

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/20/2025
NAME OF PROVIDER OR SUPPLIER WOODS HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 A STREET LA VERNE, CA 91750		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an investigation of a Facility Reported Incident. Facility Reported Incident number: CA00966360 The inspection was limited to the specific incident reported and does not represent the findings of a full inspection of the facility. One deficiency was issued for Facility Reported Incident number: CA00966360	F 000	Disclaimer: The following plan of correction is completed in accordance with State and Federal laws. It is not an admission to the alleged findings shown in the statement of deficiencies.		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received treatment for a left first toe fracture (break in bone) per physician's orders. This deficiency had the potential for Resident 1's injury to get worse. Findings:	F 684	Immediate corrective action: Following observations on 6/20/2025 resident 1's toe was checked and buddy taped. Treatment records were updated and staff in-serviced ensuring checking and taping was completed per the order summary report. Identifying other potentially affected: On 6/23/2025 The DON and Medical Records conducted a random review of three residents having treatment orders and observations. Audits and physical observation revealed successful evidence of completion. No additional concerns were noted.	6/20/25 6/23/2025	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

COO / N/A

(X6) DATE

7/18/2025

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.

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F 684	<p>Continued From page 1</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility on 10/22/2021 with multiple diagnoses including disorders of bone density and structure (condition where bones become weaker and more prone to fracture) and muscle wasting and atrophy (the loss of muscle mass and strength resulting in reduced physical function and mobility).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/2/2025, the MDS indicated Resident 1 had moderately impaired cognition (ability to understand and process information) and required partial assistance (helper does less than half the effort) for personal hygiene and to walk 10 feet.</p> <p>During a review of Resident 1's Radiology Results Report (RRR) dated 6/6/2025, the RRR of Resident 1's left foot x-ray (test that captures images of the structures inside the body) indicated had a finding of diffuse osteopenia (condition where bone mineral density is lower than normal), with an acute fracture present at the base of the left first toe without significant displacement.</p> <p>During a review of Resident 1's Interdisciplinary Team Conference Record (IDTR) dated 6/9/2025, the IDTR indicated a Certified Nurse Assistant (CNA) noticed a bruise on Resident 1's left first toe and at the base of the left second toe without known cause or complaints of pain from Resident 1. The IDTR further indicated an x-ray was completed and resulted with an acute fracture of the left first toe and diffuse osteopenia. The IDTR indicated Resident 1's physician was made aware</p>	F 684	<p>Measures for systemic change:</p> <p>Between the dates of 6/23/2025 and 6/27/2025 the DON provided in-services to licensed nurses regarding carrying out physician orders and proper completion of buddy taping and documentation of doing so for Resident 1's left toes.</p> <p>Monitoring for compliance:</p> <p>The DON and/or RN Supervisor will visually check Resident 1's toe for proper buddy taping regularly until follow up physician orders discontinue the need.</p> <p>Successful completion of items above:</p>	<p>6/27/2025</p> <p>7/17/2025</p> <p>7/17/2025</p>	

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F 684	<p>Continued From page 2</p> <p>and instructed to tape the first toe to the second toe and an appointment for orthopedic (branch of medicine that deals with the musculoskeletal system) consult was scheduled for 6/13/2025 at 3:30 PM.</p> <p>During a review of Resident 1's Order Summary Reported (OSR) with active orders as of 6/20/2025, the OSR indicated to tape the first toe to the second toe until orthopedic consult was done.</p> <p>During a review of Resident 1's Progress Notes (PN) dated 6/18/2025, the PN indicated the facility received Resident 1's after visit progress note from Resident 1's orthopedic appointment scheduled 6/13/2025. The PN indicated the orthopedics' recommendation to buddy tape (the practice of bandaging an injured finger or toe to an uninjured one) or splint (medical device used to support and protect an injured body part by immobilizing it) the left first toe fracture for four to six weeks.</p> <p>During a concurrent observation and interview on 6/20/2025 at 10:47 AM with Licensed Vocational Nurse (LVN) 1 in Resident 1's room, Resident 1's left foot was observed. LVN 1 stated Resident 1's foot had discoloration on the left great toe, but it was very light and had improved since the discoloration was initially discovered. LVN 1 stated the left first toe was not currently taped to the second toe and LVN 1 did not know how many days Resident 1 had the toes taped without looking at the chart.</p> <p>During an interview on 6/20/2025 at 11:20 AM with LVN 1, LVN 1 stated Resident 1's physician orders indicated to tape Resident 1's toes until</p>	F 684			

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F 684	<p>Continued From page 3</p> <p>the orthopedic appointment on 6/13/2025 and LVN 1 did not know if Resident 1's toes were taped after the appointment.</p> <p>During a concurrent interview and record review on 6/20/2025 at 1:45 PM with the Infectious Preventionist Nurse (IPN), Resident 1's orthopedic after visit notes titled, "Orthopedic Clinical Encounter Summaries," (OCES) dated 6/13/2025 was reviewed. The OCES indicated a recommendation to buddy tape or splint the left great big toe fracture for four to six weeks and bear weight as tolerated. The IPN stated the nurse documented the recommendations in Resident 1's PN but did not transcribe the recommendations as a physician's order and it was not followed up afterwards.</p> <p>During an interview on 6/20/2025 at 2:35 PM with the Director of Nursing (DON), the DON stated there was no documentation to indicate when Resident 1's toes were taped together per physician orders. The DON stated when the nurse received the orthopedic doctor's after visit notes, the nurse should have written the orders to buddy tape or splint the first and second toe for four to six weeks. The DON stated orders should have been placed for treatment and monitoring to ensure the orthopedic doctor's recommendations were carried out and Resident 1's toes were stabilized. The DON stated Resident 1 had potential for further injury if treatment was not followed.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Medication and Treatment Orders," dated 7/2016, the P&P indicated orders for medications and treatments will be consistent with principles of safe and</p>	F 684			

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F 684	Continued From page 4 effective order writing. During a review of the facility's P&P titled, "Charting and Documentation," dated 7/2017, the P&P indicated treatment or services performed is to be documented in the resident medical record.	F 684		