STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555021	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove Post Acute	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)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 49044 Based on observation, record review, interviews, and facility policy reviews, the facility failed to ensure an assessment was completed before they applied a bolster mattress to 1 (Resident #292) of 1 sampled resident reviewed for physical restraints to determine whether the bolster mattress was a physical restraint. Findings included: A review of the facility policy titled, Restraint Free Environment, implemented on 12/19/2022, revealed Policy: It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Definitions: Physical Restraint refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. According to the policy, 5. Before a resident is restrained, the facility will determine the presence of a specific medical symptom that would require the use of restraints, and determine: a. How the use of restraints would treat the medical symptom. b. The length of time the restraint is anticipated to be used to treat the medical symptom, who may apply the restraint, and the time and frequency that the restraint will be released. c. The type of direct monitoring and supervision that will be provided during the use of the restraint. d. How the resident will request staff assistance and how his/her needs will be met while the restraint is in place. e. How to assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being. A review of the facility policy titled, Use of Assistive Devices implemented on 12/19/2022, revealed Policy: The purpose of this policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity. Per the policy, 2. The use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care. A review of Resident #292's Admission Record revealed the facility originally admitted the resident on 03/28/2023, with diagnoses to include paroxysmal atrial fibrillation, osteoarthritis of the left hip, hypertensive heart disease, and orthostatic hypotension. Per the Admission Record, the resident had a medical history to include diagnoses of reduced mobility, lack of coordination, dizziness and giddiness, and history of falling. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555021	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove Post Acute	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)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #292's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/26/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The MDS revealed the resident required substantial/maximal assistance with the ability to roll left and right, sit to lying position, and lying to sitting on the side of their bed and was dependent on staff for sit to stand and chair/bed-to-chair transfers. A review of Resident #292's care plan, initiated on 04/04/2023, revealed the resident was at risk for falls related to impaired activities of daily living/mobility function, a history of falls, and multiple diagnoses. The care plan did not include an intervention for the use of a bolster mattress. During an observation on 04/29/2024 at 10:29 AM, Resident #292 was noted lying flat on their back in their bed with high bolsters on each side of the resident. Resident #292 was observed to fit tightly between each bolster that covered the entire length of the bed and were approximately 12 inches tall and six inches wide. During an interview on 04/30/2024 at 1:30 PM the MDS Coordinator stated the bolsters were placed on Resident #292's bed due to the resident falls. During a follow-up interview on 04/30/2024 at 1:37 PM, the MDS Coordinator stated she did not know if the facility assessed Resident #292 to determine if the resident could remove them. During an interview on 05/01/2024 at 2:07 PM, Certified Nursing Assistant (CNA) #1 acknowledged she provided care to Resident #292. CNA #1 stated Resident #292 had the bolster mattress to keep them safe and could not get out of bed when the bolster mattress was on their bed. During an interview on 05/01/2024 at 2:09 PM, Licensed Vocational Nurse (LVN) #2 stated Resident #292 required extensive assistance with activities of daily living. LVN #2 stated Resident #292 had the bolster mattress on their bed to keep them from moving out of the bed. According to LVN #2, the bolster mattress on Resident #292's bed did restrict the resident's movement and if the resident did not have it, the resident might roll out of bed. Per LVN #2, the bolster mattress was placed on Resident #292's bed because the resident had a history of falls. During an interview on 05/01/2024 at 2:46 PM, the Director of Nursing (DON) stated an assessment to determine whether a device is a restraint or not, should be defined more to ensure an assessment was completed. The DON stated an assessment should have been completed during the 04/11/2024 interdisciplinary team meeting for the use of the bolster mattress on Resident #292's bed. During an interview on 05/01/2024 at 3:14 PM, the Administrator stated the facility has had a hard time keeping Resident #292 safe. The Administrator stated he thought Resident #292 had a different type of mattress on their bed and not the bolster mattress. Per the Administrator, he expected an assessment to be completed prior the application of the bolster mattress on the resident's bed to ensure it was not a restraint. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555021	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove Post Acute	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)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/01/2024 at 3:24 PM, the Director of Rehabilitation acknowledged physical therapy had been working with Resident #292 after the resident experienced a fall; however, there was no documentation of what the treatment plan included. The Director of Rehabilitation stated she could see that there needed to be an assessment of Resident #292 for the use of the bolster mattress to determine if the bolster mattress could be a restraint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555021	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove Post Acute	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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 28196 Based on interviews, record review, and facility policy review, the facility failed to ensure a level II mental health evaluation was completed for 1 (Resident #4) of 4 sampled residents reviewed for preadmission screening and resident review (PASARR). Findings included: A review of a facility policy titled, Resident Assessment - Coordination with PASARR Program revised on 12/18/2023, revealed, Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. Per the policy, b. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD [mental disorder], ID [intellectual disability], or related condition. determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. A review of Resident #4's Admission Record revealed the facility admitted the resident on 02/19/2024, with diagnoses that included depression and bipolar disorder. A review of Resident #4's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/23/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident was currently considered by the state level II PASARR process to have a serious mental illness and/or intellectual disability or a related condition. A review of a document from the State of California-Health and Human Services Agency Department of Health Care Services, dated 02/19/2024, revealed Resident #4 had a positive level I screening and a level II mental health evaluation was required. A review of Resident #4's medical record, revealed no evidence to indicate a level II mental health evaluation was completed. During an interview on 04/30/2024 at 10:00 AM, the Administrator stated the facility did not have Resident #4's level II mental health evaluation. Per the Administrator, the Director of Nursing (DON) was responsible for the PASARR follow-up. During an interview on 04/30/2024 at 10:31 AM, the DON stated if a resident had a positive level I screening, he was responsible to ensure the level II mental health evaluation was completed. The DON stated Resident #4's level II mental health evaluation fell through the cracks. During a follow-up interview on 05/01/2024 at 3:15 PM, the Administrator stated he expected the DON to follow up if a resident had a positive level I screening to ensure a level II mental evaluation was completed so that the resident would receive any specialized mental health services deemed appropriate.