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	05/22/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide documentation regarding advance directives (AD-a legal document explaining a resident's health care wishes if he or she cannot speak for themselves) for four of four sampled residents (Residents 8, 20, 21, & 35) when:1. Resident 8 and Resident 21 were not provided with information regarding ADs.2. Facility failed to ensure a copy of Resident 20's AD was in Resident 20's medical record when Resident 20's medical records indicated Resident 20 had a POA (Power of Attorney - a legal document that allows someone else to act on your behalf to manage your financial, legal, or medical affairs).3. Resident 35's AD signature page was not included in Resident 35's medical record.This failure resulted in Residents 8 and 21 being uninformed of their health care rights and had the potential to result in conflict regarding Residents' 8, 20, 21, & 35's choices regarding health care decisions. Findings: 1. During a review of an admission Record (AR), the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnoses that included hypertensive heart disease (elevated blood pressure) and vascular dementia (decline in mental ability—such as memory, thinking, and reasoning). During a review of Resident 8's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 3/27/2026, the MDS indicated Resident 8's cognition (ability to think and make decisions) was severely impaired. The MDS indicated Resident 8 required maximal assistance (helper does less than half the effort) with toilet hygiene, showers, and bathing. During a concurrent interview and record review on 5/22/2026 at 8:27 AM with the Social Services Director (SSD), Resident 8's POA, notarized 3/21/2026, was reviewed. The SSD stated Resident 8's POA addressed the financial portion but did not address Resident 8's health. The SSD stated it was important for Resident 8 or the resident's responsible party to be informed regarding an Advanced Directive (AD) to address the residents' wishes regarding healthcare decisions. During a review of Resident 21's AR, the AR indicated Resident 21 was admitted to the facility on [DATE] with diagnosis that included sepsis (a life-threatening blood infection), due to enterococcus (bacteria [microscopic single-celled organisms some can make people sick] in the stomach), and urinary tract infection (UTI, bacteria in the urinary tract). During a review of Resident 21's History and Physical (H&P), dated 5/13/2025, the H&P indicated Resident 21 had the capacity to understand and make decisions. During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21's cognition was (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intact. During a concurrent interview and record review on 5/22/2026 at 12:46 PM with the Admissions Coordinator (AC), Resident 8's California Standard admission Agreement For Skilled Nursing Facilities and Intermediate Care Facilities [AA], dated 6/12/2023, and Resident 21's AA, dated 4/15/2022, were reviewed. The AC stated Resident 8 and Resident 21's admission agreement did not address an AD [was offered]. The AC stated Resident 8 and Resident 21's AA was outdated and did not address an AD. The AC stated it was important for the residents or their representatives to get information about ADs because it was their right. During an interview with the Director of Nursing (DON) on 5/22/2026 at 2:02 PM, the DON stated offering ADs was important to know the resident's wishes when they (residents) were able to make that decision. During a review of the facility's policy and procedure (P&P) titled Advance Directives, revised on 4/7/2025, the P&P indicated upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and formulate an advance directive if he or she chooses to do so. The P&P indicated written information will include a description of the facility 's policies to implement advance directives and applicable state law. The P&P indicated if the resident is incapacitated and unable to receive information about his or her right to formulate and advance directive, the information may be provided to the resident's legal representative. 2. During a review of Resident 20's AR, the AR indicated, Resident 20 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including acute respiratory failure with hypoxia (a medical emergency where the lungs suddenly fail to get enough oxygen [a colorless, odorless, and tasteless gas essential for life] into the blood causing severe shortness of breath), and dependence on supplemental oxygen. During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20's cognitive skills (ability to think and process information) for daily decision making were intact (decisions consistent/reasonable). The MDS indicated Resident 20 was dependent (helper does all of the effort) to requiring supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact assistance as resident completes activity) with activities of daily living (ADL – routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review on 5/22/2026 at 8:00 AM with the SSD, Resident 20's medical records were reviewed. The SSD stated an AD documented a resident's wishes regarding life sustaining treatment or medical wishes when a resident became incapacitated. A review of Resident 20's Physician Orders for Life Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life), dated 2/23/2025, the POLST did not indicate information regarding an AD. The SSD stated the POLST was not [did not substitute] an AD. A review of Resident 20's Social Services History & Initial Assessment (SSIA), dated 12/15/2026, timed at 3:32 PM, the SSIA indicated, Resident 20 had a POA (Health Care Authority) and the facility would ask for a copy. The SSIA indicated, Resident 20 reported that advanced care planning had been completed. The SSD stated the SSD was the one responsible for ensuring a copy of an AD was [obtained and] kept in the resident's (in general) medical record. The SSD stated Resident 20 did not have an AD or a (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	POA on file in Resident 20's medical record. A review of Resident 20's Social Services Quarterly Note (SSQN), dated 3/23/2026, timed at 10:18 AM, the SSQN indicated, Resident 20 had no change in status related to an AD. The SSD stated the information (on the forms) was not accurate and not updated. The SSD stated ensuring the information was accurate was important to clarify whether Resident 20 had an AD or not to avoid confusion about Resident 20's medical wishes. During a review of the facility's P&P titled, Advance Directives, date reviewed 4/7/2025, the P&P indicated, information about whether or not the resident had executed an advance directive should be displayed prominently in the medical record. 3. During a review of Resident 35's AR, the AR indicated Resident 35 was originally admitted to the facility on [DATE] and readmitted on [DATE] and on 2/28/2025 with diagnoses including muscle weakness and type 2 diabetes mellitus (a chronic [persistent or long-lasting] disease characterized by high blood sugar levels due to insufficient insulin [a hormone which regulates the amount of sugar in the blood] production) without complications. During a review of Resident 35's H&P, dated 2/18/2026, the H&P indicated Resident 35 had the capacity to understand and make decisions. During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35's cognitive (the ability to think and process information) skills for daily decision making were intact. The MDS indicated Resident 35 required setup or clean-up assistance with oral hygiene and eating, required supervision or touching assistance with upper body dressing, required partial/moderate assistance with lower body dressing, and required substantial/maximal assistance with toileting hygiene, showering, putting on/taking off footwear, and personal hygiene. During a concurrent interview and record review on 5/22/2026 at 8 AM and 8:58 AM with the SSD, Resident 35's undated AD was reviewed. The SSD stated an AD was a list of the residents (in general) medical wishes and ensured that the residents (in general) medical wishes were upheld. The SSD stated Resident 35's AD should have a signature page but did not. The SSD stated it was important to have a signature included in Resident 35's AD to verify that Resident 35 gave consent regarding Resident 35's medical wishes. During a review of the facility's P&P titled, Advance Directives, dated 4/7/2025, the P&P's policy statement indicated, Advance directives will be respected in accordance with state law and facility policy. The P&P's policy interpretation and implementation indicated, Prior to or upon admission of a resident, the social services director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to provide necessary care and services for three of three sampled residents (Residents 6, 32, & 42) when:1.Resident 6's lack of bowel movement (BM) was not addressed in a timely manner when Resident 6 was at risk for constipation and did not have a BM from 5/13/2026 to 5/19/2026.2.The facility failed to ensure their process for over the counter (OTC - medicines you can get without a prescription) product self-administration (the process where patients manage and take their own medications) was followed for Resident 32 when on 5/19/2026 Resident 32 had multiple non-legend (drugs that can be purchased OTC without a prescription) products at Resident 32's bedside without a self-administration assessment or a physician's order.3. Resident 42's right arm sling was not positioned properly following a shoulder injury.This failure had the potentials to result in serious medical complications and discomfort for Residents 6, 32, and 42. There were potentials for:Constipation and bowel impaction (a serious, life-threatening condition where a large mass of dry stool gets permanently stuck in the colon or rectum) to Resident 6. Misuse and side effects (SE -unwanted, unintended, or secondary effect that occurs in addition to the desired therapeutic effect of a drug) of OTC drugs for Resident 32 and the potential for OTC product sharing with other residents (in general) by Resident 32.No arm support, delayed healing, and further injury to Resident 42's arm. Findings: 1. During a review of Resident 6's admission Record (AR), the AR indicated the facility originally admitted Resident on 9/18/2012 and readmitted the resident on 12/3/2020 with diagnoses including difficulty in walking and osteoarthritis (a condition where the cushioning between the joints wears down over time, causing pain, stiffness, and swelling). During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 2/9/2026, the MDS indicated Resident 6's cognitive (the ability to think and process information) skills for daily decision making were severely impaired (never/rarely makes decisions). The MDS indicated Resident 6 required setup or clean-up assistance with eating and oral hygiene, required partial/moderate assistance with upper body dressing, and was dependent on toileting, showering, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 6 required substantial/maximal assistance with toilet transfer. The MDS indicated Resident 6 was always incontinent of bowel (the inability to control bowel movements). During a review of Resident 6's History and Physical (H&P), dated 9/28/2026, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6's Order Summary Report (OSR), dated active as of 5/22/2026, the OSR indicated Resident 6 had a physician's order, start date of 5/2/2022, for bisacodyl suppository (a medication that causes a bowel movement)10 milligrams (mg-a unit of measurement) as needed for daily bowel management. During a review of Resident 6's Medication Administration Records (MAR), dated 5/1/2026 – 5/31/2026, the MAR indicated Resident 6 had received a bisacodyl suppository on 5/20/2026. During a review of Resident 6's Care Plan (CP), initiated 9/13/2022, the CP indicated Resident 6 has bowel incontinence [related to the] use of opioid possible [side effects], impaired mobility, and at (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 6 was at risk for constipation. The CP's interventions indicated bisacodyl suppository 10 mg, intervention initiated 1/14/2023 and observe pattern of incontinence, and initiate toileting schedule if indicated, intervention initiated 9/13/2022. During a concurrent interview and record review on 5/22/2026 at 9:16 AM with Registered Nurse (RN) 1, Resident 6's undated Bowel Elimination task sheet was reviewed. The task sheet indicated Resident 6 had a BM on 5/12/2026 and did not have another BM until 5/20/2026. RN 1 stated Resident 6's lack of BM should have been addressed after three days but was not addressed until 5/20/2026. RN 1 stated a lack of BM greater than three days could increase Resident 6's risk for bowel impaction which is a medical emergency. Additionally, RN 1 stated the lack of BM could have caused Resident 6 discomfort. During a review of the facility's Policy and Procedure (P&P) titled, Bowel (Lower Gastrointestinal Tract) Disorders-Clinical Protocol, dated 3/17/2025 the P&P's assessment and recognition indicated, Examples of lower gastrointestinal tract conditions and symptoms include: fecal incontinence and resident taking antidiarrheal medications or medications related to bowel motility. The P&P's Treatment/Management indicated, The physician will identify and order pertinent cause-specific and symptomatic interventions; for example.institute a regimen to prevent constipation. The P&P's monitoring and follow-up indicated, The staff and physician will monitor the individual's response to interventions and overall progress; for example.frequency and consistency of bowel movements. 2. During a review of Resident 32's AR, the AR indicated Resident 32 was admitted to the facility on [DATE] with multiple diagnoses including acute (sudden) myocardial infarction (MI – heart attack), and colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body) status. During a review of Resident 32's H&P, dated (unintelligible), the H&P indicated Resident 35 had the capacity to understand and make decisions. During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32's cognitive skills (ability to think and process information) for daily decision making were intact (decisions consistent/reasonable). The MDS indicated Resident 32 was dependent (helper does all of the effort) to requiring setup or clean-up assistance (helper sets up or cleans up) with activities of daily living (ADL – routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 32 had an ostomy (including urostomy, ileostomy, and colostomy) appliance and was not rated for bowel continence (resident had an ostomy or did not have a bowel movement for the entire 7 days). During a concurrent observation and interview on 5/19/2026 at 11:37 AM with Resident 32 in Resident 32's room, Resident 32 was in bed doing a puzzle. Resident 32 had a four (4) ounce (oz - a unit of weight) CVS (retail pharmacy chain) Arthritis (pain, swelling, stiffness, and inflammation in your joints) Pain Relief Cream and a 2.7 oz IcyHot Pain Relief Lidocaine cream at the bedside credenza. Resident 32 stated, Resident 32 used to use the Lidocaine cream, but the cream had a smell and did not last long (effectiveness). Resident 32 stated Resident 32 had been using the Arthritis pain relief cream for Resident 32's arthritis. Resident 32 stated, the Arthritis Pain Relief Cream and the IcyHot Lidocaine patch had the same lidocaine ingredient. Resident 32 stated, Resident 32 was getting $150.00 worth of whatever I need, every three months from Resident 32's insurance company. Resident 32 stated, Resident 32 ordered the OTC drugs over the phone from CVS and CVS mailed the OTC drugs directly to Resident 32. Resident 32 stated, Resident 32 had more OTC drugs, stool (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	softener, diaper rash ointment, inside Resident 32's bedside drawer. Resident 32's bedside drawer had multiple OTC products including multiple supplies of stool softener, Zinc oxide ointment, ear drops, nasal spray, sore throat spray, and Desitin diaper rash ointment. Resident 32 stated, Resident 32 did not know if the facility pay any attention to Resident 32's OTC products. During a review of Resident 32's OSR, active orders as of 5/19/2026, the OSR indicate multiple medications including Lidocaine (fast acting numbing medicine) external patch 4%, apply to affected area topically as needed for pain QD (every day) PRN (as needed). The OSR did not indicate Resident 32's OTC drugs kept at Resident 32's bedside. During a concurrent interview and record reviewed on 5/20/2026 at 2:44 PM with RN 1 and Licensed Vocational Nurse (LVN) 2, Resident 32's medical records were reviewed. RN 1 stated, residents (in general) were allowed to have OTC drugs at the bedside if residents were physically and mentally able (per an assessment) to self-administer OTC drugs, but [self-administration] required a physician's order. RN 1 stated, the facility was not aware of Resident 32's OTC drugs and [the OTC drugs] should not have been stored at Resident 32's bedside. LVN 2 stated, Resident 32 had no records of physician orders or [self-administration] assessments for Resident 32's OTC drugs. RN 1 stated, obtaining a physician's order and [conducting] OTC self-administration assessments was important to prevent adverse reactions, overdosing, and Resident 32 from sharing the OTC drugs with other residents. LVN 2 stated, staff should be communicating with the residents upon admission [and inquire what is] kept at Resident 32's bedside. LVN 2 stated staff should be checking and monitoring the resident's bedside (for OTC drugs). During an interview on 5/20/2026 at 3:21 PM with the Director of Nursing (DON), the DON stated, residents could have OTC drugs when [the OTC drugs] were ordered by the physician and a self-administration assessment was completed. The DON stated [the self-administration] should also be care planned (CP). The DON stated, following the [self-administration] process was important to prevent double dosing, overdosing and side effects. The DON stated, the facility was not aware of Resident 32's OTC drugs and staff should be checking resident's bedside (for OTC drugs). During a review of the facility's P&P titled, Administering Medications, date reviewed 3/17/2025, the P&P indicated residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, had determined that they had the decision-making capacity to do. During a review of the facility's P&P titled, Self-Administration of Medications, date reviewed 4/7/2025, the P&P indicated residents had the right to self-administer medications if the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so. The P&P indicated self-administered medications were stored in a safe and secure place, which was not accessible to other residents. The P&P indicated any medications found at the bedside that were not authorized for self-administration were turned over to the nurse in charge for return to the family or responsible party. 3. During a review of an AR, the AR indicated Resident 42 was re-admitted to the facility on [DATE] with diagnoses that included congestive heart failure (heart muscle is too weak or stiff to pump blood efficiently), and generalized muscle weakness. During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 was cognitively intact. The MDS indicated that Resident 42 required maximal assistance (helper does more than half (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the effort) with ADLs such as lower body dressing and bathing. During a review of Resident 42's OSR, the OSR indicated a physician's order dated 5/17/2026, the order indicated right arm and shoulder sling monitor for placement every shift. The residents will be immobilized in a sling for one week. During a review of Resident 42's CP, initiated on 5/17/2026, the CP indicated Resident 42 had a right arm and shoulder sling, the CP's goal indicated Resident 42 would be free from complications related to right arm and shoulder sling. The CP's interventions indicated to monitor [sling] placement every shift and to monitor for sling placement. During a review of Resident 42's physician's Progress Notes (PN), dated 5/19/2026, the PN indicated x-rays (pictures of the inside of your body) were taken at an acute hospital and the report read possible for anterior (toward the front of a body) subluxation (partial dislocation) of the humeral head (the ball-like top of the humerus [the long bone in your upper arm]). During an observation and concurrent interview on 5/19/2026 at 9:54 AM of Resident 42, at the resident's bedside, Resident 42 was wearing a sling on the right arm, and both sling straps were positioned in the front of the resident's neck and right shoulder. Resident 42 stated I need to wear this [points at the sling] for a few weeks. Resident 42 stated I cannot move my neck, let alone my shoulder. It hurts. During an observation and concurrent interview on 5/19/2026 at 10:33 AM with Certified Nursing Assistant (CNA 5), Resident 42 had a sling on the right arm. CNA 5 stated Resident 42's right arm sling was not placed correctly because one of the straps needed to be placed behind the resident's neck and shoulder. During an observation and concurrent interview on 5/19/2026 at 10:35 AM with RN 1, RN 1 stated Resident 42's cushion back of the resident's sling was not placed correctly for the sling to give support to the shoulder and arm. RN 1 stated slings must be placed correctly, if not, it could further dislocate the should and not provide support due to instability. During an interview on 5/22/2026 at 1:42 PM with the Director of Nursing (DON), the DON stated placing slings correctly on the residents was important for alignment and proper positioning (of the shoulder). During a review of the facility's P&P titled Safety and Supervision of Residents, reviewed 3/17/2025, the P&P indicated the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. The P&P indicated monitoring the effectiveness of interventions shall include the following: ensuring that interventions are implemented correctly and consistently.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 17 and Received 20) received proper respiratory (relating to breathing) care by failing to date or properly date Resident 17 and Resident 20's nasal cannula (NC - a small plastic tube that fits into the person's nostrils and used to provide supplemental oxygen [02 - a colorless, odorless, tasteless gas essential for living) tubing.This deficient practice could potentially result in the facility using old or expired NC tubing leading to bacterial and mold growth and skin irritation to Resident 17 and Resident 20.Findings:During a review of Resident 17's admission Record (AR), the AR indicated Resident 17 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a long-standing lung disease causing difficulty in breathing), unspecified, and essential (primary) hypertension (HTN - high blood pressure).During a review of Resident 17's Care Plan (CP), initiated [DATE], the CP indicated Resident 17 was at risk for COPD complication. The CP's interventions indicated administration of 02 at 4 Liters/Minute (L/min - the speed or volume of oxygen a device delivers to you) via NC continuously. The CP indicated 02 tubing and humidifier change every night shift every Sunday.During a review of Resident 17's History and Physical Examination (H&P), dated [DATE], the H&P indicated Resident 17 had the capacity to understand and make decisions.During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 17's cognitive skills (ability to think and process information) for daily decision making were intact (decisions consistent/reasonable). The MDS indicated Resident 17 was dependent (helper does all of the effort) to requiring setup or clean-up assistance (helper sets up or cleans ups) with activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 17 was on continuous 02 therapy on admission and while a resident at the facility.During a review of Resident 17's Order Summary Report (OSR), active orders as of [DATE], the OSR indicated a physician's order, dated [DATE], indicating to change oxygen tubing and humidifier every night shift, every Sunday and an order for oxygen administration at 4 L/min via N/C continuous every shift.During a review of Resident 20's AR, the AR indicated, Resident 20 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including acute respiratory failure with hypoxia (a medical emergency where the lungs suddenly fail to get enough oxygen into the blood causing severe shortness of breath), and dependence on supplemental 02.During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20's cognitive skills for daily decision making were intact. The MDS indicated Resident 20 was dependent to requiring supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact assistance as resident completes activity) with ADLs. The MDS indicated Resident 20 was receiving 02 therapy while a resident at the facility.During a review of Resident 20's OSR, active orders as of [DATE], the OSR indicated a physician's order, dated [DATE], for oxygen at 2 L/min via NC continuous every shift.During a concurrent observation and interview on [DATE] at 9:30 AM with Resident 17, Resident 17 was awake, alert, and lying in bed. Resident 17 was receiving 02 4 L/min via NC and was hooked up to an 02 humidifier (a small medical device, often a refillable bottle, attached to a 02 machine or tank used to add moisture to supplemental 02) and 02 concentrator (a medical device that delivers pure, concentrated oxygen). Resident 17 stated Resident 17 always, 24/7 used 4 L/min of 02. Resident 17's 02 humidifier was dated [DATE] and the NC tubing was undated. Resident 17's nebulizer (a device that turns liquid medicine into mist breathed in through a mask or mouthpiece) was inside a bag labeled with Resident 17's name and dated [DATE], the bag was stored hanging off the 02 concentrator. Resident 17 stated Resident 17 was getting a breathing treatment through the nebulizer only as needed.During a concurrent observation and interview on [DATE] at 11:13 AM with Licensed Vocational Nurse (LVN) (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2, inside Resident 20's room, Resident 20 was sitting up in a wheelchair at Resident 20's bedside. Resident 20 was being administered 02 via NC and connected to a 02 concentrator positioned behind Resident 20's wheelchair. The NC tubing had a sticker indicating date [DATE] (the date indicates when the tubing was changed). LVN 2 stated Resident 20's NC tubing was dated [DATE], it's over a month and [the tubing] should have been changed. LVN 2 stated the facility's night shift (10:45 PM - 7:15 AM) nurse (in general) changed [and dated] NC tubing every Sunday and the facility's day shift (6:45 AM - 3:15 PM) nurse checked and verified [the change and the tubing's date] every Monday morning. LVN 2 stated changing and dating the 02 NC tubing was important to ensure the 02 NC was changed (every Sunday) and for infection control.During a concurrent observation and interview on [DATE] at 11:23 AM with LVN 2, in the physical therapy room, Resident 17 was using an exercise machine. Resident 17 was receiving 02 via NC. LVN 2 stated, Resident 17's 02 NC tubing was not labeled (undated).During an interview on [DATE] at 3:45 PM with Infection Preventionist (IP) 1 in the presence of the Director of Nursing (DON), IP 1 stated 02 NC tubing (in general) needed to be labeled with the resident's name, room number, and dated. IP 1 stated, the night shift changed the 02 set up (NC and humidifier) every Sunday and the day shift either the nurse supervisor (in general) or charge nurse (in general) verified the change every Morning. IP 1 stated, IP 1 was the last staff who checked [verified the change] every Monday. IP 1 stated, changing the 02 set up every week was important for staff to know when the 02 set up was changed and for infection control. IP 1 stated the nebulizer did not need to be changed every week if the breathing treatment was administered as needed. IP 1 stated the 02 NC cannula (tubing and humidifier) must be changed every week. IP 1 stated, the humidifier and the NC tubing were 2 separate devices.During a review of the facility's P&P titled, Oxygen Administration, date reviewed [DATE], the P&P's purpose indicated to provide guidelines for safe 02 administration. The P&P indicated one of the preparations was to review the resident's care plan to assess for any special needs of the resident.

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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. Based on interview and record review, the facility failed to ensure one of three sampled nursing staff (Certified Nursing Assistant [CNA] 3), had the appropriate competencies and skills sets necessary to care for the residents' (in general) needs when the facility failed to ensure CNA 3 met the clinical skill (the practical, hands-on tasks and critical-thinking abilities nurses use to deliver patient care) of reporting unusual occurrences.This deficient practice had the potential to result in compromised resident safety and physical declines to the residents under CNA 3's care. Findings:During a concurrent interview and record review on 5/22/2026 at 10:48 AM with the Director of Staff Development (DSD), CNA 3's employee personnel file was reviewed. The DSD stated CNA 3 was hired on 2/23/2024. The DSD stated, staff's (in general) clinical skills were conducted annually. A review of CNA 3's CNA Back to Basics Clinical Skills Checklist (CSC), date completed 5/15/2026, was reviewed with the DSD. The CSC indicated CNA 3 needed improvement in the skills of choking intervention and vital signs blood pressure. The CSC indicated the skill of reporting unusual occurrences was not completed. The DSD stated the DSD wanted to wait for all the staff's annual clinical skills to be completed so the DSD could give an in-service to all the staff at the same time. The DSD stated the DSD should have provided CNA 3 a one-on-one (1:1) in-service, as soon as possible, to ensure CNA 3 was competent to provide proper care, because resident safety is first.During an interview on 5/22/2026 at 12:12 PM with the Director of Nursing (DON), the DON stated, when a staff did not meet requirements for a clinical skill during the annual skills, the skill needed to be reviewed and a 1:1 in-service should be provided to the staff, on the spot during the skills check, this was important so staff did the right thing, staff was aware of the proper policy and procedure (P&P), and for staff to be better to improve and provide the correct care for resident safety.During a review of the facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, reviewed 4/7/2025, the P&P indicated the facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. The P&P indicated licensed nurses and certified nursing assistants were available 24 hours a day, seven (7) days a week to provide competent resident care services including assuring resident safety and responding to resident needs.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the facility was free of five percent or greater medication error rate. The facility had two total medication errors in 25 opportunities for errors during medication pass (process through which medication is administered [the act of giving a treatment, such as a drug, to a patient]) for one of two sampled residents (Resident 35) which yielded an eight percent total error rate when: a. Licensed Vocational Nurse (LVN) 2 prepared and attempted to administer the wrong dose of Fluoxetine (an anti-depressant [prescribed medication used to treat depression - a mood disorder that causes a persistent feeling of sadness and loss of interest]) to Resident 35. b. LVN 2 forgot to prepare and administer Resident 35's Estradiol Vaginal Cream 0.01% (cream used to relieve common physical discomforts caused by menopause [when a woman permanently stops having menstrual periods]) that was due to be administered during the 09:00 AM medication pass. These failures had the potential to result in ineffective treatment to Resident 35 and the potential for symptoms to persist with no optimal treatment results to Resident 35.Findings:During a review of Resident 35's admission Record (AR), the AR indicated Resident 35 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including type 2 diabetes mellitus (DM II - adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing) without complications, and depression, unspecified.During a review of Resident 35's History and Physical Examination (H&P), dated 2/18/2026, the H&P indicated Resident 35 had the capacity to understand and make decisions.During a review of Resident 35's Minimum Data Set (MDS - a resident assessment tool), dated 3/8/2026, the MDS indicated Resident 35's cognitive skills (ability to think and process information) for daily decision making were intact (decisions consistent/reasonable). The MDS indicated Resident 35 required substantial/maximal assistance (helper does more than half the effort) to setup or clean-up assistance (helper sets up or cleans up) with activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 35 was taking an antidepressant.During a review of Resident 35's Care Plan (CP), revised 5/15/2026, the CP indicated Resident 35 used antidepressant medication r/t (related to) depression m/b (manifested by) verbalizing sadness. The CP's interventions indicated Prozac (brand name for Fluoxetine) as ordered.During a review of Resident 35's Phone Orders (TO), dated 5/4/2026 and timed at 3:43 PM, the TO indicated, a physician's order for Estradiol Vaginal Cream 0.01%, insert 0.5 gram vaginally one time a day for vaginal dryness, apply pea sized amount to vaginal opening daily. The TO indicated an order, dated 5/20/2026 and timed at 7:32 PM, the TO indicated an order for Prozac oral capsule (Fluoxetine HCL) give 30 mg (milligrams - metric unit of measurement, used for medication dosage and/or amount) by mouth one time a day for depression m/b verbalization of sadness due to multiple medical conditions.During a review of Resident 35's Medication Administration Record (MAR), dated 5/1/2026 - 5/31/2026, the MAR indicated Resident 35 had 9:00 AM scheduled medications that included Prozac oral capsule, 30 mg by mouth one time a day for depression m/b verbalization of sadness due to multiple medical conditions. The MAR indicated the Estradiol Vaginal Cream 0.01%, insert 0.5 gram vaginally one time a day.was due to be administered in the AM.During a medication pass observation on 5/21/2026 at 8:14 AM, LVN 2 started preparing Resident 35's medications that were due at 9:00 AM by placing each medication in a 30 ml (milliliter - a metric unit of volume) medicine cup and marked each cup with the medication name. LVN 2 took one capsule from Resident 35's Prozac 20 mg medication bubble pack (a customized packaging method where pills are organized by day in sealed, clear plastic compartments). LVN 2 did not prepare Resident 35's Estradiol Vaginal Cream. LVN 2 proceeded to administer Resident 35's medications one at a time while explaining each medication to Resident 35. LVN 2 was in the act of administering Resident 35's Prozac and Resident 35 refused. Resident 35 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated Resident 35's physician (unidentified) spoke to Resident 35, yesterday about adjusting the dose of the Prozac. Resident 35 stated, Resident 35 was getting Prozac 20 mg before but Resident 35's physician changed the dose to 30 mg. During an interview on 5/21/2026 at 8:45 AM with LVN 2, LVN 2 stated, LVN 2 completed Resident 35's 9:00 AM medication pass. LVN 2 stated, LVN 2 would have missed Resident 35's Estradiol Vaginal Cream if the surveyor had not inquired with LVN 2 about the Estradiol Vaginal Cream, I forgot about that. LVN 2 stated, medications due in the AM were administered by the day [shift] nurse. LVN 2 stated administering medications at the right dose was important so residents did not get an adverse drug reaction (ADR, unwanted, unintended, or secondary effect that occurs in addition to the desired therapeutic effect of a drug) and received the right dose (as ordered by Resident 35's physician).During an interview on 5/22/2026 at 12:12 PM with the Director of Nursing (DON), the DON stated, the five rights to medication administration were right patient, right medication, right dose, right route, and right time. The DON stated medications due in the AM were due every morning, every day and administered at 9:00 AM by the day shift nurse.During a review of the facility's undated Medication Pass Time Schedule (MPTS), the MPTS indicated the medication pass time for QD (every day) was at 9:00 AM.During a review of the facility's policy and procedures (P&P) titled, Administering Medications, date reviewed 3/17/2026, the P&P indicated medications were administered in a safe and timely manner, and as prescribed. The P&P indicated the individual administering the medication checked the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary conditions were maintained in one of one kitchen (Kitchen 1) when the following was observed:1. [NAME] 1 (CK 1) and the dietary manager (DM) were not wearing beard covers while preparing food for the residents of the facility.2. On 5/21/2026, two of three sampled sanitizing solution buckets (SB) did not have the correct concentration required to effectively kill bacteria (microscopic single-celled organisms some can make people sick) and organisms from kitchen surfaces as indicated in the facility's policy.These deficient practices had the potential to result in cross contamination (the process by which microorganisms are unintentionally transferred from one area/object to another with a harmful effect) or foodborne illness (a sickness caused by eating or drinking food and beverages contaminated with harmful germs, parasites, or toxic chemicals) to the residents consuming the facility's food.Findings: 1. During an observation in Kitchen 1 on 5/21/2026 at 11:51 AM, the DM was in Kitchen 1's food preparation area scooping soup from the soup kettle. The DM had a beard and was not wearing a beard cover. During an observation in Kitchen 1 at 12:00 PM, CK 1 was in Kitchen 1's food preparation area, CK 1 was wearing a beard net that was not fully covering the CK 1's beard, hair stubbles were protruding outside the beard cover. During an interview with the Facility Dietician (FD) on 5/21/2026 at 12:19 PM, the FD stated wearing hair/beard covers was important to avoid facial hair falling onto the food served to the residents. The FD stated hair in the food placed residents at risk [for foodborne illness].During an interview with the DM on 5/21/2026 at 12:34 PM, the DM stated beard covers should always be worn correctly if the person [Kitchen 1 staff] had a beard because hair follicles could fall into the resident's food.During a review of the facility's policy and procedure (P&P) titled Uniform Dress Code, revised on 1/2025, the P&P indicated personal cleanliness and a neat appearance are essential for the food service worker. The P&P indicated facial hair must be kept neatly trimmed. The P&P indicated associates working with food: restrain all facial hair with a bear net/restraint when handling food.2. During an observation of Kitchen 1's solution buckets with Kitchen Aid 1 (KA 1), on 5/21/2026 at 12:25 PM, two of three solution buckets were tested on the dishwashing area by KA 1 and read 100 parts per million [ppm, unit of measurement]). KA 1 stated the sanitizing solution should be within the correct range (200-400 ppm) to avoid any cross-contamination.During an interview with the FD, on 5/21/2026 at 12:30 PM, the FD stated solution buckets should be within recommended ranges to avoid bacterial growth.During an interview with the DM, on 5/21/2026 at 12:34 PM, the DM stated solution buckets should be within the correct range to properly clean and sanitize Kitchen 1 areas where food was prepared.During a review of the facility's P&P titled Sanitizing Food Contact Surfaces, revised on 1/2025, the P&P indicated each work area shall be equipped with sanitizing solution. The P&P indicated red buckets change sanitizer solution whenever it becomes heavily soiled and/or falls out of the effective usage range (200-400 ppm).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection (the invasion and growth of germs in the body) prevention and control practices by failing to: a. Ensure two of five sampled residents' (Resident 55 and Resident 20) nasal cannula (N/C - a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen [a colorless, odorless, and tasteless gas essential for life]) tubing was not on the floor b. Label a personal care item stored inside the shared restroom for two of two sampled residents (Resident 57 and Resident 26). These deficient practices had the potential to result in cross contamination (the process by which microorganisms are unintentionally transferred from one area/object to another with a harmful effect) and/or the development and transmission of disease (an illness or sickness) and infections to Residents 20, 26, 55 and 57. Findings: a1. During a review of Resident 55's admission Record (AR), the AR indicated, Resident 55 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing) with acute [sudden] exacerbation, and dependence on supplemental oxygen. During a review of Resident 55's Skilled admission History and Physical (H&P), dated 5/19/2026, the H&P indicated, Resident 55 had the capacity to understand and make decisions. During a review of Resident 55's Order Summary Report (OSR), active orders as of 5/19/2026, the OSR indicated, an order on 5/18/2026 for oxygen (02) at two (2) liters/minute (L/min - the speed or volume of oxygen a device delivers to the person) via N/C continuous every shift, with an order date of 5/18/2026. During a review of Resident 55's Care Plan Report (CP - provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan), initiated on 5/18/2026, for The resident has COPD, the CP indicated a goal that Resident 55 would be free from signs and symptoms (s/sx) of respiratory infections through review date. During an observation on 5/19/2026 at 9:54 AM, Resident 55 was awake and alert lying in bed, with 02 on via N/C connected to a 02 concentrator (a medical device that delivers pure, concentrated oxygen). Resident 55's 02 concentrator was positioned about three (3) feet away from Resident 55 with the N/C tubing on the floor. a2. During a review of Resident 20's AR, the AR indicated, Resident 20 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including acute respiratory failure with hypoxia (a medical emergency where the lungs suddenly fail to get enough 02 into the blood causing severe shortness of breath), and dependence on supplemental oxygen. During a review of Resident 20's Minimum Data Set (MDS, a resident assessment tool), dated 3/22/2026, the MDS indicated, Resident 20's cognitive skills (ability to think and process information) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated, Resident 20 was on 02 therapy while a resident at the facility. During a review of Resident 20's OSR, active orders as of 5/19/2026, the OSR indicated an order for 02 at 2 L/min via N/C continuous every shift with an order date of 12/11/2025. During a concurrent observation and interview on 5/19/2026 at 11:13 AM with Licensed Vocational Nurse (LVN) 2, inside Resident 20's room, Resident 20 was sitting up in a wheelchair at Resident 20's bedside. Resident 20 had 02 on via N/C connected to a 02 concentrator positioned behind Resident 20's wheelchair with the N/C tubing on the floor. LVN 2 stated, Resident 20's N/C tubing was on the floor. During an interview on 5/20/2026 at 3:45 PM with the Infection Preventionist (IP) in the presence of the Director of Nursing (DON), the IP stated, 02 N/C tubing (in general) should not be on the floor for infection control. The IP stated, the IP even provided a holder for the N/C tubing close to the resident's (in [NAME]) bed for the 02 N/C cannula to be off the floor. b1. During a review of Resident 57's AR, the AR indicated, Resident 57 was admitted to the facility on [DATE] with multiple diagnoses including pneumonia (an infection/inflammation in the lungs), and severe sepsis (a life-threatening blood infection) without septic shock (the most severe, life-threatening stage of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sepsis). During a review of Resident 57's H&P, dated 5/13/2026, the H&P indicated, Resident 57 had the capacity to understand and make decisions. During a review of Resident 26's AR, the AR indicated, Resident 26 was admitted to the facility on [DATE] with multiple diagnoses including anemia (a condition where the body does not have enough healthy red blood cells), and Type 2 Diabetes Mellitus (DM II - adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing) without complications. During a review of Resident 26's H&P, dated 5/2/2026, the H&P indicated, Resident 26 had the capacity to understand and make decisions. During a review of Resident 26's MDS, dated 5/8/2026, the MDS indicated, Resident 26's cognitive skills for daily decision making was intact. The MDS indicated, Resident 26 required substantial/maximal assistance (helper does more than half the effort) to setup or clean-up assistance (helper sets up or cleans up) for activities of daily living (ADLs). During an interview on 5/19/2026 at 10:16 AM with Resident 26, Resident 26 stated, Resident 57 used the shared restroom and Resident 26 was able to use the shared restroom with help. During a concurrent observation and interview on 5/19/2026 at 10:28 AM with Certified Nursing Assistant (CNA) 1 inside Resident 57 and Resident 6's shared restroom, the restroom had two wall niches. The top wall niche was labeled with an A letter and belonged to Resident 57's roommate. The bottom wall niche was labeled with a letter B and belonged to Resident 57. An unlabeled eight (8) fl oz (fluid ounce - a measurement of volume) of [NAME] (brand name) Perineal & Skin Cleanser Rinse-Free was stored on the top wall niche that belonged to Resident 57's roommate. CNA 1 stated, the perineal and skin cleanser was considered a personal care item and belonged to Resident 57. The CNA stated all perineal care items should be labeled with resident's room number and bed to ensure there was no cross contamination. During an interview on 5/21/2026 at 11:55 AM with the IP, the IP stated the perineal and skin cleanser was considered a personal care item used for resident's private area. The IP stated personal care items should be labeled with the resident's room and bed number to identify to which resident item belonged so the personal item will not be used by the wrong resident, especially when it's a two bed. The IP stated this will prevent cross contamination and for an infection control. The IP stated Resident 57 was ambulatory and very independent and if Resident 57 could not reach the top wall niche that belongs to Resident 57's roommate. During a review of the facility's policy and procedures (P&P), titled Policies and Practices - Infection Control, reviewed on 2/24/2025, the P&P indicated, the facility's infection control P&P were intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. During a review of the facility's P&P, titled Cleaning and Disinfecting Non-Critical Resident-Care Items, reviewed on 3/17/2025, the P&P indicated, single resident use items are for single resident use only and should be marked with the resident's name and/or room number and discard upon transfer or discharge.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to submit and transmit the discharge Minimum Data Set (MDS, a standardized assessment and care-screening tool) assessment within 14 days after the MDS completion for one of one sampled resident (Resident 2) as indicated in the Centers for Medicare & Medicaid Services (CMS, is a federal agency that administers major public health insurance programs and sets the regulatory standards for the United States healthcare system) Resident Assessment Instrument (RAI, a tool used by nursing homes to assess the needs, strengths, and preferences of residents) manual.This deficient practice resulted in a late completion and transmission of Resident 2's MDS assessment to CMS's Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.Findings:During a review of a History and Physical (H&P), dated 12/15/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's Order Summary Report (OSR), the OSR indicated a physician's order, dated 2/19/2026, indicating it indicated Resident 2 was discharged from the facility on 2/23/2026 with out-patient physical therapy.During a review of an admission Record (AR), indicated Resident 2 was re-admitted to the facility on [DATE] with diagnosis that included Alzheimer's Disease (irreversible progressive mental deterioration, a condition that occurs later in life and worsens with time in which brain cells degenerate; it is accompanied by memory loss, physical decline, and confusion) and hypertension (elevated blood pressure).During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's discharge assessment was completed on 3/10/2026.During a review of a document titled Point Click Care - (MDS 3.0) Summary, the document indicated Resident 2's assessment information had a target date of 2/23/2026. The document's MDS status was completed but the submit requirement indicated Do not submit to CMS.During an interview and concurrent record review on 5/22/2026 at 11:04 AM with the Minimum Data Set Nurse (MDSN), Resident 2's medical record (chart) was reviewed with the MDSN, the MDSN stated Resident 2 was discharged from the facility on 2/23/2026. The MDSN stated Resident 2's MDS assessment was completed and during the process of sending, instead of triggering to send, I triggered do not send. The MDSN stated it was important for MDS's to be submitted in a timely manner per RAI guidelines to give CMS a proper picture of the residents, how they were doing, and the progress the residents were making.During an interview with the Administrator (ADM) on 5/22/2026 at 1:48 PM, the ADM stated the facility followed RAI rules and regulations regarding MDS.During a review of the MDS RAI Version 3.0 Manual, Chapter 2: Assessment for the RAI, dated 10/2025, the manual indicated the Part A PPS discharge assessment must be completed within 14 days after the end date of most recent Medicare stay. The manual indicated that Part A PPS discharge assessment must be submitted within 14 days after the MDS completion date.

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	05/22/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a comprehensive person-centered care plan (CP) was developed for one of one sampled resident (Resident 40) in accordance with the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered.This failure had the potential to result in unmet individualized needs for Resident 40 and the potential to affect Resident 40's physical and psychosocial well-being.Findings:During a review of Resident 40's admission Record (AR), the AR indicated Resident 40 was admitted to the facility on [DATE] with multiple diagnoses including unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, with other behavioral disturbance, and type 2 diabetes mellitus (DM II - adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing) without complications.During a review of Resident 40's History and Physical Examination (H&P), dated 10/12/2025, the H&P indicated Resident 40 did not have the capacity to understand and make decisions.During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated 2/27/2026, the MDS indicated Resident 40's cognitive skills (ability to think and process information) for daily decision making were severely impaired. The MDS indicated, Resident 40 was dependent (helper does all of the effort) to requiring partial/moderate assistance (helper does less than half the effort) for activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 40's Order Summary Report (OSR), active orders as of 5/20/2026, the OSR indicated, a physician's order, dated 2/21/2026 for artificial tears ophthalmic (relating to the eye) solution, instill one drop in the left eye one time a day everyday Monday, Wednesday, and Friday to lubricate/moisten the eye.During a concurrent observation and interview on 5/19/2026 at 2:43 PM with Resident 40 in Resident 40's room, Resident 40 was sitting up in a wheelchair at Resident 40's bedside. Resident 40's left lower eyelid was red. Resident 40 stated, Resident 40 did not know why Resident 40's left lower eyelid was red and asked, is it alright, honey?During an interview on 5/20/2026 at 2:18 PM with Certified Nursing Assistant (CNA) 2, CNA 2 stated, CNA 2 noticed Resident 40's left eye was still red. CNA 2 stated, a while ago Resident 40's left eye was glued shot. CNA 2 stated Resident 40 was receiving medication on Resident 40's left eye and Resident 40's left eye got better.During a concurrent interview and record review on 5/20/2026 at 2:27 PM with Licensed Vocational Nurse (LVN) 2, Resident 40's CP, initiated 12/28/2024, was reviewed with LVN 2. The CP indicated Resident 40 had impaired visual function r/t (related to) infection (the invasion and growth of germs in the body) conjunctivitis. LVN 2 stated, Resident 40's conjunctivitis was treated with an ointment (Erythromycin - an antibiotic used to treat bacterial infection of the eye) for ten days. LVN 2 stated, Resident 40 did not have an active CP for Resident 40's ongoing redness in the left eye and [creating a CP] was important to have a goal, interventions, and to monitor Resident 40's progress.During an interview on 5/20/2026 at 2:42 PM with the Physician (MD -medical doctor), the MD stated, the MD was aware of Resident 40's left eyelid redness that was something chronic (a health condition that is persistent, long-lasting, or constantly recurring), and was being treated with an eyedrop (artificial tears). The MD stated, Resident 40's left eyelid redness would eventually go away.During a concurrent interview and record review on 5/20/2026 at 2:44 PM with Registered Nurse (RN) 1, Resident 40's CP, initiated 12/28/2024, was reviewed with RN 1. The CP indicated Resident 40 had impaired visual function r/t (related to) infection (the invasion and growth of germs in the body) conjunctivitis. RN 1 stated, the CP was resolved since Resident 40 no longer was getting eye ointment (intervention) but a CP should still have been created for Resident 40's ongoing redness in the left eye.During an interview on 5/20/2026 at 3:21 PM with the Director of Nursing (DON), the DON stated, Resident 40's left eyelid, is so red was considered a problem and it was important to [create] (continued on next page)

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	056083	A. Building B. Wing	05/22/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a CP to have a plan of care and interventions to ensure and prevent worsening of the chronic left eye redness or complications (goal).During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, reviewed 5/19/2025, 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 were developed and implemented for each resident. The P&P indicated assessments of residents were ongoing, and care plans are revised as information about the residents and the residents' condition changes.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure irregularities identified from the Monthly Drug Regimen Review (MDRR), reported by the facility's pharmacist were acted upon for one of five sampled residents (Resident 5).These deficient practices had the potential to result in unnecessary medication administration and physical harm to Resident 5.Findings:During a review of an admission Record (AR), the AR indicated Resident 5 was re-admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus (DM II - adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing), hyperlipidemia (high concentration of fats or lipids in the blood) and long term use of insulin (an essential hormone produced by the pancreas that regulates your blood sugar levels).During a review of Resident 5's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 3/25/2026, the MDS indicated Resident 5's cognition (ability to think and make decisions) was severely impaired and Resident 5 was dependent (helper does all the effort) with toilet and personal hygiene, showers/baths.During a review of Resident 5's Note to Attending Physician/Prescriber ([NAME]), a note from the facility's pharmacist, date printed 3/12/2026, the note indicated to please consider ordering the following labs that corresponded with the Resident 5's medications: CMP (a routine blood test that measures 14 different substances in the blood), fasting lipid panel (a blood test that measures the levels of cholesterol and triglycerides in the blood), and A1c (blood test that measures the average blood sugar levels over the past 2 to 3 months). The [NAME]'s Physician/Prescribers Response, was left blank and did not indicate any documentation from Resident 2's physician indicating if the physician agreed or disagreed with the pharmacist's recommendation.During a concurrent interview and record review on 5/22/2026 at 10:18 AM, with Infection Preventionist (IP) 1, Resident 5's medical record was reviewed with IP 1, IP 1 stated IP 1 did not see a physician's order or any documentation indicating labs were ordered to follow the pharmacist's recommendations with date printed 3/12/2026. During an interview and concurrent record review on 5/22/2026 at 11:34 AM, with Registered Nurse (RN 1), RN 1 stated it was important to inform Resident 2's physician of the pharmacist's recommendations to provide [to the physician] an overall view of Resident 5's care from all aspects of the medical team.During an interview on 5/22/2026 at 1:58 PM, with the Director of Nursing (DON), the DON stated recommendations from the pharmacist were important to ensure medications were taken and monitored.During a review of the facility's policy and procedure (P&P) titled Medication Regimen Reviews, revised 5/2019, the P&P indicated the goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risk associated with medication: inadequate monitoring for adverse consequences. The P&P indicated an irregularity referred to the use of medication that is inconsistent with accepted pharmaceutical service standards of practice, is not supported by medical evidence or impedes or interferes with achieving the intended outcomes; it may also include the use of medication without adequate monitoring. The P&P indicated the attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records were complete for one of three sampled residents' (Resident 4). Resident 4's Inventory of Personal Effects (IPE) form was not signed or dated to indicate Resident 4's personal belongings were picked up by Resident 4's family when Resident 4 was discharged from the facility.This failure resulted in inaccuracy of Resident 4's IPE after Resident 4 left the facility.Findings:During a review of Resident 4's admission Record (AR), the AR indicated, Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a long standing lung disease causing difficulty in breathing) with acute (sudden) exacerbation (flare up), and essential (primary) hypertension (HTN - high blood pressure).During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 3/7/2026, the MDS indicated Resident 4's cognitive skills (ability to think and process information) for daily decision making were intact (decisions consistent/reasonable). The MDS indicated Resident 4 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 4's History and Physical Examination (H&P), dated 3/2/2026, the H&P indicated Resident 4 had the capacity to understand and make decisions.During a review of Resident 40's Phone Order (TO, physician order), dated 5/5/2026, timed at 1:40 PM, the TO indicated, ok to send out Resident 40 via 911 (a telephone number used to reach emergency medical, fire, and police services) due to SOB (short of breath)/wheezing (a high-pitched sound made when breathing is restricted/obstructed in the lungs).During a review of Resident 4's undated IPE, the IPE indicated to use the [check symbol] columns to indicate that all personal belongings were accounted for [upon discharge]. The IPE indicated Resident 4 had items of specific value including one wallet, 1 cell/mobile phone and charger, 1 computer/laptop/e-reader, 1 right and 1 left hearing aids, and 1 eyeglass on admission to the facility. The IPE was signed by Resident 4 on admission on ly. The IPE's certification of receipt on admission was undated and signed by Resident 4. The IPE's certification of receipt on discharge was blank (not signed or dated).During a concurrent interview and record review on 5/21/2026 at 2:30 PM with Registered Nurse (RN) 1, Resident 4's Progress Notes (PN), dated 5/4/2026, timed at 6:18 PM was reviewed with RN 1. The PN indicated Resident 4 was transferred out [on 5/4/2026] to the General Acute Care Hospital (GACH) for SOB. RN 1 stated Resident 4 did not return to the facility. RN 1 stated Resident 4's family (unnamed) came to the facility (date unknown) to collect Resident 4's personal belongings and the family notified the facility Resident 4 was not returning to the facility. RN 1 could not find Resident 4's IPE at time of investigation and stated, ensuring a record of resident's (in general) IPE was signed was important so personal belongings brought to the facility were accounted for and returned to the resident when resident left the facility.During a concurrent interview and record review on 5/22/2026 at 12:12 PM with the Director of Nursing (DON), Resident 4's undated IPE was reviewed. The DON stated Resident 4 went to a board and care ([unnamed] - a small, residential care facility) because Resident 4 used up Resident 4's benefit days (days a nursing home stay is covered by your insurance) and did not return to the facility. The DON stated Resident 4's family came to the facility to collect Resident 4's personal belongings. The DON stated, the IPE was not signed, nobody signed it, either by Resident 4, Resident 4's family or staff. The DON stated, signing the IPE was important for staff to have accountability and ensure Resident 4 received all of Resident 4's personal belongings back.During a review of the facility's policy and procedure titled (P&P), the P&P indicated the resident's personal belongings and clothing were inventoried and documented upon admission and updated as necessary.During a review of the facility's P&P titled, Charting and Documentation, reviewed 4/3/2026, the P&P indicated documentation in the [resident's] medical record will be objective, complete, and accurate.