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	12/31/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect in full recognition of their individuality for two of two sampled residents (Resident 33 and 39) by: 1. Failing to ensure Certified Nursing Assistant 4 (CNA 4) was not standing over Resident 33 (who was investigated under dignity care area) while assisting him during a meal. 2. Failing to provide Resident 39 with a shower. These deficient practices had the potential to affect Resident 33 and 39's self-esteem, self-worth, and their sense of independence. Findings: a. During a review of Resident 33's Admission Record, the Admission Record indicated the facility admitted the resident on 3/3/2021 with diagnoses including Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 33's History and Physical (H&P), dated 3/12/2024, the H&P indicated the resident does not have the consent/decision-making capacity due to dementia (a progressive state of decline in mental abilities). During a review of Resident 33's Minimum Data Set (MDS-a resident assessment tool), dated 12/2/2024, the MDS indicated the resident usually understood others and rarely made self-understood. The MDS indicated the resident has severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated the resident is dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) including eating, shower/bathing self, toileting hygiene, and personal hygiene. (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: 056382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 33's ADL care plan (CP), dated 12/4/2024, the CP indicated the goals of maintaining the resident's current level of function in ADLs. The CP indicated the resident required one staff assistance to eat. During an observation on 12/29/2024 at 7:46 a.m., inside Resident 33's room, observed CNA 4 standing over Resident 33's right side while assisting Resident 33 with feeding for breakfast. During a concurrent observation and interview on 12/29/2024 at 7:51 a.m., inside Resident 33's room, observed CNA 4 continued to stand over the resident while assisting him with his meal. CNA 4 stated she was not trained that she should sit down while assisting residents with their meals. CNA 4 stated she has seen other staff sit down on a chair while feeding other residents. CNA 4 stated staff sit down out of respect for the residents. During an interview on 12/31/2024 at 8:35 a.m., with the Director of Staff Development (DSD), the DSD stated when CNAs are assisting residents with their meals, CNAs are expected to get a chair and sit next to the resident. The DSD stated this is for the dignity and safety of the residents in the room or in the dining room. During an interview on 12/31/2024 at 8:57 a.m., with the Director of Nursing (DON), the DON stated CNAs are expected to sit down while assisting residents with their meals. The DON stated CNAs are checking the resident's chewing and swallowing of food and provide queuing. The DON stated CNAs should always use the chair and should not be standing over the resident. The DON stated the residents may feel disrespected that is why the staff needs to sit at eye level to show dignity and respect. During a review of the facility's policy and procedure titled (P&P) Dignity, last reviewed on 10/30/2024, the P&P indicated that staff should treat all residents with kindness, respect, and dignity. The P&P indicated the resident rights include the resident's right to a dignified existence and be treated with respect, kindness, and dignity. 43878 b. During a review of Resident 39's Admission Record, the Admission Record indicated the facility admitted Resident 39 on 8/6/2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction (a serious medical condition that occurs when blood flow to the brain is blocked, leading to brain cell death) affecting right dominant side, and essential (primary) hypertension (HTN-high blood pressure). During a review of Resident 39's H&P dated 8/6/2024, the H&P indicated Resident 39 had the capacity to understand and make decisions. During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 3 usually understands and was understood by others. The MDS indicated Resident 39 was dependent (helper does all the effort) with toileting, showering, lower body dressing, and putting on and taking off footwear, and required substantial assistance (helper does more than half the effort) with personal hygiene. During a review of Resident 39's Care Plan, initiated on 8/7/2024 for Resident 39's ADL (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-care performance deficit, the Care Plan interventions included bathing and/or showering totally dependent on one (1) staff to provide shower two times a week and as necessary. During a review of Resident 39's ADL Bathing for December 2024, the ADL Bathing indicated on 12/27/2024 Resident had a shower at 10:39 a.m. During an interview on 12/28/2024 at 3:19 p.m. with Resident 39, Resident 39 stated she has not been showered for a week because Resident 39 requires a mechanical lift (a device used to assist with transfers of individuals who require support for mobility) to be showered and the facility could not find a sling (a fabric device used on lift machines to carry patients in a hammock-type position) Resident 39 stated she gets showered on Tuesdays and Fridays. During a concurrent interview and record review of Resident 39's ADL Bathing for December 2024 on 12/20/2024 at 10:48 a.m. with CNA 3, CNA 3 stated Resident 39 gets showers on Tuesdays and Fridays, requires a sling and a mechanical lift to shower. CNA 3 stated the facility has 2 mechanical lifts but they do not have enough slings. CNA 3 stated when showering, Resident 39 requires one sling to shower and one to use for transferring. CNA 3 stated Resident 39 refused to shower on 12/27/2024 but got a bed bath. CNA 3 stated Resident 39 refused shower because she did not have an extra sling to shower but only had one to use for transferring. CNA 3 reviewed the ADL bathing for December 2024 and stated she incorrectly put that Resident 39 was showered; CNA 3 stated she should have put it was a bed bath. During an interview on 12/30/2024 at 1:19 p.m. with CNA 2, CNA 2 stated it is hard to get residents up when there are not enough slings, that is why she only got one out of my three residents up that day. CNA 2 stated when doing showers, they require two slings, one to get the resident up and the other to shower the resident. CNA 2 stated if there are not enough slings and cannot shower the resident will offer the resident a bed bath. During an interview on 12/30/2024 at 3:49 p.m. with the DON, the DON stated they only have two mechanical lifts. The DON stated there are 29 residents that require the use of a mechanical lift and 40 slings, if there are not enough slings for the residents to get a shower, there is an issue. The DON stated it is a resident's right to have a shower if that is what they request; it is also part of their dignity. The DON stated there is a risk for infection and resident not feeling well if they are dirty. During a review of the facility's P&P titled, Resident Rights last reviewed 10/30/2024, the P&P indicated employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; e. self-determination

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 43878 Based on observation, interview, and record review, the facility failed to inform residents and their responsible party about their right to formulate an advance directive (a written statement of a person's wishes regarding medical treatment) upon admission for one of one sampled resident (Resident 14) investigated for advance directives. This deficient practice violated the resident's and/or the representative's right to be fully informed of the option to formulate their advance directives and had the potential to cause conflict with the resident's wishes regarding their health care. Findings: During a review of Resident 14's Admission Record, the Admission Record indicated the facility admitted Resident 14 on 6/11/2024 with diagnoses including pneumonia (an infection/inflammation in the lungs), muscle weakness (generalized) and cerebral palsy (CP- is a group of disorders that affect a person's ability to move, maintain balance, and control muscle tone). During a review of Resident 14's History and Physical (H&P) (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 6/13/2024, the H&P indicated Resident 14 had fluctuating capacity to understand and make decision due to developmental delay. During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool), dated 12/16/2024, the MDS indicated Resident 14 sometimes understands and was sometimes understood by others. The MDS indicated Resident 14 was dependent (helper does all the effort) on oral hygiene, toileting, showering, lower body dressing, putting on and taking off footwear, and personal hygiene. During a record review on 12/28/2024 at 7:07 p.m. of Resident 14's medical records, no advance directive was noted in the chart. During an interview on 12/29/2024 at 2:10 p.m. with the Medical Records Director (MRD), the MRD stated there was no advance directive or advance directive acknowledgment form for Resident 14. During an interview on 12/29/2024 at 3:48 p.m. with the Social Services Director (SSD), the SSD stated they do not have any documentation indicating she has offered Resident 14 and/or her representative an advance directive. During an interview on 12/30/2024 at 9 a.m. with the Director of Nursing (DON), the DON stated regarding Resident 14, the SSD should have documented that an advance directive was offered but was unable to get a signature to prove that they have offered an advance directive to Resident 14. The DON stated Resident 14 is under court-ordered conservatorship (a legal arrangement where a judge appoints a person to make decisions for another person who is unable to do so for themselves). The DON stated not offering an advance directive can be neglecting the resident's right to how their care is handled for end of life. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Advance Directives, last reviewed 10/30/2024, the P&P indicated it is the policy of the facility to comply with state and federal law regarding the development and implementation of a resident's advance directive. Upon admission or as soon as practicable thereafter, the resident and/or his/her legal representative or surrogate decision- maker will be provided with information regarding preferred intensity of care and/or advance directives.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 42311 Based on interview and record review, the facility failed to ensure the physician was notified that azithromycin (antibiotic-medication used to treat infection) was not available on 12/10/2024, 12/11/2024 and 12/12/2024 for one of three sampled residents (Resident 214). This deficient practice resulted in delay of obtaining appropriate instructions from the physician for proper management and Resident 214 received an incomplete dose of the antibiotic. Cross reference F760 Findings: During a record review of Resident 214's Admission Record, the Admission Record indicated the facility admitted Resident 214 on 9/27/2024, with diagnoses that included end stage renal disease (ESRD-irreversible kidney failure), personal history of other infectious (something is capable of spreading or is spreading rapidly to others) and parasitic (an infectious disease caused by organisms that live in or on another organism, known as the host) diseases and urinary tract infections (UTI- an infection in the bladder or urinary tract). During a record review of Resident 214'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 11/20/2024, the H&P indicated Resident 214 can make needs known but cannot make medical decisions. During a record review of Resident 214's Minimum Data Set (MDS - a resident assessment tool) dated 11/6/2024, the MDS indicated Resident 214's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 214 was dependent from staff for all activities of daily living (ADL-personal hygiene, bed mobility, dressing, and transfers). The MDS indicated Resident 214 was on antibiotic. During a record review of Resident 214's Physician Order dated 12/10/2024, timed at 2:41 p.m., the Physician Order indicated azithromycin tablet 250 milligrams (mg- metric unit of measurement, used for medication dosage and or amount), give 500 mg by mouth in the afternoon for pneumonia (PNA-lung infection) for one day (12/10/2024), then give 250 mg by mouth in the afternoon for PNA for four days (from 12/11/2024-12/14/2024). During a record review of Resident 214's Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 12/2024, the MAR indicated azithromycin 500 mg was not administered on 12/10/2024, and the 250 mg was not administered on 12/11/2024 and 12/12/2024. The MAR indicated azithromycin 250 mg was given on 12/13/2024, 12/14/2024, and 12/15/2024 at 4 p.m. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/29/2024 at 9:02 a.m., with the Infection Preventionist (IP), Resident 214's MAR dated 12/2024, and Progress Notes dated 12/10/2024, 12/11/2024, and 12/12/2024, were reviewed. The IP stated the MAR did not indicate that azithromycin 500 mg was administered to Resident 214 on 12/10/2024 or 12/11/2024. The IP stated the Progress Notes dated 12/11/2024 and 12/12/2024 indicated azithromycin 250 mg was not delivered. The IP stated azithromycin should be in the facility's emergency kit (ekit-a small supply of medication that can be used when pharmacy services are unavailable. Emergency kits are designed to help nursing facilities provide medication to their residents during emergencies). The IP stated if the medication was not documented it means medication was not given. The IP stated Resident 214 received an incomplete dose because she (Resident 214) only received three doses of azithromycin instead of five doses. The IP stated Resident 214's condition can worsen. The IP stated Licensed Vocational Nurse 1 (LVN 1) and LVN 2 should have called and notified the physician that azithromycin 500 mg and 250 mg were not available therefore were not given. The IP stated the importance of notifying the physician was to make the physician informed and to obtain new orders to extend the medication to complete the dose. During an interview on 12/29/2024, at 11:16 a.m., with the Director of Staff Development (DSD), the DSD stated the physician order was azithromycin for five days. The DSD stated the LVNs should have called the physician to notify that only three doses was given instead of five. The DSD stated the importance of calling the physician was to get an order to extend the days to complete the five doses. During an interview on 12/29/2024, at 11:24 a.m., with the Director of Nursing (DON), the DON stated Resident 214 did not receive the complete dose of azithromycin. The DON stated the LVNs should have called the physician and notify that azithromycin was just started on 12/13/2024 and will be completed on 12/17/2024. The DON stated Resident 214's infection could worsen if complete dose of medication was not received. During an interview on 12/30/2024 at 11:07 a.m., with the DSD, the DSD stated, LVN 1 and LVN 2 should have called the physician because it was a change in condition meaning there was a new medication order that was not available for three days. During a concurrent interview and record review on 12/30/2024, at 6:01 p.m., with the DON, the facility's policy and procedure (PP) titled, Change in a Resident's Condition or Status dated 2/2021 and last reviewed on 10/30/2024, was reviewed. The PP indicated, The nurse will notify the residents attending physician or physician on call when there has been a need to alter the resident's medical treatment significantly. The DON stated nurses should have called the physician when the medication was not available.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 38552 Based on observation, interview, and record review, the facility failed to provide a safe and homelike environment to one of one sampled resident (Resident 114) by failing to ensure the resident's wall clock was in working condition. The deficient practice had the potential to disrupt Resident 114's daily routine and other scheduled activities. Findings: During a review of Resident 114's Admission Record, the Admission Record indicated the facility admitted the resident on 12/17/2024 with diagnoses including chronic obstructive pulmonary disorder (COPD-a chronic lung disease causing difficulty in breathing), generalized muscle weakness, and hypertension (HTN-high blood pressure). During a review of Resident 114's History and Physical (H&P), dated 12/18/2024, the H&P indicated the resident can make needs known but can not make medical decisions. During a review of Resident 114's Minimum Data Set (MDS-a resident assessment tool), dated 12/23/2024, the MDS indicated the resident sometimes understood others and usually made self-understood. The MDS indicated the resident required substantial assistance (helper does more than half the effort) with mobility including rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing, and walking 50 feet (ft-a unit of measure) with two turns; and dependent on staff with char/bed-to-chair transfers. During a concurrent observation and interview on 12/28/2024 at 8:35 a.m., inside Resident 114's room, observed wall clock indicating a time of 6:30. Resident 114 stated the wall clock does not work and she looks at the clock for the time. During a concurrent observation and interview on 12/29/2024 at 8:06 a.m., inside Resident 114's room, with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated the wall clock was not working and shows the time as 6:30. CNA 4 stated the current time was 8:06 a.m. CNA 4 stated she will report to maintenance to have it fixed. CNA 4 stated the wall clock should show the actual time, so the resident knows what time it is. During an interview on 12/31/2024 at 8:41 a.m., with the Director of Staff Development (DSD), the DSD stated the CNA should call the maintenance to have the wall clock fixed to the right time. The DSD stated it should be changed for reality orientation of the resident, so they (resident) know the time. The DSD stated it can potentially confuse the resident with the time. During an interview on 12/31/2024 at 9:01 a.m., with the Director of Nursing (DON), the DON stated the maintenance should have been notified and the wall clock should have been checked and changed. The DON stated residents need to know the time at certain day and it is also the residents' rights. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, last reviewed 10/30/2024, the P&P indicated it is the facility's policy that residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. The P&P indicated staff provides person-centered care that emphasizes the residents' comfort, independence, personal needs, and preferences.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS-a resident assessment tool) for one of one sampled resident (Resident 61) reviewed under hospitalization care area, by failing to ensure the resident's MDS discharge assessment was completed accurately when the resident's MDS was coded discharged to hospital instead of discharged to home. This deficient practice had the potential to negatively affect the resident's plan of care and delivery of necessary care and services upon discharge. Findings: During a review of Resident 61's Admission Record, the Admission Record indicated the facility admitted the resident on 9/17/2024 with diagnoses including pneumonia (an infection/inflammation in the lungs), generalized muscle weakness, and unsteadiness of feet. During a review of Resident 61's History and Physical (H&P), dated 9/18/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 61's Minimum Data Set (MDS-a resident assessment tool), dated 10/8/2024, the MDS indicated the resident was discharged on [DATE] to short-term general hospital. During a review of Resident 61's physician order, dated 10/4/2024, the physician order indicated the resident may discharge home on 10/8/2024 with all of resident's belongings and medications to home and home health services to follow. During a review of Resident 61's Discharge Summary, dated 10/8/2024, the Discharge Summary indicated the resident's disposition was home with home health. During a review of Resident 61's Nurses' Notes, dated 10/8/2024, the Nurses' Notes indicated the resident was discharged home and was picked up by his son. During a concurrent interview and record review of Resident 61's MDS dated [DATE], and physician order dated 10/4/2024, on 12/30/2024 at 2:33 p.m., with the MDS Coordinator (MDSC), the MDSC stated the resident was discharged on [DATE] to home. The MDSC stated she coded the discharge assessment incorrectly and should have coded 1 for home or community. The MDS stated the MDS Assessment should be coded accurately to reflect the actual location where the resident was discharged and ensure home health services were arranged. During an interview on 12/31/2024 at 9:03 a.m., with the Director of Nursing (DON), the DON stated the MDS should be coded accurately. The DON stated coding the resident's disposition depends on where the resident is going, and they would need to know where resident is. The DON stated this could potentially place the resident at risk for inaccurate assessment and may cause miscommunication to the other disciplines. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Record Content: Minimum Data Set (MDS)-Resident Assessment Instrument (RAI), last reviewed 10/30/2024, the P&P indicated that each responsible interdisciplinary team staff who completes portion(s) of the MDS shall sign and certify the accuracy of the portion(s) of the MDS which he/she completed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review, the facility failed to provide necessary services to maintain good grooming and personal hygiene for two of two sampled residents (Resident 33 and 39) by: 1. Failing to trim Resident 33's fingernails. 2. Failing to provide Resident 39 with a shower. These deficient practices had the potential to negatively affect the residents' psychosocial wellbeing. Findings: a. During a review of Resident 33's Admission Record, the Admission Record indicated the facility admitted the resident on 3/3/2021 with diagnoses including Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 33's History and Physical (H&P), dated 3/12/2024, the H&P indicated the resident does not have the consent/decision-making capacity due to dementia (a progressive state of decline in mental abilities). During a review of Resident 33's Minimum Data Set (MDS-a resident assessment tool), dated 12/2/2024, the MDS indicated the resident usually understood others and rarely made self-understood. The MDS indicated the resident has severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated the resident is dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) including eating, shower/bathing self, toileting hygiene, and personal hygiene. During a review of Resident 33's ADL care plan (CP), dated 12/4/2024, the CP indicated the goals of maintaining current level of function in ADLs. The CP indicated the resident required staff assistance with bathing/showering two times a week and as necessary; to check nail length and trim and clean on bath day and as necessary; and to report any changes to the nurse. During a review of Resident 33's Documentation Survey Report (DCS-a document that details a resident's ability to perform ADL) for the month of 12/2024, the DCS indicated Certified Nursing Assistant 5 (CNA 5) provided Resident 33 bath/towel bath on 12/27/2024, 12/28/2024, and 12/29/2024. During a concurrent observation and interview on 12/28/2024 at 12:19 p.m., inside Resident 33's room, with Family Member 1 (FM 1), observed Resident 33's left hand nails were long and chipped. FM 1 stated Resident 33's nails were long and chipped. (continued on next page)

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 12/31/2024
NAME OF PROVIDER OR SUPPLIER: The Grove Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 14122 Hubbard Street Sylmar, CA 91342	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/29/2024 at 8 a.m., inside Resident 33's room, with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated Resident 33's left hand nails were long and the second digit next to the pinky finger was chipped. CNA 4 stated she does not know who would trim the resident's fingernails. CNA 4 stated it should have been done last Friday because that was his (Resident 33) scheduled shower day. CNA 4 stated CNAs are trained to trim residents' fingernails but she's not sure who trims Resident 33's fingernails. CNA 4 stated trimming of residents' fingernails should be done because it is part of the residents' hygiene. During a concurrent interview and record review of Resident 33's care plans on 12/30/2024 at 12:40 p.m., with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated he has not received any report from the CNAs regarding Resident 33's noncompliance with shower and/or nail trimming. During an interview on 12/30/2024 at 3:50 p.m., with CNA 5, CNA 5 stated he only provide Resident 33's shower every Tuesday and Friday. CNA stated he never trimmed the resident's nails because resident tends to scratch while he (CNA 5) provides him (Resident 33) care. CNA 5 stated he has not reported to the charge nurse and has not documented on the CNA communication binder. CNA 5 stated he just did not do it. CNA 5 stated the resident's tendency to scratch staff is not new, but he has not told his charge nurse. During an interview on 12/30/2024 at 5:40 p.m., with the Director of Staff Development (DSD), the DSD stated when the resident refuse to shower or nail trimming, CNAs are expected to notify their charge nurse and document on the communication report binder. The DSD stated for Resident 33, CNAs are expected to trim the resident's fingernails. The DSD stated this should have been done during the resident's shower day, but any other shift the CNAs can also do it. The DSD stated when a resident's fingernails are not trimmed, the resident may scratch himself and increase risk for infection due to the scratches or dirt build up underneath the nails. The DSD stated Resident 33's fingernails should have been trimmed. During an interview on 12/31/2024 at 9:04 a.m., with the Director of Nursing (DON), the DON stated the resident's (Resident 33) nails should have been trimmed. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, last reviewed 10/30/2024, the P&P indicated resident will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. The P&P indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 43878 b. During a review of Resident 39's Admission Record, the Admission Record indicated the facility admitted Resident 39 on 8/6/2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction (a serious medical condition that occurs when blood flow to the brain is blocked, leading to brain cell death) affecting right dominant side, and essential (primary) hypertension (HTN-high blood pressure). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 39's H&P dated 8/6/2024, the H&P indicated Resident 39 had the capacity to understand and make decisions. During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 39 usually understands and was understood by others. The MDS indicated Resident 39 was dependent (helper does all the effort) with toileting, showering, lower body dressing, and putting on and taking off footwear, and required substantial assistance (helper does more than half the effort) with personal hygiene. During a review of Resident 39's Care Plan, initiated on 8/7/2024 for Resident 39's ADL self-care performance deficit, the Care Plan interventions included bathing and/or showering totally dependent on one (1) staff to provide shower two times a week and as necessary. During a review of Resident 39's ADL Bathing for December 2024, the ADL Bathing indicated on 12/27/2024 Resident had a shower at 10:39 a.m. During an interview on 12/28/2024 at 3:19 p.m. with Resident 39, Resident 39 stated she has not been showered for a week because Resident 39 requires a mechanical lift (a device used to assist with transfers of individuals who require support for mobility) to be showered and the facility could not find a sling (a fabric device used on lift machines to carry patients in a hammock-type position) Resident 39 stated she gets showered on Tuesdays and Fridays. During a concurrent interview and record review of Resident 39's ADL Bathing for December 2024 on 12/20/2024 at 10:48 a.m. with CNA 3, CNA 3 stated Resident 39 gets showers on Tuesdays and Fridays, requires a sling and a mechanical lift to shower. CNA 3 stated the facility has 2 mechanical lifts but they do not have enough slings. CNA 3 stated when showering, Resident 39 requires one sling to shower and one to use for transferring. CNA 3 stated Resident 39 refused to shower on 12/27/2024 but got a bed bath. CNA 3 stated Resident 39 refused shower because she did not have an extra sling to shower but only had one to use for transferring. CNA 3 reviewed the ADL bathing for December 2024 and stated she incorrectly put that Resident 39 was showered; CNA 3 stated she should have put it was a bed bath. During an interview on 12/30/2024 at 1:19 p.m. with CNA 2, CNA 2 stated it is hard to get residents up when there are not enough slings, that is why I she only got one out of my three residents up that day. CNA 2 stated when doing showers, they require two slings, one to get the resident up and the other to shower the resident. CNA 2 stated if there are not enough slings and cannot shower the resident will offer the resident a bed bath. During an interview on 12/30/2024 at 3:49 p.m. with the DON, the DON stated they only have two mechanical lifts. The DON stated there are 29 residents that require the use of a mechanical lift and 40 slings, if there are not enough slings for the residents to get a shower, there is an issue. The DON stated it is a resident's right to have a shower if that is what they request. The DON stated there is a risk for infection and resident not feeling well if they are dirty. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Activities of Daily Living (ADL), Supporting, last reviewed 10/30/2024, the P&P indicated resident will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services for two of four residents (Resident 14 and Resident 214) at risk for developing pressure ulcer (a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) by failing to follow the manufacturer guideline for low air loss mattress (LAL- a mattress that uses air to help prevent and treat pressure wounds and maintain a comfortable temperature and moisture level for the patient). This deficient practice had the potential for Resident 14 and Resident 214 to develop a pressure ulcer or for the wounds to worsen. Findings: a. During a review of Resident 14's Admission Record, the Admission Record indicated the facility admitted Resident 14 on 6/11/2024 with diagnoses including pneumonia (an infection/inflammation in the lungs), muscle weakness (generalized) and cerebral palsy (CP- is a group of disorders that affect a person's ability to move, maintain balance, and control muscle tone). During a review of Resident 14's History and Physical (H&P) (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 6/13/2024 indicated Resident 14 had fluctuating capacity to understand and make decision due to developmental delay. During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool), dated 12/16/2024, the MDS indicated Resident 14 sometimes understands and was sometimes understood by others. The MDS indicated Resident 14 was dependent (helper does all the effort) on oral hygiene, toileting, showering, lower body dressing, putting on and taking off footwear, and personal hygiene. During a review of Resident 14's Physician Order, dated 7/25/2024, the Physician Order indicated the resident may have LAL mattress every day shift. During a review of Resident 14's weight dated 12/6/2024, the weight indicated Resident 14 weighed 86 pounds [lbs-unit of measurement]). During an observation on 12/28/2024 at 9:43 a.m., observed Resident 14 on bed with a LAL mattress set at 4 (weight 175 lbs). During a concurrent observation and interview on 12/28/2024 at 9:45 a.m. with Registered Nurse 1 (RN 1), RN 1 stated LAL mattresses need to be set according to residents' weight. RN 1 stated Resident 14's LAL mattress was set at 4 and it should have been set at 1. RN 1 stated if LAL mattress is set incorrectly, it can cause skin tissue damage to the resident. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/30/2024 at 3:57 p.m. with the Director of Nursing (DON), the DON stated LAL mattress need to be set according to weight. The DON stated, if the LAL is too firm, it defeats the purpose of the LAL. The DON stated the setting needs to be accurate to be effective; otherwise, it can lead to decline of wounds and improper healing. During a review of the undated Resident 14's LAL #1 User Manual provided by the facility, the User Manual indicated the comfort control LED displays the patients comfort pressure level from 0 to 9 and provides a guide to the caregiver to set approximate comfort pressure level depending on the patients' weight. During a review of the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, last reviewed 10/30/2024, the P&P indicated select appropriate support surface based on the resident's risk factors, in accordance with current clinical practice. Review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application, and ability to secure the device. Monitor regular for comfort and signs of pressure-related injury. b. During a review of Resident 214 Admission Record, the Admission Record indicated the facility admitted Resident 214 on 9/27/2024 and readmitted the resident on 11/25/2024 with diagnoses including pressure-induced deep tissue damage (when prolonged pressure on a part of the body, like from sitting or lying down for too long, damages the tissues underneath the skin, even if the skin surface appears intact, causing a deep bruise-like area due to poor blood flow to that area) of sacral region (the triangular bone at the base of the spine that connects the spine to the pelvis), muscle weakness (generalized), and unsteadiness of feet. During a review of Resident 214's MDS dated [DATE], the MDS indicated Resident 214 usually understands others and and was usually understood. The MDS indicated Resident 14 was dependent (helper does all the effort) on oral hygiene, toileting, showering, lower body dressing, putting on and taking off footwear, and personal hygiene. During a review of Resident 214's Physician Order dated 11/18/2024, the Physician Order indicated the resident may have LAL mattress every day shift. During a review of Resident 214's Care Plan created on 10/23/2024 for Resident 214's potential for skin integrity decline, the Care Plan interventions included the resident may have LAL mattress for wound management, setting between 90-110 lbs. During a review of Resident 214's weight dated 12/6/2024, the weight indicated Resident 214 weighed 97 lbs. During an observation on 12/28/2024 at 9:02 a.m., observed Resident 214 on bed with LAL mattress set at 3 (weight 164 lbs). During a concurrent interview and observation on 12/28/2024 at 9:52 a.m. with Registered Nurse 1 (RN 1), RN1 stated Resident 214's LAL mattress was set at 3 but should have been set at 1 or 2. RN 1 stated a resident can be a risk for skin breakdown if the LAL mattress pressure is too firm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/30/2024 at 3:57 p.m. with the DON,the DON stated LAL mattress need to be set according to weight. The DON stated, if the LAL is too firm, it defeats the purpose of the LAL. The DON stated the setting needs to be accurate to be effective; otherwise, it can lead to decline of wounds and improper healing. During a review of the facility's P&P titled, Prevention of Pressure Injuries, last reviewed 10/30/2024, the P&P indicated select appropriate support surface based on the resident's risk factors, in accordance with current clinical practice. Review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application, and ability to secure the device. Monitor regular for comfort and signs of pressure-related injury.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review the facility failed to provide an environment free from accidents and hazards for two of two sampled residents (Resident 44 and 23) reviewed under the Accidents care area by: 1. Failing to ensure Resident 44, who was identified as a smoker requiring supervision, had staff supervising the resident while the resident was smoking. This deficient practice had the potential to result in harm to the resident leading to burns and injuries. 2. Failing to properly manage and secure all cords and cables by Resident 23's left side bed rail (a bar attached to the side of a hospital bed to help prevent patients from falling out). This deficient practice had the potential to result in harm to the resident leading to risk of electric shock or fire. Findings: a. During a review of Resident 44's Admission Record, the Admission Record indicated the facility admitted the resident on 7/23/2024 with diagnoses including acute on chronic diastolic (congestive) heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and epilepsy (a condition that affects the brain and causes frequent seizures [sudden, uncontrolled body movements and changes in behavior that occurs because of abnormal electrical activity in the brain]). During a review of Resident 44's History and Physical (H&P), dated 8/1/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 44's Minimum Data Set (MDS-a resident assessment tool), dated 11/1/2024, the MDS indicated the resident understood others and made self understood. The MDS indicated the resident utilized mobility devices including wheelchair and cane/crutch. The MDS indicated the resident required supervision with eating and oral hygiene; and required partial assistance (helper does less than half the effort) from staff with toileting hygiene, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated the resident required partial assistance from staff with mobility. During a review of Resident 44's Smoking-Safety Screen, dated 11/19/2024, the Smoking-Safety Screen indicated the resident needs a smoking apron and was safe to smoke with supervision. During a review of Resident 44's care plan for smoking, dated 11/19/2024, the care plan indicated the resident with goals of not having any injury related to smoking with interventions including supervision of resident during smoking activities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/29/2024 at 10:10 a.m., in the smoking area/patio, observed Resident 44 smoking in the smoking area with no staff noted. Observed Resident 44 with a lit cigarette and no apron noted. Resident 44 stated he has smoking breaks at 10 a.m., 2 p.m., and 4 p.m. Resident 44 stated staff will light his cigarette and then leave; once he is done, he will just wheel himself back inside the facility. Resident 44 stated staff do not stay with him or other residents when he is smoking in the smoking patio. During an observation on 12/29/2024 at 10:19 a.m., observed the Activity Director (AD) serving drinks in the dining room. During a concurrent interview and record review of Resident 44's Smoking-Safety Screen, dated 11/19/2024, on 12/30/2024 at 1:02 p.m., with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated the activities department provides the apron and cigarettes to the residents who have smoking privileges. LVN 6 stated Resident 44 needs to have an apron and should have someone with him while he is smoking. During an interview on 12/30/2024 at 4:53 p.m., the AD stated she is scheduled to work from Monday to Friday, from 8:30 a.m. to 5 p.m. The AD stated it was just her working that day and the facility was in the process of hiring one more activity staff scheduled on the weekends. The AD stated it is in her role to make sure that residents who smoked are supervised and have an apron on for safety. The AD stated she is supposed to be at the patio area when the residents smoke, but she was in the activity room that day looking out on the patio. The AD stated Resident 44 requires supervision while smoking. The AD stated residents are supervised to ensure they are safe because the cigarette ashes could potentially burn into his clothing or start a fire. During an interview on 12/30/2024 at 5:30 p.m., with the Director of Staff Development (DSD), the DSD stated Resident 44 required supervision according to the resident's care plan and should be supervised for the resident's safety. During an interview on 12/31/2024 at 9:11 a.m., with the Director of Nursing (DON), the DON stated the staff supervising the residents while smoking ensures the residents are safe, making sure the residents are in a designated smoking area and are wearing their apron, and assist the residents if they need help. During a review of the facility's policy and procedure (P&P) titled, Smoking Policy-Residents, last reviewed 10/30/2024, the P&P indicated the facility has established and maintains safe resident smoking practices. The P&P indicated that any resident with smoking privileges requiring monitoring shall have direct supervision of a staff member, family member, visitor, or volunteer worker at all times while smoking. 43878 b. During a review of Resident 23's Admission Record, the Admission Record indicated the facility admitted Resident 23 on 1/12/2019 and readmitted the resident on 12/19/2024 with diagnoses that included muscle weakness (generalized), end stage renal disease (ESRD- irreversible kidney failure) and unsteadiness on feet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 23's MDS, dated [DATE], the MDS indicated Resident 23 had the ability to understand and be understood by others. The MDS indicated Resident 23 required substantial assistance (helper does more than half the effort) with lower body dressing and required partial assistance (helper does less than half the effort) with toileting, showering, upper body dressing, putting on and taking off footwear, and personal hygiene. During a concurrent observation and interview on 12/28/2024 at 8:41 a.m., with Resident 23, observed an extension cord with power adapters wrapped around Resident 23's left side bed rail. Resident 23 stated she had asked facility since Monday to remove the extension cord and place it somewhere else as all the wires get in her way. During a concurrent observation and interview on 12/28/2024 at 8:46 a.m. with the DON, the DON stated Resident 23 has cords on the bed rail which should not be as it is a risk for a fire. During an interview on 12/30/2024 at 4 p.m. with the DON, the DON stated regarding Resident 23 and the extension cord on her bed side rail, there can be a risk for fire hazard and/or trip hazard. During a review of the facility's P&P titled, Hazardous Areas, Devices and Equipment, last reviewed 10/30/2024, the P&P indicated all hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. A hazard is defined as anything in the environment that has the potential to cause injury or illness.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 43878 Based on interview and record review the facility failed to ensure the Infection Preventionist (IP) was competent in implementing the facilities infection control program by failing to: 1. Follow the facility's policy titled, Scabies [a parasitic infestation caused by tiny mites (a group of insect-like organisms, some of which bite or cause irritation to humans) that burrow into the skin and lay eggs, causing intense itching and a rash] Identification, Treatment and Environmental Cleaning, when Resident 52 was removed from isolation prior to the completion of treatment and or it was determined the resident was free from scabies. 2. Follow facility's policy titled, Unusual Occurrence Reporting , when Resident 52 was positive for scabies and it was not reported to the state agency. These failures had the potential to spread scabies infestation to other residents and staff. Findings: During a review of Resident 52's Admission Record, the Admission Record indicated the facility admitted Resident 52 on 6/13/2024 with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), muscle weakness (generalized), and essential (primary) hypertension (HTN-high blood pressure). During a review of Resident 52's History of Present Illness (H&P), dated 6/13/2024, the H&P indicated Resident 52 can make needs known but cannot make medical decision due to dementia. During a review of Resident 52's Minimum Data Set (MDS - a resident assessment tool), dated 12/18/2024, the MDS indicated Resident 52 had the ability to usually understand and the ability to be understood. The MDS indicated Resident 52 was dependent (helper does all the effort) with toileting, showering, lower body dressing, and putting on and taking off footwear, and required substantial assistance (helper does more than half the effort) with personal hygiene. During a review of Resident 52's Physician Order, dated 12/3/2024, the Physician Order indicated may have skin scrape (allows visualize of the superficial layer of the skin- the abnormal cells, any infections or even parasites [an organism that lives on or in a host organism and gets its food from or at the expense of its host] or mites to rule out scabies. During a review of Resident 52's Physician Order, dated 12/4/2024, the Physician Order indicated: - Clobestasol propionate external cream 0.05% (medication used to treat a variety of skin conditions) apply to general body topically every day and evening shift for prurigo nodularis (PN- a chronic skin condition that causes hard, itchy bumps called nodules to appear on the skin) for four weeks. (continued on next page)

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 12/31/2024
NAME OF PROVIDER OR SUPPLIER: The Grove Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 14122 Hubbard Street Sylmar, CA 91342	

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Generalized body dermatitis (skin condition that causes skin irritation and swelling) unspecified apply halobetasol 0.05% cream (medication used to treat a variety of skin conditions) to general body twice a day every day and evening shift for four weeks until finished. - Ivermectin (medication used to treat infections caused by parasites) oral tablet 3 milligrams (mg- a unit of measurement for mass) give 21 mg by mouth one time a day every Thursday for dermatitis unspecified for four weeks until finished. - Dermatitis unspecified apply permethrin 5% cream (medication used to treat conditions caused by tiny insects, such as scabies) 1 tube from neck to toes. Leave on for 12 hours then rinse once a week for four weeks at bedtime every Wednesday for four weeks. - Prednisone (medication used to treat inflammation) oral tablet 10 mg give 3 tablets by mouth one time a day for dermatitis unspecified for 3 days then give 2 tablets by mouth one time a day for dermatitis unspecified for 3 days then give 1 tablet by mouth one time a day for dermatitis unspecified for 3 days. During a review of Resident 52's Diagnostic Laboratories and Radiology Results, dated 12/7/2024, at 2:07 p. m., the Diagnostic Laboratories and Radiology Results indicated scabies mites seen. During a review of Resident 52's Change of Condition (COC) SBAR-Acute COC, dated 12/7/2024, at 10:30 p. m., the COC SBAR-Acute COC indicated received result from scabies scrape test. The results indicated, scabies mites seen, informed doctor with order to continue 21 mg ivermectin orally every Thursday for four weeks, place resident on contact (don [put on] gloves and a gown when entering a patient or resident room and when in contact with the individual, surfaces, or objects within their environment) isolations precautions indefinitely. During a review of Resident 52's Physician Order, dated 12/7/2024, the Physician Order indicated an order for ivermectin oral tablet 3 mg give 21 mg by mouth one time a day every Thursday for scabies infection for four weeks until finished. During a review of Resident 52's Care Plan for infection and isolation, revised on 12/7/2024, the Care Plan indicated skin scraping result scabies mites seen with intervention to isolate (contact) precautions for scabies infection. During a review of Resident 52's Physician Order, dated 12/8/2024, the Physician Order indicated contact isolation precautions for scabies infection. During a review of Resident 52's Physician Order, dated 12/17/2024, the Physician Order indicated contact isolation precautions for scabies infection was discontinued. During an observation on 12/28/2024, at 7:34 a.m., Resident 52's room did not have transmission-based precautions and a personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) cart. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During an interview on 12/29/2024, at 8:06 a.m., with the Infection Preventionist (IP), the IP stated Resident 52 is no longer on isolation, the isolation was discontinued on 12/17/2024, and Resident 52 was on contact isolation for 10 days. The IP stated Resident 52 was on isolation for scabies. The IP stated she was not sure how long scabies isolation should be for. The IP stated the doctor discontinued the isolation and Resident 52 is still scratching but is on topical medication. The IP stated treatment is effective when the rash has improved. During a concurrent interview and record review with the IP, on 12/29/2024, at 8:26 a.m., the facility's policy and procedure (P&P) titled, Scabies Identification, Treatment and Environmental Cleaning, reviewed on 10/30/2024, was reviewed and the P&P indicated to maintain contact precaution until treatment is done or the resident is determined to be scabies free. The IP stated Resident 52 is still on treatment, and no other scraping has been done to determine Resident 52 is scabies free. The IP stated according to policy, Resident 52 should still be on contact isolation, and staff, including housekeeping, and visitors must wear gown and gloves. The IP stated not following contact isolation can be a risk for spread of infection. During an interview on 12/30/2024, at 4:03 p.m., with the Director of Nursing (DON), the DON stated it is important for the IP to be competent in policies and infection control, due to the increased risk for improper isolation, and risk for transmission to residents and staff. During a review of the facility's P&P titled, Scabies Identification, Treatment and Environmental Cleaning, last reviewed 10/30/2024, the P&P indicated the purpose of this procedure is to treat residents infected with and sensitized to Sarcoptes scabiei and to prevent the spread of scabies to other residents and staff. The P&P further indicated to maintain contact precautions until treatment is complete and or resident is determined to be scabies free. During a review of the facility's P&P titled, Isolation-Categories of Transmission-Based Precautions, last reviewed 10/30/2024, the P&P indicated transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has laboratory confirmed infection; and is at risk of transmitting the infection to other residents. The P&P further indicated contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. 2. During an interview on 12/30/2024, at 8:39 a.m., with the IP, the IP stated she did not report Resident 52's scabies to any state agency because it was only one case. The IP stated scabies is not a common occurrence in the facility, the positive scabies would fall under the facility's unusual occurrence and should have been reported to local state agency. The IP stated she was not sure what the process for reporting an unusual occurrence is, the IP stated there may be an incident report that must be done. During an interview on 12/30/2024, at 4:03 p.m., with the DON stated it is important for the IP to be competent in policies and infection control because there can be a risk for improper isolation and increase risk for transmission to residents and staff. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Unusual Occurrence Reporting, last reviewed 10/30/2024, the P&P indicated as required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees, or visitors. The P&P indicated other occurrences include occurrences that interfere with facility operations and affect the welfare, safety, or health of residents, employees, or visitors. The P&P further indicated a written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency within forty-eight (48) hours of reporting the event or as required by federal and state regulations. During a review of the facility's P&P titled, Scabies Identification, Treatment and Environmental Cleaning, last reviewed 10/30/2024, the P&P indicated the purpose of this procedure is to treat residents infected with and sensitized to Sarcoptes scabiei and to prevent the spread of scabies to other residents and staff. Maintain contact precautions until treatment is complete and or resident is determined to be scabies free.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on interview and record review, the facility failed to provide a Registered Nurse (RN) for eight consecutive hours on 11/19/2023 for 57 of 58 residents. This deficient practice had the potential to delay necessary care and services. Findings: During a record review of the facility's Nursing Staffing Assignment and Sign-In Sheet (Staff Assignment) dated 11/19/2023, the Nursing Staff Assignment indicated no RN was assigned to work on 11/19/2023. During a record review of the facility's Daily Room Census (Census) dated 11/19/2023, the Census indicated there were 57 residents in house (number of residents inside the facility). During a concurrent interview and record review on 12/28/2024 at 5:12 p.m., with the Director of Staff Development (DSD), the facility's Staff Assignment and Census dated 11/19/2023 were reviewed. The DSD stated there were no RN who worked on 11/19/2023. During an interview on 12/28/2024 at 5:20 p.m., with the Director of Nursing (DON), the DON stated the facility do not have a policy for requiring RN to work eight hours a day. The DON stated it could be in the Facility Assessment (determines the resources necessary to care for residents competently during the day-to-day operations and emergencies). During a concurrent interview and record review on 12/30/2024 at 6:01 p.m., with the DON, the Facility assessment dated [DATE] was reviewed. The Facility Assessment indicated Staffing Plan. Our facility provides adequate staffing to meet needed care and services for our resident's population. Day shift: one Nursing Supervisor RN for eight hours. The DON stated the importance of having an RN was to supervise Licensed Vocational Nurses (LVNs), to intervene in resident change in condition, to administer intravenous medication (administers fluids, medications and nutrients directly into a person's vein), and to provide support to charge nurses.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) by: 1. Failing to destroy medications discontinued by the physician for Residents 25, 63, and 64. 2. Failing to label multidose medication bottle per facility policy with open date for two of four medication cart (Station 2 Medication Cart 2 and Station 1 Medication Cart 2) and one of two medication room (Medication room [ROOM NUMBER]) 3. Failing to sign Controlled Drug Record (narcotic sheet-a detailed log or documentation that tracks the dispensing, administration, and inventory of controlled substances [drugs classified as having a high potential for abuse]) of Resident 63's pregabalin (medication used to treat nerve pain) after medication administration on 12/28/2024. These deficient practices had the potential to result in drug diversion (illegal distribution or abuse of prescription drugs or their use for unintended purposes) and medication error. Findings: a. During a concurrent observation, interview, and record review of Medication room [ROOM NUMBER] during a medication storage observation on 12/28/2024, at 7:31 a.m., with Licensed Vocational Nurse 3 (LVN 3), observed bubble packs (a package that contains multiple sealed compartments with medication/s) of labeled medications on gray and white bins beside the refrigerator. LVN 3 stated the medications were discontinued. LVN 3 stated all discontinued medications should be placed inside the incinerator (an apparatus for burning waste material, especially industrial waste, at high temperatures until it is reduced to ash) found beside the door of the medication room. LVN 3 stated the discontinued medications belonged to Residents 25, 63 and 64 were as follows: 1. Resident 25's amoxicillin potassium clavulanate (medication used to treat infection) 875 milligrams (mg-metric unit of measurement, used for medication dosage and or amount) - 13 tablets left 2. Resident 63's losartan (medication used to treat high blood pressure) 25 mg - 38 tablets left 3. Resident 63's midodrine (medication used to treat low blood pressure) 5 mg - 11 tablets left 4. Resident 63's tamsulosin (medication used to treat enlarge prostate to improve the flow of urine) 0.4 mg- 14 tablets left 5. Resident 64's-erythromycin ophthalmic (medication used to treat eye infections) 5mg -1 tube (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 25's Admission Record, the Admission Record indicated the facility admitted Resident 25 on 11/11/2024, with diagnoses that included pneumonia (lung infection), essential hypertension (HTN- high blood pressure), and unsteadiness on feet. During a record review of Resident 25'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 11/13/2024, the H&P indicated Resident 25 had the capacity to understand and make decisions. During a record review of Resident 25's Physician Order dated 12/20/2024, the Physician Order indicated amoxicillin potassium clavulanate 875 mg was discontinued on 12/20/2024, at 2:18 p.m. During a record review of Resident 63's Admission Record, the Admission Record indicated the facility admitted Resident 63 on 12/19/2024, with diagnoses that included cervical fusion of spine (a surgical procedure that joins two or more vertebrae in the neck to treat neck pain and stabilize the spine), essential hypertension, and unsteadiness of feet. During a record review of Resident 63's H&P dated 12/20/2024, the H&P indicated Resident 63 had the capacity to understand and make decisions. During a record review of Resident 63's Minimum Data Set (MDS- a resident assessment tool) dated 12/26/2024, the MDS indicated Resident 63's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. During a record review of Resident 63's Physician Order dated 12/23/2024, the Physician Order indicated on 12/23/2024, at 2:35 p.m., losartan 25 mg was discontinued. During a record review of Resident 63's Physician Order dated 12/26/2024, the Physician Order indicated on 12/26/2024, at 2:18 p.m., midodrine 5 mg was discontinued. During a record review of Resident 63's Physician Order dated 12/27/2024, the Physician Order indicated on 12/27/2024, at 8:26 a.m., tamsulosin 0.4 mg tablet was discontinued. During a record review of Resident 64's Admission Record, the Admission Record indicated the facility admitted Resident 64 on 3/21/2024, and was discharged on [DATE], with diagnoses that included urinary tract infection (UTI- an infection in the bladder or urinary tract), repeated falls, and essential hypertension. During a record review of Resident 64's H&P dated 11/16/2024, the H&P indicated Resident 64 had the capacity to understand and make decisions. During a record review of Resident 64's Medication Administration record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 12/2024, the MAR indicated erythromycin ophthalmic ointment was last given on 12/12/2024, at 5 p.m. During an interview on 12/28/24, at 11:16 a.m., with the Director of Staff Developer (DSD), the DSD stated discontinued medications should be handed to the Director of Nursing (DON). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/28/2024, at 11:24 a.m., with the Director of Nursing (DON), the DON stated the facility had an incinerator bin located in each medication room that was picked up weekly by outside company. The DON stated discontinued medications should be emptied in the incinerator for destruction. During a concurrent interview and record review on 12/30/2024, at 6:01 p.m., with the DON, of the facility's policy and procedure (P&P) titled, Discarding and Destroying Medications dated 11/2022 and last reviewed on 10/30/2024, the P&P indicated, Medications that cannot be returned to the dispensing pharmacy (example given, non-unit dose medications, medications refused by the resident and or medications left by the residents upon discharge) are disposed of in accordance with federal, state and local regulations governing management of nonhazardous (not dangerous) pharmaceuticals, hazardous waste (dangerous) and controlled substances. Non-controlled and scheduled V (non-hazardous) controlled substances are disposed of in accordance with state regulations and federal guidelines regarding disposition of nonhazardous medications. The DON stated the importance of destroying medication was to prevent others from accessing discontinued medication and nurses need to dispose them. b. During a concurrent observation and interview on 12/28/24, at 7:31 a.m., with LVN 3 inside Medication room [ROOM NUMBER], observed calcium 500 mg with vitamin D (medication used to prevent and treat low calcium and vitamin D levels in your body) bottle inside the top cabinet with no open date. LVN 3 stated the bottle was opened and used, and there was no open date written on the bottle. LVN 3 stated once medication bottle was open, the medication bottle should be placed in the medication cart and labeled with open date. During a concurrent observation and interview on 12/28/2024, at 11:43 a.m., with LVN 4, Station 2 Medication Cart 2 was observed. LVN 4 stated the following medications had no open date. 1. Tums (medication used to relieve heartburn, sour stomach, and upset stomach) 2. Mucinex (medication used to relieve cough) 3. Budesonide (medication used to treat a variety of conditions, including asthma (lung inflammation making breathing difficult) 4. Fluticasone (medication used to prevent difficulty in breathing) 5. Lidocaine (medication used to temporarily numb and relieve pain) 6. Lidocaine viscous During a concurrent observation and interview on 12/28/2024, at 1:23 p.m., with the Infection Preventionist (IP), Station 1 Medication Cart 2 was observed. The IP stated the following medications had no open date. 1. Tums 2. Fluticasone (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Lactulose (medication used to constipation [when bowel movements are infrequent or difficult to pass]) 4. Sodium chloride (medication used to prevent heat cramps caused by too much sweating) During an interview on 12/28/2024, at 11:24 a.m. with the DON, the DON stated all medications must have an open date as per facility policy. During a concurrent interview and record review on 12/30/2024, at 6:01 p.m., with the DON, facility's undated P&P titled, Specific Medication Administration Procedures, was reviewed. The P&P indicated, When opening a multidose container, place the date on the container. The DON stated the policy was last reviewed on 10/30/2024. During a record review of facility's P&P titled, Administering Medications dated 4/2019 and last reviewed on 10/30/2024, the P&P indicated, The expiration, beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. c. During a concurrent observation, interview, and record review of Station 1 Medication Cart 2 during a medication cart observation on 12/28/2024, at 1:23 p.m., with the IP, observed Resident 63's pregabalin 100 mg had eight tablets left in the bubble pack. Resident 63's Controlled Drug Record (narcotic sheet) for pregabalin indicated there were nine tablets left. The IP stated one pregabalin was not signed in the narcotic sheet. During an interview on 12/28/2024, at 1:36 p.m., with LVN 5, LVN 5 stated she (LVN 5) just administered pregabalin to Resident 63 at 1 p.m. During a record review of Resident 63's MAR dated 12/28/2024, the MAR indicated Resident 63 was medicated by LVN 5 with pregabalin at 1 p.m. During an interview on 12/29/2024, at 11:16 p.m., with the DSD, the DSD stated once a narcotic medication was removed from the bubble pack or container, nurses should sign the narcotic sheet with date, time, and sign with the nurses' signature. The DSD stated it is a controlled drug and medication needs to be accounted for. During an interview on 12/29/2024, at 11:24 a.m., with the DON, the DON stated narcotic sheet should be signed right after getting the medication and before resident administration. The DON stated pregabalin is a controlled medication that needed to be counted. During a concurrent interview and record review on 12/30/2024, at 6:01 p.m., with the DON, the facility's P&P titled, Controlled Substances dated 4/2019 and last reviewed on 10/30/2024 was reviewed. The P&P indicated, The facility complies with all laws, regulations and other requirements related to handling, storage, disposal, and documentation of controlled medications. Controlled substances are reconciled upon receipt, administration, disposition and at the end of the shift. The DON stated nurses should sign the narcotic sheet right away after removing the narcotic from the bubble pack or container.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 42311 Based on interview and record review, the facility failed to ensure the resident was free from any significant medication error for one of three sampled residents (Resident 214) by not following the physician's order. This deficient practice resulted in delay of antibiotic (medication used to treat infection) administration, incomplete antibiotic dose (a quantity of medicine prescribed by the physician) and had the potential to prolong Resident 214's pneumonia (PNA- lung infection). Cross reference 580 Findings: During a record review of Resident 214's Admission Record, the Admission Record indicated the facility admitted Resident 214 on 9/27/2024, with diagnoses that included end stage renal disease (ESRD- irreversible kidney failure), personal history of other infectious (something is capable of spreading or is spreading rapidly to others) and parasitic (an infectious disease caused by organisms that live in or on another organism, known as the host) diseases and urinary tract infections (UTI- an infection in the bladder/urinary tract). During a record review of Resident 214'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 11/20/2024, the H&P indicated Resident 214 can make needs known but cannot make medical decisions. During a record review of Resident 214's Minimum Data Set (MDS - a resident assessment tool) dated 11/6/2024, the MDS indicated Resident 214's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 214 was dependent from staff for all activities of daily living (ADL-personal hygiene, bed mobility, dressing, and transfers). The MDS indicated Resident 214 was on antibiotic. During a record review of Resident 214's Physician Order dated 12/10/2024, timed at 2:41 p.m., the Physician Order indicated azithromycin (antibiotic- medication used to treat infection) tablet 250 milligrams (mg- metric unit of measurement, used for medication dosage and or amount), give 500 mg by mouth in the afternoon for pneumonia (PNA-lung infection) for one day (12/10/2024) then give 250 mg by mouth in the afternoon for PNA for four days (from 12/11/2024-12/14/2024). During a record review of Resident 214's Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 12/2024, the MAR indicated azithromycin 500 mg was not administered on 12/10/2024, and the 250 mg was not administered on 12/11/2024 and 12/12/2024. The MAR indicated azithromycin 250 mg was given on 12/13/2024, 12/14/2024, and 12/15/2024 at 4 p.m. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/29/2024, at 9:02 a.m., with the Infection Preventionist (IP), Resident 214's MAR dated 12/2024 and Progress Notes dated 12/10/2024, 12/11/2024, and 12/12/2024, were reviewed. The IP stated the MAR did not indicate that azithromycin 500 mg was administered to Resident 214 on 12/10/2024, or 12/11/2024. The IP stated the Progress Note dated 12/11/2024, and 12/12/2024 indicated azithromycin 250 mg was not delivered. The IP stated azithromycin should be in the facility's emergency kit (ekit-a small supply of medication that can be used when pharmacy services are unavailable. Emergency kits are designed to help nursing facilities provide medication to their residents during emergencies). The IP stated if the medication was not documented it means medication was not given. The IP stated Resident 214 received an incomplete dose because she (Resident 214) only received three doses of azithromycin 250 mg instead of one dose of 500 mg and four doses of 250 mg. The IP stated Resident 214's condition can worsen. The IP stated she (IP) should made sure that residents on antibiotics received the full dose of medication as per physician order. During an interview on 12/29/2024, at 11:16 a.m., with the Director of Staff Development (DSD), the DSD stated after Registered Nurse 2 (RN 2) received the physician order for azithromycin, Licensed Vocational Nurse 1 (LVN 1) should have called the pharmacy, and the pharmacist will decide if LVN 1 can open the ekit to get the 500 mg of azithromycin. The DSD stated if the antibiotic was not given on 12/10/2024, from 3 p.m., to 11p.m. shift, the next shift from 11 p.m., to 7 a.m., should have administered and started the first dose of 500 mg of azithromycin. During an interview on 12/29/2024, at 11:24 a.m., with the Director of Nursing (DON), the DON stated Resident 214 did not receive the complete dose of azithromycin. The DON stated Resident 214's infection could worsen if condition not treated. During a concurrent interview and record review on 12/29/2024, at 11:55 a.m., with LVN 4, facility's Packing Slip (receipt of medications delivered by pharmacy to the facility) dated 12/10/2024, was reviewed. The Packing Slip received and signed by LVN 4 on 12/10/2024 indicated four tablets of 250 mg of azithromycin were delivered for Resident 214. LVN 4 confirmed she (LVN 4) received the medication and placed the medication in the medication cart. During an interview on 12/30/2024, at 9:12 a.m., with the Pharmacist the Pharmacist stated, the pharmacy delivered four tablets of azithromycin 250 mg on 12/10/2024. The Pharmacist stated both 500 mg and 250 mg were available in the facility ekit. The Pharmacist stated 500 mg should have been administered to Resident 214 on 12/10/2024, and the 250 mg started on 12/11/2024, until 12/14/2024. The Pharmacist stated azithromycin is a medication used to treat infection and if not given according to physician's order may prolong the infection. The Pharmacist stated currently as of 12/30/2024, the facility's ekit had a stock of three tablets of azithromycin 500 mg and 10 tablets of 250 mg. During an interview on 12/30/2024, at 10:37 a.m., with RN 2, RN 2 stated she (RN 2) received the physician order to start 500 mg azithromycin that day (12/10/2024). RN 2 stated she notified LVN 1 that the medication was in the ekit. RN 2 stated the importance of starting the medication right away was for Resident 214's PNA. RN 2 stated Resident 214 missed the 500 mg and the first 250 mg of azithromycin. RN 2 stated there was a delay of three days after the medication was ordered by the physician. RN 2 stated azithromycin is a medication used to treat the infection. RN 2 stated nurses have to call the pharmacy before they (nurses) can open the ekit. (continued on next page)

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 12/31/2024
NAME OF PROVIDER OR SUPPLIER: The Grove Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 14122 Hubbard Street, Sylmar, CA 91342	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/30/2024, at 10:42 a.m., with LVN 2, LVN 2 stated on 12/12/2024, azithromycin 250 mg was not available in the medication cart. LVN 2 stated she called the pharmacy and was informed that medication will be delivered. LVN 2 stated medications delivered should be in the medication cart and on 12/12/2024, at 4 p.m., azithromycin was not in the medication cart which was why she (LVN 4) did not administer to Resident 214. LVN 2 stated the ekit was computerized and there was no way of knowing what medication and how many was inside the ekit. During an interview on 12/30/2024, at 11:07 a.m., with the Director of Staff Development (DSD), the DSD stated if medication administration was not documented, the medication was not given. The DSD stated LVN 1 and LVN 2 should have called the pharmacy, get the medication from the ekit, administer to Resident 214, and document that medication was given. During a concurrent interview and record review on 12/30/2024, at 6:01 p.m., with the DON, facility's policy and procedure (P&P) titled, Antibiotic Stewardship-Order for Antibiotics, dated 12/2024, was reviewed. The P&P indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program and in conjunction with the facility's general policy for medication utilization and prescribing. If antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements: d. duration of treatment: 1 start and stop date or 2. Number of days of therapy. The DON stated if antibiotic is indicated, medication should have been administered. During a record review of facility's P&P titled, Administering Medications, dated 4/2019 and last reviewed on 10/30/2024, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber's orders, including any required time frame. Medications are administered within one hour of the prescribed time, unless otherwise specified (for example, before and after meal orders).

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 47441 Based on observation, interview, and record review, the facility failed to ensure kitchen staff were routinely trained and evaluated for competency (measurable pattern of training, skills, experience, and knowledge in order to perform occupational tasks successfully) skills when staff: a. Failed to follow recipes and portion sizes for coffee cake for regular diet (diet with no restriction). b. Failed to blend the food, follow recipes, and portion sizes for puree diet (foods that are smooth with pudding like consistency)/International Dysphagia Diet Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) Level four (4) for all breakfast food items. These failures had a potential to result in inadequacy of food and nutrients leading to weight loss and increased nutrient intake leading to unplanned weight gain of 62 of 63 residents who are on puree diet, regular diet, and modified diet textures (food texture that is intended to be safe and easy to swallow) getting food from the kitchen. Cross-Reference F803, F804, and F805 Findings: a. During an interview on 12/29/2024 at 7:10 a.m. with [NAME] 1, [NAME] 1 stated she prepared regular cake that day for breakfast and they did not have coffee cake. [NAME] 1 stated she did not know why they did not have the coffee cake. During an interview on 12/29/2024 at 12:19 p.m. with the DS, the DS stated they did not have any menu substitution hat day. The DS stated [NAME] 1 did not put brown sugar and coffee on top of the plain cake. The DS stated the recipe for the coffee cake calls for preparing regular cake then putting coffee and brown sugar on top. The DS stated [NAME] 1 forgot to do that and it was not okay as it affected the taste and flavor of the cake resulting to residents not eating the food and can potentially lead to residents' unplanned weight loss. During a review of the facility's recipe titled Recipe: Coffeecake dated 2024, the recipe indicated Ingredients: white flour, baking powder, brown sugar, salt, pasteurized large eggs, milk, oil. Crumb topping: margarine, sugar, white flour, cinnamon, and salt. Directions: - Combine dry ingredients in a mixer bowl. - Combine eggs and milk and add dry ingredients. Mix on low speed until dry ingredients are just moistened. - Add oil and mix on low speed for 1 minute. Spread into well-greased pans. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Mix margarine, sugar, flour, cinnamon, and salt until crumbly. Sprinkle over batter. Bake 24 minutes at 400 F. - Serve on trayline (an area where foods were assembled) warm or at room temperature. The recipe further indicated the coffeecake did not have a coffee ingredient and the brown sugar should be mixed with the wet and dry ingredients and not to sprinkle on top. During a review of the facility's P&P dated Menu Planning dated 10/30/2024, the P&P indicated, Standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation. b. During a review of the facility's daily cook's spreadsheet titled Winter Menus, dated 12/29/2024, the spreadsheet indicated residents on puree diet/IDDSI Level 4 would include the following foods in the tray: - Orange juice four (4) fluid ounces (oz, a unit of measurement) - Puree oatmeal three-fourth (3/4) cup (c, household measurement) - Puree western omelet one third (1/3) c - Puree coffee cake 1/3 c - Margarine one (1) teaspoon (tsp, household measurement) - Parsley sprig garnish: no - Milk eight (8) oz During a concurrent observation and interview on 12/29/2024 at 7:13 a.m. of the food on the steamtable with [NAME] 1, [NAME] 1 stated she prepared bread soaked in milk, a same pot of oatmeal for regular diet and puree diet and plain scrambled eggs for puree diet residents. During an observation on 12/29/2024 at 7:14 a.m. of puree food in trayline (an area where foods were assembled) inside the kitchen, [NAME] 1 plated bread soaked in milk that had whole chunks of bread, scrambled eggs that were not smooth and pureed, and oatmeal with lumps from the steamtable to the residents' plates on puree diets. During an interview on 12/29/2024 at 7:31 a.m. with the DS, the DS stated [NAME] 1 did not follow the recipe for puree omelet and residents on puree diet were given scrambled eggs instead. The DS stated the staff used #10 scoop (3/8 cups) instead of #12 scoop (1/3 cup) to portion the puree Western omelet. The DS stated #10 was more portions than #12 scoops. The DS stated residents were getting larger portions of foods and could cause unplanned weight gain as a potential outcome of not using the correct scoop sizes. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 12/29/2024 at 7:43 a.m. of the test tray (a process of tasting, temping, and evaluating the quality of food) with the DS, the DS stated puree diet contains food that are blended, moist and not too runny, and it is used for residents with chewing and swallowing difficulty. The DS stated the foods that [NAME] 1 prepared including the puree bread and oatmeal have lumps and the puree scrambled eggs was not smooth. The DS stated [NAME] 1 must follow the recipe, but she (Cook 1) did not follow it. The DS stated residents could have swallowing problems and would not be able to eat the food resulting to weight loss as a potential outcome of not following the recipe for puree foods. The DS stated she was not familiar with the spoon tilt test, but she will get an in-service right away. During an interview on 12/31/2024 at 1:37 p.m. with the Administrator (ADM), the ADM stated there was no competency done for the DS prior to 12/30/2024. During a review of the facility's P&P dated Food Preparation dated 10/30/2204, the P&P indicated, Procedure: (1) The facility will use approved recipes, standardized to meet the resident census. This count is to be kept current so that an accurate amount of food is prepared. (2) Recipes are specific as to portion yield, method of preparation, quantities of ingredients, and time and temperature guidelines. During a review of the facility's P&P titled Portion Control, dated 10/30/2024, the P&P indicated, Policy: Various portion sizes of the food served will be available to better meet the needs of the residents. During a review of the facility's job description (JD) titled Job Description-Cook dated and signed on 8/7/2020 by [NAME] 1 and Director of Staff Development (DSD), the JD indicated The primary purpose of your job position is to provide assistance in all food functions as directed/instructed and in accordance with established food policies and procedures. Administrative duties included: - Review menus prior to preparation of food. - Inspect special diet trays to verify that the correct diet is served to the resident. - Ensure that all food procedures are followed in accordance with established procedures. The facility's JD further indicated [NAME] 1 food service responsibilities were as follows: - Prepare meals in accordance with planned menus. - Serve food in accordance with established portion control procedures. - Prepare food for therapeutic diets in accordance with planned menus. - Prepare foods in accordance with standardized recipes and special diet order. During a review of the facility's job competency titled Verification of Job Competency Demonstration-Cooks dated 8/27/2024, the JD indicated [NAME] 1 demonstrated knowledge of the use of recipes, spreadsheets and record substitution, portion sizes of food being served and utensils selection. The job competency further indicated [NAME] 1 was trained by DS on using the blender and Robo coupe. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's JD titled Job Description-Director of Food Services dated and signed by the DS on 7/1/2020, the JD indicated, The primary purpose of your job position is to assist the Dietitian in planning, organizing, developing and directing the overall operation of the Food Services Department in accordance with current federal, state, and local standards, guidelines and regulations governing our facility, and as may be directed by Administrator and/or consulting dietitian. The JD further indicated the DS duties included: - Review therapeutic and regular diet plans and menus to verify they are in compliance with the physician's orders. - Review and check competence of food services personnel and make necessary adjustments/corrections as required or that may become necessary. - Make rounds to verify the food services personnel are performing required duties and to verify that appropriate food services procedures are being rendered to meet the needs of the facility. - Assist support services in developing, implementing, and conducting in-service training programs that relate to the Food Services Department.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47441 Based on observation, interview, and record review the facility failed to follow the menu and did not meet nutritional needs of 62 of 63 residents on regular (diet with no restriction) and puree texture diets (foods that are smooth and pudding like consistency) when: 1. [NAME] 1 was unable to find the menu spreadsheet for 12/29/20224 breakfast. 2. [NAME] 1 did not prepare puree baked Western omelet for residents on puree diet/ International Dysphagia Diet Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) Level 4. 3. [NAME] 1 did not prepare coffee cake and used regular cake for all the residents for breakfast. 4. [NAME] 1 used scoop size number (#) 10 (3/8 cup) instead of #12 (1/3 cup) scoop for puree eggs and bread soaked in milk. This failure had the potential to result in increased food and nutrient intake resulting to unintended (not done on purpose) weight gain or decreased in food and nutrient intake resulting to unintended weight loss. Findings: 1. During an interview on 12/29/2024 at 7:07 a.m. with [NAME] 1, [NAME] 1 stated she followed the menu at-a-glance (a list of food residents would receive for everyday for a week). [NAME] 1 stated she did not have the menu spreadsheet that day and could not find it. [NAME] 1 stated they used the menu spreadsheet (a sheet that contains each diet and what food and portions each diet would get) for what food each diet would get and for portion sizes of food. [NAME] 1 stated if spreadsheet was not available, they look at the resident's meal ticket for the portion sizes. During an observation on 12/29/2024 at 7:08 a.m. of the meal ticket on the trays, the meal tickets did not indicate any portion sizes of the food. During an interview on 12/29/2024 at 7:31 a.m. with the Dietary Supervisor (DS), the DS stated the spreadsheet could be found on week four (4) tab in the menu binder. The DS stated it was important that the menu spreadsheet is available to the staff so they would know what kind of food and portion size for each diet they would be serving the residents for the day. The DS stated inaccurate portion sizes for each diet for residents would be potential outcome for not having the spreadsheet available for staff and this could lead to unplanned weight loss or weight gain for the residents. During a review of the policies and procedures (P&P) titled Menu Planning dated 10/30/2024, the P&P indicated (2) Menus and cook's spreadsheet are to be dated and posted in the kitchen and on the consumer bulletin board in the entrance of the facility by the FNS Director two (2) weeks in advance. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of the facility's daily cook's spreadsheet titled Winter Menus, dated 12/29/2024, the spreadsheet indicated residents on puree diet/IDDSI] Level 4 would include the following foods in the tray: - Orange juice four (4) fluid ounces (oz, a unit of measurement) - Puree oatmeal three-fourth (3/4) cup (c, household measurement) - Puree western omelet one third (1/3) c - Puree coffee cake 1/3 c - Margarine one (1) teaspoon (tsp, household measurement) - Parsley sprig garnish: no - Milk eight (8) oz During an observation on 12/29/2024 at 7:14 a.m. of the trayline (an area where foods were assembled on the trays), residents on puree diet received plain scrambled eggs that were not smooth in texture. During an interview on 12/29/2024 at 7:40 a.m. with the DS, the DS stated [NAME] 1 did not follow the recipe for baked Western omelet for residents on puree/IDDSI Level 4 instead, staff gave plain scrambled eggs to residents on puree diet. The DS stated residents would not get the right number of calories and it would change the flavor of the food because plain scrambled eggs would be missing other ingredients the puree baked western omelet had. The DS stated residents would not like the food and would not eat that could potentially lead to weight loss for not following the recipe. During a review of the facility's P&P titled Menu Planning, dated 10/30/2024, the P&P indicated this menu service provides the seasonal menus with corresponding recipes. The menus are planned to meet nutritional needs of residents in accordance with established national guidelines. Physician's orders and, to the extent medically possible, in accordance with the most recent recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences. During a review of the facility's recipe titled Baked Western Omelet dated 2024, the recipe indicated Ingredients: margarine, all-purpose flour, milk, pepper, large, pasteurized eggs, vegetables of choice such as fresh mushrooms, onions, green and red pepper, diced potatoes, cooked bacon, shredded cheddar cheese. During a review of the facility's recipe titled Recipe: Pureed (IDDSI Level 4) Eggs, dated 2024, the recipe indicated ingredients: prepared eggs per recipe, warm milk, if needed stabilizer: instant potato, non-fat dry milk, or commercial instant food thickener. 3. During an interview on 12/29/2024 at 7:10 a.m. with [NAME] 1, [NAME] 1 stated she prepared regular cake today for breakfast and they did not have coffee cake. DS stated she did not know why they did not have the coffee cake. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/29/2024 at 12:19 p.m. with the DS, the DS stated they did not have any menu substitution today. The DS stated [NAME] 1 did not put brown sugar and coffee on top of the plain cake. The DS stated the recipe for the coffee cake called for preparing regular cake then putting coffee and brown sugar on top. The DS stated [NAME] 1 forgot to do that and it was not okay as it affected the taste and flavor of the cake resulting to residents not eating the food and potentially lead to resident's unplanned weight loss. During a review of the facility's recipe titled Recipe: Coffeecake dated 2024, the recipe indicated Ingredients: white flour, baking powder, brown sugar, salt, pasteurized large eggs, milk, oil. Crumb topping: margarine, sugar, white flour, cinnamon, and salt. Directions: 1. Combine dry ingredients in a mixer bowl. 2. Combine eggs and milk and add dry ingredients. Mix on low speed until dry ingredients are just moistened. 3. Add oil and mix on low speed for 1 minute. Spread into well-greased pans. 4. Mix margarine, sugar, flour, cinnamon, and salt until crumbly. Sprinkle over batter. Bake 24 minutes at 400 F. 5. Serve on trayline warm or at room temperature. The recipe further indicated the coffeecake did not have a coffee ingredient and brown sugar is mixed with the wet and dry ingredients and not to sprinkle on top. During a review of the facility's P&P dated Food Preparation dated 10/30/2204, the P&P indicated, Procedure: (1) The facility will use approved recipes, standardized to meet the resident census. This count is to be kept current so that an accurate amount of food is prepared. (2) Recipes are specific as to portion yield, method of preparation, quantities of ingredients, and time and temperature guidelines. 4. During a review of the facility's cook's spreadsheet titled Winter Menus, dated 12/29/2024, the spreadsheet indicated residents on regular die (diet without restriction) would include the following foods in the tray: - Orange Juice 4 oz - Oatmeal 3/4 c. - Baked Western omelet 3x2 1/2 inches ([in.] a unit of measurement) = 1 serving - Coffee cake 2x2 1/2 in. - Margarine 1 tsp. - Parsley sprig garnish: yes (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Milk 8 oz During an observation on 12/29/2024 at 7:21 a.m. of the trayline, #10 scoop (3/8 c). During a concurrent observation and interview on 12/29/2024 at 7:31 a.m., of the scoop sizes in trayline with the DS, the DS stated color ivory scoop was used in scooping the baked Western Omelet. The DS stated this was #18 scoop which was three (3) oz in size. The DS stated she needed to correct the portion size to what the recipe say of 3x2 1/2 in. per serving, but she did not know what the equivalent scoop size for it. The DS stated the puree diet portion size was #12 scoop hence the regular diet would get the same. The DS rechecked the scoop size and stated the staff were using #10 scoop which was 3/8 c., and it was not the correct portion size. The DS stated the staff should be using #12 scoop which was 1/3 c. The DS stated residents would be getting more portions and could lead to unplanned weight gain. During a review of the facility's recipe titled Recipe: Baked Western Omelet dated 2024, the recipe indicated Portion size 3x2 1/2 in. (#12 scoop). During a review of the facility's P&P titled Portion Control, dated 1/18/2024, the P&P indicated, Policy: Various portion sizes of the food served will be available to better meet the needs of the residents.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47441 Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved flavor and appearance for breakfast when: a. [NAME] 1 did not follow the recipe for coffee cake and prepared plain cake instead. b. [NAME] 1 did not follow the recipe and cut the baked Western omelet to 3x2 1/2 inches serving and used number (#) 10 scoop (3/8 cup) instead. This failure had a potential to result in 62 of 63 facility residents at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Findings: a. During an interview on 12/29/2024 at 7:10 a.m. with [NAME] 1, [NAME] 1 stated she prepared regular cake today for breakfast and they did not have coffee cake. DS stated she did not know why they did not have the coffee cake. During an interview on 12/29/2024 at 12:19 p.m. with the DS, the DS stated they did not have any menu substitution today. DS stated [NAME] 1 did not put brown sugar and coffee on top of the plain cake. The DS stated the recipe for the coffee cake calls for preparing regular cake then putting coffee and brown sugar on top. The DS stated [NAME] 1 forgot to do that and it was not okay as it affected the taste and flavor of the cake resulting to residents not eating the food and potentially lead to resident's unplanned weight loss. During a review of the facility's recipe titled Recipe: Coffeecake dated 2024, the recipe indicated Ingredients: white flour, baking powder, brown sugar, salt, pasteurized large eggs, milk, oil. Crumb topping: margarine, sugar, white flour, cinnamon, and salt. Directions: 1. Combine dry ingredients in a mixer bowl. 2. Combine eggs and milk and add dry ingredients. Mix on low speed until dry ingredients are just moistened. 3. Add oil and mix on low speed for 1 minute. Spread into well-greased pans. 4. Mix margarine, sugar, flour, cinnamon, and salt until crumbly. Sprinkle over batter. Bake 24 minutes at 400 F. 5. Serve on trayline warm or at room temperature. The recipe further indicated the coffeecake did not have a coffee ingredient and brown sugar is mixed with the wet and dry ingredients and not to sprinkle on top. (continued on next page)

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 12/31/2024
NAME OF PROVIDER OR SUPPLIER: The Grove Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 14122 Hubbard Street Sylmar, CA 91342	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure titled Food Preparation dated 10/30/2024, the P&P indicated PROCEDURE: (1) The facility will be approved recipes, standardized to meet the resident census. This count is to be kept current so that an accurate amount of food is prepared. (2) Recipes are specific as to portion yield, method of preparation, quantities of ingredients, and time and temperature guidelines. b. During a review of the facility's cook's spreadsheet titled Winter Menus, dated 12/29/2024, the spreadsheet indicated residents on regular die (diet without restriction) would include the following foods in the tray: - Orange Juice 4 oz - Oatmeal 3/4 cup (c., household measurement). - Baked Western omelet 3x2 1/2 inches ([in.] a unit of measurement) = 1 serving - Coffee cake 2x2 1/2 in. - Margarine 1 tsp. - Parsley sprig garnish: yes - Milk 8 oz During an observation on 12/29/2024 at 7:21 a.m. of the trayline, #10 scoop (3/8 c). During a concurrent observation and interview on 12/29/2024 at 7:31 a.m., of the scoop sizes in trayline with the DS, the DS stated, color ivory scoop was used in scooping the baked Western Omelet. The DS stated this was #10 scoop which was three (3/8 c) oz in size. The DS stated she needed to correct the portion size to what the recipe say of 3x2 1/2 in. per serving. The DS stated staff should have cut the omelet for better presentation instead of using a scoop. The DS stated residents would not eat it leading to weight loss if food did not look appetizing. During a review of facility's P&P titled Food Preparation dated 1/18/2024, the P&P indicated POLICY: Food shall be prepared by methods that conserve nutritive value, flavor, and appearance. Prepared food will be sampled. The Food and Nutrition Service employee who prepares the food will sample it to be sure the food has satisfactory flavor and consistency. Use a clean spoon or put a small portion of the food in a dish and taste from the dish.

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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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47441 Based on observation, interview, and record review, the facility failed to prepare food in a form designed to meet individual needs (requirements that a person has in order to be well such as food) for one of 62 sampled residents (Resident 214) on puree diet (a texture modified diet that consists of smooth, moist foods that are easy to swallow) by not following the recipes for puree oatmeal, puree scrambled eggs, and puree wheat breads and in accordance with the International Dysphagia Diet Initiative (IDDSI - a framework made up of levels and describes food textures and drink thickness) Level Four (pureed foods and extremely thick drinks) Standards when on 12/29/2024 Resident 214 was served bread soaked in milk, oatmeal with lumps, and scrambled eggs that were not smooth and not pureed. This deficient practice had the potential to cause the residents to not be able to eat their food and/or choke (when food gets stuck in your airway, blocking the flow of air to your lungs) on the food. On 12/29/2024 at 5:55 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ- a situation in which the provider's non-compliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident) under 42 CFR S483.60 Food and Nutrition Services in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to ensure that facility staff followed the recipe for puree diet and served pureed food to Resident 214. On 12/30/2024 at 4 p.m., the ADM provided an IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the non-compliance that has resulted to IJ situation) which included the following summarized actions: 1. On 12/30/2024, the Registered Dietitian (RD) provided an in-service (staff training) to [NAME] 2, [NAME] 3, and Dietary Aide 1 (DA 1) regarding food preparation of IDDSI Level 4 foods. 2. On 12/30/2024, the RD provided an in-service and competency (measurable pattern of training, skills, experience, and knowledge to perform occupational tasks successfully) test to the Dietary Supervisor (DS) regarding puree food consistency to meet IDDSI Level 4 standards. The DS provided supervision to the dietary staff to ensure a blender (an electric mixing machine used in food preparation for pureeing food) was used on pureed foods for dinner service to meet IDDSI Level 4 standards. On 12/30/2024, the RD verified the DS's competency through return demonstration (a teaching method where a staff practices a skill after an instructor demonstrates it) and the RD acknowledged the DS to be competent in providing in-services to the dietary staff. 3. On 12/29/2024 at 4:10 p.m., the DON assessed Resident 214 for signs and symptoms of respiratory distress (a condition that makes it difficult to breathe) and for presence of food particles in the oral cavity (mouth) and there were no issues found. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. On 12/29/2024, the DON provided an in-service to Licensed Vocational Nurse 1 (LVN 1) on food texture and consistency based on IDDSI Level 4 standards. The DON verified LVN 1's competency through return demonstration by observing and verbalizing the correct texture of puree diets using IDDSI Level 4 standards. 5. On 12/29/2024, the Infection Preventionist (IP) and the Minimum Data Set Coordinator (MDSC) checked all residents receiving pureed food to ensure proper consistency and texture for lunch and dinner meals. The licensed nursing staff will continue to check meal trays for breakfast, lunch, and dinner on an ongoing basis for proper puree consistency and texture of food. 6. On 12/29/2024, the DS checked the puree food items for proper texture and consistency per IDDSI Level 4 standards using the spoon tilt test (a method used to determine the stickiness of food and ability of the food to hold together) and fork drip test (a test used to check the correct thickness and cohesiveness of food). The DS will continue this process until six (6) months. 7. On 12/30/2024, the ADM, the RD, and the DS examined the process of food preparation and food distribution for all residents on puree diet to ascertain and confirm food items that did not pass IDDSI Level 4 standards would not be given to the residents and will be remade. 8. On 12/30/2024, the DON assessed the residents on puree diet for signs and symptoms of respiratory distress and ensured aspiration precautions (safety measures taken to prevent food or liquid from accidentally entering the airway while eating or drinking), were maintained for the residents on puree diet. The DON reviewed and revised the care plans as necessary. No other residents were affected by this deficient practice. 9. On 12/30/2024, the Speech Language Pathologist (SLP - a health professional who evaluates and treats speech, language, and swallowing disorders) assessed the residents on pureed diet for signs and symptoms of respiratory distress and aspiration. No other residents were affected by this deficient practice. 10. On 12/30/2024 at 2 p.m., the SLP provided an in-service to the dietary staff and the nursing staff on the risk of eating food that was not properly pureed per physician's order, choking hazards, what signs and symptoms to monitor, and what consistency and texture of a pureed diet should look like. 11. On 12/30/2024, the RD provided an in-service and competency test to [NAME] 1, [NAME] 2, DA 1, DA 2, and DA 3 on how to puree foods following the recipes and IDDSI Level 4 standards. The RD provided an in-service to six (6) of seven (7) dietary staff. [NAME] 4 was scheduled to attend an in-service on 12/31/2024 at 11:15 a.m. 12. A qualified RD will be supervising the DS for a period of one (1) month or until such time the RD determined the DS to be competent to supervise the workflow of the dietary staff and kitchen. At such time, if it is determined that the DS is not competent, the ADM will replace the DS with a qualified and competent DS. 13. A Spanish version of the menu and recipe will be obtained by the ADM as soon as applicable. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	14. On 12/31/2024 at 10:45 a.m., the RD provided another in-service to the licensed nursing staff on testing the puree diet per IDDSI Level 4 standards. 15. The DS or licensed nurse will test the pureed foods on the menu per IDDSI Level 4 standards with a fork and spoon tilt test after the in-service training. The in-service training and competency test started on 12/30/2024. Training would continue until all licensed nursing staff and dietary staff have been completed. 16. The assigned designee for testing the puree foods will be the Station 2 charge nurse when the DS is not available such as on weekends, holidays. The 11 p.m. to 7 a.m. shift Station 2 charge nurse will be in-charge for breakfast, the 7 a.m. to 3 p.m. shift Station 2 charge nurse for lunch, and the 3 p.m. to 11 p.m. Station 2 charge nurse for dinner. 17. On 12/30/2024, a pureed food adherence tool titled Puree Texture Checklist was used for breakfast to ensure food on the menu are prepared using a blender per IDDSI standards. The Puree Texture Checklist will be used for breakfast, lunch, and dinner including weekends and holidays. 18. On 12/30/2024, the RD checked the snacks for the residents on puree diets which included blended yogurt, apple sauce, and pudding. No other snacks would be provided by staff to residents on puree diet except snacks approved by the RD. 19. Beginning the first week of 1/2025, the RD will conduct weekly Quality Assurance (QA- a data driven proactive approach to improvement used to ensure services are meeting quality standards) rounds (audits) in the kitchen to monitor meal tray accuracy including pureed food texture based on IDDSI Level 4 standards. The results of the audit will be presented to the Quality Assessment and Assurance (QAA- a continuous process used in healthcare to evaluate and improve the quality of care and services provided to the residents) committee monthly and at a minimum of quarterly for further action planning and monitoring as necessary. The benchmark (a standard or point of reference used to compare and measure the quality of performance and outcomes of healthcare services) for compliance will be 100 percent (%) for a period of three (3) months. On 12/31/2024 at 12:58 p.m., while onsite and after verifying the facility's full implementation of the IJ removal plan, the SSA accepted the IJ Removal Plan and removed the IJ in the presence of the Administrator and the DON. Cross reference F802 Findings: (continued on next page)

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F 0805

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

During a review of Resident 214's Admission Record, the Admission Record indicated the facility originally admitted Resident 214 on 9/27/2024 and readmitted the resident on 11/18/2024 with diagnoses including dysphagia oropharyngeal phase (swallowing problems occurring in the mouth and/or throat), end stage renal disease (final and permanent stage of kidney disease where kidney function has declined to the point that the kidneys can no longer function on their own), and adult failure to thrive (syndrome of weight loss, decreased appetite, poor nutrition, and inactivity, often accompanied by dehydration [when body loses more water than it takes in and could disrupt normal bodily function], depressive symptoms [refer to feelings and behaviors that may include sadness, loss of interest in usual daily activities, changes in appetite, and sleep issues], impaired immune function [body's defense system is not working well as it should, making it harder for the body to fight off infection and illness] and low cholesterol [level of fatty substance in the blood is low]).

During a review of Resident 214's Minimum Data Set (MDS- a resident assessment tool), dated 11/6/2024, the MDS indicated Resident 214 usually made self understood and understand others. The MDS further indicated Resident 214 required moderate assistance with eating and had complaints of difficulty or pain when swallowing. The MDS further indicated Resident 214 had mechanically altered diet (food texture that is intended to be safe and easy to swallow) while a resident of the facility and within the last seven days.

During a review of Resident 214's History and Physical (H&P) dated 11/9/2024, the H&P indicated the resident can make needs known but cannot make medical decisions.

During a review of Resident 214's Order Summary Report, dated 11/18/2024, the Order Summary Report indicated a physician's order for fortified diet (a food that has extra nutrients added to it), pureed texture, thin liquids consistency (no restriction), fortified for lunch.

During a review of Resident's 214's Nutritional Risk Assessment, dated 12/2/2024, the Nutritional Risk Assessment indicated Resident 214 had chewing or swallowing problems and was unable to communicate needs.

During a review of Resident 214's Care Plan titled [Resident 214] has decreased swallow safety and skills, last revised on 11/19/2024, the Care Plan indicated interventions including assessing the diet, providing compensatory strategies (actions used to offset difficulties and improve performance in specific areas of limitation, physical disability, and health condition), and providing resident and caregiver education.

During a review of Resident 214's Speech Therapy Evaluation and Plan of Treatment, dated 10/21/2024, the Speech Therapy Evaluation and Plan of Treatment indicated Resident 214 presented with mild oropharyngeal dysphagia. The Speech Therapy Evaluation and Plan of Treatment also indicated for Resident 214 to be on puree diet consistencies and thin liquid.

During a review of the facility's daily cook's spreadsheet titled Winter Menus, dated 12/29/2024, the spreadsheet indicated residents on puree diet in accordance with IDDSI Level 4 would include the following in the meal tray:

o Orange juice four (4) fluid ounces (oz, a unit of measurement)

o Puree oatmeal three-fourth (3/4) cup (c, household measurement)

(continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Puree western omelet one third (1/3) c o Puree coffee cake 1/3 c o Margarine one (1) teaspoon (tsp, household measurement) o Parsley sprig garnish: no o Milk eight (8) oz During a concurrent observation of the food at the steamtable (kitchen appliance that keeps food warm at a safe temperature for serving) and interview on 12/29/2024 at 7:13 a.m. with [NAME] 1, [NAME] 1 stated she prepared the bread soaked in milk and plain scrambled eggs for residents on puree diet. [NAME] 1 stated she made a pot of oatmeal to be used for residents on regular (diet with no restriction) diet and residents on puree diet. During an observation on 12/29/2024 at 7:14 a.m. of puree food in trayline (an area where foods were assembled) inside the kitchen, observed [NAME] 1 plated bread soaked in milk that had whole chunks of bread, scrambled eggs that were not smooth and pureed, and oatmeal with lumps from the steamtable to the residents' plates on puree diets. During an interview on 12/29/2024 at 7:31 a.m. with the DS, the DS stated [NAME] 1 did not follow the recipe for puree omelet when [NAME] 1 prepared scrambled eggs that were not smooth and pureed instead of puree western omelet. During a concurrent observation of the test tray (a process of tasting, temping [measuring the temperature of food to ensure it is safe to eat] and evaluating the quality of food) and interview on 12/29/2024 at 7:43 a.m. with the DS, the DS stated puree diet contains food that are blended, moist, and not too runny, and was served for residents with chewing and swallowing difficulties. The DS stated the foods that [NAME] 1 prepared including the puree bread and oatmeal had lumps and the puree scrambled eggs were not smooth. The DS stated [NAME] 1 must follow the recipe, but she (Cook 1) did not follow it. The DS stated residents could have swallowing problems and would not be able to eat the food resulting to weight loss as a potential outcome of not following the recipe for puree foods. The DS stated she was not familiar with the spoon tilt test, but she will get an in-service right away. During an interview on 12/29/2024 at 10:31 a.m. with the RD, the RD stated puree diet in accordance with IDDSI Level 4 standards were used for residents with no teeth and with issues on swallowing and chewing. The RD stated puree diet in accordance with IDDSI Level 4 should be smooth, with no lumps or chunks, or any food that residents could choke on, and all food should not require chewing or swallowing like mashed potato and pudding. The RD stated bread that was soaked in milk would not pass as pureed diet and texture. The RD stated Resident 214 and other residents with dysphagia diagnosis on pureed diet who received foods not passing a puree texture could be harmed, as food could get stuck in their throat and the residents could aspirate (accidentally inhale a substance into the lungs). (continued on next page)

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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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/29/2024 at 10:45 a.m. with the SLP, the SLP stated pureed diets included foods that are blended like baby food, with no chunks, or any textured food. The SLP stated Resident 214 and other residents with dysphagia diagnosis and pharyngeal (throat) impairments on puree diet could potentially choke food if the prepared food was in a form not designed to meet individual needs. The ST stated bread soaked in milk is not considered puree as it has mixed consistency of thin liquid and thickened food. The SLP stated Resident 214 and other residents with pharyngeal impairment and dysphagia diagnosis had more challenges with mixed consistency items, as they could choke on thin liquids. During an interview on 12/29/2024 at 11:45 a.m., Certified Nursing Assistant 1 (CNA 1) stated that on 12/29/2024, she (CNA 1) assisted Resident 214 with breakfast, and on Resident 214's meal tray, Resident 214 had oatmeal, eggs, tea, and bread that was soaked in milk. CNA 1 stated Resident 214 was on pureed diet. CNA 1 stated Resident 214 ate all the oatmeal and about half of the bread. During an interview on 12/29/2024 at 12:18 p.m. with the DS, the DS stated [NAME] 1 did not follow the recipe for puree diet and did not blend the foods. During an interview on 12/29/2024 at 2:02 p.m. with the DS, the DS stated there was no recipe for the bread soaked in milk. The DS stated [NAME] 1 should have followed the puree bread recipe, but she (Cook 1) did not. During an interview on 12/30/2024 at 7:05 a.m. with [NAME] 1, [NAME] 1 stated Sorry, ma'am I forgot to blend the food yesterday. During a review of the facility's policy and procedures (P&P) titled, Menu Planning, dated 10/30/2024, the P&P indicated the menu service provides the seasonal menus with corresponding recipes. The P&P indicated the menus are planned to meet nutritional needs of residents in accordance with established national guidelines, physician's orders and, to the extent medically possible, in accordance with the most recent recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences. The P&P indicated the menus are planned to consider texture and color of all foods in meals. The procedure indicated the facility's diet manual and the diets ordered by the physician should mirror the nutritional care provided by the facility. The P&P indicated menus are written for regular and therapeutic diets in compliance with the facility's diet manual and to refer to the diet manual as needed. The P&P indicated standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation. During a review of the facility's diet manual titled Regular Pureed Diet/IDDSI Level 4, dated 10/30/2024, the diet manual indicated Description: The pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture pureed food items included on this diet should be smooth and free of lumps, hold their shape, while not being too firm or sticky, and should not weep. Detailed recipes and procedures for pureeing foods maybe found in Book #1, under the Food Safety/Miscellaneous Section. All foods are prepared in a food processor or blender, except for foods, which are normally in a soft and smooth state such as pudding, ice cream, applesauce, mashed potato. The diet manual further indicated foods avoided in the puree diet included lumpy cereal (oatmeal) dry cereal, unless pureed. IDDSI Testing Requirements: The finished pureed food items must pass IDDSI Level 4 testing requirements (like the fork drip, fork pressure, and spoon tilt tests.) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14122 Hubbard Street Sylmar, CA 91342	

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's recipe titled Recipe: Pureed (IDDSI Level 4) Eggs dated 10/30/2024, the recipe indicated (5) The finished pureed items should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. The finished pureed item must pass IDDSI Level 4 testing requirements. During a review of the facility's recipe titled Recipe: Pureed (IDDSI Level 4) Breads, Cakes, Cookies, Pancakes, French Toast, Sweet Rolls, Waffles, Tortillas, Sandwiches and Other Bread Products, dated 10/30/2024, the recipe indicated (4) The finished pureed items should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. The finished pureed item must pass IDDSI Level 4 testing requirements. During a review of the facility's recipe titled Recipe: Pureed (IDDSI Level 4) Hot Cereal, dated 10/30/2024, the recipe indicated (4) The finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. The finished product must pass IDDSI Level 4 testing requirements. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated, Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test.

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NAME OF PROVIDER OR SUPPLIER: The Grove Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 14122 Hubbard Street Sylmar, CA 91342	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47441 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: a. Expired items were stored in the kitchen refrigerator and undated foods were stored in the refrigerator. 1. Expired hotdog buns dated [DATE] and hamburger buns dated [DATE] in the kitchen and staff foods were stored in the kitchen refrigerator. 2. Resident foods were not labeled and dated in the resident's refrigerator and staff's foods were stored in the resident's refrigerator. b. Staff did not wash her hands after touching the paper towel dispenser button and before returning to work. c. Food preparation surfaces and kitchen equipment were not cleaned and sanitized. 1. Walk-in freezer's roof had ice crystals. 2. Canned food racks were dusty and dirty to touch. 3. Reach-in refrigerator gasket had dust and dirt debris. 4. Kitchen hood had dust buildup. d. One dented can was stored with non-dented cans. e. Expired sanitizer test strips were not disposed. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 62 of 63 medically compromised residents who received food and ice from the kitchen. Findings: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a.1. During a concurrent observation and interview during the initial kitchen tour on [DATE] at 7:13 a.m. with [NAME] 3, observed hot dog buns with best by date of [DATE] and hamburger buns with best by date of [DATE]. [NAME] 3 stated hot dog buns and hamburger buns were no longer good and should be discarded; they were not safe for the residents to consume. An observation of the facility refrigerator noted a container with liquid item with no date on the container. [NAME] 3 stated it was salsa that was brought in by facility staff. An observation of the kitchen refrigerator noted a zip lock bag with a white substance. [NAME] 3 stated it was cream cheese which was also brought in by facility staff. [NAME] 3 stated she would discard both the salsa and the cream cheese. [NAME] 3 stated staff items should not be kept in the facility refrigerator. During an interview on [DATE] at 3:43 p.m. with the Dietary Supervisor (DS), the DS stated if food items indicate best by date, it is the expiration date. The DS stated hot dog buns dated [DATE] and hamburger buns dated [DATE] would be considered expired and they should have been discarded; this can be a risk for the residents because residents can get sick if they consume expired food. The DS stated staff should not be placing items that belong to them in the refrigerator, and that only food that is bought from facility for residents can be placed in the refrigerator. The DS stated there can be a risk for contamination that can lead to residents getting sick. During an interview on [DATE] at 4:07 p.m. with the Director of Nursing (DON), the DON stated for expired hotdog buns and hamburger buns in kitchen, there can be a risk for residents to consume placing them at can be a risk for gastrointestinal issues and poisoning. The DON stated staff items do not belong in the facility refrigerators as there can be a risk for cross contamination which can lead to residents getting sick. 2. During a concurrent observation and interview on [DATE] at 11:29 a.m. at the nurse's station with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated they label and date food in the resident's refrigerator in the nursing station. LVN 2 stated they could store food for 48 hours and three were unlabeled and undated food inside the resident's refrigerator. LVN 2 stated it was important to label food for them to know how long the food has been in the refrigerator and if it was still okay to consume. LVN 2 stated there was staff food (2 yogurts) that were stored in the resident's refrigerator. LVN 2 staed they were not allowed to store staff food in the resident's refrigerator as they have a separate storage for food for staff and residents but did not know the reason why they were not allowed to do so. LVN 2 stated she needed to discard the foods that were not labeled as it could cause residents sickness such as stomachache when consuming expired foods. During a review of the facility's policy and procedure (P&P) titled, Storage of Food and Supplies, last reviewed [DATE], the P&P indicated food and supplies will be stored properly and in a safe manner. Bread will be delivered frequently and used in the order that it is delivered to assure freshness. During a review of the facility's P&P titled, Employee Meals, last reviewed [DATE], the P&P indicated food [NAME] by employees from outside the facility shall not be kept in the facility's refrigerator in the kitchen nor prepared or reheated in the facility's kitchen. Employees brining food from outside the facility may not keep their food in the refrigerator used to store food for the residents. They may bring food, which can be kept in the employee lounge. (continued on next page)

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 12/31/2024
NAME OF PROVIDER OR SUPPLIER The Grove Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 14122 Hubbard Street Sylmar, CA 91342	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated, ,d+[DATE].17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture's use-by- date if the manufacturer determined the use-by date based on food safety. b. During an observation on [DATE] at 7:04 a.m. with Dietary Aide 1 (DA 1) handwashing, DA 1 washed her hands, held the paper towel push button, and returned to work. During an interview on [DATE] at 8:24 a.m. with the DS, the DS stated after handwashing, staff were not supposed to touch the paper towel notch as it was considered dirty and could contaminate clean hands. The DS stated DA 1 should have rewashed her hands before going back to work and prior to handling food and clean utensils of the residents. The DS stated residents could get sick from contaminated food. During a review of facility's P&P titled Handwashing Procedures, reviewed [DATE], the P&P indicated, Handwashing is important to prevent the spread of infection. When to washed hands: (1) After handling soiled dishes and utensils. (2) Before and after handling foods with the hands (cutting, peeling, mixing). During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated ,d+[DATE].14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S , d+[DATE].12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; P (B) After using the toilet room; P (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in ,d+[DATE].11(B); P (D) Except as specified in ,d+[DATE].11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; P (E) After handling soiled EQUIPMENT or UTENSILS; P (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; P (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; P (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands. c.1. During an observation on [DATE] at 8:05 a.m. of the walk-in freezer, the freezer ceiling had ice crystals. During a concurrent observation and interview on [DATE] at 8:20 a.m., of the walk-in freezer with the DS, the DS stated the ice crystals at the roof of the freezer was caused when the freezer gets defrosted, and it was not acceptable as the temperature could drop and affect the temperature of food causing food borne illnesses if residents consume it. The DS stated she needed to call the maintenance and check if the freezer was properly functioning. (continued on next page)

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	056382	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove Post-Acute Care Center	14122 Hubbard Street Sylmar, CA 91342

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Refrigerator and Freezer dated [DATE], the P&P indicated, Maintaining a clean refrigerator and freezer can improve the safety and quality of your foods. For the best cleaning results, always refer to your owner's manual. 2. During a concurrent observation and interview on [DATE] at 8:15 a.m. of the racks in the dry storage area with the DS, the DS stated, the racks where the cans were stored were dusty to touch. DS stated this was not okay as it could cross-contaminate resident's foods. During a review of the facility's P&P titled Storeroom dated [DATE], the P&P indicated The general cleanliness and care of the storeroom and supplies are important to ensure safe wholesome food. (1) The floor, walls, lights, shelves, and equipment must be kept clean by setting up, maintaining, and monitoring a regular cleaning schedule. Routine inspections must be made to ensure cleanliness and high standards of sanitation. (Refer to shelves, walls, ceiling, and floor cleaning). (2) All will be cleaned weekly and noted on the cleaning schedule. Best to clean prior to food delivery. 3. During a concurrent observation and interview on [DATE] at 8:20 a.m. with the DS, the DS stated the refrigerator gasket had dust debris and needed to be cleaned. The DS stated the refrigerators were cleaned once a month and as needed. The DS stated it was important to maintain the cleanliness of freezer and refrigerators to prevent contamination of food. During a review of the facility's P&P titled Refrigerator and Freezer dated [DATE], the P&P indicated, (5) Wipe down gaskets with soapy water. 4. During a concurrent observation and interview on [DATE] at 8:23 a.m. of the kitchen hood where the staff cook with the DS, the DS stated the kitchen hood vent was cleaned a week ago and the outside company cleaned it last [DATE]. The DS stated the vent was dusty and it was not okay because they were cooking under it. The DS stated they could contaminate the food as dust could fall in the food that they were cooking. During a review of facility's P&P titled Hood, Filters, and Vents, dated [DATE], the P&P indicated, Hoods: Hoods must be cleaned every two weeks and must be free of dust and grease. During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated, ,d+[DATE].11 (A) Equipment Food Contact Surfaces and utensils shall be cleaned: (1) Except as specified in (B) of this section, before use with a different type of raw animal food such as beef, fish, lamb, pork or poultry; (2) Each time there is a change from working with raw foods to working with ready-to-eat food; (3) Between uses with raw fruits and vegetables and with time/temperature control for safety food. (4) Before using or storing a food temperature measuring device, and (5) At the time during the operation when contamination may have occurred. During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated,,d+[DATE].13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated, ,d+[DATE].12 Cooking and Baking Equipment. (A) The food contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours. This section does not apply to hot oil cooking and filtering equipment if it is cleaned as specified subparagraph ,d+[DATE].11 (D)(6). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated, ,d+[DATE].11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under Subparts [DATE]-306. d. During an observation on [DATE] at 8:10 a.m. at the dry storage area, there was 1 dented can stored with the non-dented cans. During a concurrent observation and interview on [DATE] at 8:15 a.m. at the dry storage area with the DS, the DS stated there was one dented can stored with non-dented cans. The DS stated dented cans were placed separately in the rack in the dishwashing area because they could not use it as they were damage and contaminated. The DS stated residents could get sick associated with consuming food from the dented cans, but she could not remember the sickness. During a review of the facility's P&P titled Storeroom dated [DATE], the P&P indicated (2) Leaking or severely dented cans and spoiled foods should be disposed of promptly to prevent contamination of other foods. If damaged when delivered, return them to the purveyor for credit. During a review of the facility's P&P titled Food Storage-Dented Cans dated [DATE], the P&P indicated Policy: Food in unlabeled, rusty, leaking, broken containers or cans with side seam dents, rim dents, or swells shall not be retained or used by the facility. Procedure: All dented cans (defined as a side seam or rim dents) and rusty cans were to be separated from remaining stock and placed in a specified labeled area for return to purveyors for refund. All leaking cans are to be disposed of immediately. During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated, ,d+[DATE].11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under , d+[DATE].12, honestly presented. ,d+[DATE].11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S,d+[DATE].11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 43878 e. During a concurrent observation and interview on [DATE] at 5:28 p.m. with the DS, the DS stated they used a test strip to test the concentration of the sanitizer used in cleaning food preparation surfaces in the kitchen. The DS stated two (2) of the sanitizer test strips had an expiration date of [DATE]. The DS stated test strips should not be expired to ensure it was reading the right concentration of the sanitizer for disinfecting surfaces. The DS stated the test strips had passed the expiration date and it would not be safe to use because it would not be reading the concentration of the sanitizer correctly. The DS stated dishes and food preparation surfaces could be contaminated causing sickness to the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the undated facility's manufacturer's guidelines titled Safety Information on Hydrion pH Test Papers, the manufacturer's guidelines indicated Hydrion pH test papers are marked with an expiration date and will perform as designed until that date as long as they are stored in a dry area, protected from sunlight. During a review of Food Code 2022, dated [DATE], the Food Code 2022 indicated, ,d+[DATE].116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using test kit or other device.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 47441 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly by: a. Not putting a plastic liner in the trash can used in the kitchen. b. Not completely closing 1 (one) of 2 black dumpsters (large trash container designed to be emptied into a truck). These failures had a potential to result to attracting birds, flies, insects, pest and possibly spread infection to 62 of 63 facility residents. Findings: a. During an initial kitchen tour observation on 12/29/2024 at 7 a.m., the trash can in the kitchen had no plastic liner. During a concurrent observation and interview on 12/29/2024 at 8:30 a.m. with the Dietary Supervisor (DS), the DS stated the trash can used for handwashing did not have a plastic lining and it must have it to avoid contamination (transfer of harmful bacteria from one place to another)). b. During an observation on 12/29/2024 at 2:02 p.m. of the dumpster area, one dumpster bin was overflowing in trash and was not completely closed. During a concurrent observation and interview on 12/29/2024 at 5:31 p.m. of the dumpster area outside of the facility with the DS, the DS stated the dumpster was not closed and it was not acceptable as it could attract rats or cats that could spread germs in the facility. During an interview on 12/30/2024 at 11:46 a.m. with the Maintenance Supervisor (MS), the MS stated trash pickup was every day except Sunday. The MS stated the dumpster needed to be closed to prevent mosquitoes and rats that would go to the trash and go inside the facility. The MS stated residents could get sick as animals could spread sickness such as vomiting and diarrhea. The MS stated overflowing trash was not acceptable. During a review of the facility's policies and procedures (P&P) titled Trash Disposal/Dumpster, dated 12/31/2024, the P&P indicated The nursing home is committed to maintaining a clean, safe, and sanitary environment for residents, staff, and visitors. Proper trash disposal procedures shall be followed to prevent contamination, pests, and potential health risks, and to comply with local, state, and federal regulations. Bins must be emptied regularly to prevent overfilling. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.15 Outside receptacles. (A) Receptacles and waste handling units for REFUSE, recyclables, and returnable used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 43878 Based on interview and record review, the facility failed to designate a Medical Director (MD) for 12 months of 12 months (12/30/2023 to 12/30/2024) whose responsibilities were outlined in a job description or facility policy in coordinating of medical care in the facility and failed to submit a MD application to State Agency 1 (SA 1). This failure had the potential to lead to confusion among staff regarding clinical decision-making and accountability. Findings: During an interview on 12/30/2024, at 1:20 p.m., with the Administrator (ADM), the ADM stated their facility license does not show the Medical Director (MD) of their facility. The ADM stated he will submit an MD application to SA 1. During an interview on 12/30/2024, at 3:37 p.m., with the ADM , the ADM stated they do not have policy and procedures and job description for their medical director. The ADM stated they have a physician agreement with their MD commenced on 4/1/2020 and renews yearly. The ADM stated the physician agreement would show their MD's job description. During an interview on 12/30/2024, at 4:18 p.m., with the MD, the MD stated he is involved in seeing the residents of the facility and does follow-up on residents, and if the resident's attending physician is not answering, the facility reaches out to him. The MD stated he attends the quality assurance performance improvement (QAPI - a data driven and proactive approach to quality improvement) meetings. The MD stated he does direct communication with the physicians through phone calls or in-person. The MD stated he participates in the facility assessment during their monthly QAPI and annual meetings. During a concurrent interview and record review with the ADM, on 12/30/2024, at 4:32 p.m., the MD's Physician Agreement, dated 4/1/2020, and the State Operations Manual, dated 8/8/2024, the ADM stated the MD's Physician Agreement does not indicate the MD's responsibilities outlining their participation in organizing and coordinating physician services and services provided by other professionals as they relate to resident care. The ADM stated the job description is there to show the de-alienation of the roles and responsibilities. The ADM stated he does not know how it could hurt the quality of care of the residents of not having a job description or not having a policy and procedure, but he does know it could help. During an interview on 12/31/2024, at 9:15 a.m., with the Director of Nursing (DON), the DON stated if he needs to consult his MD , he will reach out to him when there is an urgent matter and he cannot get a hold of the resident's attending physician to get an order. The DON stated if he needs clarification, he would need to call on the MD's expertise. The DON stated the MD provides oversight of the facility's clinical practices. The DON stated the MD attends their monthly QA meetings and discusses quality of care issues and if the facility had any infection control questions, the questions will be addressed with their panel of physicians.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on interview and record review the facility failed to maintain medical records in accordance with accepted professional standards two of two sampled residents (Resident 33 and 39) investigated under Activities of Daily Living (ADL - activities such as bathing, dressing and toileting a person performs daily) by: 1. Failing to document accurately when showers were provided to Resident 33 from 12/23/2024 to 12/29/2024. 2. Failing to ensure Certified Nursing (CNA) 3 documented accurately Resident 39's bed bath as a shower on 12/27/2024. These failures had the potential to result in inaccurate documentation of the residents' clinical record. Findings: 1. During a review of Resident 33's Admission Record, the Admission Record indicated the facility admitted the resident on 3/3/2021 with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 33's History and Physical (H&P), dated 3/12/2024, the H&P indicated the resident does not have the consent/decision-making capacity due to dementia (a progressive state of decline in mental abilities). During a review of Resident 33's Minimum Data Set (MDS - a resident assessment tool), dated 12/2/2024, the MDS indicated the resident usually understood others and rarely made self-understood. The MDS indicated the resident has severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated the resident is dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) including eating, shower/bathing self, toileting hygiene, and personal hygiene. During a review of Resident 33's ADL Care Plan (CP), dated 12/4/2024, the CP indicated the resident with goals of maintaining current level of function in ADLs. The CP indicated the resident required staff assistance with bathing/showering two times a week and as necessary; to check nail length and trim and clean on bath day and as necessary; and to report any changes to the nurse. During a review of Resident 33's Documentation Survey Report (DCS - a document that details a resident's ability to perform ADL) for the month of 12/2024, the DCS indicated CNA 5 provided Resident 33 bath/towel bath on 12/27/2024, 12/28/2024, and 12/29/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 12/28/2024, at 12:19 p.m., inside Resident 33's room, with Family Member (FM) 1, Resident 33's nails on her left hand were long and chipped. FM 1 stated Resident 33's nails were long and chipped. During a concurrent observation and interview, on 12/29/2024, at 8:00 a.m., inside Resident 33's room, with CNA 4, CNA 4 stated Resident 33's nails on her left hand were long and the second digit next to the pinky finger was chipped. CNA 4 stated she does not know who would trim the resident's fingernails. CNA 4 stated it should have been done last Friday because that was his scheduled shower day. CNA 4 stated CNAs are trained to trim resident's fingernails but she's not sure who trims Resident 33's fingernails. CNA 4 stated residents' fingernails should be trimmed because it is part of the residents' hygiene. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 6, on 12/30/2024, at 12:40 p.m., Resident 33's Care Plans were reviewed and LVN 6 stated he has not received any report from the CNAs regarding Resident 33's noncompliance with shower and/or nail trimming. LVN 6 stated there was no care plan developed for noncompliance of nail trimming. During an interview on 12/30/2024, at 3:50 p.m., with CNA 5, CNA 5 stated he only provides Resident 33's shower every Tuesday and Friday. CNA 5 stated he needs glasses to see and when he was documenting he did not have his glasses on and entered the wrong information. CNA 5 stated he should have documented 1 for shower and not 3 for bed bath. CNA 5 stated he never trimmed the resident's nails because Resident 33 tends to scratch while he provides him care. CNA 5 stated he has not reported to the charge nurse and has not documented on the CNA communication binder. CNA 5 stated he just did not do it. CNA 5 stated Resident 33's tendency to scratch staff is not new, but he has not told his charge nurse. CNA 5 stated he has provided Resident 33 with showers and has not refused. CNA 5 stated he never gave Resident 33 a bed bath and had always been showering during the resident's scheduled shower day. During an interview on 12/30/2024, at 5:40 p.m., with the Director of Staff Development (DSD), the DSD stated when residents refuse to shower or trim their nails, CNAs are expected to notify their charge nurse and document on the communication report binder. The DSD stated for Resident 33, CNAs are expected to trim the resident's fingernails. The DSD stated this should have been done during the resident's shower day, but any other shift, the CNAs can also do it. The DSD stated there should be a communication and a care plan will be developed for multiple instances of refusal. The DSD stated when Resident 33's fingernails are not trimmed, the resident may scratch himself and increase risk for infection due to the scratches or dirt build up underneath the nails. The DSD stated Resident 33's nails should have been trimmed. During a concurrent interview and record review with the DSD, on 12/30/2024, at 5:43 p.m., Resident 33's DCS, dated 12/2024, was reviewed and the DSD stated CNAs are trained to accurately document the care they have provided. The DSD stated the DCS indicated Resident 33 received bed baths daily two to three times a day for the last seven days from 12/29/2024 and every day from 12/23/2024 to 12/29/2024 in the evenings, 3:00 p.m. to 11:00 p.m. shift. The DSD stated Resident 33's DCS does not appear accurate because shower days are about twice a week and more per resident's preference. The DSD stated CNAs should document accurately for consistency and continuity of care. (continued on next page)

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 12/31/2024
NAME OF PROVIDER OR SUPPLIER: The Grove Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 14122 Hubbard Street, Sylmar, CA 91342	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/31/2024, at 9:03 a.m., the Director of Nursing (DON) stated it should be coded accurately and staff are expected to maintain proper documentation. The DON stated the documentation process provides a means of communication to all disciplines. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, last reviewed 10/30/2024, the P&P indicated documentation in the medical record will be objective, complete, and accurate. 47441 2. During a review of Resident 39's Admission Record, the Admission Record indicated the facility admitted Resident 39 on 8/6/2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction (a serious medical condition that occurs when blood flow to the brain is blocked, leading to brain cell death) affecting right dominant side, and essential (primary) hypertension (HTN - high blood pressure). During a review of Resident 39's H&P, dated 8/6/2024, indicated Resident 39 had the capacity to understand and make decisions. During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 39 had the ability to usually understand and was understood. The MDS indicated Resident 39 was dependent (helper does all the effort) with toileting, showering, lower body dressing, and putting on and taking off footwear, and required substantial assistance (helper does more than half the effort) with personal hygiene. During a review of Resident 39's Care Plan for Activities of Daily Living (ADLs - activities related to personal care, including bathing, dressing, and eating), initiated on 8/7/2024, the Care Plan indicated Resident 39 had self-care performance deficit related to activity intolerance, hemiplegia right side, history of CVA, impaired balance with interventions included bathing and or showering totally dependent on one (1) staff to provide shower two times a week and as necessary. During a review of Resident 39's ADL Bathing, dated 12/27/2024, the ADL Bathing indicated Resident 39 had a shower at 10:39 a.m. During an interview on 12/28/2024, at 3:19 p.m., with Resident 39, Resident 39 stated he has not been showered for a week because he requires a mechanical lift (a device used to assist with transfers of individuals who require support for mobility) to be showered and the facility could not find a sling (a fabric device used on lift machines to carry patients in a hammock-type position) and was not able to be showered. Resident 39 stated he gets showered on Tuesdays and Fridays. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with CNA 3, on 12/30/2024, at 10:48 a.m., Resident 39's ADL Bathing, dated 12/2024, was reviewed and CNA 3 stated Resident 39 gets showers on Tuesday and Fridays, requires a sling and mechanical lift to shower. CNA 3 stated the facility has two mechanical lifts and does not have enough slings. CNA 3 stated, when showering, Resident 39 requires one sling to shower and one sling to clean and use for transferring. CNA 3 stated Resident 39 refused to shower on 12/27/2024 but got a bed bath. CNA 3 stated Resident 39 refused to shower because she did not have an extra sling to shower and only had one to use for transferring. CNA 3 reviewed the ADL Bathing for 12/2024 and stated she incorrectly documented Resident 39 was showered and should have documented Resident 39 received a bed bath. During an interview on 12/30/2024, at 4:32 p.m., with the DON, the DON stated CNA 3 documenting a shower instead of the bed bath she gave Resident 39 is inaccurate documentation. The DON stated CNA 3 should have documented she gave Resident 39 a bed bath because it is a risk for inaccurate documentation and is false. During a review of the facility's P&P titled, Charting and Documentation, last reviewed 10/30/2024, the P&P indicated documentation in the medical record will be objective, complete, and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on interview and record review, the facility failed to implement infection control measures by: 1. Failing to ensure water management plan was followed as per policy to prevent legionella (a bacteria that causes Legionnaires' disease -a serious type of pneumonia [lung infection] that can be life-threatening if left untreated. Legionella is found in [NAME] and soil, but it's usually spread through the air when water droplets containing the bacteria are inhaled. This can happen in places that hold or process warm water, like hot tubs, showers, fountains, and cooling towers.) 2. Failing to ensure one of two medication rooms (Medication room [ROOM NUMBER]) was maintained in a sanitary environment. These deficient practices may result in unidentified case of legionella and the spread of infection. 3. Failing to continue to place Resident 52 on contact isolation (keeping a sick person in a separate area to prevent the spread of germs that can be passed through direct touch with them or their environment) when the resident was positive for scabies (a parasitic infestation caused by tiny mites that burrow into the skin and lay eggs, causing intense itching and a rash) and had ongoing treatment with completion date 1/5/2025. This deficient practice had the potential to spread scabies infestation to other residents and staff. 4. Failing to ensure one of one sampled resident (Resident 214) received respiratory care that was consistent with professional standards of practice when on 12/28/2024 Resident 214 was observed wearing a nasal cannula (a medical device that provides supplemental oxygen to a patient through their nose) with no labeled date of when it was last changed. This deficient practice had the potential for risk of infection control. Findings: a. During an interview on 12/29/2024, at 8:08 a.m., with the Maintenance Supervisor (MS), the MS stated they do not have a standard in legionella prevention. During a concurrent interview and record review on 12/29/2024, at 8:15 a.m., with the MS, the facility ' s Water Management Plan dated 6/26/2024, and Daily Temperature Record of Water dated 10/2024, 11/2024 and 12/2024 were reviewed. The Water Management Plan indicated the following: III. Areas where legionella could grow and spread includes cooling tower, boiler, water softener, ice machine, dishwasher, shower heads and faucets and decorative fountain (control points- potential risk areas). (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During a concurrent interview and record review on 12/29/2024, at 1:04 p.m., with the Infection Preventionist (IP), the facility ' s Water Management Committee, dated 4/24/2024, 7/31/2024 and 10/30/2024 and their Water Management Policy last reviewed on 10/30/2024 were reviewed. The Water Management Committee indicated the ADM, the Director of Nursing (DON), the IP, and the MS had attended. The Water Management Policy indicated, 7. The effectiveness of the Water Management Program shall be evaluated no less than annually. Routine infection control surveillance data, water quality data and rounding data shall be utilized to validate the effectiveness. The IP stated she (IP) had never rounded with the MS around the facility to check for Legionella signs. The IP stated if she (IP) had never rounded around the facility she (IP) would not know if there were signs of Legionella. The IP stated she (IP) signed the Water Management Committee because there was an in-service provided by the ADM and the DON. The IP stated she was part of the Water Management Plan team and had never seen the IP surveillance data, the water quality data, and the rounding data indicated in the policy. The IP stated it is important to have those data for the resident safety and to identify areas to test for possible signs of legionella.

During a concurrent interview and record review on 12/29/2024, at 1:11 p.m., with the MS, the MS provided the Daily Temperature Record of Water from the shower room dated 6/2023. The Daily Temperature Record of Water indicated the last date the shower room water temperature was checked was on 6/21/2023. The MS stated he (MS) checked the shower room water temperature but did not document.

During an interview on 12/29/2024, at 1:15 p.m., with the DON, the DON stated the MS should know the potential signs of legionella. The DON stated the shower room water temperature should be checked for resident comfort and prevent burns. The DON stated shower room water temperature should be done and documented daily.

During a concurrent interview and record review on 12/29/2024, at 6:01 p.m., with the DON, facility ' s Water Management Policy last reviewed on 10/30/2024 was reviewed. The Water Management Policy indicated, It is the policy of this facility to establish water management plans to reduce for reducing the risk of legionella and other opportunistic pathogens in the facility ' s water systems.

3.A risk assessment will be conducted by the water management team annually to identify where legionella and other opportunistic waterborne pathogens could grow and spread in the facility ' s water systems. Based on the risk assessment, control points will be identified.

4.Control measure will be applied to address potential hazards at each control point. A variety of measures may be used, including physical controls, temperature management, disinfectant level control, visual inspections, or environmental testing of pathogens.

7. The effectiveness of the Water Management Program shall be evaluated no less than annually. Routine infection control surveillance data, water quality data and rounding data shall be utilized to validate the effectiveness.

12. Documentation of all activities related to the water management program shall be maintained with the water management program binder for a minimum of three years.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a medication storage observation and concurrent interview on 12/28/2024 at 7:31 a.m., with Licensed Vocational Nurse 3 (LVN 3), inside Medication room [ROOM NUMBER], observed one donut wrapped in paper towel placed on top of a drainage kit box. LVN 3 stated medication rooms should not contain food for infection control. During an interview on 12/28/2024 at 11:24 a.m., with the DON, the DON stated there was a signage by the door to remind staff not to leave food inside the medication room for sanitary purposes. During a concurrent interview and record review on 12/30/2024 at 6:01 p.m., with the DON, the facility ' s P&P titled, Medication Labeling and Storage, dated 2/2023 and last reviewed on 10/30/2024 was reviewed. The PP indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. The DON stated no food was allowed in the medication room. 43878 c. During a review of Resident 52's Admission Record, the Admission Record indicated the facility admitted Resident 52 on 6/13/2024 with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), muscle weakness (generalized), and essential (primary) hypertension (HTN-high blood pressure). During a review of Resident 52'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 6/13/2024, the H&P indicated Resident 52 can make needs known but cannot make medical decision, reason: dementia. During a review of Resident 52's Minimum Data Set (MDS - a resident assessment tool), dated 12/18/2024, the MDS indicated Resident 52 had the ability to usually understand others and had the ability to be understood. The MDS indicated Resident 52 was dependent (helper does all the effort) with toileting, showering, lower body dressing, and putting on and taking off footwear, and required substantial assistance (helper does more than half the effort) with personal hygiene. During a review of Resident 52's Physician Order dated 12/3/2024, the Physician Order indicated may have skin scrape (allows visualize of the superficial layer of the skin- the abnormal cells, any infections or even parasites [an organism that lives on or in a host organism and gets its food from or at the expense of its host] or mites [a term commonly used to refer to a group of insect-like organisms, some of which bite or cause irritation to humans] findings) to rule out (to exclude a diagnosis) scabies. During a review of Resident 52's Physician Orders dated 12/4/2024, the Physician's Orders indicated: - Clobestasol propionate (treats a variety of skin conditions) external cream 0.05 percent (%) apply to general body topically every day and evening shift for prurigo nodularis (PN- a chronic skin condition that causes hard, itchy bumps called nodules to appear on the skin) for four weeks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Generalized body dermatitis (broad term that describes various types of skin inflammation) unspecified, apply halobetasol (treats a variety of skin conditions) 0.05% cream to general body twice a day every day and evening shift for four weeks until finished. - Ivermectin (treats skin conditions due to parasites) oral tablet 3 milligrams (mg- a unit of measurement) give 21 mg by mouth one time a day every Thursday for dermatitis unspecified for four weeks until finished. - Dermatitis unspecified apply permethrin (treats a variety of skin conditions) 5% cream 1 tube from neck to toes. Leave on for 12 hours then rinse once a week for four weeks at bedtime every Wednesday for four weeks. - Prednisone (decreases inflammation) oral tablet 10 mg give 3 tablets by mouth one time a day for dermatitis unspecified for 3 days then give 2 tablets by mouth one time a day for dermatitis unspecified for 3 days then give 1 tablet by mouth one time a day for dermatitis unspecified for 3 days. During a review of Resident 52's Diagnostic Laboratories and Radiology results dated 12/7/2024 at 2:07 p.m. , the results indicated scabies mites seen. During a review of Resident 52's Change of Condition (COC) SBAR-Acute COC dated 12/7/2024 at 10:30 p. m., the COC SBAR-Acute COC indicated the facility received result from scabies scrape test. The results indicated scabies mites seen, informed doctor with order to continue 21 mg ivermectin orally every Thursday for four weeks, place resident on contact isolations precautions indefinitely. During a review of Resident 52's Physician Order dated 12/7/2024, the Physician Order indicated ivermectin oral tablet 3 mg give 21 mg by mouth one time a day every Thursday for scabies infection for four weeks until finished. During a review of Resident 52's Care Plan revised on 12/7/2024 for Resident 52's infection and isolation, the Care Plan indicated skin scraping result scabies mites seen with intervention to isolate (contact) precautions for scabies infection. During a review of Resident 52's Physician Order dated 12/8/2024, the Physician Order indicated contact isolation precautions (don [put on] gloves and a gown when entering a patient or resident room and when in contact with the individual, surfaces, or objects within their environment) for scabies infection. During a review of Resident 52's Physician Order dated 12/17/2024, the Physician Order indicated contact isolation precautions for scabies infection was discontinued. During an observation on 12/28/2024 at 7:34 a.m. observed Resident 52's room with no transmission-based precautions, no personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) cart noted. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/29/2024 at 8:06 a.m. with the IP, the IP stated Resident 52 is was no longer on isolation, the isolation was discontinued on 12/17/2024, and that Resident 52 was on contact isolation for 10 days. The IP stated Resident 52 was on isolation for scabies. The IP stated she not sure how long scabies isolation should be for. The IP stated the doctor discontinued the isolation; Resident 52 was still scratching but is on topical medication. The IP stated to determine the treatment is effective is when the rash has improved. During a concurrent interview and record review of the facility's P&P titled, Scabies Identification, Treatment and Environmental Cleaning, on 12/29/2024 at 8:26 a.m. with the IP, the IP stated the P&P indicated to maintain contact precaution until treatment is done or the resident is determined to be scabies free. The IP stated Resident 52 is still on treatment, and no other scraping has been done to determine Resident 52 is scabies free. The IP stated according to their P&P, Resident 52 should still be on contact isolation and staff must wear gown, gloves, all staff including housekeeping and visitors. The IP stated not following contact isolation can be a risk for spread of infection. During an interview on 12/30/24 at 9:15 a.m. with the DON, the DON stated the only way to confirm a resident is scabies free is to do another scrape test to see if there are any mites. The DON stated Resident 52 would still need to be on isolation; stopping isolation prior to completion of treatment and/or confirmed negative scraping can be a risk for the spread of scabies. During a review of the facility's P&P titled, Scabies Identification, Treatment and Environmental Cleaning, last reviewed 10/30/2024, the P&P indicated the purpose of this procedure is to treat residents infected with and sensitized to sarcoptes scabiei (itch mite) and to prevent the spread of scabies to other residents and staff. Maintain contact precautions until treatment is complete and /r resident is determined to be scabies free. During a review of the facility's P&P titled, Isolation-Categories of Transmission-Based Precautions, last reviewed 10/30/2024, the P&P indicated transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. d. During a review of Resident 214 Admission Record, the Admission Record indicated the facility admitted Resident 214 on 9/27/2024 and readmitted the resident on 11/25/2024 with diagnoses including pressure-induced deep tissue damage (when prolonged pressure on a part of the body, like from sitting or lying down for too long, damages the tissues underneath the skin, even if the skin surface appears intact, causing a deep bruise-like area due to poor blood flow to that area) of sacral region (the triangular bone at the base of the spine that connects the spine to the pelvis), muscle weakness (generalized), and unsteadiness of feet. During a review of Resident 214's Minimum Data Set (MDS - a resident assessment tool), dated 11/6/2024, the MDS indicated Resident 214 usually understands others andand was usually understood. The MDS indicated Resident 14 was dependent (helper does all the effort) on oral hygiene, toileting, showering, lower body dressing, putting on and taking off footwear, and personal hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 214's Physician Orders dated 12/9/2024, the Physician Orders indicated oxygen (O2) inhalation at 2 liters per minute (LPM- a unit of measurement) via nasal cannula as needed to keep O2 saturations (measurement of the amount of oxygen in the bloodstream) at 92 percent (%) and above. During an observation on 12/28/2024 at 9:06 a.m. observed Resident 214 sitting up on bed wearing a nasal cannula with oxygen set at 2 LPM, the nasal cannula was noted with no date. During a concurrent observation and interview on 12/28/2024 at 9:53 a.m. with Registered Nurse 1 (RN 1), RN 1 stated nasal cannulas get changed weekly and must indicate the date on the nasal cannula when it was changed. RN 1 stated since Resident 214's nasal cannula does not have a date, they cannot verify when the nasal cannula was last changed placing the resident at risk for infection. During an interview on 12/30/2024 at 4:01 p.m. with the Director of Nursing (DON), the DON stated Resident 214's nasal cannula not being dated can be a risk for infection as the nasal cannula can be dirty and/or old which was why it should be dated. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, last reviewed 10/30/2024, the P&P indicated change humidifiers and tubing weekly unless otherwise directed and discard accordingly.

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 12/31/2024
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)
F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on observation, interview, and record review, the facility failed to meet the requirement for no more than four resident per room for 1 out of 25 rooms (room [ROOM NUMBER]). This deficient practice had the potential to result in inadequate space to provide safe nursing care, privacy for the residents, and limit the residents' ability to maneuver personal care devices. Findings: During an observation tour of the facility on 12/28/2024 at 8:22 a.m. observed room [ROOM NUMBER] with 5 beds, 4 residents were noted occupying the room. The residents had adequate space to move about freely inside the rooms and nursing staff had enough space to safely provide care to these residents, with space for the beds, side tables, dressers, and resident care equipment. During an interview on 12/30/2024 at 1:16 p.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated room [ROOM NUMBER] has 5 beds with 4 residents. CNA 2 stated there were no issues with room space and the staff can safely perform all care and activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) for residents without any issue. During a concurrent interview and record review on 12/30/2023 at 3:20 p.m., a facility letter dated 12/29/2024 was reviewed with the Administrator (Adm). The letter indicated a request for a waiver for the 5 beds in room [ROOM NUMBER], each bed will allow for 92.23 square feet (sq ft - unit of measurement) of space. The Adm stated a request for room waiver was made for room [ROOM NUMBER]. The Adm stated there was no clutter and all residents were happy. The Adm stated if the residents had any concerns, they would try to accommodate their needs. Room # No. # of beds Total Square feet Total square feet per resident/bed 11 5 461.15 92.23 During the recertification survey between 12/28/2024 and 12/30/2024, observed that the above listed room had sufficient space for the residents' freedom of movement. The nursing staff had enough space to provide nursing care, privacy during care, and ability to maneuver residents' care equipment within the room. The room size did not present any adverse effect on the residents' personal space, nursing care, and comfort. During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, last revised on 10/30/2024, the P&P indicated the facility's environment and staff behavior are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being.