

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>48874</p> <p>Based on observation, interview, and record review, the facility failed to notify the RP (Responsible Party) of the transfer and the reason for the transfer for one resident (Resident 132) out of 32 sampled residents.</p> <p>This failure increased the risk for Resident 132's RP not be informed of the resident's discharge rights.</p> <p>Findings:</p> <p>Review of Resident 132's admission record indicated Resident 132 was admitted in December 2024 with several diagnoses including memory deficit following other cerebral vascular disease (memory problems caused by inadequate blood flow in parts of the brain) and dementia (a progressive decline in mental abilities).</p> <p>Review of Resident 132's Minimum Data Set (MDS, a federally mandated assessment tool) dated 12/13/24, indicated Resident 132 had severely impaired cognition.</p> <p>Review of Resident 132's Nurse's Notes dated 12/13/24, indicated, Resident sent to ER [emergency room] due to disturbing behaviors.</p> <p>During a concurrent observation and interview on 3/7/25 at 9:02 a.m. with the Director of Nursing (DON), the DON confirmed that there was no documentation that Resident 132's RP was notified of resident's transfer to an acute care hospital. The DON stated that her expectation was that the RP be notified by the Licensed Nurse before a resident is transferred.</p> <p>Review of the facility's Policy and Procedure (P&P) dated October 2022, and titled, Transfer or Discharge, Facility Initiated. The P&P indicated, When a resident is transferred or discharged from the facility, the following information is documented in the medical records .That an appropriate notice was provided to the resident and/or legal representative .</p>

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

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

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45770</p> <p>Based on interview and record review, the facility failed to timely submit a Minimum Data Set (MDS, a federally mandated resident assessment tool) for one of 32 sampled residents (Resident 119) when the discharge assessment was not completed and transmitted according to the required regulatory time frame.</p> <p>This failure had the potential to result in incomplete information being submitted to Centers for Medicare and Medicaid Services (CMS).</p> <p>Findings:</p> <p>A review of Resident 119's admission record indicated she was admitted to the facility on ,d+[DATE] and discharged on [DATE].</p> <p>In a concurrent interview and record review on 3/6/25 at 11:08 a.m., with the MDS Coordinator 1 (MDSC 1), Resident 119's MDS assessments were reviewed. MDSC 1 confirmed Resident 119's discharge assessment was completed and transmitted more than 14 days from the date of discharge.</p> <p>In an interview on 3/7/25 at 8:35 a.m. with the Director of Nursing (DON), the DON stated she expected the MDSC 1 to follow the required timeframes for MDS submission.</p> <p>A review of the facility's policy titled MDS Completion and Submission Timeframes revised in 2023 stipulated the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.</p> <p>A review of a document titled Assessments for the RAI [Resident Assessment Instrument], dated 10/23, indicated MDS completion date for discharge assessment must be completed no later than the discharge date plus 14 calendar days.</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>50351</p> <p>Based on interview and record review, the facility failed to ensure one of 32 sampled residents (Resident 125) had a PASARR (Pre admission Screening and Resident Review, a federal requirement to ensure individuals with serious mental illness, intellectual disability, or other related conditions are not inappropriately placed in nursing homes for long term care and receive services in the most integrated setting) completed.</p> <p>This failure had the potential for the facility not to provide or seek appropriate mental health services for Resident 125.</p> <p>Findings:</p> <p>A review of Resident 125's Admission Record indicated Resident 125 was admitted to the facility in December 2024 with multiple diagnoses including Major Depressive Disorder (a common and serious condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life).</p> <p>During a review of Resident 125's medical record, under PASARR, the document titled DHCS[Department of Health Care Services], dated 12/13/2024 indicated, . If the individual remains in the NF[Nursing Facility] longer than 30 days, the facility must resubmit a new Level 1 [a screening used to determine if an individual has or is suspected of having a PASARR condition]Screening as a Resident Review on the 31st day,</p> <p>During a concurrent interview and record review on 3/7/25 at 1:56 p.m. with Director of Nursing (DON) and Administrator (ADM), the DON and ADM reviewed the PASARR document provided by the facility located in Resident 33's medical record. The DON and ADM confirmed there should be an additional PASARR to be completed for Resident 125. DON and ADM stated this was missed and it should have been done.</p> <p>A request was made to the Administrator(ADM) on 3/7/25 at 2:53 p.m. for additional PASARR documentation for Resident 125 and facility PASARR policy and there was no documentation provided.</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45770</p> <p>Based on observation, interview, and record review, the facility failed to provide services according to professional standards of quality for four residents (Resident 13, Resident 83 Resident 115 and Resident 33) of 32 sampled residents, when:</p> <ol style="list-style-type: none"> 1. Licensed Nurse 1 (LN 1) did not follow the physician's order in administering Resident 13's prescribed medication; 2. Three of Resident 83's morning medication were combined and administered at the same time through the feeding tube; 3a. Resident 115 was given another resident's supply of insulin glargine (long-acting insulin); and, 3b. Resident 115's order for compression socks was not followed as ordered. 3c. Resident 33's physician order to flush an indwelling Foley catheter (a thin flexible tube inserted into the urinary bladder to drain urine) was not followed as ordered. <p>These failures increased the resident's potential to have unmet health needs and decreased the facility's potential to provide a responsible and accurate care for residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of an admission record for Resident 13 indicated he was admitted to the facility in December 2009 with diagnoses including hyperlipidemia (high cholesterol, too much fat in the blood). <p>In an observation on 3/4/25 at 8:50 a.m., during medication pass with LN 1, LN 1 was observed preparing Resident 13's morning medications, LN 1 scooped a teaspoon (tsp., unit of measurement) of psyllium powder (used for constipation) and stirred it with 5 ounces (oz., unit of measurement) of water. LN 1 stated Resident 13 drinks the mixture without difficulty.</p> <p>A review of Resident 13's Order Summary Report (OSR) dated 12/30/22 indicated an order for Resident 13 to receive a tablespoon (tbsp., unit of measurement) of psyllium powder mixed in 8 oz. of water daily in the morning.</p> <p>In a concurrent interview and record review on 3/7/25 at 8:05 a.m., with LN 1 Resident 13's OSR was reviewed. LN 1 confirmed that on 3/4/25, she did not administer the right dosage of psyllium powder to Resident 13, instead of giving 1 tbsp. LN 1 gave 1 tsp. of psyllium mixed in 5 oz. of water. 2. A review of an admission record for Resident 83 indicated he was admitted to the facility in December 2023 with diagnoses including anoxic brain damage (irreversible brain damage caused by an interrupted oxygen supply to the brain). <p>(continued on next page)</p> </p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 83's OSR dated 12/8/23 indicated Resident 83 takes nothing by mouth, receives nutrition and medication through the feeding tube.</p> <p>A review of Resident 83's OSR dated 12/13/23 indicated to flush feeding tube with 60 ml.[ml, milliliter is a unit of measurement] of water before and after medication administration.</p> <p>In an observation on 3/4/25 at 10 a.m., during medication administration with LN 2, LN 2 was observed preparing medications for Resident 83. LN 2 crushed two 100 milligram (mg., unit of measurement) tablets of docusate sodium (stool softener), one tablet of multi-vitamin with minerals, opened two soft gel capsules of ultimate omega, and six capsules of herbal supplements.</p> <p>During a continued medication administration observation on 3/4/25 starting at 10 a.m., LN 2 combined all crushed and opened medications and mixed it with water in a 5 oz cup. LN 2 flushed Resident 83's feeding tube with 40 ml., of warm water then poured the medication mixture right after. Resident 83's feeding tube stopped draining after a few minutes, and the Assistant Director of Nursing (ADON) came in Resident 83's room to assist LN 2. The ADON confirmed the feeding tube was plugged up because of the medication mixture. The ADON stated the medications should have been administered one at a time with water flushes in between to keep the feeding tube patent and prevent it from getting blocked.</p> <p>3a. A review of Resident 115's Admission Record indicated he was admitted in January 2025 with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>A review of Resident 115's OSR dated 2/27/25 indicated an order for insulin glargine (long acting insulin, a medication used to manage diabetes), inject 22 units subcutaneously (SQ, under the skin) daily in the morning.</p> <p>On 3/4/25 the following concurrent observations and interviews were conducted with LN 2:</p> <ul style="list-style-type: none"> - At 9:45 a.m., LN 2 checked Resident 115's blood sugar level, LN 2 stated it was 375; - At 9:50 a.m., LN 2 took one vial of insulin glargine (long-acting insulin) from the medication cart without checking the label and withdrew 22 units in a syringe, LN 2 used another resident's supply of the same insulin, LN 2 stated she was in a hurry and did not check the name on the insulin vial; and, - At 9:55 a.m. LN 2 injected the 22 units of insulin glargine to Resident 115's abdomen, insulin that belonged to another resident. <p>In an interview on 3/7/25 at 8:35 a.m. with the Director of Nursing (DON) the DON stated all the nurses had undergone skills training in medication administration including administration through a feeding tube. The DON stated she expected all nurses to be able to utilize what they had learned in training to be able to properly care for the residents and prevent errors when giving medications that can lead to complications.</p> <p>(continued on next page)</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy titled Administering Medications Through an Enteral Tube revised in 2018 indicated .safe administration of medications through an enteral tube .Administer each medication separately .If administering more than one medication, flush with 15 ml warm purified water between medications.</p> <p>A review of the facility's policy titled Administering Medications revised in 2019 indicated Medications are administered in a safe .manner .The individual administering the medication checks the label to verify the right resident, right medication, right dose, right time and right method (route) of administration before giving the medication.</p> <p>36681</p> <p>3b. A review of the Admission Record indicated Resident 115 was initially admitted [DATE] and recently admitted [DATE]. with diagnoses including Diabetes mellitus with diabetic neuropathy (nerve damage caused by high blood sugar levels).</p> <p>A review of Resident 115's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 1/17/25 indicated Resident 115 had moderate cognitive impairment with a score of 12 out of 15 in the Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident).</p> <p>A review of Resident 115's physician order dated 1/13/25 indicated, COMPRESSION SOCKS: CNA [Certified Nursing Assistant] to apply COMPRESSION SOCKS to BLE [bilateral lower extremities] during the day and remove at bedtime as tolerated .</p> <p>Further review of Resident 115's clinical records indicated the following:</p> <ul style="list-style-type: none"> - Admission H & P [History & Physical] dated 1/10/25 indicated, .Edema [swelling caused by excess fluid buildup] of lower extremity due to peripheral venous insufficiency [veins in the legs have trouble returning blood to the heart] .chronic, continue compression stocking daily; - the Medication Administration Record (MAR) from 1/13/25 to 3/4/25 had no documentation of Resident 115's refusal to use the compression socks. The MAR was signed by LNs all shifts; and, - there was no care plan initiated for Resident 115's use of compression socks from 1/13/25 to 3/4/25. <p>In a concurrent observation and interview on 3/4/25 at 9:08 a.m., Resident 115 was up in his wheelchair inside his room and had socks and shoes on. Resident 115 stated he had been in the facility for a couple of weeks and he was ready to go home.</p> <p>A concurrent observation and interview was conducted on 3/5/25 at 2:15 p.m.,inside Resident 115's room with his wife at bedside. Resident 115 and his wife stated he was wearing regular socks. Resident 115's wife further stated [Resident 115] had not been using the compression socks for 6 weeks and resident just quit using it.</p> <p>(continued on next page)</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A concurrent interview and record review was conducted on 3/5/25 at 2:20 p.m. in the nurses' station with LN 5. The LN 5 confirmed Resident 115 had an order for compression socks dated 1/13/25. The LN 5 stated she had not checked if resident was wearing the compression socks and she did not get a report from the CNA of resident refusing to wear the compression socks.</p> <p>A subsequent observation and interview was conducted on 3/5/25 at 2:22 p.m., inside Resident's 115 room with his wife at bedside. The LN 5 checked Resident 115's socks and confirmed he was using non skid socks and not compression socks.</p> <p>A concurrent observation and interview was conducted on 3/6/25 at 10:06 a.m., inside Resident 115's room with CNA 4. The CNA 4 confirmed Resident 115 was using his own socks provided by his wife and it was not compression socks. The CNA 4 stated she did not know if Resident 115 should wear compression socks. The CNA 4 further stated LN 5 did not inform her Resident 115 had to use compression socks. The CNA 4 added she had worked with Resident 115 three weeks ago and resident was using the socks provided by his wife.</p> <p>In a concurrent interview and record review on 3/7/25 at 10:43 a.m., the DON stated Resident 115 had episodes of refusing the compression socks. The DON further stated she confirmed with one of the CNAs Resident 115 sometimes wears his compression socks and sometimes he does not. The DON said her expectation was for LNs to document resident refusal either in the MAR or TAR [Treatment Administration Record] since the resident has the right to refuse. The DON confirmed the care plan for the use of compression socks was initiated on 3/6/25 and there was no documented refusals in the MAR from 1/13/25 to 3/4/25.</p> <p>A review of the facility's policy and procedure revised October 2010 and titled, Applying Anti-Emboli Stockings (TED Hose) indicated, The purpose of this procedure is to improve venous return to the heart, to improve arterial circulation to the feet, to minimize edema to the legs and feet .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 procedure.</p> <p>50351</p> <p>3c. A review of Resident 33's Admission Record indicated Resident 33 was admitted to the facility in November 2024 with multiple diagnoses including history of urinary tract infection and diabetes.</p> <p>During a review of Resident 33's Physician order, dated 11/21/24, the order directed, . Catheter: irrigated with 60 mL[milliliters, a unit of measurement] of Normal Saline [a sterile solution] PRN [as needed] (Clogging) .</p> <p>During an observation on 3/4/25 at 9:41 a.m. in Resident 33's room, Resident 33 was observed resting in bed with catheter tubing noted with cloudy yellow urine.</p> <p>During a follow up observation on 3/7/25 at 7:17 a.m. in Resident 33's room, Resident 33 was observed sitting up in bed. The catheter tubing was noted with yellow thick sediments and dark cloudy urine.</p> <p>(continued on next page)</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 3/7/25 at 7:33 a.m. with CNA 5 in Resident 33's room, Resident 33's catheter tubing was observed with thick yellow sediment, was cloudy and yellow in color. CNA 5 confirmed the observation of thick yellow sediment and she stated [the observation] should be reported to the nurse.</p> <p>During an interview on 3/7/25 at 9:21 a.m. at nursing station 1 next to the administration office with Treatment Nurse (TN), the TN stated, catheter care can be completed by the treatment nurse and shift nurses. TN further stated the catheter tubing flush for Resident 33 was ordered as needed. The TN confirmed there were sediments in Resident 33's catheter tubing via photo images taken by surveyor and should be flushed.</p> <p>During a review of Resident 33's progress note dated 2/9/25, the progress note indicated, . Family member concerned with cath [catheter] bag containing light sediment with dark urine in part of tubing and requested to change cath out. Checked order with last change 1/18/25 per Q30 [every 30] days schedule order for patient. Flushed cath .</p> <p>During a review of Resident 33's care plan titled Resident has altered elimination due to use of indwelling catheter . dated 11/21/24 indicated, . Change FC [Foley catheter] . per facility protocol . Check urine for any significant change in color, odor, amount, and Notify MD [Medical Doctor, physician] .</p> <p>During a review of Resident 33's Treatment Administration Record (TAR), the TAR indicated order dated 11/21/24 to . Observe for s/s [signs and symptoms] of infexn [sic, infection] & complications r/t [related to] use . Thick/cloudy urine . Excessive sediments . early detection of possible infection for use of indwelling catheter . On 3/5/25 TAR documentation indicated there was thick cloudy urine noted. There was no documentation the resident's physician was notified of the s/s of infection.</p> <p>During a concurrent interview and record review on 3/7/25 at 1:24 p.m. with DON, the DON stated her expectation for catheter care and flushes was the nursing staff to follow physician's orders, if they are monitoring it daily, it should be documented according to what they observed. DON confirmed sediment in catheter tubing via photograph image and confirmed monitoring order for catheter for Resident 33.</p> <p>During a review of policy and procedure titled, Catheter Care, Urinary, dated August 2022, indicated, . change catheters and drainage bags based on clinical indication such as infection, obstruction . Residents who form encrustations can quickly lead to an obstruction need more frequent catheter changes Report unusual findings to Physician or supervisor . if urine has an unusual appearance . color . if signs of symptoms of urinary traction infections .occur The following information should be recorded in the resident's medical record . character of urine such as color .</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>45770</p> <p>Based on observation, interview, and record review, the facility failed to promote safety measures for one of 32 sampled residents (Resident 50) when Resident 50's order for the use of wander guard (a device that allows sensors on doors to alarm to keep track of wandering residents) was not followed as ordered.</p> <p>This failure increased Resident 50's risk for elopement.</p> <p>Findings:</p> <p>A review of an admission record for Resident 50 indicated she was admitted in November 2024 with diagnoses including vascular dementia (a type of dementia caused by problems with blood flow to the brain affecting thinking, memory, and behavior).</p> <p>A review of Resident 50's Order Summary Report (OSR) dated 11/10/24 indicated an order to apply wander guard to the left arm/wrist and check placement every shift due to episodes of going out of the facility unassisted.</p> <p>During observations on 3/4/25 at 11:50 a.m., 3/5/25 at 1:45 p.m., and 3/6/25 at 9 a.m., Resident 50 was observed not wearing a wander guard.</p> <p>During a concurrent observation, interview, and record review on 3/6/25 at 10:28 a.m., with the Assistant Director of Nursing (ADON), Resident 50's OSR, and Medication Administration Record (MAR) were reviewed. ADON confirmed Resident 50 was not wearing a wander guard to the left arm or to any of Resident 50's upper/lower extremities, but the order was still active due to Resident 50's history of wandering.</p> <p>During an interview on 3/7/25 at 8:35 a.m., with the Director of Nursing (DON) the DON acknowledged that Resident 50 should always wear the wander guard as ordered to maintain resident's safety with proper supervision and prevent wandering that may lead to accidents.</p> <p>A review of the facility's policy titled Wandering and Elopements revised in 2019 indicated The facility will identify residents who are at risk for unsafe wandering . care plan .will include strategies and interventions to maintain resident's safety.</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36681</p> <p>Based on interview and record review, the facility failed to ensure the pharmacy recommendations for one of 32 sampled residents (Resident 54) during a Medication Regimen Review (MRR) was communicated to the physician.</p> <p>This failure had the potential for Resident 54 to experience adverse effects from the medication.</p> <p>Findings:</p> <p>A review of the Admission Record indicated Resident 54 was admitted [DATE] with multiple diagnoses including insomnia (trouble falling asleep or staying asleep).</p> <p>A review of Resident 54's Medication Administration Record (MAR, daily documentation record used by a licensed nurse to document medication and treatment given to a resident) included the following orders:</p> <ul style="list-style-type: none"> -an order dated 4/4/24 for Melatonin (used to treat insomnia) 3 mg (milligram, unit of measurement) give 1 tablet by mouth for insomnia; -an order dated 4/4/24 for Melatonin 3 mg give 1 tablet by mouth as needed for insomnia. May give one additional tablet at bedtime, total of 6 mg per day; and, -an order dated 6/1/24 for Melatonin 3 mg give 1 tablet by mouth as needed at bedtime for circadian rhythm (internal clock in the brain that regulates cycles of alertness and sleepiness). <p>A review of the MRR from the Consultant Pharmacist created between 1/1/25 and 1/26/25 for Resident 54 indicated, There are two PRN [given as needed or requested] orders for Melatonin. One of these should be discontinued.</p> <p>In a concurrent interview and record review on 3/6/25 starting at 3:33 p.m., the Director of Nursing (DON) stated the facility communicates the pharmacy recommendations to the physician. The DON confirmed Resident 54 had 2 PRN orders for Melatonin and a scheduled Melatonin 3 mg at bedtime for insomnia. The DON further stated the additional Melatonin PRN order should have been discontinued since Resident 54 was on routine Melatonin.</p> <p>In a follow up interview on 3/7/25 at 10:54 a.m., the DON stated she had a conversation with the physician regarding Resident 54's Melatonin orders and she was not sure if the conversation was documented. The DON further stated she will check with medical records.</p> <p>In a concurrent interview and record review on 3/7/25 at 2:52 p.m., the Medical Records Director (MRD) stated she could not find documented evidence the physician was notified of the pharmacy recommendations for Resident 54's PRN Melatonin orders.</p> <p>(continued on next page)</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedure revised May 2019 and titled, Medication Regimen Reviews indicated, .The consultant pharmacist performs a medication regimen review (MRR) for every resident in the facility .The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems .and other irregularities, for example .duplicative therapies .Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physician for each resident identified as having a non-life threatening medication irregularity .The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) was taken to address it.</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>45770</p> <p>Based on observation, interview, and record review the facility failed to ensure the medication error rate was less than five percent (5%) for a census of 132 when:</p> <ol style="list-style-type: none"> 1. Licensed Nurse 1 (LN 1) did not follow the physician's order in administering Resident 13's prescribed medication; 2. Resident 115 was given another resident's supply of insulin glargine (long-acting insulin); and 3. Three of Resident 83's morning medication were combined and administered at the same time through the feeding tube with no regard for medication reactions (therapeutic response). <p>These failures resulted in a medication error rate of 23.08% for the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of an admission record for Resident 13 indicated he was admitted to the facility in December 2009 with diagnoses including hyperlipidemia (high cholesterol, too much fat in the blood). <p>In an observation on 3/4/25 at 8:50 a.m., during Medication Administration with LN 1, LN 1 was observed preparing Resident 13's morning medications, LN 1 scooped a teaspoon (tsp., unit of measurement) of psyllium powder (used for constipation) and stirred it with 5 ounces (oz., unit of measurement) of water. LN 1 stated Resident 13 drinks the mixture without difficulty.</p> <p>A review of Resident 13's Order Summary Report (OSR) dated 12/30/22 indicated an order for Resident 13 to receive a tablespoon (tbsp., unit of measurement) of psyllium powder mixed in 8 oz. [ounce,unit of volume measurement] water daily in the morning.</p> <p>In a concurrent interview and record review on 3/7/25 at 8:05 a.m., with LN 1 Resident 13's OSR was reviewed. LN 1 confirmed that on 3/4/25, she did not administer the right dosage of psyllium powder to Resident 13, instead of giving 1 tbsp. LN 1 gave 1 tsp. of psyllium mixed in 5 oz. of water.</p> <ol style="list-style-type: none"> 2. A review of Resident 115's Admission Record indicated he was admitted in January 2025 with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). <p>A review of Resident 115's OSR dated 2/27/25 indicated an order for insulin glargine (long acting insulin), inject 22 units subcutaneously (SQ, under the skin) daily in the morning.</p> <p>On 3/4/25 the following concurrent observations and interviews were conducted with LN 2:</p> <ul style="list-style-type: none"> - At 9:45 a.m., LN 2 checked Resident 115's blood sugar level, LN stated it was 375; <p>(continued on next page)</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- At 9:50 a.m., LN 2 took one vial of insulin glargine (long-acting insulin) without inspecting the label properly from the medication cart then withdrew 22 units in a syringe, LN 2 used another resident's supply of the same insulin, LN 2 stated she was in a hurry and did not check the name on the insulin vial.</p> <p>- At 9:55 a.m. LN 2 injected 22 units of insulin glargine to Resident 115's abdomen taken from another resident's vial.</p> <p>3. A review of the admission record for Resident 83 indicated he was admitted to the facility in December 2023 with diagnoses including anoxic brain damage (irreversible brain damage caused by an interrupted oxygen supply to the brain).</p> <p>A review of Resident 83's OSR dated 12/8/23 indicated Resident 83 took nothing by mouth, received nutrition and medication through the feeding tube.</p> <p>A review of Resident 83's OSR dated 12/13/23 indicated to flush feeding tube with 60 ml. (milliliter, volume measurement) of water before and after medication administration.</p> <p>In an observation on 3/4/25/at 10 a.m., during Medication Administration with LN 2, LN 2 was observed preparing all medications for Resident 83. LN 2 crushed two 100 milligram (mg., unit of measurement) tablets of docusate sodium (stool softener), one tablet of multi-vitamin with minerals, opened two soft gel capsules of ultimate omega, and six capsules of herbal supplements.</p> <p>During a continued Medication Administration observation on 3/4/25 starting at 10 a.m., LN 2 combined all crushed and opened medications then mixed it with water in a 5 oz cup. LN 2 flushed Resident 83's feeding tube with 40 ml. of warm water then poured the medication mixture right after. Resident 83's feeding tube stopped draining after a few minutes, and the Assistant Director of Nursing (ADON) went inside Resident 83's room to assist LN 2. The ADON confirmed the feeding tube was plugged up because of the medication mixture. The ADON stated the medications should have been administered one at a time with water flushes in between to keep the feeding tube patent and prevent it from getting blocked and as per policy.</p> <p>In an interview on 3/7/25 at 8:35 a.m. with the Director of Nursing (DON) the DON stated all the nurses had undergone skills training in medication administration including administration through a feeding tube. DON expected all nurses to be able to utilize what they've learned in training to be able to properly care for the residents and prevent errors when giving medications that can lead to complications.</p> <p>A review of the facility's policy titled Administering Medications Through an Enteral Tube revised in 2018 indicated .safe administration of medications through an enteral tube .Administer each medication separately .If administering more than one medication, flush with 15 ml warm purified water between medications.</p> <p>A review of the facility's policy titled Administering Medications revised in 2019 indicated Medications are administered in a safe .manner .The individual administering the medication checks the label to verify the right resident, right medication, right dose, right time and right method (route) of administration before giving the medication.</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>45770</p> <p>Based on observation, interview, and record review the facility failed to ensure one resident (Resident 115) for a census of 132 was free from significant medication error when Resident 115 was administered another resident's insulin.</p> <p>This failure increased Resident 115's risk for receiving the wrong medication and complications of diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) including diabetic coma.</p> <p>Findings:</p> <p>A review of Resident 115's Admission Record indicated he was admitted in January 2025 with diagnoses including Type 1 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>A review of an Order Summary Report (OSR) for Resident 115 dated 2/27/25 indicated an order for insulin glargine, inject 22 units subcutaneously (SQ, under the skin) daily in the morning.</p> <p>On 3/4/25 the following concurrent observations and interviews were conducted with Licensed Nurse 2 (LN 2):</p> <ul style="list-style-type: none"> - At 9:45 a.m., LN 2 checked Resident 115's blood sugar level, LN 2 stated it was 375; - At 9:50 a.m., LN 2 took one vial of insulin glargine (long-acting insulin) without checking the label properly from the medication cart then withdrew 22 units in a syringe, LN 2 used another resident's supply of the same insulin, LN 2 stated she was in a hurry and did not check the name in the insulin vial. - At 9:55 a.m. LN 2 injected 22 units of insulin glargine to Resident 115's abdomen taken from another resident's vial. <p>In an interview on 3/7/25 at 8:35 a.m. with the Director of Nursing (DON) the DON stated all the nurses had undergone skills training in proper medication administration, she expected nurses to use what they've learned and should follow the seven rights of medication when administering medications to prevent errors from occurring.</p> <p>A review of the facility's policy titled Administering Medications revised in 2019 indicated Medications are administered in a safe manner. The individual administering the medication checks the label to verify the right resident, right medication, right dose, right time and right method (route) of administration before giving the medication.</p>

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>45770</p> <p>Based on observation, interview, and record review, the facility failed to update the medication label for one (Resident 115) out of a census of 132 when Resident 115's insulin glargine (long-acting insulin) order was changed.</p> <p>This failure increased the potential for unsafe administration of medication to residents.</p> <p>Findings:</p> <p>A review of Resident 115's Admission Record indicated he was admitted in January 2025 with diagnoses including Type 1 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>A review of an Order Summary Report (OSR) for Resident 115 dated 2/27/25 indicated an order for insulin glargine, inject 22 units subcutaneously (SQ, under the skin) daily in the morning.</p> <p>In a concurrent observation and interview on 3/4/25 at 9:50 a.m., during Medication Administration with Licensed Nurse 2 (LN 2), LN 2 withdrew 22 units of insulin glargine from the vial, LN 2 stated the order for Resident 115 had been changed to 22 units daily in the morning . LN 2 confirmed the dosage [27 units] written on the label in the insulin vial was incorrect.</p> <p>In a concurrent interview and record review on 3/7//25 at 11:45 a.m., with the Assistant Director of Nursing (ADON), Resident 115's OSR and insulin vial were reviewed, ADON confirmed the label on the insulin vial for Resident 115 stored in the cart was not updated per order. The ADON stated Resident 115's insulin glargine order had been changed from 27 units to 22 units on 2/27/25. ADON added the nurse who changed the order should have updated the label on Resident 115's insulin vial and should have attached an order sticker to alert the nurses that the order had been changed to prevent errors in the administration of the medication.</p> <p>A review of the facility's policy titled Administering Medications revised in 2019 indicated Medications are administered in a safe .manner .and as prescribed. The individual administering the medication checks the label to verify .the right dose .before giving the medication.</p>

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50351</p> <p>Based on observation, interview, and record review, the facility failed to ensure sanitary conditions were maintained in the kitchen for a census of 132 when:</p> <ol style="list-style-type: none"> 1. Unsanitary conditions were observed in the kitchen's dry storage area; and, 2. Expired items were found in the walk-in refrigerator. <p>These failures had the potential to cause food borne illnesses.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview on [DATE] at 8:19 a.m. with the Dietary Manager (DM), the dry storage area located in the kitchen was observed. A blue used cookie wrapper was observed on silver rack on shelf next to condiment sauce bottles. The DM stated, . I don't know how it got there and that should not have been there .</p> <p>During a continued concurrent observation and interview on [DATE] at 8:19 a.m. with the DM in the dry storage area located in the kitchen, a thickener container was observed open and exposed to air with a piece of yellow cereal and silver foil piece inside. DM stated that the container would be removed and confirmed the area was not in sanitary conditions.</p> <p>2. During a continued concurrent observation and interview on [DATE] at 8:22 a.m. with the DM in the walk in refrigeration area in the kitchen, a plastic container with diced apples with an open date of [DATE] and expiration date of [DATE] were observed. The DM confirmed the diced apples were expired.</p> <p>During a continued concurrent observation and interview on [DATE] at 8:26 a.m. with the DM in the walk in refrigeration area in the kitchen, a plastic container of expired boiled eggs was found with an expiration date of [DATE]. The DM confirmed the boiled eggs were expired.</p> <p>During a review of facility policy and procedure (P&P) titled Storage of Food and Supplies dated 2023, the P&P indicated, Routine cleaning . should be developed and followed . Dry bulk food .thickener . should be stored in seamless metal or plastic container with tight covers .All food products will be used per the times specified .</p> <p>During a review of the United States (US) FDA (Food and Drug Administration) 2022 Food Code, section , d+[DATE].11 titled Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, the document indicated, (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch (C) Non-food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris .</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36681</p> <p>Based on interview and record review, the facility failed to ensure services furnished by outside resources had written agreements when two of 32 sampled residents' (Resident 56 and Resident 96) dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) services were provided without existing agreements with dialysis clinic.</p> <p>This failure had the potential to result in the lack of responsibility and accountability in the dialysis services received by Resident 56 and Resident 96.</p> <p>Findings:</p> <p>1a. A review of the Admission Record indicated Resident 56 was initially admitted [DATE] with diagnoses including end stage renal disease (ESRD, irreversible kidney failure) and dependence on renal dialysis.</p> <p>A review of Resident 56's physician order dated 12/3/24 indicated, DIALYSIS: Hemodialysis [Dialysis company name and address] .Schedule: (Monday, Wednesday, Friday) .</p> <p>2a. A review of the Admission Record indicated Resident 96 was initially admitted [DATE] with diagnoses including end stage renal disease and dependence on renal dialysis.</p> <p>A review of Resident 96's physician order dated 8/22/23 indicated, DIALYSIS M-W-F [Monday-Wednesday-Friday] AT [Dialysis company name] .</p> <p>A review of Resident 96's undated care plan indicated, .needs hemodialysis r/t [related to] ESRD</p> <p>A review of the clinical records indicated Resident 56 and Resident 96 go to the same dialysis clinic.</p> <p>In an interview on 3/6/25 at 11:30 a.m., the Administrator (ADM) stated he was waiting for the contract from the Dialysis clinic.</p> <p>In a follow up interview on 3/7/25 at 11:53 a.m., the ADM confirmed the Dialysis contract was not available for review.</p> <p>A review of the facility's policy and procedure (P & P) revised September 2010 and titled, End Stage Renal Disease, Care of a Resident with indicated, Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care .Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: .how the care plan will be developed and implemented .how information will be exchanged between the facilities .</p> <p>(continued on next page)</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's P & P revised October 2008 and titled, Referral Agreements indicated, The facility shall maintain written agreements with agencies providing services to our residents .To facilitate referrals, the facility has entered into referral agreements with agencies that will provide services to residents. The scope of agencies and the agreements are consistent with the needs of the facility's resident population. When appropriate, the agreements will be reviewed and approved by other departments or disciplines (e.g., the medical director should review agreements to provide medical .as well as specialized services such as dialysis .</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48874</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective infection control program, for a census of 132, when:</p> <ol style="list-style-type: none"> 1. Personal Protective Equipment (PPE-clothing and equipment that is worn or used for for protection against hazardous substances and or environments) was not contained properly in the trash for Resident 15; 2. The Licensed Nurse 2 (LN 2) did not perform safe administration of insulin for Resident 115; and, 3. Resident 46's nebulizer (machine that turns liquid medication into an inhalable mist through a connected mouthpiece that allows the medication to enter the lungs directly) tubing was not changed as scheduled and the incentive spirometer (a handheld plastic device that helps exercise the lungs and breathe deeply) was not stored appropriately. <p>These failures increased the risk of spreading infections and or transmission of diseases to the vulnerable residents residing in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. Review of Resident 15's admission record indicated Resident 15 was admitted [DATE] with several diagnoses including a history of Urinary Tract Infections (UTI-an infection in the urinary tract/bladder). <p>Review of Resident 15's physician order dated 12/20/24, indicated that Resident 15 was on Enhanced Barrier Precautions (EBP, involves the use of gowns and gloves to reduce the transmission of multidrug-resistant organisms in nursing homes) during high contact time due to history of ESBL (a type of chemical produced by bacteria that makes an infection difficult to treat) UTI.</p> <p>During a concurrent observation and interview on 3/4/25 at 9:15 a.m. in Resident 15's room, observed a sign on the door that indicated Resident 15 was on EBP and a black large garbage bag tied to the closet handle and there was a blue plastic gown coming out onto the floor. Resident 15 stated that, I wondered what [the] bag is for and it does bother me that stuff is coming out [from] it.</p> <p>During a concurrent observation and interview on 3/4/25 at 9:20 a.m. with Licensed Nurse 3 (LN 3), LN 3 confirmed that there was a used EBP gown coming out of the black plastic bag. LN 3 stated normally they are stored in a special trash can, and we do not have enough barrels because a lot of people are on EBP.</p> <p>During an interview on 3/5/25 at 12:20 p.m. with Infection Preventionist (IP), the IP stated that the used gowns can be disposed of in a regular trash. The IP further stated that this is an infection control issue for residents if used gowns are not contained properly.</p> <p>(continued on next page)</p>

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Center for Disease Control (CDC) guidelines titled Framework for Applying Enhanced Barrier Precautions in Skilled Nursing Facilities, dated June 2021, the guidelines indicated, .a trash can (or laundry bin, if applicable) large enough to dispose of multiple gowns should be available in each room.</p> <p>45770</p> <p>2. A review of Resident 115's Admission Record indicated he was admitted in January 2025 with diagnoses including Type 1 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>A review of Resident 115's Order Summary Report (OSR) dated 2/27/25 indicated an order for insulin glargine (long-acting insulin) injection 22 units subcutaneously (SQ, under the skin) daily in the morning.</p> <p>In a concurrent observation and interview during Medication Administration on 3/4/25 at 9:55 a.m., LN 2 after checking Resident 115's blood sugar took an insulin glargine vial from the medication cart, then inserted an insulin syringe (has a needle) into the vial without disinfecting the top of the vial before withdrawing the insulin. LN 2 stated she forgot to wipe the top of the vial with an alcohol swab.</p> <p>During an interview on 3/7/25 at 8:35 a.m. with the Director of Nursing (DON) the DON stated she expected the nurses to follow proper infection control practices while administering medications to minimize the spread of infection among residents.</p> <p>A review of the facility's policy titled Insulin Administration revised in 2014 indicated To provide safe administration of insulin to residents with diabetes .check the order for the amount of insulin .wash hands . disinfect the top of the vial with an alcohol wipe.</p> <p>36681</p> <p>3. A review of the Admission Record indicated Resident 46 was admitted [DATE] with diagnoses including respiratory disorders and pneumonia (an infection/inflammation in the lungs).</p> <p>A review of Resident 46's physician orders indicated:</p> <p>-an order dated 2/6/25 indicated, Ipratropium-Albuterol Solution [helps to relax and open air passages to the lungs to make breathing easier] .inhale orally via nebulizer four times a day for SOB [shortness of breath] .; and,</p> <p>-an order dated 2/6/25 indicated, Incentive Spirometer Treatments .four times a day .</p> <p>A concurrent observation and interview was conducted on 3/4/25 starting at 3:52 p.m. inside Resident 46's room. The nebulizer tubing was dated 2/11/25 and the mouthpiece was on top of the bedside table. Resident 46 stated she was on antibiotic for pneumonia and she just had a breathing treatment 15 minutes ago. The incentive spirometer was located below the bed lodged in between the bed and the garbage bin, resident was unable to reach [incentive spirometer] from the bed.</p> <p>(continued on next page)</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a subsequent concurrent observation and interview on 3/4/25 at 4:10 p.m. with Licensed Nurse 4 (LN 4), LN 4 confirmed the nebulizer tubing was dated 2/11/25. The LN 4 stated pretty bad, the nebulizer tubing including the mouthpiece should be changed every 10 days and night shift change it. The LN 4 further confirmed the incentive spirometer had no date and it was located below the bed. The LN 4 stated the spirometer should be dated and LN 4 threw said spirometer in the garbage bin. When Resident 46 was informed the spirometer will be replaced she stated good since the side of the spirometer was broken.</p> <p>In an interview on 3/6/25 at 3:50 p.m., the DON stated the nebulizer mouthpiece should be in a black mesh bag when not in use and the tubing and mouthpiece should be changed every 2 weeks. The DON further stated there was no special policy for incentive spirometer, the incentive spirometer should be within reach and should not be in that location (below the bed and near the garbage bin).</p> <p>In a follow up interview on 3/7/25 at 11:02 a.m., the DON stated the facility change the nebulizer tubing due to infection control since residents are breathing in medication. The DON further stated the facility's practice is to change the incentive spirometer every 30 days.</p> <p>A review of the facility's policy & procedure (P & P) revised January 2024 and titled, Oxygen and Nebulizer Tubing indicated, .nebulizer tubing will be changed every 14 days and as needed .nebulizer tubing may be stored, coiled and attached to equipment between uses, or may be stored in storage bag between uses.</p> <p>A review of the facility's P & P revised October 2018 and titled, Infection Prevention and Control Program indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .Those with potential direct exposure to blood or body fluids are trained in and required to use appropriate precautions and personal protective equipment.</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>50351</p> <p>Based on observation, interview, and record review, the facility failed to ensure call lights were accessible and in good repair for three of 32 sampled residents (Resident 16, Resident 24, and Resident 1).</p> <p>This failure had the potential to jeopardize the safety of these residents and limited accessibility for them to call for help.</p> <p>Findings:</p> <p>1a. A review of Resident 16's Admission Record indicated Resident 16 was admitted to the facility in December 2024 with multiple diagnoses including heart failure and encephalopathy (a medical condition characterized by general dysfunction of the brain).</p> <p>A review of Resident 16's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 12/19/24, indicated Resident 16 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 9 out of 15 that indicated Resident 16 was moderately cognitively impaired. Resident 16's Functional Abilities indicated he required substantial maximum assistance for toileting, bathing, dressing, and hygiene and dependent on staff for bed mobility and transfers.</p> <p>During an observation on 3/4/25 at 8:31 a.m. in Resident 16's room, Resident 16 was observed with a call light hanging next to resident right side of bed, pinned in between bed rail without a red button to push to call for help.</p> <p>During a review of Resident 16's undated care plan titled, . at risks for falls ., the care plan indicated, . Resident's call light is [placed] within reach and encouraged resident to use it for assistance .</p> <p>During an interview on 3/4/25 at 10:32 a.m. in Resident 16's room, Certified Nursing Assistant 1 (CNA 1) confirmed call light button was not within easy reach for the resident. Resident 16's call light was observed with no red button to call for help and the CNA 1 stated this can prevent resident from calling for help and it was a safety risk.</p> <p>During a follow up observation on 3/5/25 at 8:53 a.m., in Resident 16's room, Resident 16 was observed sitting up in bed. The call light for Resident 16 was observed hanging out of reach with no red button to press and call for help.</p> <p>During a follow up observation on 3/6/25 at 7:15 a.m. in Resident 16's room, Resident 16 was observed lying in bed, call light was out of reach on right side of resident bed with no red button to press for help.</p> <p>1b. A review of Resident 24's Admission Record indicated Resident 24 was admitted to the facility in March 2022 with multiple diagnoses including muscle weakness.</p> <p>(continued on next page)</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 24's MDS Cognitive Patterns, dated 2/19/25 indicated a BIMS score of 0 out of 15 indicating severe cognitive impairment. Resident 24's Functional Abilities indicated, he required substantial maximum assistance for toileting, and dependent on staff for transferring, bathing, and hygiene.</p> <p>During an observation on 3/4/25 at 10:24 a.m. in Resident 24's room, Resident 24 was observed sitting up in bed and call light was hanging on the left side of bed, out of resident's reach, with no red button to press to call for help when needed.</p> <p>During a review of Resident 24's undated care plan titled, Potential alteration in comfort ., the care plan indicated, .Ensure call light is within reach and encourage [Resident 24] to use it for assistance as needed .</p> <p>During an interview on 3/4/25 at 10:32 a.m. in Resident 24's room, CNA 1 confirmed call light button not placed within reach for resident and no red button to push. CNA 1 stated this can prevent the resident from calling for help and was a safety risk.</p> <p>During a follow up observation on 3/5/25 at 8:53 a.m., in Resident 24's room, Resident 24 was observed sitting up in bed. Resident 24's call light was observed pinned between the mattress and side rail on left side with no button to press for assistance.</p> <p>During a concurrent observation and interview on 3/6/25 at 7:19 a.m. with CNA 2, CNA 2 confirmed Resident 16 and Resident 24's call light was out of reach and Resident 16 had no red button to press and call for help. CNA 2 was asked the process regarding reporting repairs of equipment and CNA 2 stated the process was to report repairs needed by entering the information in maintenance binder. The surveyor reviewed the maintenance binder with CNA 2 and confirmed there was no previous report of call light button missing the press buttons for Resident 16 and Resident 24.</p> <p>1c. A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility in March 2018 with multiple diagnoses including Muscle weakness and difficulty in walking.</p> <p>A review of Resident 1's MDS, Cognitive Patterns, dated 12/10/24, indicated Resident 1's BIMS score was 3 out of 15 that indicated Resident 1 was severely cognitively impaired. Resident 1's Functional Abilities, indicated Resident 1 required substantial maximum assistance for toileting, bathing, dressing, bed mobility, and personal hygiene.</p> <p>During a concurrent observation and interview on 3/5/25 at 8:55 a.m. in Resident 1's room, Resident 1 was observed with call light out of reach, Resident 1 asked surveyor for help, resident stated he could not reach the call light. CNA 3 stated, . I can't find the call light . CNA 3 confirmed the call light was under a urinal, spirometer, and black bag and it was out of resident's reach. CNA 3 stated Resident 1 cannot call for help without the call light and can result in harm if Resident 1 tried to get out of their bed.</p> <p>During a review of Resident 1's undated care plan titled, Resident found ., the care plan indicated, . keep call light within reach and answer promptly . maintain a hazard free environment .</p> <p>(continued on next page)</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 3/6/25 starting at 10:49 a.m., with Maintenance Director (MD) at the Hall 5 nursing station, MD stated the process for repairs was the facility had a maintenance log at each nursing station that was checked 3 times a day. The staff are supposed to write in the log, concern, room number, and which patient. Reviewed maintenance binder with MD, the MD confirmed there was a report dated 3/6/25 of Resident 24's call light and no previous report for Resident 16's call light. MD confirmed call light without button for Resident 16 via photograph taken by surveyor, MD stated, . it should have been reported, we have extras and could have fixed the call light right away .</p> <p>During an interview and record review on 3/7/25 at 9:44 a.m. with Central Supply (CS), the CS stated, for room rounds generally goes early in the morning. CS further stated Resident 16's call light was missed. CS stated aware of missed call light for Resident 16. Reviewed photograph of Resident 16's call light with CS. CS confirmed call light had no red button and Resident 16 would be unable to call for help. Reviewed room rounds paperwork with CS, confirmed call light marked not accessible for Resident 24.</p> <p>During an interview on 3/7/25 at 9:53 a.m. with Director of Staff Development (DSD), the DSD stated the expectations for CNAs were to answer call lights in timely fashion. Staff should report any repairs needed with call lights to maintenance immediately and they should be adding any equipment concerns in the maintenance binder.</p> <p>During an interview on 3/7/25 at 1:17 p.m. with Administrator (ADM), the ADM confirmed resident call light was out of reach for Resident 1, Resident 16, and Resident 24. ADM stated the resident could not call for help and it should have been reported to maintenance immediately.</p> <p>During a review of facility policy and procedure (P&P) titled, Answering the Call light dated September 2022, the P&P directed, . Ensure that the call light is accessible to the resident when in bed . Report all defective call lights to the nurse supervisor promptly . Answer the resident call system immediately .</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>50351</p> <p>Based on observation, interview, and record review, the facility failed to maintain a homelike environment for one of 32 sampled residents (Resident 99) when a patio door was in disrepair.</p> <p>This failure had the potential to minimize Resident 99's psychosocial well-being and made the resident feel uncomfortable.</p> <p>Findings:</p> <p>A review of Resident 99's Admission Record indicated Resident 99 was admitted to the facility in September 2024 with multiple diagnoses including muscle weakness, difficulty walking, and depression (a mental health condition characterized by persistent sadness, loss of interest, and low energy that can significantly interfere with daily life).</p> <p>A review of Resident 99's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 12/30/24, indicated Resident 99 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 12 out of 15 that indicated Resident 99 had moderate cognitive impairment.</p> <p>During a concurrent observation and interview on 3/4/25 at 8:29 a.m. in Resident 99's room, a shattered glass patio door with plastic covering was observed on the right side of bed. Resident 99 stated he had asked for weeks for it to be fixed and it made him feel uncomfortable. Resident 99 further stated staff had asked maintenance to take a look and no one had fixed it.</p> <p>During a review of the maintenance log at the nursing station close to Resident 99's room, the maintenance binder indicated, . Job Requested: Sliding glass window is cracked and broken in RM [Resident 99's] Date 1-4-25 .</p> <p>During a concurrent interview and record review on 3/6/25 at 10:52 a.m. with Maintenance Director (MD) at nursing station 5, the MD stated the process for reported repairs was the facility had a maintenance log at each nursing station. Reviewed maintenance binder with MD, MD confirmed log noted on 1/4/25 a report of shattered cracked glass in Resident 99's room. MD stated, .they put a plastic film on the door and didn't replace it . MD further confirmed this may be uncomfortable for Resident 99.</p> <p>During a follow up interview on 3/6/25 at 1:00 p.m. with MD, when requested to provide date plastic film was applied, MD stated film was placed in January. MD provided document of an invoice company dated 1/27/25 for window repair. Reviewed the invoice documentation and noted there was no signature of acceptance of proposed estimate.</p> <p>During a review of facility policy and procedure (P&P), titled Maintenance Service, dated December 2009, the P&P indicated, .maintaining the building in good repair and free from hazards, . that are comfortable .</p> <p>(continued on next page)</p>		

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 03/07/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 124 Walnut Street Woodland, CA 95695	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A request was made to the Administrator (ADM) on 3/7/25 at 1:23 p.m. to provide documentation of a signed order for Resident 99's window and there was none provided by the ADM.</p>