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	04/12/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36681 Based on observation, interview, and record review, the facility failed to ensure a safe, comfortable, and homelike environment was provided when: 1. One of 32 sampled residents (Resident 106) low air loss mattress (LAL, a pressure relieving and redistribution device to help prevent skin breakdown) was not in good working condition; and 2. Five of 12 sampled rooms had holes and peeling paint on the walls. This failure increased the risk for Resident 106 to develop skin breakdown and the disrepair in the rooms may negatively impact the well being of residents. Findings: 1. A review of the clinical record indicated Resident 106 was admitted early September of 2023 with diagnoses including difficulty in walking and low back pain. Resident 106's physician order dated 12/14/23 indicated, TREATMENT: LAL (Low air loss) Mattress for wound management/preventative measures. Check placement, SETTING and functionality QS [every shift]. A review of Resident 106's care plan indicated resident was at risk for skin breakdown/further skin breakdown due to decreased mobility. The interventions included, LAL mattress for pressure relief. A concurrent observation and interview was conducted on 4/9/24 at 4:06 p.m. Resident 106 verbalized he had a problem with his bed and stated nobody should be in a bed like this. Upon further observation, Resident 106 had a low air loss mattress and had 2 rows of deflated support surface in the middle portion of the mattress. In a concurrent observation and interview on 4/11/24 at 7:59 a.m., inside Resident 106's room, the Maintenance Supervisor (MS) confirmed the finding. The MS stated the dip in the middle of the LAL is not normal. The MS further stated he did not receive a report regarding a problem with Resident 106's mattress. (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

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 04/12/2024
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/11/24 at 8:03 a.m., the Central Supply (CS) talked to Resident 106 inside his room. Resident 106 stated with a raised voice the bed had been like this for 5 months. The CS stated she did not receive a report regarding the LAL mattress. In an interview on 4/11/24 at 8:16 a.m., the Certified Nursing Assistant 6 (CNA 6) stated she just came back from a 17 day vacation and she was aware of the dip in Resident 106's mattress prior to her vacation. The CNA 6 further stated she informed someone regarding Resident 106's concern. CNA 6 was unable to remember the name of the staff whom she made the report and if she wrote the report in the maintenance log. In a concurrent interview and record review on 4/11/24 at 8:10 a.m., the MS stated he and his assistant checked the maintenance log twice a day. The MS confirmed there was no work order report regarding Resident 106's mattress in the maintenance log. In an interview on 4/12/24 at 12:35 p.m., the Director of Nursing (DON) stated her expectation was for a CNA to report a complaint received from a resident such as a problem with LAL to either the nurse or maintenance and write the report in the maintenance log. A review of the facility's policy revised February 2021 and titled, Homelike Environment indicated, Residents are provided with a safe .comfortable .environment .Staff provides person-centered care that emphasizes the residents' comfort . A review of the facility's policy revised January 2020 and titled, Accommodation of Needs indicated, Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning .Staff will help to keep . adaptive devices . in working order for resident. 50168 2. During an observation on 4/9/24 starting at 10:00 a.m., rooms 458's, 459's and 461's walls by bed A and door openings had patches of paint peeling and damage to drywall. During an observation on 4/9/24 approximately at 11:45 a.m., patches of missing paint with drywall exposed were observed in room [ROOM NUMBER] and 566 on the wall opposite beds and under the TV. A concurrent observation and interview was conducted on 4/11/24 at 2:45 p.m., with Assistant Director of Nursing (ADON). The ADON confirmed that rooms 458, 459, 561, 565, and 566 were in disrepair with peeling paint. During a concurrent observation and interview on 4/11/24 at 2:55 p.m., with the Administrator (ADM), the ADM confirmed the damage to the walls in the 5 rooms. A review of the facility's policy and procedure titled, Maintenance Service, dated 12/2009, indicated, Maintenance service shall be provided to all areas of the building .Functions of the Maintenance personnel include, but are not limited to maintain the building in good repair .

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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. 45718 Based on interview and record review, the facility failed to ensure the discharge MDS (Minimum Data Set, an assessment tool) assessment was completed and transmitted to the Centers for Medicare and Medicaid Services (CMS) System within the required time frame for one resident (Resident 112), for a census of 120. This failure resulted in the most recent MDS resident assessment not being reported to CMS as required. Findings: A review of Resident 112's clinical record indicated, he was admitted to the facility late 2023 with multiple diagnoses that included essential hypertension (high blood pressure). A review of Resident 112's NOTICE OF TRANSFER/ DISCHARGE indicated, Resident 112 was discharged from the facility on 12/6/23. During a concurrent interview and record review on 4/12/24 at 8:51 a.m., the Minimum Data Set Coordinator (MDSC) verified Resident 112 had no MDS discharge assessment. She stated the discharge assessment was missed and she was not able to complete the assessment on time. She further stated the discharge assessment was supposed to be completed within 14 days of discharge. A review of Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2019 indicated, OBRA [The Omnibus Budget Reconciliation Act] Required Tracking Records and Assessments are Federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. They include: .Discharge (return not anticipated or return anticipated) . Encoding data: Within 7 days after a facility completes a resident's assessment .Transmitting data: Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45718 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, an assessment tool used to guide care) for one of 32 sampled residents (Resident 52) accurately reflected Resident 52's Physician's Order for Life Sustaining Treatment (POLST) when her MDS Section S RESIDENT ASSESSMENT AND CARE SCREENING was not accurately documented. This failure had the potential to result in Resident 52 receiving interventions that were contrary to his own choices. Findings: A review of Resident 52's clinical record indicated, he was admitted to the facility early 2024 with multiple diagnoses that included acute paralytic syndrome (weakness that progresses) following cerebral infarction (blood vessel in the brain is blocked or narrowed, causing lack of blood flow to a part of the brain). A review of Resident 52's POLST dated, [DATE] and [DATE] indicated the following: Section A Cardiopulmonary Resuscitation Section (CPR, emergency procedure that combines chest compressions and artificial ventilation) was marked as Do Not Attempt Resuscitation (DNR). A review of Resident 52's RESIDENT ASSESSMENT AND CARE SCREENING MDS Section S dated [DATE], [DATE] and [DATE] indicated the following: Item selected in [name of State] POLST Section A: was marked as 1. Attempt resuscitation / CPR. During a concurrent interview and record review on [DATE] at 8:39 a.m., the Minimum Data Set Coordinator (MDSC) verified Resident 52's MDS Section S, dated [DATE], [DATE] and [DATE] were inaccurate. She stated Resident 52's Section S indicated to attempt CPR, but his POLST indicated he had chosen DNR. She further stated, she should have corrected the information when she did the MDS admission assessment. During an interview on [DATE] at 12:46 p.m., the Director of Nursing (DON) stated, the information in the MDS assessment should match what is documented in the POLST. She further stated, MDS assessment is important because that is how resident gets the appropriate care.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 45718 Based on interview and record review, the facility failed to refer one (Resident 22) of 32 sampled residents for Pre-Admission Screening and Resident Review (PASRR, a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) when the resident received a new mental illness diagnosis. This failure had the potential for Resident 22 to not receive necessary services to meet his mental and psychosocial needs. Findings: A review of Resident 22's clinical record indicated he was admitted to the facility late 2011. His clinical record also indicated he had a diagnosis of Schizoaffective disorder, unspecified (mental illness that affects thought, mood and behavior) with onset date of 11/24/21 and Major Depressive disorder (mood disorder that causes persistent feeling of sadness), single episode with onset date of 8/28/17. During a concurrent interview and record review on 4/10/24 at 10:06 a.m., the Medical Records Director (MRD) verified Resident 22's PASRR Level I assessment was done on 10/24/11 and the form indicated, No referral needed for PASRR II assessment. She stated, Resident 22 was not recently referred for PASRR assessment per the PASRR website. During a concurrent interview and record review on 4/11/24 at 8:39 a.m., the Minimum Data Set Coordinator (MDSC) verified Resident 22 was not referred for PASRR II assessment when he was diagnosed with Mental Disorder. She stated, he should have been referred for assessment when he had been newly diagnosed with Mental Disorder. During an interview on 4/11/24 at 12:46 p.m., the Director of Nursing (DON) stated, PASRR is done as pre-admission screening, if there was change in condition, then we needed to update the PASRR assessment. A review of facility policy titled, Pre- admission Screening and Resident Review (PASRR), effective date January 2016, indicated, It is the policy of this facility to utilize the most current guidelines of the federal Centers for Medicare and Medicaid (CMS) for Pre-admission Screening and Resident Review (PASRR) to ensure that applicants and residents with mental illness and intellectual/developmental disabilities are appropriately placed and receive necessary services to meet their needs. In conjunction with the facility policy and procedure, the DON or designee has overall responsibility for ensuring the timely completion of the PASRR per guidelines of the CMS .

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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. 36681 Based on observation, interview, and record review, the facility failed to ensure a comprehensive care plan for refusing nail care was developed for one of 32 sampled residents (Resident 20). This failure had the potential for Resident 20 to spread infection and inflict injury to self due to long fingernails. Findings: A review of the clinical record indicated Resident 20 was admitted with diagnoses that included hemiplegia and hemiparesis (paralysis or muscle weakness on one side of the body) following unspecified cerebrovascular disease (a condition wherein blood flow to the brain was interrupted) affecting right dominant side. Resident 20's Minimum Data Set (MDS, an assessment tool) dated 3/8/24, indicated Resident 20 was cognitively intact with a Brief Interview for Mental Status (BIMS, a tool used to screen cognitive ability) score of 14. A concurrent observation and interview was conducted on 4/9/24 starting at 2 p.m. Resident 20 was observed with fingernails on the left hand approximately 3 inches in length starting to curl and the fingernails on the right hand with blackish substance underneath the nails. Resident 20 stated he had been in this place for a long time and somebody will trim his nails. In an interview on 4/10/24 at 12:18 p.m., Certified Nursing Assistant 7 (CNA 7) confirmed Resident 20 had long fingernails. CNA 7 stated Resident 20 had been refusing care including showers and she had reported the refusals to the nurse. In a follow-up observation on 4/11/24 at 8:31 a.m., Resident 20 was lying in bed with a white washcloth covering his left hand. In a concurrent interview and record review on 4/11/24 starting at 4:16 p.m., the Director of Nursing (DON) stated when she checked on Resident 20 today his left hand was covered with a washcloth. The DON described Resident 20's fingernails on the left hand as extremely long and she cannot approximate the length since it [nails] was starting to curl. The DON further described Resident 20's fingernails on the right hand as dirty and it could be from bowel movement. The DON stated Resident 20 did not want his nails to be touched and the staff also informed DON of Resident 20's refusal. The DON confirmed there was no care plan of Resident 20's refusals for staff to trim his nails. The DON further stated her expectation was for staff to document and care plan any new problem or situation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy revised March 2022 and titled, Care Plans, Comprehensive Person-Centered indicated, .The comprehensive, person-centered care plan: . includes measurable objectives and timeframes; .describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: .services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment .The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 36681 Based on observation, interview, and record review, the facility failed to ensure one of 32 sampled residents (Resident 20) who was dependent on staff to perform activities of daily living (ADLs, daily activity such as self care including personal hygiene) received the necessary nail care. This failure had the potential for Resident 20 to spread infection and self inflicted injury due to long fingernails. Findings: A review of the clinical record indicated Resident 20 was admitted with diagnoses including hemiplegia and hemiparesis (paralysis or muscle weakness on one side of the body) following unspecified cerebrovascular disease (a condition wherein blood flow to the brain was interrupted) affecting right dominant side. Resident 20's Minimum Data Set (MDS, an assessment tool) dated 3/8/24 indicated Resident 20 was cognitively intact with a Brief Interview for Mental Status (BIMS, a tool used to a screen cognitive ability) score of 14 and he was dependent on staff for personal hygiene. A concurrent observation and interview was conducted on 4/9/24 starting at 2 p.m. Resident 20 was observed with fingernails on the left hand approximately 3 inches in length starting to curl and the fingernails on the right hand had blackish substance underneath the nails. Resident 20 stated he had been in this place for a long time and somebody will trim his nails. In an interview on 4/10/24 at 12:18 p.m., Certified Nursing Assistant 6 (CNA 6) confirmed Resident 20 had long fingernails. The CNA 6 stated Resident 20 had been refusing care including showers and she had reported the refusals to the nurse. In a follow-up observation on 4/11/24 at 8:31 a.m., Resident 20 was lying in bed with a white washcloth covering his left hand. In a concurrent interview and record review on 4/11/24 starting at 4:16 p.m., the Director of Nursing (DON) stated when she checked on Resident 20 today his left hand was covered with a washcloth. The DON described Resident 20's fingernails on the left hand as extremely long and she cannot approximate the length since it [nails] was starting to curl. The DON further described Resident 20's fingernails on the right hand as dirty and it could be from bowel movement. The DON stated Resident 20 did not want his nails to be touched and the staff also informed DON of Resident 20's refusal. The DON confirmed there was no care plan of Resident 20's refusals for staff to do his nails. The DON further stated her expectation was for staff to document and care plan any new problem or situation. Further review of Resident 20's clinical record did not contain documented evidence the facility staff explained to the resident the risks associated with refusal of nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy revised February 2018 and titled, Fingernails/Toenails, Care of indicated, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections . Nail care includes daily cleaning and regular trimming . The following information should be recorded in the resident's medical record: . If the resident refused the treatment, the reason(s) why and the intervention taken. Notify the supervisor if the resident refuses the care. A review of the facility's policy revised March 2018 and titled, Activities of Daily Living (ADL), Supporting indicated, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain .grooming and personal .hygiene.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36681 Based on observation, interview, and record review, the facility failed to ensure adequate supervision and assistive devices were provided for 2 of 32 sampled residents (Resident 87 and Resident 90) when: 1. Resident 87 had a fall with a facility staff present; and 2. Resident 90 had an unwitnessed fall. These failures had the potential for Resident 87 and Resident 90 to have increased incidences of fall and injury. Findings: 1. A review of the clinical record indicated Resident 87 was admitted with diagnoses that included encounter for surgical aftercare following surgery on the nervous system (includes the brain and spinal cord) and history of falling. The Minimum Data Set (MDS, an assessment tool), dated 2/5/24, indicated Resident 87 had short term and long term memory problems and required the assistance of 2 or more staff to walk at least 10 feet in a room. Further review of the clinical record indicated Resident 87 had a Fall Assessment, dated 1/29/24, that indicated Resident 87 was a high risk for falls with a score of 55. A care plan, dated 1/29/24, indicated Resident 87 was at risk for falls related to unsteady gait, altered balance while standing and/or walking and history of falls and the intervention included frequent visual checks. A review of the SBAR (stands for Situation, Background, Assessment, Recommendation) for Falls, dated 4/8/24 indicated, Resident 87 had a fall on 4/7/24 at 16:40 [4: 40 p.m.]. The details of the fall included, [Resident 87] was being assisted while using a FWW [front wheel walker] to the bathroom by the CNA [Certified Nursing Assistant]. The CNA turned to the bathroom to open the door. The door bumped the walker and [Resident 87] fell . backwards .No visible injury noted. During a concurrent observation and interview on 4/9/24 at 9:21 a.m., Resident 87 was lying in bed, the bed was in the lowest position and she stated she had no pain. In a telephone interview on 4/11/24 at 1:03 p.m., the CNA stated she was present when Resident 87 had a fall on 4/7/24. The CNA further stated she was in the nurses station when she saw Resident 87 trying to get up from bed and CNA assisted resident to use the walker to stand up. The CNA confirmed her back was facing the resident when she was opening the bathroom door and Resident 87 fell down. The CNA stated the safe practice when assisting a resident was to open the bathroom door before assisting the resident to get up. The CNA further stated she was aware of resident's history of falling and surgery to repair a broken bone from a previous fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a concurrent interview and record review on 4/11/24 at 1:50 p.m., the Director of Nursing (DON) stated Resident 87 was typically a 2 person assist for transfer due to being unsteady. The DON further stated if there was a second person on 4/7/24, the fall could have been prevented and the CNA should have stayed at the resident's side instead of doing what she did (CNA's back was facing the resident). A review of the facility's policy revised July 2017 and titled, Safety and Supervision of Residents indicated, . Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. 45718 2. A review of Resident 90's clinical record indicated he was admitted to the facility end of 2023 with multiple diagnoses that included anoxic brain damage (damage to the brain due to lack of oxygen), persistent vegetative state (state of brain dysfunction in which a person shows no signs of awareness) and epilepsy unspecified intractable, without status epilepticus (seizures that cannot be completely controlled by medicine). A review of Resident 90's Minimum Data Set (MDS, an assessment tool), dated 3/15/24 indicated, he was in vegetative state, and he had functional limitations in range of motion on both his upper and lower extremities. His functional status also indicated he was dependent to care, and he needed 2 or more staff to assist in bed mobility. A review of Resident 90's Physician's order dated 12/8/23 indicated, Put .1/4 side rails up when in bed: to assist resident in bed mobility and/or transfer. A review of Resident 90's SBAR [Situation, Background, Assessment, Recommendation]-FALLS document dated 12/17/23 indicated, .Date and time of fall: 12/17/23 .Was fall witnessed? No .Possible Contributing Factors .Bed has no side rails . A review of Resident 90's REHAB POST FALL assessment dated [DATE] indicated, Location of fall: from bed .Recommendations .Ensure bed is low, frequent visual checks to ensure proper positioning. Fall Mats recommended . A review of Resident 90's Care plan indicated, [Resident 90] is at risk for fall .interventions .Use of safety devices like landing pad, pommel cushion and wedge cushion .Requires 2 half Bedrails- to prevent risk of Falls . During an observation on 4/9/24 at 9:44 a.m. in Resident 90's room. Resident 90 was lying in bed with Low Air loss mattress (LAL, mattress designed to prevent and treat pressure ulcer). Resident 90 did not respond when spoken to. He had no fall mat in place and had no cushions. During a concurrent observation and interview on 4/11/24 at 8:25 a.m. with Licensed Nurse (LN 3) in Resident 90's room, Resident 90 was on left side lying position in bed with LAL mattress, 1/4 rails were up on both sides of the bed. LN 3 verified Resident 90 had no fall mat on either side of his bed, and he had no cushions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/11/24 at 1:20 p.m., LN 4 verified Resident 90 had a fall on 12/17/23. She stated the CNA (Certified Nursing Assistant) found him on the floor. She stated the resident was in a vegetative state and he does not move. She further stated she does not know how the resident slid out of the bed. She stated Resident 90 did not have side rails when he fell from his bed. During a telephone interview on 4/11/24 at 3:18 p.m., CNA 1 verified Resident 90 had a fall last December and the CNA found him on the floor. She stated Resident 90 could not move on his own and he was total care. She further stated Resident 90 did not have siderails when he fell , it was not safe for him to not have siderails. During an interview on 4/11/24 at 12:46 p.m., the Director of Nursing (DON) stated she was not sure why the resident fell . She stated she expected bedbound residents to not have a fall and be frequently checked and siderails should be up as ordered. She further stated, she also expected care plan interventions are followed, if the care plan indicated fall mat, then there should be fall mat in place. A review of facility policy titled, Safety and Supervision of Residents revised July 2017, indicated, .The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices . Implementing interventions to reduce accident risks and hazards shall include the following: d. Ensuring that interventions are implemented .Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly and consistently . A review of facility policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022 indicated, .4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights .and implementation of his or her plan of care, including the right to: .g. receive the services and/or items included in the plan of care .

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 04/12/2024
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 38834 Based on observation, interview, and record review, the facility failed to administer appropriate treatment and services to maintain continence for one of 32 sampled residents (Resident 47), who was assessed as a candidate for bladder retraining and the bladder retraining was not provided. This failure resulted in Resident 47 not receiving the services and assistance to maintain her continence and resulted in decline of resident's continence. Findings: A review of the Admission Record indicated the facility admitted Resident 47 in 2023 with multiple diagnoses which included muscle weakness and difficulty in walking. A review of the quarterly Minimum Data Set (MDS, an assessment tool) completed 1/31/24, indicated that Resident 47 scored 11 out of 15 on a BIMS assessment (Brief Interview of Mental Status, a test of cognition) indicating the resident's cognition was moderately impaired. The MDS indicated Resident 47 exhibited no indications of psychosis, such as hallucinations (sensory experience of something not present), delusions (an impression or belief not based in reality), and had no behaviors of rejection of care. A review of the admission 'Bowel and Bladder Program Screener,' dated 5/19/23, indicated that Resident 47 was alert and oriented and was always mentally aware of need to toilet. According to the assessment, Resident 47 scored at 17 and was categorized as Good Candidate for Retraining. A review of the quarterly MDS assessments, dated 5/26/23 and 8/26/23 pertaining to urinary continence, indicated that Resident 47 was always continent. Both assessments indicated that Resident 47 did not receive a trial of a toileting program, including scheduled toileting or bladder retraining. A review of the MDS assessment, completed on 10/31/23, indicated that Resident 47 experienced a change in condition and became 'frequently incontinent.' The MDS indicated that the resident did not receive a trial of any toileting program prior to 10/31/23. A review of the electronic clinical records and paper documents indicated there was no documented evidence Resident 47 was offered bladder retraining or was placed on scheduled toileting to maintain her continence since admission. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/11/24 at 1:30 p.m., Resident 47 was observed laying in her bed. Resident 47 was pleasant, soft spoken, and answered the questions appropriately. Resident 47 stated that her health declined since admission and she was in bed most of the time. Resident 47 became sad and added that sometimes she knew when she needed to urinate but was frequently incontinent. Resident 47 stated, If they [staff] come right away and .walk me to the bathroom .I will urinate. Resident 47 explained that even if she knew when she needed to urinate, she was not able to hold her urine for long and if the staff did not come to assist her right away, she had to urinate into a brief. Resident 47 stated, Earlier this morning I called for help by pushing the call button and by the time they got here, I was flooded [wet] and cold. Very uncomfortable to lay in my urine, especially early morning when its cold. Resident 47 added that sometimes she had to wait longer for staff assistance to the bathroom or to be changed, especially at night. During an interview with Certified Nursing Assistant (CNA 3) on 4/11/24 at 1:43 p.m., CNA 3 stated she was familiar with Resident 47 and described the resident as alert and oriented. CNA 3 stated that Resident 47 was able to use a call light and to verbalize her needs. CNA 3 stated that Resident 47 urinated a lot and was mostly incontinent of the bladder. CNA 3 stated she was not aware if Resident 47 was on any bladder retraining program or scheduled toileting currently or in the past. During an interview with CNA 8 on 4/1/24 at 1:46 p.m., CNA 8 stated she was assigned to Resident 47 frequently. CNA 8 stated she was not sure if Resident 47 was placed on bladder retraining program in the past. During a concurrent interview and record review on 4/11/24 at 4:15 p.m., the MDS nurse (MDSN) validated Resident 47 was continent upon admission and was a candidate for bladder retraining or scheduled toileting. The MDSN explained that if the resident had capability of maintaining her bladder and bowel function and had the potential to participate in a toileting program, she was assisted to the toilet at fixed intervals to prevent decline in the bladder or bowel function. The MDSN was unable to find any records Resident 47's bladder retraining was offered upon her admission until October 31, 2023 when the resident became frequently incontinent. A review of the facility's policy titled Urinary Continence and Incontinence - Assessment and Management, with the revision date of 8/22, indicated,The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function .The nursing staff .will identify risk factors for becoming incontinent .The staff will initiate a toileting plan .The staff will provide scheduled toileting, prompted toileting, or other interventions .The staff will document the results of the toileting trial in the resident's medical records .The staff and physician will evaluate the effectiveness of interventions and implement additional pertinent interventions. On 4/11/24 at 3:15 p.m., an interview and a concurrent record review for Resident 47 was conducted with the Director of Nursing (DON). The DON reviewed Resident 47's admission bladder and bowel assessment completed on 5/19/23 and confirmed that the assessment indicated the resident was a good candidate for bladder retraining. The DON acknowledged that in less than six months after the admission Resident 47's bladder function changed and the resident became frequently incontinent. The DON stated the resident should have been provided a toileting retraining program and acknowledged there was no documented evidence that the program had been attempted for Resident 47.

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38834

Based on observation, interview, and record review, the facility failed to provide one of 32 sampled residents (Resident 97), who was identified at risk for dehydration with sufficient fluids to maintain proper hydration, when Resident 97 did not meet her estimated fluid needs as assessed by the Registered Dietitian.

This failure placed Resident 97 at further risk for dehydration.

Findings:

A review of the Admission Record indicated the facility admitted Resident 97 last year with multiple diagnoses, which included dementia (impaired ability to remember, think and make decisions) and chronic mental disorders.

A review of Resident 97's Minimum Data Set (MDS, an assessment tool), dated 2/21/24, indicated the resident had severe cognitive impairment.

A review of the physician's order, dated 3/1/23, indicated Resident 97's diet consisted of mechanical soft (texture -modified diet, designed for residents who have difficulty chewing and swallowing) and thickened fluids.

A review of the care plan titled, Alteration in communication, indicated Resident 97 had impaired ability to make self-understood related to cognitive deficit.

A review of Resident 97's 'At risk for dehydration' care plan indicated the resident needed assistance with meals and fluids intake. The care plan interventions directed staff to administer adequate amounts of fluids and monitor and record the resident's fluid intake and output.

A review of Resident 97's 'Dehydration Risk Assessment,' dated 2/16/24, indicated the resident was identified at risk for dehydration.

A review of the Nutritional assessment dated [DATE], indicated the Registered Dietician (RD) assessed Resident 97's daily estimated needs to be 1625 milliliters (ml, unit of measurement).

A review of Resident 97's 'Oral fluid intake' flow sheet from 3/14/24 through 4/12/24, indicated an average daily intake of 874 ml, which was 751 ml less than her daily estimated need.

During an observation on 4/9/24 at 9:52 a.m., Resident 97 was laying in her bed with her eyes open. Resident 97 did not respond when spoken to. Resident 97 was breathing through her mouth and her lips were dry. A pitcher with thickened water was noted 1/3 full and was located on the nightstand and not within resident's reach. A small plastic cup was flipped over next to the pitcher.

During an observation on 4/10/24 at 11:47 a.m., Resident 97 was in bed, with her eyes closed. The water pitcher was 1/3 full on the nightstand with plastic cup flipped over next to the pitcher.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/10/24 at 3:50 p.m., Resident 97 was in bed with eyes closed. The pitcher 1/3 full with water was on the same spot on nightstand with plastic cup flipped over next to the pitcher. During an observation on 4/11/24 at 08:03 a.m., Resident 97 was in bed, with eyes open and had no verbal response on prompting. The pitcher 1/3 full with water was on the same place on nightstand with plastic cup flipped over next to the pitcher. During an interview with Certified Nursing Assistant (CNA 3) on 4/11/24 at 8:05 a.m., CNA 3 stated Resident 97 was confused and unable to talk. CNA 3 stated Resident 97 was unable to eat or drink by herself and dependent on staff for feeding and drinking. CNA 3 stated the water was far from the resident's reach because the resident would not know how to pour the water and was unable to hold the cup. CNA 3 stated Resident 97 had good appetite and consumed all liquids on her meal trays. During an observation on 4/12/24 at 11:55 a.m., Resident 97 was napping in bed with opened mouth and her lips were dry. The pitcher 1/3 filled with thickened water and clear plastic cup flipped over were on nightstand. During an observation and a concurrent interview on 4/12/24 at 12:05 p.m., Licensed Nurse (LN 6) stated she was familiar with the resident and resident's needs. LN 6 stated Resident 97 was totally dependent on staff for feeding and personal care. LN 6 stated she was not sure how much fluids Resident 97 received with meals and what was her average daily fluid intake. LN 6 explained, If resident is at risk for dehydration or on fluid restriction, we should be addressing fluid intake in weekly summaries to make sure the resident is adequately hydrated. During an interview and a concurrent record review with Director of Nursing (DON) on 4/12/24 at 12:15 p.m., the DON stated that Resident 97 was totally dependent on staff for assistance with food and fluids and was identified at risk for dehydration. The DON reviewed Resident 97's fluids intake and validated that for most of the days, the resident received less than 1000 ml of fluids which was less than her estimated needs. The DON acknowledged that during the period from 3/14/24 through 4/12/24, there was no documented evidence that water was offered to Resident 97 at night. The DON stated her expectation for nurses was to monitor Resident 97's fluid intake and address it if the need for fluids were not met. The DON reviewed weekly nursing summaries for April and March 2024 and validated that fluid intake was not addressed. The DON stated that the documentation did not contain evidence that Resident 97 was properly hydrated and met her daily fluids need.

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	055438	A. Building B. Wing	04/12/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 38834 Based on observation, interview, and record review, the facility failed to administer oxygen therapy in accordance with the physician's order and the resident's care plan for one of 32 sampled residents (Resident 80), when Resident 80 did not receive the prescribed amount of oxygen. This failure resulted in Resident 80 receiving more oxygen than ordered by the physician and had the potential for the resident to experience serious health complications related to too much supplemental oxygen. Findings: A review of the Admission Record indicated the facility admitted Resident 80 in 2021 with multiple diagnoses, including Chronic Obstructive Pulmonary Disease, (COPD, a chronic lung disease causing airflow blockage and breathing problems) and respiratory failure. A review of the physician's order, dated 12/14/23 indicated, Oxygen at 2 L/min [liters - a unit of measurement/minute] continuous via Nasal Cannula [NC, a thin plastic tube with two prongs to deliver supplemental oxygen directly into nostrils]. Maintain O2 [oxygen blood saturation level] above 92% (for COPD 89% and above). A review of Resident 80's Risk for Ineffective Breathing Pattern care plan initiated on 11/6/21 and revised 3/30/24, indicated the following nursing interventions: Administer continuous supplemental oxygen .via NC . Administer oxygen as prescribed. During an observation on 4/9/24 at 1:35 p.m., Resident 80 was laying in bed. Resident 80 had a nasal cannula in her nostrils delivering supplemental oxygen. The oxygen concentrator (a machine that extracts oxygen from surroundings, filters and delivers it for the person to breathe) setting was at 3 liters per minute. During an observation on 4/10/24 at 11:19 a.m., Resident 80 was laying in bed. Resident 80's had a nasal cannula in her nostrils and the oxygen concentrator setting was at 3 liters/minute. During an interview with Licensed Nurse (LN 5) on 4/10/24 at 3:57 p.m., LN 5 stated she was assigned to Resident 80 frequently and was familiar with resident's needs and care. LN 5 stated that Resident 80 had a physician order to receive oxygen at 2 liters per minute continuously. Upon entering the room and checking Resident 80's oxygen concentrator setting, LN 5 acknowledged that the oxygen was delivered at 3 liters per minute. LN 5 stated, [It] should be at 2 liters per minute. We are supposed to check the amount delivered every shift. A review of the facility's policy titled, Oxygen Administration, dated 10/2010, indicated, Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration . Preparation .Review the physician's orders .for oxygen administration .Review the resident's care plan .Turn on the oxygen .Adjust the oxygen delivery device so .the proper flow of oxygen is being administered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/10/24 at 5:05 p.m., the Director of Nursing (DON) validated that Resident 80 had respiratory condition and administering supplemental oxygen at a higher rate could be harmful to the resident's health. The DON stated, My expectation is that nurses follow physician's order and administer oxygen at the rate ordered by the physician.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41600 Based on observation, interview, and record review, the facility failed to implement its pharmaceutical policies and procedures for a census of 120, when: 1. Two used and unsealed E-Kit boxes (Emergency-Kit, storage box containing emergency supplies of medication) were not removed and replaced with the potential for not having all the emergency medications available to the residents and increased risk of drug diversion; and 2. Resident 433's intravenous (IV, medication given through the vein) antibiotics (medication that treat bacterial infections) was not administered per physician's order with the potential for his infection not to be resolved. Findings: 1. During an inspection of medication room for units 4 and 5 on 4/9/24 at 2:10 p.m., E-kit #3 was found to be previously opened with missing 1 out of three medications. There was no record when the missing medication was taken out of the E-kit. E-Kit #16 was accessed on 2/16/24 with missing 1 out of four medications, but still not replaced by the pharmacy. During an interview on 4/9/24 at 2:10 p.m. with Infection Preventionist (IP) nurse, the IP acknowledged that both E-kits were previously opened and not replaced by the pharmacy. IP was unable to find any records for the E-kit boxes. During an interview on 4/11/24 at 1 p.m. with the Director of Nursing (DON), the DON stated the E-kits should have been replaced and the facility has been having issues with the pharmacy replacing the E-kits. During a review of the facility's policy and procedure (P&P) titled, Emergency Pharmacy Service and Emergency Kits, dated 3/18, the P&P indicated, The nurse opening the kit also records use of the kit in the emergency kit log book .opened kits are replaced with sealed kits within 72 hours of opening. 45718 2. A review of Resident 433's clinical record indicated he was admitted to the facility April 2024 with multiple diagnoses that included sepsis, unspecified (a life-threatening complication of an infection). His most recent Minimum Data Set (MDS, an assessment tool) indicated he had moderate cognitive impairment. A review of Resident 433's Physician's order indicated, Ampicillin Sodium Intravenous Solution Reconstituted 2GM [gram, unit of measurement] .use 2000 mg [milligrams, unit of measurement] intravenously every 4 hours for Sepsis until 05/11/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/9/24 at 10:34 a.m., in Resident 433's room, Resident 433 was lying in bed. He stated he was admitted to the facility because he had an infection and he was receiving antibiotics. A 100 ml (milliliters, unit of measurement) IV antibiotic bag labeled Ampicillin 2 GM/100 ml NS [Normal Saline, solution to dilute] Infuse via IV line .over 30 min [minutes] or until bag is empty . was observed hanging on the IV pole with approximately 30 ml of medication remaining in the bag and not attached to the Resident. Resident 433 stated he could not recall when the staff removed the IV medication. During a concurrent observation and interview on 4/9/24 at 11:11 a.m., the Infection Preventionist Nurse (IP) verified the IV antibiotics bag hanging on the IV pole in Resident 433's bedside was not empty. He stated he started the medication at 8 a.m. and he was not sure why the medication was disconnected. He further stated, the bag still contained medication and the resident did not receive the full dose of the antibiotic. During a concurrent interview and record review on 4/9/24 at 3:50 p.m., the Assistant Director of Nursing (ADON) verified the photo of the IV bag contained approximately 30 ml of fluids. She stated the entire medication was not administered. During an interview on 4/11/24 at 12:46 p.m., the Director of Nursing (DON) stated she expected the staff to follow the doctor's orders when administering medications. If the IV pump (medical device that delivers fluids and medications, into the body in controlled amounts) is beeping, the staff should not disconnect without checking on the cause of the beeping and make sure all the medication was infused. A review of the facility policy titled, Administering Medications revised April 2019, indicated, .Medications are administered in a safe and timely manner, and as prescribed .4. Medications are administered in accordance with prescriber orders, including any required time frame .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 38834 Based on observation, interview, and record review, the facility failed to ensure one of 32 sampled residents (Resident 107), was free from unnecessary drugs when Resident 107 did not have adequate indication for the use of Seroquel (a psychotropic medication indicated for psychosis; affects the mind, emotions, and behavior). This failure resulted in Resident 107 receiving unnecessary medication for an excessive duration and placed the resident at risk for adverse (unwanted) effects and further decline in health. Findings: A review of the admission record indicated the facility admitted Resident 107 in the fall of 2023 with diagnoses which included dementia (a decline in memory and social skills that interfere with daily functioning) without behavioral, psychotic, and mood disturbances. A review of the Minimum Data Set (MDS, an assessment tool), dated 1/17/24, indicated Resident 107 was cognitively impaired. The MDS indicated the resident did not exhibit any verbal or physical symptoms toward others and had no behaviors of causing self injury. The MDS indicated the resident had no behaviors of rejection of care. A review of Resident 107's physician orders, dated 1/4/24, indicated the resident had an order for Seroquel 25 milligram (mg, unit of measurement) twice a day for dementia manifested by physical aggression. A review of the care plan initiated on 11/14/23 indicated Resident 107 was non-compliant with care and treatment that was manifested by flailing arms throughout incontinence care [and] refusing medication administration. The nursing interventions included to monitor episodes of refusals, determine reasons for refusals, and provide a safe environment and reapproach at a later time. A review of the care plan initiated on 1/9/24, indicated Resident 107 used antipsychotic medication Seroquel related to dementia. The nursing interventions directed staff to monitor medication effectiveness every shift. A review of the Interdisciplinary Team (a team of healthcare staff from different disciplines) psychotropic assessment, dated 1/4/24, indicated Resident 107 had 0 episodes of physical aggression in the month of October, November, and December 2023. A review of Resident 107's target behavior monitoring flowsheet indicated the resident had 0 aggressive episodes in January, three (3) episodes of aggressive behaviors in February, and 0 aggressive episodes in April. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 107's physician progress notes dated 1/25/24, 2/9/24, and 3/25/24, did not indicate the rationale to support the use of Seroquel for the resident with dementia without behavioral disturbance and who had not exhibited behaviors of physical aggression. A review of facility's Consultant Pharmacist's Medication Regimen Review notes dated 12/17/23 and 2/5/24, did not contain justification for the continued use of Seroquel given the lack of appropriate diagnosis and the lack of documented behaviors. Resident 107's Medication Administration Record (MAR) indicated the resident was given Seroquel 25 mg in the morning and evening from 10/31/23 to present, for a period of over 6 months. During a concurrent observation and interview on 4/9/24 at 10:15 a.m., Resident 107 was laying in her bed. Resident 107 was drowsy and at times attempted to communicate, but would fall asleep after a few words. Resident 107's family member and RP (responsible party designated by the resident to make decisions on resident's behalf) was sitting at bedside. The RP stated that the resident used to be on hospice care and was prescribed Seroquel for her restlessness. The RP stated that Resident 107 was no longer receiving hospice care but continued to receive some medications prescribed by hospice physician. During an interview on 4/10/24 at 3:30 p.m., Certified Nursing Assistant (CNA 5) stated Resident 107 was confused but was able to follow simple commands. CNA 5 stated the resident was wearing a left arm sling related to arm fracture and occasionally would try to hit staff with her right arm during personal care, especially when the resident was repositioned or had her briefs changed. CNA 5 stated Resident 107 was not aggressive and not a danger to self or others. During an interview on 4/10/24 at 3:53 p.m., CNA 2 stated when Resident 107 was admitted , she was unfamiliar with staff and routine procedures, and was resistive at times when the care was provided. CNA 2 added, Lately she's pleasant, non-combative, and not a danger to herself or others. She's in bed all the time. During an interview on 4/10/24 at 4:05 p.m., Licensed Nurse (LN 5) stated she was frequently assigned to Resident 107 and was familiar with the resident's care needs. LN 5 stated that Resident 107 received Seroquel for dementia and was monitored for behaviors. LN 5 was asked how often Resident 107 exhibited aggressive behaviors and she stated, No behaviors. If she said 'no' I won't touch her and will come back later. No physical aggression to me and nobody reported that the resident is physically aggressive. An interview and a concurrent record review was conducted with Director of Nursing (DON) on 4/10/24 at 4:50 p.m. The DON stated that the resident received Seroquel for diagnosis of dementia. The DON acknowledged Resident 107's clinical records had no documented episodes of aggressive behaviors in October, November, December 2023 and January, February, and April of 2024. The DON acknowledged that a diagnosis of dementia was not appropriate for use of antipsychotic medication and added, It bothers me too why the resident with dementia is on antipsychotic. The DON stated the facility had an IDT meeting in January 2024 and discussed Resident 107's use of antipsychotic medication prescribed for dementia. The DON stated the facility had not attempted a dose reduction of Seroquel dose and decided to continue the medication to keep the resident stable. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview with the DON on 4/11/24 at 3:15 p.m., the DON stated her expectation for nurses was to attempt non-pharmacological interventions for resident's physical aggression behaviors, if any, prior to administering antipsychotic medication. The DON searched Resident 107's clinical records and acknowledged there was no documented evidence non-drug interventions were attempted while the resident received Seroquel. A review of the facility's 'Psychotropic Medication Use' policy dated 7/22, indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition .Non-pharmacological approaches are used .to minimize the need for medications, permit the lowest dose, and allow for discontinuation of medications .When determining whether to .modify or discontinue medication therapy, the IDT conducts an evaluation of the resident .to clarify whether .signs and symptoms are clinically significant enough to warrant medication therapy .[or]medication is clinically indicated . During a phone interview and a concurrent record review on 4/12/24 at 10:15 a.m., the Consultant Pharmacist (CP 2) stated the Seroquel was not technically approved (the medication was determined to be safe and effective for its intended use) for dementia treatment by the Food and Drug Administration (FDA, a federal agency responsible for protecting the public health), but had an off label indication for use in residents with dementia for short term, if the resident exhibited aggression or psychosis. The CP 2 added he was not familiar with Resident 107's medical history and did not know if the resident exhibited psychosis or aggression.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41600 Based on observation, interview, and record review the facility failed to properly store medications for a census of 120, when: 1. Two expired medications were found in the medication refrigerator, which could lead to the resident receiving expired or ineffective medication; 2. Three loose pills were found in a medication cart, which could result in diversion of the loose medication; and 3. Two prescription blister packs were found displaced and stuck in the back of the medication cart, which could result in drug diversion. Findings: 1. During an observation of medication storage room for units 2 and 3 on 4/9/24 at 11:15 a.m., two expired ertapenem intravenous medication bags (an antibiotic medication used to treat infections) were found in the medication refrigerator with an expiration date of 4/7/24 on the label. During an interview with Licensed Nurse (LN) 1 on 4/9/24 at 11:17 a.m., LN 1 acknowledged the medication bags were expired. LN 1 stated expired medications should have been removed. During an interview with the Director of Nursing (DON) on 4/11/24 at 1:05 p.m., the DON stated the storage rooms are to be checked for expired medication every shift by nursing staff and the expired medication should have been removed. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, revised 2/2023, the P&P indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 2. During an observation of medication cart for unit 2 on 4/9/24 at 11:20 a.m., three loose pills were found in the bottom of the drawer of the medication cart. During an interview with LN 2 on 4/9/24 at 11:22 a.m., LN 2 acknowledged the three loose pills should have not been in the medication cart. LN 2 stated she would dispose of the pills and let the DON know that the three loose pills were found in the medication cart. During an interview with the DON on 4/11/24 at 1:07 p.m., the DON acknowledged the loose pills should have not been in the medication cart. The DON stated the medication carts are expected to be cleaned after each shift to ensure carts are cleaned and prepared for the next shift and medications are properly accounted for. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	

During a review of the facility's P&P titled, Medication Labeling and Storage, revised 2/2023, the P&P indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each residents' medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.

3. During an observation of medication cart for unit 2 on 4/9/24 at 11:20 a.m., two prescription blister packs were found displaced and stuck in the back of the medication cart.

During an interview with LN 2 on 4/9/24 at 11:27 a.m., LN 2 acknowledged there were two prescription medication blister packs stuck at the back of the medication cart. LN 2 stated, Medication should not have been kept there .I'm not sure how we can get them out.

During an interview with the DON on 4/11/24 at 1:07 p.m., the DON acknowledged the blister packs should not be stuck in the back of the medication cart. The DON stated the medication carts are expected to be cleaned after each shift to ensure carts are cleaned and prepared for the next shift and medications are properly accounted for.

During a review of the facility's P&P titled, Medication Labeling and Storage, revised 2/2023, the P&P indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each residents' medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48445 Based on observation, interview and record review, the facility failed to prepare foods that conserved nutritive value, flavor, and palatability when vegetables and pureed meals were prepared without following the recipe with measured ingredients. This failure had the potential of leading to poor intake, malnutrition, and weight loss for the 117 residents eating facility prepared meals. Findings: During an observation on 4/10/24 at 10:54 a.m., in the kitchen, Cook 1 (CK 1) was observed preparing stir fry vegetables for lunch. After placing the vegetables into the steam pan, CK 1 was observed adding unmeasured garlic powder and salt to the vegetables by pouring into her gloved hand and proceeding to add to the mixture. During an interview on 4/10/24 at 4:20 p.m. with the Registered Dietitian (RD), the RD stated, The recipe should be followed. It should be measured, it could be salty or not salty enough. During a review of the facility provided recipe titled, RECIPE: STIR FRY VEGETABLES (Healthcare Menus Direct, LLC. 2024), the recipe indicated, Ingredients .Salt, Serves 120, 1Tbsp 3/4 tsp. During a concurrent observation and interview on 4/10/24 at 11:08 a.m. with CK 1 in the kitchen, CK 1 was observed preparing pureed chicken for eight to nine servings. CK 1 was observed adding cooked pre-made breaded chicken nuggets (of various sizes) to the blender. CK 1 then added an unmeasured amount of broth and an unmeasured amount of thickener to the mixture. After blending, added more broth (unmeasured) and stated it thickens in the steam table pan because of the breading. CK 1 made another batch of pureed chicken by adding an unmeasured, uncounted number of chicken nuggets and unmeasured amount of broth. CK 1 did not add thickener on the next batch and stated she will mix the two batches together before putting the mixture into a steam table pan. During a concurrent observation and interview on 4/10/24 at 11:15 a.m., with CK 1 in the kitchen, CK 1 was observed preparing pureed vegetables. CK 1 was observed adding cooked vegetables, broth, and thickener without recipe or measuring. During an observation on 4/10/24 at 11:26 a.m. in the kitchen, CK 1 was observed preparing pureed noodles. CK 1 was observed adding cooked noodles (unmeasured) to the blender container, then proceeded to add an unmeasured amount of broth and thickener. CK 1 blended the mixture, then added more broth (unmeasured) twice, before she was satisfied with the product. During an interview on 4/10/24 at 4:25 p.m. with the RD, the RD stated, Recipes are there to get resident specific amounts. The RD further stated pureed diet not prepared accordingly will alter nutrition. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy and procedure (P&P) titled, FOOD PREPARATION (Healthcare Menus Direct, LLC. 2023), the P&P indicated, Food shall be prepared by methods that conserve nutritive value, flavor, and appearance .2. Recipes are specific as to portion yield, method of preparation, quantities of ingredients, and time and temperature guidelines.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48445 Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety for a total of 117 residents who received facility prepared foods when: 1. Food labeling not followed; 2. Expired foods not discarded; 3. Egg and tuna salad not kept in safe food temperature range; 4. Freezer door frame had ice build-up suggesting temperature fluctuations; 5. Ice build-up on food items stored in reach-in freezer; 6. Can opener had missing metal from the cutting tip; 7. Dust, dirt, and food debris in kitchen areas including dry food storage, refrigerator and under the stove; 8. Box of lentils was left open to air; 9. Improper use of thermometer during food temperature check; and 10. Wet pans on storage, and wet, stained blender container. These failures had the potential to lead to food borne illness. Findings: 1. During an observation on [DATE], within the initial kitchen tour beginning at 8:34 a.m., the following items were observed not having proper labeling: - Eight bowls of undated cereals -Three plastic containers of mayonnaise inside the dry food storage and one plastic container of mayonnaise inside the walk-in refrigerator marked with incorrect received date of [DATE]. -One carton of lactose-free milk inside the walk-in refrigerator marked with incorrect received date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 9:02 a.m., with the Assistant Dietary Manager (AD), in the dry storage area of the kitchen, the AD confirmed the observation and stated cereal bowls should be dated and labeled. When asked about the dating on the containers of mayonnaise, the AD stated someone must have put the wrong date, and stated, They are not following directions. During an interview on [DATE] at 4:20 p.m. with the Dietary Manager (DM), when asked regarding the undated cereal bowls, the DM stated those are leftovers from breakfast and that was a potential hazard. The DM also confirmed the incorrect labels of the three mayonnaise containers and stated, They can cause food-borne illnesses. During a review of the facility policy and procedure (P&P) titled, Labeling and Dating of Foods (Healthcare Menus Direct, LLC. 2023), the P&P indicated, Food delivered to facility needs to be marked with a received date .All prepared foods need to be covered, labeled and dated . 2. During an observation on [DATE], within the initial kitchen tour beginning at 8:34 a.m., the following expired items were observed in storage: - A clear container of celery labeled, [DATE] - [DATE] - A clear container of lettuce labeled, [DATE] - [DATE] - A clear container of bell peppers labeled, [DATE] - [DATE] - Six bottles of breakfast syrup expired on [DATE] - One bottle of caramel sauce expired on [DATE] - One plastic container of basil leaves expired on [DATE] - Parmesan cheese expired on [DATE] During a concurrent observation and interview on [DATE] at 9:11 a.m., with the DM in the dry storage area of the kitchen, the DM confirmed the observations of expired products and stated they should have been thrown away. During a concurrent observation and interview on [DATE] at 9:39 a.m. with the AD, the AD confirmed the outdated produce and stated, All that stuff are gonna get thrown. During an interview on [DATE] at 4:20 p.m. with the DM, the DM confirmed the produce were incorrectly dated and should have been discarded based on the dates. The DM stated the expired items were food safety issues and posed a hazard. During a review of the facility P&P titled, Storage of Food and Supplies (Healthcare Menus Direct, LLC. 2023), the P&P indicated, .No food will be kept longer than the expiration date on the product. 3. During an observation on [DATE], within the initial kitchen tour beginning at 8:34 a.m., in the walk-in refrigerator, the egg salad was observed to have temperature of 45.5 F (degrees Fahrenheit, a unit of temperature measurement) and tuna salad have temperature of 47.5 F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 9:39 a.m., with the AD in the kitchen walk-in refrigerator, the AD measured the temperature using facility's thermometer and confirmed the egg salad had a temperature of 42 F and the tuna salad had 45 F. The AD stated, Temps are not good. During an interview on [DATE] at 4:20 p.m. with the DM, the DM confirmed the recorded temperatures were health hazards. During a review of the facility P&P titled, Cooling and Reheating of Potentially Hazardous or Time/Temperature Control for Safety Food (Healthcare Menus Direct, LLC. 2023), the P&P indicated, Refrigerate prepared, ready-to-eat foods such as, tuna salad and cut melons, at 41 F or Less, since they are potentially hazardous foods. During a review of the United States Food and Drug Administration (US FDA) 2022 Food Code, section , d+[DATE].16, titled, Time/Temperature Control for Safety Food, Hot and Cold Holding, [DATE] version, indicated, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD .shall be maintained .(2) At 5 C [degrees Celsius, a unit of temperature measurement] (41 F) or less. 4. During a concurrent observation and interview on [DATE], within the initial kitchen tour beginning at 8:34 a.m., with the AD in the freezer area of the kitchen, ice build-up was observed around the top of the reach-in freezer door frame on the first of the two freezers (nearest the kitchen interior). The AD confirmed the observation and stated he would have maintenance work on freezer. During a concurrent observation and interview on [DATE] at 8:25 a.m., with the AD in the freezer area of the kitchen, the AD confirmed the reach-in freezer still had the ice build-up. During a review of the facility P&P titled, Procedure for Freezer Storage (Healthcare Menus Direct, LLC. 2023), the P&P indicated, 7. Freezer doors are to close tightly and should be opened as little as possible to prevent storage temperature fluctuations. Review of the website from Commercial Equipment Services, Inc. on Steps You Can Take to Resolve Commercial Freezer Icing Issues (https://commercialequipmentserviceinc.com/, d+[DATE]/steps-you-can-take-to-resolve-commercial-freezer-icing-issues), dated [DATE], stated, One of the most common issues that occurs in commercial freezers is an excessive buildup of ice. Over time, icing can reduce the efficiency of the system, and potentially compromise the freshness and quality of the food due to the elevated moisture content in the unit .In most cases, ice buildup in a freezer is a result of a combination of warm, humid air in the cold environment of the freezer. The presence of this humidity could be due to improper seals at the doors (due to old or worn gaskets or seals). If the door doesn't seal properly, outside air can get inside, where it causes problems such as icing. 5. During a concurrent observation and interview on [DATE], within the initial kitchen tour beginning at 8:34 a.m., with the AD in the freezer area in the kitchen, ice crystals and freezer burns were observed on the food inside of bags of vegetable patties and waffles stored inside the reach-in freezer. The AD confirmed the observation and stated these foods should not have ice collection inside the bag and should be tossed. During a review of the facility P&P titled, Procedure for Freezer Storage (Healthcare Menus Direct, LLC. 2023), the P&P indicated, Store frozen foods in an airtight moisture-resistant wrapper such as a plastic bag or freezer paper to prevent freezer burn. (continued on next page)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

6. During an observation on [DATE] at 9:39 a.m. in the kitchen, the can opener was observed with missing metal on the cutting blade and lacking the original metal coating.

During an interview on [DATE] at 4:20 p.m. with the DM, the DM confirmed the observation and stated, If it's worn out, we replace it. The DM confirmed the can opener tip was already replaced and stated, That's potential hazard going into the can.

During a review of the facility P&P titled, SANITATION, undated, the P&P indicated, 11. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas.

During a review of the US FDA 2022 Food Code, section ,d+[DATE].11, [DATE] version, titled, Good Repair and Proper Adjustment, indicated, The cutting or piercing parts of can openers may accumulate metal fragments that could lead to food containing foreign objects and, possibly, result in consumer injury.

During a review of the US FDA 2022 Food Code, section ,d+[DATE].15, [DATE] version, titled, Can Openers, indicated, Once can openers become pitted or the surface in any way becomes uncleanable, they must be replaced because they can no longer be adequately cleaned and sanitized.

7. During a concurrent observation and interview on [DATE], within the initial kitchen tour beginning at 8:34 a.m., with the DM in the kitchen dry storage, black dust particles were observed on the vent cover on the ceiling. Dust particles were also observed on top of six breakfast syrup containers located below the vent. The DM confirmed the observations and removed the vent cover.

During a concurrent observation and interview on [DATE], within the initial kitchen tour, beginning at 8:34 a.m., with the AD, in the kitchen walk-in refrigerator, red food debris were observed splattered on the left side of the refrigerator wall. The same debris were observed on top of a bin of produce. Dust particles were also observed on the ceiling and close to the vents. The AD confirmed the observations and stated, That needs to be cleaned.

During a concurrent observation and interview on [DATE] at 9:54 a.m. with Cook 1 (CK1), in the kitchen, food debris was observed inside the storage on the right side under the stove. The oven on the left side under stove was also observed dirty with pans stored on it. CK 1 confirmed the observations and stated the ovens are not really used these days. CK 1 confirmed the food debris was food from spillage while cooking.

During a review of the facility P&P titled, Storage of Food and Supplies (Healthcare Menus Direct, LLC. 2023), the P&P indicated, The storeroom should be well-lighted, well-ventilated, cool, dry, and clean at all times .Routine cleaning and pest control procedures should be developed and followed.

During a review of the facility P&P titled, PROCEDURE FOR REFRIGERATED STORAGE (Healthcare Menus Direct, LLC. 2023), the P&P indicated, 3. Refrigeration equipment should be routinely cleaned.

During a review of the facility P&P titled, SANITATION, undated, the P&P indicated, 11. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. During a concurrent observation and interview on [DATE], within the initial kitchen tour beginning at 8:34 a. m., with the DM in the dry food storage, a box of lentils was observed left open to air. The box was noted to be under the vent and next to the bottles of syrup covered in dust. The DM stated this box should not be open to air and should be switched to a plastic container with a lid. During a review of the facility P&P titled, Storage of Food and Supplies (Healthcare Menus Direct, LLC. 2023), the P&P indicated, Dry bulk foods (flour sugar, dry beans, food thickener, spices, etc.) should be stored in seamless metal or plastic containers with tight covers, or bins which are easily sanitized .Remove foods from the packing boxes upon delivery. This is to minimize pests. 9. During an observation on [DATE], at 10:58 a.m., in the kitchen, CK 1 was observed checking temperature of cooked chicken using a digital thermometer. CK 1 inserted the full length of the thermometer probe into the chicken. The thermometer head (which was held by the testers fingers) was observed touching the chicken. During an interview on [DATE] at 4:25 p.m., with the DM, when asked about how kitchen staff are trained to use a thermometer to measure food temperatures, the DM stated the temperature probe should only be inserted as far into the food as needed to measure the temperature and the probe head should not touch the food being measured. The DM stated, It is supposed to be on the round tip by the mid. During a review of the facility P&P titled, THERMOMETER USE AND CALIBRATION (Healthcare Menus Direct, LLC. 2023), the P&P indicated, Food thermometers are to be used properly and calibrated to ensure accurate temperature reading .Most digital thermometers have temperature sensors within ,d+[DATE] [inches, a unit of measurement] from the probe tip .Insert the thermometer into the thickest part of the food, so that the sensor is covered . During a review of the facility P&P titled, MEAL SERVICE (Healthcare Menus Direct, LLC. 2023), the P&P indicated, 2. The Food and Nutrition Services staff member will take the food temperatures prior to service of the meal with a thermometer that has been cleaned and sanitized .The same thermometer may be used for all the hot foods, wiping the stem with an alcohol swab, clean cloth, or paper towel between each food item. 10. During a concurrent observation and interview on [DATE], within the initial kitchen tour on beginning at 8:34 a.m., two steam table pans were found stored wet. The DM confirmed the observation and stated, They should be dry. Blender containers were also observed wet inside and had brownish staining. The DM confirmed the observation and took them to be cleaned. During a review of the facility P&P titled, DISHWASHING (Healthcare Menus Direct, LLC. 20123 [sic], the P&P indicated, 5. Dishes are to be air dried in racks before stacking and storing. During a review of the facility P&P titled, SANITATION, undated, the P&P indicated, 12. Plastic ware, china, and glassware that become unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. Plastic ware is bleached as necessary to prevent staining. During a review of the US FDA 2022 Food Code, Section ,d+[DATE].11, titled, Equipment and Utensils, Air-Drying Required, [DATE] version, indicated, After cleaning and sanitizing, equipment and utensils: shall be air-dried . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the US FDA 2022 Food Code, Annex ,d+[DATE].11, titled, Equipment and Utensils, Air-Drying Required, [DATE] version, indicated, Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. 48445 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly when the garbage dumpster was found open, for a census of 120. This failure had the potential to attract pests to the facility. Findings: During a concurrent observation and interview on 4/9/24 within the initial kitchen tour at 9:39 a.m., with the Assistant Dietary Manager (AD) in the parking lot, one of four covers of the garbage dumpster was observed open. The AD confirmed the observation and stated, This thing should have been shut. We'll get bacteria on that. During a review of the facility policy and procedure (P&P) titled, Miscellaneous Areas (Healthcare Menus Direct, LLC. 2023), the P&P indicated, 2. Garbage and trashcans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. During a review of the US FDA 2022 Food Code, section 5-501.15, titled, Outside Receptacles, 1/18/23 version, indicated, (A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or get specialized rehabilitative services as required for a resident. 38834 Based on interview and record review, the facility failed to provide rehabilitation services for one of 32 sampled residents (Resident 4), when Resident 4 did not receive physical therapy (PT) evaluation and treatment as ordered by the resident's physician. This failure prevented Resident 4 from attaining and maintaining the highest practicable functional level and had the potential to result in further decline of Resident 4's mobility. Findings: A review of the Admission Records indicated that the facility admitted Resident 4 in 2022 with multiple diagnoses which included high blood pressure and heart disease. Resident 4 was admitted while receiving hospice services which was revoked on 12/28/23. A review of Resident 4's history and physical indicated the resident had a history of multiple falls and the last fall resulted in a right femur (thigh bone) fracture. Resident 4's clinical records indicated the resident was readmitted from the hospital on 11/18/23 with non-weight bearing status (not allowed to put any weight on her right leg) for 6 weeks following the hospitalization . A review of the Minimum Data Set (MDS, an assessment tool), dated 3/19/24, indicated Resident 4 was cognitively intact, had no delusions or hallucinations, and had no history of rejection of care. During an observation and interview on 4/9/24 at 2:07 p.m., Resident 4 was laying in her bed. Resident 4 was alert and oriented and able to carry out a conversation. When the resident was asked if she had any concerns with her care, the resident stated, Yes, waiting for therapy. My doctor had told me back in January that I will get therapy, still waiting .I want to be up, I want sit up, and start walking again .I was told that I will start therapy .My legs are so weak, need to exercise them before I start walking .I'm looking forward to work with physical therapist. Resident 4 stated that she had talked to several staff regarding the order for physical therapy and everyone was saying that there was no order yet. A review of Resident 4's clinical records contained a physician order, dated 1/16/24, to Progress to WBAT [weight bearing as tolerated; indicating could put some weight on her right leg] over the next 2-3 wks [weeks]. Start PT [physical therapy]. A review of Resident 4's electronic clinical records contained Occupational Therapist (OT) evaluation and plan of treatment note which indicated Resident 4 received occupational therapy services from 1/12/24 through 2/10/24. The OT care plan of treatment note, dated 1/11/24, indicated Resident 4 had physical impairments and functional deficits and had exhibited a strong motivation to achieve prior level of functioning. A review of OT progress notes from 1/15/24 through 2/7/24 indicated Resident 4, actively participated with skilled interventions during each of the OT treatment sessions with the exception of treatment on 1/19/24. On 1/19/24, the OT documented, Pt [patient] refusing to participate in OOB [out of bed] activities and therapy session today .Barriers Impacting Session: Pain levels. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence Resident 4 had a physical therapy evaluation and treatment as ordered by the resident's physician on 1/16/24. A review of Resident 4's clinical records contained another physician order, dated 3/19/24, which indicated, OK to proceed WBAT [weight bearing as tolerated] .PT [physical therapy] start today. There was no documented evidence Resident 4 received a physical therapy evaluation and treatment as prescribed by her physician. There was no documented evidence the resident's physician was notified that the order for PT was not followed. During an interview on 4/11/24 at 8:17 a.m., the Restorative Nursing Assistant (RNA, staff that has additional training in therapeutic rehabilitation and helps residents to exercise), stated she had not provided any exercises to Resident 4 since the resident had leg fracture last year. The RNA stated, She [Resident 4] verbalized a few times that she wants to walk and I explained that there is no order. I talked to .rehabilitation director .a while ago. The RNA stated that she was told that the resident needed to be cleared by her physician to start therapy. An interview and a concurrent record review was conducted on 4/11/24 at 9:05 a.m. with the Physical Therapist (PT) and the PT confirmed Resident 4 did not receive physical therapy recently, following the fracture. The PT reviewed Resident 4's order dated 1/16/24 for weight bearing and PT services and explained, She [Resident 4] . had PT and OT services .Probably needed PT evaluation first before someone got her up. The PT stated the resident had occupational therapy services from 1/11/24 through 2/9/24, but did not provide clear explanation why the physician order for physical therapy from January was not followed. During a continuing interview, the PT stated that he was aware Resident 4 verbalized that she wanted to get stronger and walk and that not long ago he was informed by one of the resident's physician the resident needed to be evaluated for PT. The PT added, I was off last week .She's on my list to be seen this week, but haven't seen her yet. Upon reviewing the physician's order for physical therapy located in the resident's paper chart, the PT stated he was not aware Resident 4 had another order for physical therapy dated 3/18/24. The PT stated, Nobody communicated that to me and the order never made it to electronic charting. During a concurrent interview and record review on 4/11/24 at 10:15 a.m., the Assistant Director of Nursing (ADON) stated that she was aware of both physician orders, dated 1/16/24 and 3/19/24, and verbally notified the PT (Director of Rehabilitation Therapy (DRT) regarding Resident 4's physician orders to start physical therapy. The ADON stated Resident 4 should have received physical therapy services as soon as the order was received and the PT was informed of these orders, but it did not happen. During a concurrent interview and record review on 4/12/24 at 12:15 p.m., the Director of Nursing (DON) acknowledged that the physician order for physical therapy was not followed and Resident 4 did not receive therapy from 1/16/24 to to date. A review of the facility's policy titled Scheduling Therapy Services, dated 7/13, indicated, Therapy shall be scheduled in accordance with the resident's treatment plan .Therapy is scheduled in coordination with nursing service and is documented in the resident's medical records.

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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** 41600 Based on observation, interview, and record review, the facility failed to ensure infection prevention and control practices were followed when, 1. A blood pressure monitor (device used to measure blood pressure) was not disinfected according to manufacturer's instructions after being used during medication pass observation, and 2. A laundry room exhaust fan located above the clean linen area was coated with thick, sticky substance. These failures had the potential to transmit pathogens or bodily fluids for 120 residents residing in the facility. Findings: 1. During a medication pass observation with Licensed Nurse (LN) 1 on 4/9/24 at 8:30 a.m., LN 1 used a blood pressure monitor to measure a resident's blood pressure inside the resident's room. The blood pressure monitor was then taken out of resident's room and parked outside in the hallway without being cleaned and disinfected. LN 1 moved on to the next patient on the list for morning medication pass. During an interview with LN 1 on 4/9/24 at approximately 11:15 a.m., LN 1 acknowledged that the blood pressure monitor and cuffs were not cleaned and sanitized between patients. LN 1 stated, I usually clean them in between, but forgot to do it this morning. During an interview with an Infection Prevention (IP) nurse on 4/11/24 at 11:17 a.m., the IP stated, staff must disinfect equipment and blood pressure cuffs in between residents to prevent possible infection spread. During an interview with the Director of Nursing (DON) on 4/11/24 at 1 p.m., the DON stated, the blood pressure monitor needed to be sanitized prior and after use. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfecting of Resident-Care Items and Equipment, revised 11/2023, the P&P indicated, Resident-care equipment .will be cleaned and disinfected according to current CDC [Centers for Disease Control and Prevention] recommendations for disinfection .include bedpans, blood pressure cuffs .Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions. During a review of the manufacturer's instructions for use titled, [NAME] Allyn FlexiPort Blood Pressure Cuffs, revised 2019, the instructions indicated, Disinfect: thoroughly re-saturate (spray or immerse) all surfaces of the cuff and accessories with germicidal cleaner. 38834 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a laundry room observation accompanied by a Laundry and Housekeeping Supervisor (LHS) on 4/12/24, at 11:20 a.m., a large exhaust fan (a fan for ventilating an interior) was observed in the center of the ceiling above the clean linen folding area. The exhaust fan opening to the laundry room did not have a screen or filter to prevent objects from falling to the clean linen area. A thick layer of gray, sticky and fluffy substance was observed covering the fan blades and the area between the blades. The LHS confirmed the observation and stated that it had not been cleaned for a while. The LHS acknowledged that the gray substance that covered the blades of the fan was very thick and when the fan was turned on, the air might push the substance down and contaminate the clean linen below the exhaust. During an interview on 4/12/24 at 11:50 a.m., the Administrator (ADM) stated the LHS had shown him the photo of the exhaust fan blades and was aware the exhaust fan was dirty. The ADM was asked who was responsible for cleaning and maintaining the exhaust fan, the ADM replied, As you can see nobody cleaned it. A review of the facility's 'Departmental (Environmental Services) - Laundry and Linen' policy, revised 1/2014 indicated, The purpose of this policy is to provide a process for the safe and aseptic handling .and storage of linen.