intervention. The DON stated pain assessments should be accurately and consistently documented to ensure staff are able to appropriately monitor the resident's condition, identify changes in pain status, evaluate effectiveness of interventions, and ensure continuity of care. The DON stated staff are expected to accurately document residents' reported pain level, location of pain, and reassessment findings, especially following a fall or change in condition. The DON further stated inconsistent or inaccurate pain documentation could result in difficulty determining the resident's actual pain status and could affect clinical decision-making and resident care follow-up.During a review of the facility's Policy and Procedures (P&P) titled, Woods Health Services - Change in a Resident's Condition or Status, reviewed 7/31/2025, the P&P indicated the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The P&P indicated, The nurse will notify the resident's attending physician or physician on call when there has been an accident or incident involving the resident and.significant change in the resident's physical/emotional/mental condition.A significant change of condition is a major decline or improvement in the resident's status that will not normally (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resolve itself without intervention by staff or by implementing standard disease-related clinical interventions and.requires interdisciplinary review and/or revision of the care plan.During a review of the facility's P&P titled, Pain - Clinical Protocol, revised dated 3/2018, the P&P indicated the nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain.During a review of the facility's Policy and Procedure (P&P) titled, Woods Health Services - Pain Assessment and Management, revised 3/2020, the P&P indicated:Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program.Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident's medical record.

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	05/05/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure adequate safety precautions during activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) care for one (1) of three (3) sampled residents (Resident 1) by failing to ensure:A. A safe environment during post-shower care on 4/23/2026 by allowing Resident 1 to stand while the floor remained wet.B. Safe ADL care practices were implemented during post-shower care on 4/23/2026 by allowing Resident 1 to stand while clothing remained positioned at the resident's knees, creating increased instability and fall risk.C. Two (2) staff assisted Resident 1 to get up and stand from the shower chair on 4/23/2026.These deficient practices resulted in Resident 1 sustaining a fall to the floor during ADL care and experiencing pain on 4/23/2026, placing the resident at increased risk for continued pain and injury, including, head injury, fracture, and further decline in functional status.Cross reference F580 and F684During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 3/24/2026, with diagnoses including displaced bimalleolar fracture of right lower leg, subsequent encounter for closed fracture with routine healing (broken bones on both sides of the right ankle/lower leg that were out of place, currently healing normally after treatment), unspecified abnormalities of gait and mobility (difficulty walking, balancing, or moving safely), and generalized muscle weakness.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 3/31/2026, the MDS indicated Resident 1's cognition (the ability to think and process information) was intact. The MDS indicated Resident 1 required substantial/maximum assistance (helper does more than half the effort to complete the activity) for showering/bathing, lower body dressing, and with mobility (moving around in bed, transferring in and out of chair/bed, and to sit to stand).During a review of Resident 1's Fall Risk Evaluation (FRE), dated 3/24/2026, the FRE indicated Resident 1 was assessed as a high fall risk.During a review of Resident 1's Physician Order Report (POR), dated 3/25/2026, the POR indicated to keep Resident 1 non-weight bearing (NWB-unable to place weight or stand on the affected foot or leg) on the right foot for 4 to 6 weeks.During a review of Resident 1's Bowel and Bladder Program Screener (BBPS), dated 3/28/2026, the BBPS indicated that Resident 1 was immobile (unable to move), or required a two-person assist with the ability to get to the bathroom, transfer to toilet, commode, urinal, adjust clothing, and wipe.During a review of a Change in Condition Evaluation (CCE), with an effective date of 4/23/2026 and timed at 9:29 AM, the CCE indicated Resident 1 had a fall. The CCE indicated CNA (unidentified) called Charge Nurse (unidentified) into Resident 1's room and upon arrival at resident 1's room, the Charge Nurse found Resident 1 sitting in an upright position (on the floor).During a review of Resident 1's Progress Notes (PN), dated 4/23/2026, the PN indicated Resident 1 was administered Hydrocodone-Acetaminophen (a narcotic pain medication used to treat moderate to severe pain) oral tablet 5-325 milligrams (mg-a unit of measurement used to show the amount or strength of medication) at 12 PM, due to Resident 1's complaint of pain on a numeric pain scale (a rating system where the resident rates pain from zero (0) to ten (10), with 0 meaning no pain and 10 meaning the worst pain possible) rating of 7/10 to the right ankle and buttocks.During a review of Resident 1's Interdisciplinary Team Conference Record (ITCR), dated 4/24/2026, the ITCR indicated the Interdisciplinary Team (IDT, a team of professionals from various disciplines who work in collaboration to address the resident's care) discussed Resident 1's fall incident which occurred on 4/23/2026 during the stand-up meeting (brief meeting to discuss resident status updates and resident care coordination), with no injury identified at that time. The ITCR indicated Licensed Vocational Nurse 1 (LVN 1) documented on 4/23/2026 at 9:15 AM that Certified Nursing Assistant 2 (CNA 2) called the Charge Nurse (LVN 1) into Resident 1's room. Upon LVN 1's arrival in Resident 1's room, Resident 1 was observed sitting upright (on the floor). Assessment findings indicated Resident 1 was able to move the upper and lower left extremities with the right boot (a medical device worn to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immobilize and protect the foot or ankle after surgery or an injury) in place. Vital signs (measurements of the body's basic functions, such as heart rate, breathing rate, blood pressure, and temperature) were stable. Equal hand grips were noted, and the resident was assisted into a wheelchair with a two-person assist. Documentation indicated there was no change in Resident 1's level of consciousness (alertness and awareness) and Resident 1 denied pain at that time. Resident 1's primary physician (MD 1) was notified of the fall and neurological checks (neurological exam, a check of how well the brain, nerves, and muscles work often performed after a suspected head injury) were initiated. Resident 1's family member (FM 1) was also notified. The ITCR also indicated according to CNA 1's statement, Resident 1 had just had a shower and was transported back to the room in a shower chair due to a scheduled beauty salon appointment. CNA 1 stated the plastic bag placed on Resident 1's right boot to prevent the boot from getting wet was removed and the floor was wiped dry prior to asking Resident 1 to stand so Resident 1's bottom could be dried. The shower chair brakes were locked when Resident 1 stood. The resident stood with assistance from CNA 1 and was supported on Resident 1's right side while bearing weight on the left foot due to non-weight-bearing (NWB-unable to put weight on the affected foot/leg) orders to the right foot. CNA 1 stated the incident occurred quickly and Resident 1 slipped while CNA 1 attempted to lower the resident safely to the floor. The resident landed on the buttocks and reportedly lightly hit the head on the shower chair. CNA 1 called for assistance from CNA 2, who was at the nurses' station at the time, and then notified LVN 1. LVN 1 assessed Resident 1 and with CNA 2, assisted the resident back into the wheelchair.During a review of Resident 1's Addendum (a document added to an existing contract or agreement after it has been drafted, used to include new information, clarify details, or make minor changes) Radiology Report (ARR), dated 4/28/2026 and timed at 5:43 AM, the ARR indicated that the cortical step off/angulation (misalignment or abnormal bend) of the distal coccyx (tailbone area closest to the tip) is suspicious for a fracture (possible broken bone), although as noted in the report there is normal variation in the appearance of the coccyx (tailbone can naturally vary in shape). The ARR also indicated fracture could be confirmed with bone scan (special imaging test that looks for bone injury) or MRI (detailed imaging scan using magnets) if indicated and fractures of the coccyx (tailbone) are often best evaluated clinically (based on direct observation, examination, and treatment of the resident) rather than radiographically (based only on X-ray imaging).During an interview on 5/1/2026 at 10:43 AM with Resident 1, Resident 1 stated that CNA 1 wheeled Resident 1 back to the room in a shower chair after assisting Resident 1 with a shower. Resident 1 stated CNA 1 was assisting with drying and dressing Resident 1 for an appointment. Resident 1 stated Resident 1had NWB orders to the right foot and was wearing a controlled ankle motion (CAM-a protective walking boot used to limit movement and help the foot or ankle heal) boot to the right foot at the time. Resident 1 stated CNA 1 removed the protective bag covering the CAM boot prior to asking Resident 1 to stand. Resident 1 stated Resident 1 was barefoot on the left foot and had pants and brief around the knees when asked to stand from the shower chair. Resident 1 stated standing on one foot was difficult due to Resident 1's inability to bear weight on the right foot and because Resident 1's pants were around Resident 1's knees. Resident 1 stated the floor may still have been wet and recalled slipping and falling on Resident 1's buttocks.During a telephone interview on 5/1/2026 at 11:30 AM with CNA 1, CNA 1 stated that on 4/23/2026 at approximately 9:30 AM, after completing Resident 1's shower, CNA 1 asked Resident 1, who had NWB orders to the right foot, to stand while CNA 1 dried Resident 1's buttocks area. CNA 1 stated Resident 1's pants and brief remained around Resident 1's knees at the time Resident 1 stood, and no additional staff were present to assist. CNA 1 stated Resident 1 slipped and fell while standing, landing on Resident 1's buttocks. CNA 1 stated that although CNA 1 had dried the floor prior to having Resident 1 stand, CNA 1 observed water residue on the floor after the fall, which may have been caused by water dripping from Resident 1 or from the wet shower chair. CNA 1 stated CNA 1 should have ensured the floor was completely dry and safe prior to asking Resident 1 to stand. CNA 1 stated that having Resident 1 stand with pants and brief around the knees despite NWB (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders increased Resident 1's risk for slipping and falling and assistance from another CNA would have been a safer approach.During an interview on 5/1/2026 at 12:40 PM with LVN 1, LVN 1 stated Resident 1 had known NWB orders to the right lower foot and required two-person assistance for transfers. LVN 1 stated residents with mobility limitations should receive assistance from additional staff during post-shower care and transfers. LVN 1 stated staff should ensure the floor is completely dry and free from hazards prior to asking a resident to stand. LVN 1 stated LVN 1 observed and noted water on the floor when LVN 1 responded to the incident involving Resident 1's fall. LVN 1 stated having pants and undergarment around Resident 1's knees while asking Resident 1 to stand created a safety concern and increased the risk for fall. LVN 1 stated the safest and most appropriate method would have been to obtain assistance from another staff member or complete Resident 1's dressing and care while the resident remained seated or in bed, rather than having the resident stand on one foot despite known NWB orders to the right foot.During an interview on 5/1/2026 at 1:57 PM with CNA 2, CNA 2 stated that CNA 1 had previously notified CNA 2 that assistance would be needed for Resident 1's post-shower transfer. CNA 2 stated Resident 1 had known NWB orders to the right foot and wore a CAM boot to the right foot when out of bed. CNA 2 stated Resident 1 was already on the floor prior to CNA 2 arriving to assist. CNA 2 stated upon entering the room, Resident 1 was seated upright on the floor, CNA 2 noted that the floor was wet, and Resident 1 had Resident 1's pants around the knee area. CNA 2 stated Resident 1's left foot was barefoot, and Resident 1 was not wearing non-skid socks (socks with grips on the bottom to help prevent slipping) or shoes on that left foot at the time of the incident. CNA 2 stated residents with NWB orders and mobility limitations should have another staff member present during transfers and post-shower care. CNA 2 stated the safest practice would have been to ensure the floor was dry and assistance was present prior to asking Resident 1 to stand.During an interview on 5/5/2026 at 4:05 PM with the Director of Nursing (DON), the DON stated staff were expected to ensure floors were dry and free from hazards prior to asking a resident to stand following showers. The DON stated residents with NWB orders and balance limitations are at increased risk for falls and should have additional staff assistance during transfers and post-shower care. The DON stated having another staff member present was the safest practical approach to reduce the risk of slips and falls during standing and transfers.During a review of the facility's Policy and Procedure (P&P) titled, Woods Health Services - Safety and Supervision of Residents, dated 3/17/2025, the P&P indicated that the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P indicated:Our facility-oriented approach to safety addresses risks for groups of residents.Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents.The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and the adjust interventions accordingly.During a review of the facility's P&P titled, Woods Health Services - Falls and Fall Risk, Managing, revised 3/2018, the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P&P indicated environmental factors that contribute to the risk of falls include wet floors.