STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555613	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grove Care and Wellness	3401 Lemon Street Riverside, CA 92501

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 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** 40000 Based on interview and record review the facility failed to ensure necessary treatment and services to promote healing of pressure injuries (a localized area of skin damage caused by prolonged or intense pressure on the skin, often over bony parts of the body) are provided in a timely manner, for one of three residents (Resident A), when: - The pressure injury on the sacral area (lower portion of spinal column) was not identified on admission and treatment orders not initiated timely; and - Treatment orders were not administered as ordered by the physician. These failures had the potential in the delay in care and treatment of Resident A's pressure injury which could affect healing. Findings: On November 6, 2024, at 12: 30 p.m., an unannounced visit to the facility was conducted to investigate complaints and facility reported incident of quality of care and neglect. On November 6, 2024, at 1:30p.m., an interview and concurrent record review was conducted with the Treatment Nurse (TN). The TN stated when Resident A was admitted to the facility, it was hard to notice the wound on the resident's sacrum, due to the resident ' s dark skin tone. The TN stated Resident A came from the hospital with a scaral wound which was unable to stage because of presence of necrotic tissue (black dead tissue) and was difficult to see and took two people to examine her sacral area because the resident had loose skin around her bottom, it. The TN stated she forgot to document a description of the sacral wound bed on Resident A's skin assessment note, dated October 22, 2024. The TN stated Resident A's sacral wound bed had an eschar (dark colored leathery dead tissue) present when she assessed it on October 15, 2024. The TN stated the facility's protocol for prevention of pressure injury which includes a wound consult. The TN stated usually a wound consultant comes in and would document an assessment of the wound weekly and would give any treatment recommendations for the licensed nurse to implement, but there was no wound consult done. The TN stated she last worked on October 29, 2024, and returned to work on November 5, 2024. On November 6, 2024, at 4:00 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated Resident A did not have an order for a wound care consult upon identification of the pressure injuries. The DON stated but Resident A did not see a wound care consultant. (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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 6, 2024, a review of Resident A ' s medical record was conducted. Resident A was admitted to the facility on [DATE], with diagnoses which included a urinary tract infection (bladder infection) and dementia (problems with thinking and remembering). A review of Resident A's Initial Admission Record, dated October 14, 2024, indicated, .Patient had dry skin on lower extremities and red heel, has edema (swelling) at both lower extremities and her left upper arm. Has pressure injury on sacrum .Signed date: 11/04/2024 (November 4, 2024) . A review of Resident A's Audit Report .Admission Assessment, dated November 12, 2024, indicated documentation on the pressure injury on the sacrum was added on November 4, 2024, and not on admission on October 14, 2024. A review of Resident A's care plan, dated October 14, 2204, indicated, .has pressure ulcer development r/t (related to) poor mobility, requires assistance with adls (Activities of Daily Living) .pt (patient) admitted with left heel P/I .sacrum p/i .right heel p/i .Interventions .Administer treatments as ordered and monitor its effectivenesss .Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress . A review of Resident A's Order Summary Report, indicated the following physician's order: - .(L)(left) heel P/I (pressure injury): Cleanse with NS (normal saline) pat dry apint (sic) with betadine cover with DD (dry dressing) every day shift for 21 days ., date ordered October 15, 2024; - .(R)(right) heel P/I: with NS pat dry apint (sic) with betadine cover with DD (dry dressing) every day shift for 21 days ., date ordered October 15, 2024; - .Sacrum P/I: Cleanse with NS pat dry apply xeroform cover with DD every day shift for 21 days ., date ordered October 15, 2024; and - .Sacrum P/I: Cleanse with NS pat dry paint with beetadine cover with DD every day shift for 21 days ., date ordered October 19, 2024. A review of Resident A ' s Treatment Administration Records (TAR), indicated all treatment orders were completed on the day the treatment was scheduled for October 2024. A review of Resident A's Administration Audit Report, indicated the following: - Left heel treatment scheduled for October 15, 2024, was documented as administered on October 19, 2024; - Sacrum pressure injury treatment scheduled for October 16, 17, and 18, 2024, was documented as administered on October 19, 2024; - Right heel treatment scheduled for October 16, 17, 18, and 19, 2024, was documented as administered on October 22, 2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s undated policy titled, Change of Condition Reporting, indicated, .all changes in resident condition will be communicated to the physician .timely notification of a change in resident condition . change in a resident ' s condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit .or acute care evaluation .document resident change of condition and response in nursing progress notes per policy and update resident care plan, as indicated . comprehensive care plan completed . A review of the facility ' s policy and procedures titled, Skin Management System, dated December 2023, indicated, .Residents will have a head to toe skin assessment by a licensed nurse at the time of admission. Any skin lesions will be documented on the Nursing Admission Assessment. A treatment order will be obtained from the attending physician for areas requiring treatment .A plan of care will be initiated to address areas of actual skin breakdown. The plan of care will be reviewed and revised as needed. Resident will have ongoing head to toe assessment done weekly, incorporated into the LN Weekly Summary review .report of all wounds and their progress will be updated by the treatment nurse weekly .