

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/15/2024
NAME OF PROVIDER OR SUPPLIER  The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  124 Walnut Street Woodland, CA 95695	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40841</b></p> <p>Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 1 and Resident 2) were free from physical abuse when Resident 1 and Resident 2 were in a physical altercation that resulted in Resident 1 sustaining a skin tear on her right forearm and discoloration on her right upper arm.</p> <p>This failure had the potential to result in serious physical injuries for Resident 1 and Resident 2.</p> <p>Findings:</p> <p>A review of a facility document titled Admission Record, indicated Resident 1 was admitted to the facility in 2023 with diagnoses including depression and anxiety disorders.</p> <p>Review of Resident 1 ' s Minimum Data Set (MDS, an assessment tool), dated 2/6/24, indicated Resident 1 had a Brief Interview of Mental Status (BIMS) score of 11 out of 15, which indicated moderate cognitive impairment.</p> <p>Review of Resident 1 ' s medical record titled, SBAR [Situation, Background, Assessment, Recommendation] and Initial COC [Change of Condition]/Alert charting and Skilled Documentation, dated 5/1/24, indicated Resident 1 had a skin tear on her right arm approximately 3 inches long on 5/1/24 at 9 p.m.</p> <p>Review of Resident 1 ' s Nurses Notes, dated 5/2/24, indicated Resident 1 had a resident altercation with roommate and, .Sustained a skin tear on her [right] forearm and discoloration on her [right] upper arm.</p> <p>Review of Resident 1 ' s note titled, IDT [Interdisciplinary Team] - Grievance Investigation, intervention/s and Resolution, dated 5/2/24, indicated Resident 1 reported on 5/1/24 around 8 p.m. that her roommate struck the front of her right arm causing a skin tear and discoloration, as well as discoloration on her right upper arm.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1 ' s Nurse Practitioner (NP) note titled, Skilled Nursing/ Rehab Office/ Clinic Note, dated 5/2/24, indicated Resident 1 had a physical altercation with roommate resulting in trauma. The NP note further wrote, Per resident she was trying to open the balcony door last night but her roommate hit her right arm with a hard object. She had a large discoloration with skin tear on her forearm as a result of the trauma. She also has a new bruising on her deltoid region.</p> <p>Review of Resident 1 ' s Order Summary Report, dated 5/2/24, indicated Resident 1 had a right arm skin tear to be cleansed with normal saline and to apply xeroform once daily until healed.</p> <p>A review of a facility document titled Admission Record, indicated Resident 2 was admitted to the facility in 2023 with diagnoses including anxiety.</p> <p>Review of Resident 2 ' s MDS, dated [DATE], indicated Resident 2 had a BIMS scored 13 out of 15, indicating they were cognitively intact.</p> <p>Review of Resident 2 ' s note titled, IDT - Grievance Investigation, intervention/s and Resolution, dated 5/2/24, indicated, [Resident 1] .was swinging her arms .and hitting [Resident 2] .and [Resident 2] pushed [Resident 1] . The IDT note further stipulated both residents were interviewed, and both parties confirmed a physical altercation had occurred.</p> <p>During an interview on 5/15/24 at 12:15 p.m. in Resident 2 ' s room, Resident 2 stated the incident happened at night when she wanted to close the sliding door and Resident 1 wanted to open the sliding door. Resident 2 further stated Resident 1 was angry and hit Resident 2 in the arms and shoulder multiple times. Resident 2 stated she pushed Resident 1.</p> <p>During a concurrent observation and interview on 5/15/24 at 12:55 p.m. inside Resident 1 ' s room, Resident 1 stated the event happened in the evening time, it was dark outside. Resident 1 further stated, We were both swinging arms at each other. As the result, Resident 1 blocked Resident 2 ' s swinging arm and got a skin tear on the right arm and bruising on the right upper arm. Resident 1 was seen with a skin tear on her right forearm with steri strips (thin adhesive bandages), and bruising on her right upper arm.</p> <p>During a concurrent interview and record review of the Report of Suspected Dependent Adult/Elder Abuse on 5/15/24 at 1:30 p.m. with the Administrator (ADM), the ADM confirmed the physical altercation occurred on 5/1/24 with injuries to Resident 1's arm.</p> <p>Review of the facility ' s policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 12/2023, indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>40841</p> <p>Based on interview and record review, the facility failed to report immediately to officials an alleged violation involving physical abuse between two residents (Resident 1 and Resident 2) of three sampled residents, when the Department received the report of alleged violation greater than two hours after the incident's occurrence.</p> <p>This failure decreased the facility's potential to protect vulnerable residents and provide a safe environment.</p> <p>Findings:</p> <p>Review of Resident 1's note titled, IDT [Interdisciplinary Team] - Grievance Investigation, intervention/s and Resolution, dated 5/2/24, indicated Resident 1 reported on 5/1/24 around 8 p.m. that her roommate struck the front of her right arm causing a skin tear and discoloration, as well as discoloration on her right upper arm.</p> <p>Review of Resident 2's note titled, IDT - Grievance Investigation, intervention/s and Resolution, dated 5/2/24, indicated, [Resident 1] .was swinging her arms .and hitting [Resident 2] .and [Resident 2] pushed [Resident 1] . The IDT note further stipulated that both residents were interviewed, and both parties confirmed a physical altercation had occurred.</p> <p>During a concurrent interview and record review of the Report of Suspected Dependent Adult/Elder Abuse on 5/15/24 at 1:30 p.m. with the Administrator (ADM), the ADM confirmed the alleged abuse happened on 5/1/24, the licensed nurse and certified nursing assistant were aware of the incident on 5/1/24 but did not notify the ADM on 5/1/24. The ADM confirmed the facility had no proof the alleged abuse had been reported to the Department within 2 hours of becoming aware of the situation according to facility policy.</p> <p>Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation - Reporting and Investigating, dated 12/2023, indicated, If resident abuse, neglect, exploitation, misappropriation of resident property or injury or unknown source is suspected, the suspicion must be report immediately to the administrator and to other officials according to state law. The policy further stipulated, Immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury .</p>