STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055438	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove Post-Acute	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48445 Based on interview and record review, the facility failed to report an incident of an injury of unknown origin timely for one of three sampled residents (Resident 1) as required by the regulations. This failure resulted in a delay in the investigation process and decreased the facility's potential to protect patients from physical and psychosocial harm. Findings: During a review of Resident 1's admission records, the records indicated Resident 1 was admitted in October 2023 with diagnoses that included pathological fracture (broken bone caused by disease) of right humerus (upper arm bone), displaced oblique fracture (diagonal break in the bone) of shaft of humerus (long middle portion of the upper arm bone) of right arm, and dementia (group of symptoms affecting memory, thinking and social abilities). Residents 1's Minimum Data Set (MDS, an assessment tool) indicated Resident 1 had severe cognitive impairment. During a review of Resident 1's nurses notes, dated 6/19/24 at 1:05 p.m., the notes indicated, CNA [Certified Nursing Assistant] reported that res [resident] has R [right] arm pain before transferring the res from bed to shower chair. @ [at] around 07:30 [am] I assessed, and no swelling noted but res complains of pain and unable to lift the R arm. During a review of Resident 1's nurses notes, dated 6/22/24 at 1:01 p.m., the notes indicated, .Resident is on day 2 of 7 po [by mouth] atb [antibiotic] .for R arm cellulitis [deep infection of the skin] .R arm still swollen but now color is dark purple to area .[family member] in facility requesting resident to get an xray to resident's R elbow and arm .Received orders from NP [Nurse Practitioner] .Stat [immediately] xray to R elbow and arm . Orders carried out. During a review of Resident 1's Radiology Results Report, reported on 6/22/24 at 3:53 p.m., the report indicated, Reason for Study: .PAIN IN RIGHT ELBOW .CONCLUSION: Acute transverse distal humerus supracondylar fracture [break in the lower end of the arm bone just above the elbow joint]. During a review of Resident 1's nurses notes, dated 6/23/24 at 7:16 a.m., the notes indicated, Message received from PCP to send resident to ED [emergency department] d/t [due to] x-ray results regarding right elbow x-ray results. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's nurses notes, dated 6/23/24 at 2:14 p.m., the notes indicated, Resident returned back from [acute hospital] at approx. 1345 [1:45 p.m.] .R arm is on a splint. During a review of a document titled Report of Suspected Dependent Adult/Elder Abuse (SOC 341), dated 6/24/24, the document indicated the report was received by the Department on 6/24/24 at 5:45 p.m. During an interview on 7/3/24 at 12:15 p.m. with the Director of Nursing (DON), the DON stated, Staff did not report the result to management on the weekend and we found out by Monday .I should have been notified the minute they had the fracture result .They contacted the MD [medical doctor] and followed the orders but obviously we are late reporting and that's a practice that we don't want to happen. Safety is always first. They followed policy except notifying me or the admin. We ended up reporting late and intervened late. There were delays with interventions too and things were all pushed back. During an interview on 7/3/24 at 2:01 p.m. with the Administrator (ADM), the ADM stated, I was notified about the fracture on 6/24/24 Xray was reported on 6/22/24 .I reported as soon as I found out. It should have been reported the day it was discovered .for unknown injury, it should be reported to us as soon as discovery, with this case, it wasn't reported to us .If I have gotten the call, it would have been reported earlier . During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 1/2023, the P&P indicated, All reports of resident abuse (including injuries of unknown origin) .are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management .1. If resident abuse, neglect .or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law .3. Immediately is defines as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 48445 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, an assessment tool) for one of three sampled residents (Resident 1) accurately reflected Resident 1 ' s behavioral symptoms when her MDS Section E Behavior was not accurately documented. This failure had the potential to result in Resident 1 not receiving interventions to improve behavioral symptoms and placed Resident 1 at risk for injury. Findings: During a review of Resident 1 ' s admission records, the records indicated Resident 1 was admitted in October 2023 with diagnoses that included pathological fracture (broken bone caused by disease) of right humerus (upper arm bone), displaced oblique fracture (diagonal break in the bone) of shaft of humerus (long middle portion of the upper arm bone) of left arm, and dementia (group of symptoms affecting memory, thinking and social abilities). Residents 1 ' s Minimum Data Set (MDS, an assessment tool) indicated Resident 1 had severe cognitive impairment. During a review of Resident 1 ' s quarterly MDS Section E, dated 4/16/24, the section indicated behaviors were not exhibited for physical behavioral symptoms directed towards others, for verbal behavioral symptoms directed towards others, and for other behavioral symptoms not directed towards others such as hitting or scratching self. During a review of Resident 1 ' s care plan, initiated on 11/14/23 and revised on 6/24/24, the care plan indicated, [Resident 1] is non-compliant with care/treatment. AEB [as evidenced by]: flailing arms throughout incontinence and ADL [activities of daily living] cares, refusing medication administration, and nail care .If [Resident 1] becomes agitated throughout cares, please provide a safe environment, excuse yourself and reapproach at a later time to complete care. During a review of Resident 1 ' s physician order, dated 4/15/24, the order indicated, Seroquel [medication used to improve mood, thoughts, and behaviors] Oral Tablet 25 MG (milligrams, a unit of measurement) . Give 0.5 tablet by mouth two times a day for DEMENTIA with BEHAVIORAL DISTURBANCE, PSYCHOTIC [disconnection from reality] DISTURBANCE. During a review of Resident 1 ' s Medication Administration Record (MAR) dated 4/2024, the record indicated behavior monitoring for Seroquel m/b [manifested by] physical aggression .every shift .Start date 10/31/2023 . The MAR further indicated there were 13 episodes of aggressive behavior including behaviors on the evening shift of 4/6/24 and the evening shift of 4/15/24. During a review of Resident 1 ' s Radiology Results Report, reported on 6/22/24 at 3:53 p.m., the report indicated, Reason for Study: .PAIN IN RIGHT ELBOW .CONCLUSION: Acute transverse distal humerus supracondylar fracture [break in the lower end of the arm bone just above the elbow joint]. During an interview on 7/3/24 at 9:50 a.m. with the Director of Nursing (DON), the DON stated Resident 1 had behaviors, flailing arms, can be very combative, and swing on staff. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/3/24 at 10:45 a.m. with the Restorative Nursing Assistant (RNA), the RNA stated, Sometimes [Resident 1] can be very nice, sometimes she fights and hits . Sometimes she ' s combative to [family member]. During an interview on 7/3/24 at 10:50 a.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated, [Resident 1] usually has behaviors, she calls us names, curses at you, she ' s combative .we have to do two persons [to provide care] because she was so combative. During an interview on 7/3/24 at 11 a.m. with CNA 2, CNA 2 stated, [Resident 1] has been super combative, name calling .we report all the time, nurses document it . two-person assist all the time. During an interview on 7/3/24 at 11:30 a.m. with the Social Services Director (SSD), the SSD stated, With [Resident 1] case, the cause [of fracture] was still unknown, but the possible cause is being combative. During a concurrent interview and record review on 7/3/24 at 12:59 p.m. with the DON, the DON confirmed the MDS Section E indicated Resident 1 did not exhibit behaviors. The DON stated, It [behavior symptoms] should have been reflected in the MDS, the care plans are not matching with the MDS assessment .it should all match across the board. During a concurrent interview and record review on 7/3/24 at 1:30 p.m. with the MDS Coordinator (MDSC), the MDSC confirmed the MDS Section E indicated no behaviors were coded for behavioral symptoms. The MDSC stated, This section was improperly coded .On her behavior MAR for April, it shows she had 13 episodes of physical aggression and for March, there ' s a lot of behaviors noted, for February there was a couple. The MDSC further stated, MDS is how we complete our plan of care. If it ' s not properly coded, the behavior might not be properly treated. During a review of the Resident Assessment Instrument (RAI) Version 3.0 Manual, dated 10/2019, the manual indicated, Section E: Behavior .The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may by distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illnesses. Behaviors include those that are potentially harmful to the resident himself or herself .Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact.