

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 02/10/2026
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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of four sampled residents (Resident 1) was readmitted back to the facility. * The facility failed to readmit Resident 1 back into the facility during the seven-day bed hold period. This failure had the potential for Resident 1 to have an inappropriate discharge. Findings: Review of the facility's P&P titled Bed Hold Notice Upon Transfer revised 12/2022 showed the facility must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless:a. the transfer of discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;b. the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;c. the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;d. The resident has failed after reasonable and appropriate notice, to pay for (or to have paid for under Medicare or Medicaid) a stay at the facility. Non- payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge only allowable charges under Medicaid; ande. The facility ceases to operate. Review of the facility's P&P titled Management of Candida Auris revised 12/2022 showed it is the policy of this facility to identify, treat, and control the spread of Candida auris as per current guidelines and standards of practice.a. the resident will be placed on transmission-based contact precautions or enhanced barrier precautions, dependent upon the situation and local or state jurisdiction recommendations. Staff will don the proper PPE prior to giving care to the resident and dispose of it appropriately to prevent the spread of infection.b. The resident may be placed into a single resident room period if a single resident room is not available, the facility may cohort the resident with another resident with the same organism. On 2/6/26, the CDPH L&C Program received a report from the Office of Administrative Hearings and Appeals from the Department of Health Care Services. The report showed Resident 1 was granted an appeal for readmission to the facility on [DATE]. The report further showed the following timeline of events:- on 11/17/25, Resident 1 was transferred from the facility to the hospital for treatment;- on 11/18/25, the hospital case manager requested re-admission of the resident to the facility;- on 11/18/25, the facility informed the hospital case manager the facility would not readmit the resident. A seven-day bed hold was provided to the resident upon transfer to the hospital;- on 11/18/25, the facility was informed the resident tested positive for candida aures while at the hospital and required enhanced standard precautions; and- on 11/19/25, Resident 1 filed an appeal of the facility's refusal to readmit. Closed medical record review for Resident 1 was initiated on 2/6/26. Resident 1 was admitted to the facility on [DATE] and transferred</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555021
		If continuation sheet Page 1 of 4

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>to an acute care facility on 11/17/25. Review of Resident 1's Social Services Assessment-V4 dated 9/19/25, showed the following:- preferred discharge plan was resident prefers to stay LTC; - assistance available at home none; and- additional notes, remains appropriate for LTC due to medical condition, requires extensive to total assistance with ADL's and transfers. Review of Resident 1's eINTERACT Transfer Form V5 dated 11/17/25, showed Resident 1 was transferred to an acute care facility for slurred speech. Review of Resident 1's Progress Note dated 11/17/25, showed Resident 1 was noted with slurred speech. Resident 1 was on the phone with Family Member 1 who contacted emergency medical services because she was concerned for the resident's speech. Paramedics arrived at approximately 2350 hours and Resident 1 was transported to the acute care hospital for further evaluation due to slurred speech. Further review of Resident 1's progress notes from 11/17-11/24/25, showed the resident was out on leave and/or hospitalization. There was no documentation on whether the acute care facility contacted the facility for the resident to return. Review of the facility's Daily Census for 11/18-11/20/25, showed bed hold for Resident 1's room. Further review showed Resident 1 had no other roommates assigned for three days. Review of Resident 1's Order Summary Report for November 2025 did not show a physician's order to transfer Resident 1 to the acute care facility and to have a bed hold in place. Review of the facility document titled Timeline of Events (undated), showed the following:- on 12/17/25 at approximately 1115 hours, the Administrator called Family Member 1 to inform her of the decision to readmit the resident and told her that the facility would accommodate Resident 1 to return to the facility;- on 12/17/25 at 1603 hours, the Administrator informed Family Member 1 a decision would need to be made by the following day so the facility can reserve a bed, and arrange room changes to accommodate his EBP isolation.- on 12/18/25 at 1602 hours, Family Member 1 informed the Administrator Resident 1 preferred not to transfer back to the facility. On 2/6/26 at 0957, an interview was conducted with the Administrator. The Administrator stated Resident 1 was not readmitted back to the facility due to his acute care facility diagnosis of candida auris (MDRO fungal infection), and the facility has not accepted residents with candida auris in the past. The Administrator stated after Resident 1's appeal, the facility offered for Resident 1 to return, but he declined. On 2/6/26 at 1154 hours, an interview was conducted with the DON. The DON stated residents are eligible for readmission within seven days of the bed hold. The DON stated residents with isolation precautions were eligible for readmission. The DON further stated it depended on the isolation, they would have to look at room assignments and cohort if possible since the facility has only one private room that is used for isolation. On 2/6/26 at 1345 hours, the DON verified Resident 1 was in room alone with no other roommates from 11/18-11/20/25, and if he would have been readmitted with candida auris, he would have been in the room alone. On 2/10/26 at 1115 hours, an interview, medical record review, and concurrent facility document review was conducted with RN 1. RN 1 stated contact precautions, or EBP if asymptomatic were required for candida auris. RN 1 further stated residents with candida auris could be cared for at the facility, and there were many EBP residents, as well as contact isolation residents. When asked if Resident 1 had any roommates on 11/18-11/20/25, RN 1 verified there was no one in the room at the time. RN 1 stated if they need an isolation room, they would move residents around to accommodate the isolation. On 2/10/26 at 1459 hours, the DON acknowledged the above findings.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the proper discharge process was followed for three of four sampled residents (Residents 1, 2 and 3) when they were transferred/discharged from the facility. * The facility failed to show Resident 1's written Notice of Transfer/Discharge was provided to the resident upon transfer to acute care. * The facility failed to show Resident 1 was provided with written information about the bed-hold information upon the resident transferring to an acute care hospital. *The facility failed to show the Ombudsman was notified of Residents 1, 2, and 3's transfer/discharge. These failures had the potential for the residents not receiving accurate information about their transfer/discharge status and their rights. Findings: Review of the facility's P&P titled Transfer and Discharge revised 12/2022 showed non-emergency transfers or discharges initiated by the facility: provide transfer/discharge notice to the resident/representative and Ombudsman as indicated.a. emergency transfers/discharges: provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated.b. The Social Services Director or designee, will provide copies of notices for emergency transfers to the Ombudsman.c. In situations where the facility has decided to discharge the resident while the resident is still hospitalized, the facility will send a notice of discharge to the resident and resident representative before the discharge, and must also send a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. Review of the facility's P&P titled Bed Hold Notice Upon Transfer revised 12/2022 showed at the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and address information explaining the return of the resident to the next available bed. In the event of an emergency transfer of a resident, the facility will provide within 24 hours, written notice of the facility's bed-hold policies, as stipulated in the State's plan. 1.a. Closed medical record review for Resident 1 was initiated on 2/6/26. Resident 1 was admitted to the facility on [DATE] and transferred to an acute care facility on 11/17/25. Review of Resident 1's Notice of Transfer/discharge dated 11/17/25, showed Resident 1 was transferred to an acute care facility. Further review of the document showed two carbon copies (white and yellow) present in Resident 1's closed medical record. On 2/10/26 at 1115 hours, an interview was conducted with RN 1. RN 1 stated the process of a transfer would include filling out the Notice of Transfer/Discharge form, and providing the yellow copy to the resident. On 2/10/26 at 1303 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON stated written transfer notice would include to the fill out the Notice of Transfer/Discharge form, fax it to the Ombudsman, and provide the resident the yellow copy. On 2/10/26 at 1449 hours, a follow up interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified the Notice of Transfer/Discharge form dated 11/17/25, showed the white and yellow copy remained in Resident 1's closed medical record. The DON verified the written Notice of Transfer/Discharge was not provided to Resident 1. b. Review of Resident 1's Bed Hold Notification dated 9/18/25, showed blank entries for the Confirmation of Transfer and Bed Hold Provision and 24 Hour Confirmation. On 2/10/26 at 1303 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified the Confirmation of Transfer and Bed Hold Provision for Resident 1 was blank. The DON stated the form should have been filled out. 2.a. Closed medical record review for Resident 1 was initiated on 2/6/26. Resident 1 was admitted to the facility on [DATE] and transferred to an acute care facility on 11/17/25. Review of</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 1's Notice of Transfer/Discharge notice dated 11/17/25, failed to show the Ombudsman was notified. b. Closed medical record review for Resident 2 was initiated on 2/6/26. Resident 2 was admitted to the facility on [DATE] and discharged on 11/5/25. Review of Resident 2's Notice of Transfer/Discharge notice dated 10/23/25, failed to show the Ombudsman was notified. c. Closed medical record review for Resident 3 was initiated on 2/6/26. Resident 3 was admitted to the facility on [DATE] and transferred to an acute care facility on 1/22/26. Review of Resident 3's Notice of Transfer/Discharge notice dated 1/22/26, failed to show the Ombudsman was notified. On 2/6/26 at 1543 hours, an interview and concurrent medical record review for Residents 1, 2 and 3 was conducted with the SSD. The SSD stated when a resident is transferred to an acute care facility, the nurses are responsible to notify the Ombudsman. The SSD further stated when the resident is transferred to another facility or home, the SSD will notify the Ombudsman. The SSD stated when she faxes the Ombudsman of the notification of transfer, she retains a copy of the fax confirmation sheet and attaches it to the Notice of Transfer/Discharge document. The SSD verified the Notice of Transfer/Discharge for Residents 1, 2, and 3 showed blank entries under the section copy to LTC Ombudsman Office-date. The SSD stated it should be filled out. On 2/10/26 at 1303 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged if there was no documented evidence showing the Ombudsman was notified of a resident transfer/discharge, it could not be verified if the task was completed. On 2/10/26 at 1459 hours, the DON acknowledged all the above findings.</p>