

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER The Grove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 12332 Garden Grove Blvd. Garden Grove, CA 92843	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0676</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46128</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of three sampled residents (Residents 1 and 2) were provided the necessary care and services to maintain their ADL capabilities.</p> <p>* The facility failed to ensure Residents 1 and 2's dentures were cleaned and stored properly according to the facility's P&P. These failures had the potential to negatively impact the residents' well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Accommodation of Needs reviewed on 12/19/22, showed the facility will evaluate and make reasonable accommodations for the individual needs and preferences of a resident. Under the Policy Explanation and Compliance Guidelines, based on individual needs and preferences, the facility will assist the resident as much as possible in maintaining and/or achieving independent functioning, dignity, and well-being to the extent possible.</p> <p>Review of facility's P&P titled Care of Dentures reviewed on 12/19/22, showed it is the practice of this facility to provide denture care to residents. Under the Policy Explanation and Compliance Guidelines, dentures may be placed in a properly labeled denture cup with warm water and a commercial denture cleaner and cleaned as per package instructions. Store dentures in a properly labeled denture cup in tepid water when not in use and place in a secure place to prevent loss.</p> <p>1. Medical record review for Resident 1 was initiated on 2/12/25. Resident 1 was admitted to the facility on [DATE].</p> <p>Review of Resident 1's MDS dated [DATE], showed Resident 1 had a BIMS score of 7, which indicated severe cognitive impairment. The MDS further showed Resident 1 required substantial or maximal assistance in oral hygiene.</p> <p>On 2/12/25 at 0830 hours, Resident 1 was observed lying in bed and the resident's denture cup was observed on top of the beside drawer by the resident's bed.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0676</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>On 2/12/25 at 0835 hours, an observation and concurrent interview was conducted with CNA 1 for Resident 1. CNA 1 stated the resident had already eaten breakfast and usually refused to wear her dentures. Resident 1's upper and lower dentures were observed in a denture cup filled with very small amount of clear liquid, resembling water. CNA 1 verified the findings and stated she had not cleaned Resident 1's dentures this morning. CNA 1 further stated Resident 1's dentures should have been cleaned from the previous evening and submerged in water with the denture cleanser tablet.</p> <p>On 2/12/25 at 1158 hours, Resident 1 was observed sitting in the wheelchair in the dining room, waiting to be served lunch. Resident 1 was observed without her upper and lower dentures inside her mouth. Resident 1 shook her head indicating no, when she asked if she wanted to wear her dentures. When Resident 1 was asked if she had any discomfort when she wore her dentures, the resident shook her head again indicating no.</p> <p>On 2/12/25 at 1205 hours, a follow up observation and concurrent interview was conducted with CNA 1 for Resident 1. Resident 1's upper and lower dentures were observed in a denture cup filled with a very small amount of clear liquid, resembling water. CNA 1 stated she offered to place the dentures in for Resident 1 but Resident 1 refused to wear her dentures. When asked, CNA 1 stated she did not clean the dentures when she offered them for Resident 1 to wear. CNA 1 further stated she would clean Resident 1's dentures before her shift ended.</p> <p>On 2/12/25 at 1210 hours, an interview was conducted with LVN 1. LVN 1 stated Resident 1 would sometimes refuse to wear her dentures. However, review of Resident 1's plan of care failed to show a care plan problem addressing the resident's refusal to wear the dentures.</p> <p>2. Medical record review for Resident 2 was initiated on 2/12/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 2's H&P examination dated 8/16/24, showed the resident had no capacity to understand and make decisions.</p> <p>Review of Resident 2's MDS dated [DATE], showed Resident 2 required partial to moderate assistance from the staff for oral hygiene.</p> <p>On 2/12/25 at 0840 hours, an observation and concurrent interview was conducted with CNA 1 for Resident 2. Resident 2 was observed lying in bed. Resident 2's upper and lower dentures were observed in a denture cup filled with a very small amount of clear liquid, resembling water. CNA 1 stated Resident 2 usually refused to wear her dentures. CNA 1 further stated the resident's dentures should have been cleaned from the previous evening and submerged in a water with the denture cleanser tablet. CNA 1 verified the above findings.</p> <p>On 2/12/25 at 0855 hours, an interview was conducted with LVN 1. When asked about the facility's policy regarding denture care for the residents, LVN 1 stated the residents' dentures should be cleaned and stored in water at night. LVN 1 further stated the CNAs were expected to clean the dentures and offer them to the residents in the morning before breakfast.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>On 2/12/25 1220 hours, an interview was conducted with the DSD. The DSD stated the CNAs in the morning shift were expected to clean the residents' dentures every morning, before offering them to the residents. The DSD further stated the CNAs in the evening shift should clean the dentures and store them in water with the denture cleanser tablet.</p> <p>On 2/12/25 at 1552 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated denture care should be provided by the CNAs daily. The DON stated when the residents' dentures were not being used, the dentures should be submerged in water with the denture cleanser tablet. The DON verified there was no care plan addressing Resident 1's refusal to wear the dentures. The DON was informed and acknowledged the above findings.</p>		