STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056382	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove Post-Acute Care Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record review, the facility failed to report the allegation of a visitor-to-resident sexual abuse (sexual behavior or a sexual act forced upon a woman, man, or child without their consent) to the State Survey Agency (SSA) for one of three sampled residents (Resident 1). On 7/3/2025, Resident 1 reported an allegation of abuse by the transportation company personnel to the Social Services Director (SSD). The Abuse Coordinator reported the allegation to the SSA on 7/30/2025, 27 days after the allegation of abuse was made. This deficient practice had the potential to result in unidentified abuse and failure to protect other residents from abuse.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 8/3/2024 with diagnoses including aftercare following joint replacement surgery, major depressive disorder (mental health condition that causes a persistently low or sad mood and a loss of interest in activities that once brought joy), and anxiety disorder (persistent and excessive worry that interferes with daily activities). During a review of Resident 1's History and Physical (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 6/13/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/24/2025, the MDS indicated Resident 1's cognition (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. During a review of the facility-provided Grievance/Complaint Resolution Report, dated 7/3/2025, the Grievance/Complaint Resolution Report indicated Resident 1 reported to the SSD about the allegation that happened on 7/2/2025 at 2 p.m. to 3 p.m., where the transportation company personnel inappropriately touched her face and called the resident beautiful. During an interview on 8/13/2025 at 9:41 a.m. with the Social Services Director (SSD), the SSD stated Resident 1 reported to her on 7/3/2025 that the transportation company personnel allegedly touched the resident's face and had unspecified inappropriate actions towards Resident 1. The SSD stated she notified the Director of Nursing (DON) and the Administrator (ADM) about Resident 1's allegations. During an interview on 8/13/2025 at 2:23 p.m. with the DON and a concurrent record review of the facility's policy and procedure (PnP) titled, Prevention, Reporting, and correction of Inappropriate Conduct Including Abuse, neglect, and Mistreatment of Residents and Investigations of Injuries of Unknown Origin, last reviewed on 1/2/2025, the PnP indicated .all personnel, vendors, and volunteers do not abuse or neglect any resident in the facility at any time for any reason. The PnP indicated The Administrator in coordination with General Counsel will.verify that any allegation of abuse is reported.to the California Department of Public Health Licensing and Certification.within two hours. The DON stated the ADM was the facility's Abuse Coordinator. The DON stated Resident 1's allegation of being inappropriately touched by the transportation company personnel should be reported within two hours to the SSA, Ombudsman, and law enforcement. The DON stated Resident 1 had the potential to experience distress and cause harm to other residents. The DON stated the facility failed to report the allegation of abuse within two hours.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on interview and record review, the facility failed to follow professional standards of practice for one of three sampled residents (Resident 1) by failing to ensure licensed nurses and social services monitored Resident 1's psychological (anything concerning the mind, mental processes, or emotions) and psychosocial (a person's mental, emotional, social, and spiritual health) health after Resident 1's reported allegation of being inappropriately touched by the transportation company personnel. This deficient practice placed Resident 1 at risk of not being provided necessary care and services.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 8/3/2024 with diagnoses including aftercare following joint replacement surgery, major depressive disorder (mental health condition that causes a persistently low or sad mood and a loss of interest in activities that once brought joy), and anxiety disorder (persistent and excessive worry that interferes with daily activities). During a review of Resident 1's History and Physical (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 6/13/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/24/2025, the MDS indicated Resident 1's cognition (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. During a review of the facility-provided Grievance/Complaint Resolution Report, dated 7/3/2025, the Grievance/Complaint Resolution Report indicated Resident 1 reported to the SSD about the allegation that happened on 7/2/2025 at 2 p.m. to 3 p.m., where the transportation company personnel inappropriately touched her face and called the resident beautiful. During an interview on 8/13/2025 at 9:41 a.m. and a concurrent record review of Resident 1's Progress Notes, reviewed with the Social Services Director (SSD), the SSD stated Resident 1 reported to her on 7/3/2025 that the transportation company personnel allegedly touched the resident's face and had unspecified inappropriate actions towards Resident 1. The SSD stated there was no documented evidence in Resident 1's Progress Notes, dated 7/2/2025 to 8/13/2025, that the resident was monitored after the reported allegation of being inappropriately touched. The SSD stated she did not document her follow-up visits to Resident 1. The SSD stated that if the monitoring was not documented, it did not happen. The SSD stated Resident 1 had the potential to experience depression. During an interview on 8/13/2025 at 2:23 p.m. with the Director of Nursing (DON), the DON stated the licensed nurses, and the social services did not document the monitoring of Resident 1's psychological and psychosocial well-being after the resident reported the allegation of being inappropriately touched. The DON stated Resident 1's depression and anxiety had the potential to worsen if the resident's psychological and psychosocial health were not monitored. The DON stated the facility failed to monitor the psychological and psychosocial effects of the reported allegation on Resident 1. During a review of the facility's policy and procedure (PnP) titled, Prevention, Reporting, and correction of Inappropriate Conduct Including Abuse, neglect, and Mistreatment of Residents and Investigations of Injuries of Unknown Origin, last reviewed on 1/2/2025, the PnP indicated Evaluation of facts as deemed appropriate based on a case -by-case analysis, which may include. the assessment, care planning, and monitoring of residents with needs and behaviors that might lead to conflict or neglect.