

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14122 Hubbard Street Sylmar, CA 91342	

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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>46445</p> <p>Based on interview and record review, the facility failed to follow the facility's policy and procedure on submitting the 5-day report to the State Survey Agency (SSA) within five working days of the incident for one of three sampled residents (Resident 1). The alleged family-resident financial abuse was reported to the SSA on 6/21/2024 and the 5-day report was submitted on 7/3/2024, eight days after the alleged incident.</p> <p>This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect other residents from abuse.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated the facility admitted the resident on 4/17/2024 with diagnoses including bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), and essential hypertension (abnormally high blood pressure that's not the result of a medical condition).</p> <p>A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 4/29/2024, indicated the resident's cognitive (involving conscious intellectual activity such as thinking, reasoning, or remembering) skills was intact.</p> <p>On 7/3/2024 at 3:35 p.m., during a telephone interview, the Administrator (ADM) stated he completed the investigation on the alleged family-resident financial abuse but did not submit the 5-day report to the SSA. The ADM stated that he reviewed the facility's policy and procedure on abuse investigation and stated he should have submitted the 5-day report to the SSA. On 7/3/2024 at 6:53 p.m., the ADM submitted the 5-day report on the surveyor.</p> <p>A review of the facility's policy and procedure titled, Abuse Investigation, dated 9/27/2023, indicated the ADM will provide a written report of the results of all abuse investigations and appropriate action taken to the State Survey and Certification Agency, the local police department, the Ombudsman, and others as may be required by state or local laws, within five working days of the reported incident.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 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>46445</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services for one of three sampled residents (Resident 3) by failing to ensure the resident ' s medications were not left unattended at bedside.</p> <p>This deficient practice had the potential to cause medication errors and can possibly lead to unsafe drop in Resident 1's blood pressure and heart rate, and may have other adverse side effects.</p> <p>Findings:</p> <p>A review of Resident 3 ' s Admission Record indicated the facility admitted the resident on 2/28/2023 with diagnoses that included type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), chronic obstructive pulmonary disease (a group of diseases that cause airflow blockage and breathing-related problems), and essential hypertension (abnormally high blood pressure that ' s not the result of a medical condition).</p> <p>A review of Resident 3 ' s History and Physical, dated 5/1/2024, indicated the resident had the capacity to understand and make decisions.</p> <p>A review of Resident 3 ' s Physician Orders, dated 5/3/2024, indicated an order for hydralazine hydrochloride (a medication used to control high blood pressure) 25 milligrams (mg - unit of measurement) one tablet by mouth every six hours for hypertension (a condition in which the force of the blood against the artery walls is too high).</p> <p>A review of Resident 3 ' s Minimum Data Set (MDS - a standardized assessment and care-screening tool), dated 6/7/2024, indicated the resident ' s cognitive (involving conscious intellectual activity such as thinking, reasoning, or remembering) skills was severely impaired.</p> <p>A review of Resident 3 ' s Physician Orders, dated 7/1/2024, indicated an order for nitrofurantoin macrocrystal (a medication to treat or prevent certain urinary tract infection [UTI - an infection in any part of the urinary system: kidneys, bladder, or urethra]) 50 mg by mouth four times a day for prophylaxis after ureteral stent placement (a procedure to place a thin, flexible plastic tube that temporarily help drain urine from in case of a blockage) for three days.</p> <p>A review of Resident 3 ' s Care Plan on hypertension, dated 3/3/2023, indicated the goal that the resident will remain free of complications related to hypertension. The Care Plan interventions indicated to give anti-hypertensive medications as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/3/2024 at 3:47 p.m., during a concurrent observation and interview, observed Resident 3 sitting on bed with a medicine cup on top of the overbed table. Registered Nurse 1 (RN 1) stated that there were six pills inside the medication cup. RN 1 stated that she gave the medications to Resident 3 and left them on the table for Resident 3 to take. RN 1 stated that she should not leave medications unattended. RN 1 stated that she should wait for Resident 3 to swallow the medications to ensure the medications were administered properly. RN 1 stated that the medications given to Resident 3 included hydralazine hydrochloride 25 mg and nitrofurantoin macrocrystal 50 mg. RN 1 stated that medications left unattended had the potential for other residents to take the medications or for Resident 3 to not take the medications and result to an increased blood pressure.</p> <p>On 7/3/2024 at 4:45 p.m., during a concurrent interview and record review, RN 2 stated that nurses should witness Resident 3 swallow the medications given and should not be left unattended on the table. RN 2 stated that medications should be given according to the physician orders. RN 1 stated that medications taken by mouth may be given one hour before or one hour after the scheduled time. The Medication Administration Record (MAR), dated 7/1/2024 to 7/31/2024, was reviewed with RN 2 and indicated that Resident 3 ' s hydralazine hydrochloride 25 mg was given at 1:26 p.m. and 3:55 p.m. on 7/3/2024. RN 2 stated Resident 3 ' s hydralazine hydrochloride 25 mg dose was given three hours and 31 minutes early. RN 2 stated that blood pressure medications given too early had the potential for Resident 3 ' s blood pressure to drop lower than the resident ' s usual blood pressure. RN 2 stated the facility failed to follow the medication administration policy and procedure to ensure medications were not left unattended and to ensure medications were given on time.</p> <p>A review of the facility ' s policy and procedure titled, Administering Medications, dated 9/27/2023, indicated that medications shall be administered in a safe and timely manner and as prescribed. The policy indicated that medications must be administered in accordance with the orders, including any required time frame. The policy indicated that for residents not in their rooms or otherwise unavailable to receive medications on the pass, the MAR may be flagged and after completing the medication pass, the nurse returns to the missed resident to administer the medication.</p>		

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<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>46445</p> <p>Based on observation, interview, and record review, the facility failed to maintain one of four means of egress (designated exit door) was free from obstructions.</p> <p>This deficient practice had the potential to prevent prompt evacuation of residents and staff due to obstruction of egress access in the event of an emergency.</p> <p>Findings:</p> <p>On 7/3/2024 at 3:47 p.m., during a concurrent observation and interview, observed an emergency exit door located beside resident room one was blocked by a medication cart and a dirty linen bin. Registered Nurse 1 (RN 1) stated that she did not know where the medication cart should be stored when not in use. RN 1 stated the dirty linen bin and the medication cart should not block the emergency exit doors.</p> <p>On 7/3/2024 at 3:56 p.m., during a concurrent observation and interview, the blocked emergency exit door beside resident room one was observed with the Minimum Data Set Nurse (MDSN). The MDSN stated the medication cart was empty and was not in use. The MDSN stated the medication cart and the dirty linen bin should not block the emergency exit doors. MDSN stated that the emergency exit doors should be clear with an open pathway to the outside of the facility in case of emergency. MDSN moved the items blocking the emergency exit doors.</p> <p>A review of the facility's policy and procedures titled, Environmental Services Safety, dated 9/27/2023, indicated to keep exits free from obstruction. The policy indicated that access to exits must remain clear of obstructions at all times.</p>