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	02/20/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to follow its policy and procedure regarding individualized care planning for one of three sampled residents (Resident 1), by: 1. Failing to ensure Resident 1 had a care plan to address refusal of care. 2. Failing to ensure Resident 1 had a care plan to address Resident 1's needs for assistance with going to and from activities. These deficient practices increased Resident 1's potential risks for deterioration in health conditions related to refusal of care and need for assistance with going to and from activities.Findings:During a review of Resident 1's admission Record, undated, the admission Record indicated the facility originally admitted Resident 1 on 3/26/2025 with diagnoses including encephalopathy (brain dysfunction causing memory loss, personality changes, agitation, or altered thought process), epilepsy (a chronic brain disorder causing seizures due to abnormal electrical brain activity), and essential hypertension (having higher than average blood pressure). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/5/2026, the MDS indicated Resident 1's cognitive functioning (the ability to think, learn, remember, use judgment, and make decisions) was severely impaired. The MDS also indicated Resident 1 was dependent (helper does all the effort) on staff for brushing teeth, toileting needs, showering or bathing, lower body dressing, and with personal hygiene needs such as combing hair or washing and drying hands. During an observation on 2/19/2026 at 3:48 p.m., Resident 1 was observed asleep in bed. During an observation on 2/20/2026 at 12:31 p.m., Resident 1 was again observed in bed watching television. During an interview with Certified Nursing Assistant 1 (CNA 1) on 2/20/2026 at 2:10 p.m., CNA 1 stated that Resident 1 was confused, but sometimes alert. CNA 1 stated yesterday (2/19/2026) in the morning, Resident 1 originally refused to have a shower, but was able to be convinced in having a shower around 9 a.m. - 9:30 a.m. CNA 1 stated Resident 1 would scream while refusing to have a shower in the past. CNA 1 also stated Resident 1 did not want to participate in activities yesterday (2/19/2026) and today, but CNA 1 did not inform the charge nurse of Resident 1's decision to not participate in activities.During concurrent interview and record review with Registered Nurse 1 (RN 1) on 2/20/2026 at 2:18 p.m., RN 1 stated in the past 72 hours, Resident 1's records show no documentation to indicate Resident 1 was offered or refused to participate in activities. RN 1 stated, The risks and benefits of joining activities is socialization with peers. It maintains reality orientation and being out and not just in the room for fresh air, because they do have outdoor activities. If the resident (Resident 1) was offered and refused, there should be documentation that it was offered, as it is the resident's right to decline activity if his preference is just to watch television. Then we would make sure the television is operational and the remote control is within reach of the resident. During concurrent record review, RN 1 stated Resident 1 did not have an existing care plan for refusal of care. Concurrent review with RN 1 of Resident 1's record titled Activities-Quarterly/Annual Participation Review dated 1/5/2026 at 3:33 p.m., the record indicated, The resident (Resident 1) has very little (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	participation in group activities due to physical limitations. RN 1 stated the new interventions & approaches that were to be added to Resident 1's care plan was Assistance is being provided to and from group activities. During further record review with RN 1, RN 1 stated Resident 1's activities care plan dated 3/31/2026 did not include the intervention for Resident 1 that Assistance is being provided to and from group activities. RN 1 stated, We failed to update the care plan and update the comprehensive person-centered care plan which includes measurable objectives and timeframes and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. During an interview with RN 1 on 2/20/2026 at 3:38 p.m., RN 1 stated that a care plan is a holistic plan of care developed with interdisciplinary team members (facility's team members from dietary, rehabilitation, social services, activities, etc.) to determine if there are any risk factors to address and would be updated accordingly. During a review of the facility provided policy and procedure (P & P) titled Care Plans, Comprehensive Person-Centered with revision date 3/2022, indicated, The comprehensive, person-centered care plan: a. Includes measurable objectives and timeframes; b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including (1) Services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment . c. Includes the resident's stated goals upon admission and desired outcomes; d. Builds on the resident's strengths; and e. Reflects currently recognized standards of practice for problem areas and conditions.