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	09/02/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews, and record review, the facility failed to protect one of five sampled residents' (Resident 1) right to be free from physical/mental abuse by Resident 2 when Resident 2 shoved a walker into Resident 1's legs.As a result of this failure, Resident 1 experienced a skin tear in the left knee. Findings:Resident 1 was admitted to the facility in March of 2025 with diagnoses that included chronic respiratory failure and adult failure to thrive.A review of Resident 1's Minimum Data Set (MDS, a standardized assessment tool used in nursing homes), dated 7/16/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS) score of 13 of 15 indicating Resident 1 was cognitively intact.Resident 2 was admitted to the facility in December of 2023 with diagnoses that included dementia (a decline in cognitive abilities, such as memory, thinking, and reasoning).During a review of the facility's document titled, Event Statement Form, dated 8/19/25, the document indicated that Certified Nursing Assistant 1 (CNA 1) gave the following statement after the incident between Resident 1 and 2 had occurred, I heard [Resident 1] and [Resident 2] arguing from the hallway over their curtain. I rushed over there and witnessed [Resident 1] standing above [Resident 2] who was seated in his wheelchair. [Resident 1's] walker was in front of [Resident 2], and [Resident 2] pushed the walker into [Resident 1] right as I walked into the room.During a review of Resident 1's SBAR [situation, background, assessment, and recommendation] & INITIAL COC [change in condition]/ALERT CHARTING & SKILLED DOCUMENTATION, dated 8/19/25, the document indicated, Describe the problem/symptom: Verbal Disagreement with roommate resulting in ST [skin tear] to L [left]. knee.Other things that have occurred with this problem/symptom are: ST 0.9x0.2x.0.1 cm [centimeters] to Right (sic) front knee, with scant bleeding, controlled and stopped.During an interview on 9/2/25 at 10:28 a.m. with CNA 1, CNA 1 confirmed that she witnessed Resident 2 shove a walker into Resident 1's legs during her shift on 8/19/25 at approximately 6:20 p.m. CNA 1 indicated that, as a result of the incident, Resident 1 ended up with a skin tear to his left knee.During a concurrent observation and interview on 9/2/25 at 11:02 a.m. with Resident 1, Resident 1's left anterior knee had a circular scab of approximately 1 inch diameter. Resident 1's knee also had purplish and reddish bruising to the medial aspect of his left knee. Resident 1 indicated that, on 8/19/25, Resident 2 shoved a walker into his knees and stated, I was surprised he did what he did.I put my hands up in fear during the incident.During an interview on 9/2/25 at 11:47 a.m. with the Social Services Director Assistant (SSDA), the SSDA indicated that a resident using a walker to strike another resident would be considered physical abuse.During an interview on 9/2/25 at 1:03 p.m. with Licensed Nurse 2 (LN 2), LN 2 indicated she assessed Resident 1 immediately after the incident between Resident 1 and Resident 2. LN 2 indicated Resident 1 sustained a skin tear to his left knee that was bleeding, so she proceeded to bandage it. LN 2 further indicated that, after a short time after applying the dressing, the wound had bled through the dressing and required a new dressing.During a review of the facility's policy and procedure (P&P) titled Abuse Prevention Policy, revised 3/24, the P&P indicated, Each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff off other agencies serving the resident, family member(s) or legal guardian, friend(s), or other individuals.