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	04/09/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a thorough investigation was conducted to address a grievance filed regarding care provided, for one of three residents reviewed (Resident A), when Resident A notified the facility staff that the Registered Nurse smelled alcohol while providing care to her.This failure resulted in Resident A's grievance not being investigated in a prompt manner and the resident was fearful of the RN caring for her. In addition, this failure had the potential for other residents' psychosocial well-being to be affected.Findings:On March 11, 2026, at 8:45 a.m., an unannounced visit was made to the facility regarding a facility reported incident.On March 11, 2026, at 12:40 p.m., a review of Resident A's medical record was conducted. Resident A was admitted to the facility on [DATE] with diagnoses which included osteomyelitis (bacterial infection of the bone causing swelling, fever, tissue damage), bacteremia (presence of bacteria in the blood in an immunocompromised individual), and MRSA (Methicillin-resistant Staphylococcus aureus - a type of bacteria that is resistant to several antibiotics).A review of Resident A's Change in Condition Evaluation, dated March 8, 2026, at 10:04 p.m., indicated; .false allegation towards staff and falsifying stories.resident having false accusations.On March 11, 2026, at 2:30 p.m., an interview was conducted with the Administrator (Admin). The Admin stated the following:-The Director of Nursing (DON) informed him about Resident A's concern regarding the Registered Nurse (RN), who was noticed to have an odor of alcohol while beginning her intravenous (IV- through the veins) line procedure;-The RN on the afternoon shift was working with Licensed Vocational Nurse (LVN) 1, who had called the DON on March 7, 2026, to inform the DON about Resident A's allegation on the RN. LVN 1 informed the DON that she did not smell alcohol on the RN, and then the DON spoke with the RN, who also denied drinking alcohol;-He spoke with the RN who had denied using alcohol, as well as LVN 1 verifying the RN did not smell alcohol;- The Admin stated he did not interview Resident A or other residents regarding the incident. The Admin stated he did interview other staff working with the RN the evening of the incident; and- The Admin stated he is the Grievance Officer for the facility, the protocol is if a resident files a grievance, an investigation is to be started. The Admin stated he is aware LVN 2 completed a change of condition form regarding Resident A. The Admin stated they should have followed their policy and procedure on addressing grievances.On March 11, 2026, at 2:55 p.m., an interview was conducted with LVN 2. LVN 2 stated she was receiving report on March 8, 2026, and the staff were discussing Resident A's allegation that the RN was smelling of alcohol. LVN 2 stated she notified the DON, the DON instructed her to do a change of condition form and write a care plan regarding the incident. LVN 2 stated she did not talk with the RN, nor did she speak with Resident A, she filled out the change of condition form and wrote what the DON told her to write about false allegations.On March 11, 2026, at 3:15 p.m., an interview was conducted with Resident A. Resident A stated there was a male nurse who came to her room to check on her IV line and gave her medicine. Resident A stated the RN had alcohol on his breath, and the RN acted arrogantly towards her. Resident A stated she told another employee about the alcohol smell on the RN. Resident A stated no one came to talk with her about the incident.A review of the facility's policy and procedure (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled Grievances, dated April 2025, indicated, .establish a grievance process that allows the resident (s) a way to execute their right to voice concerns or grievances to the facility or other agency/entity without fear of discrimination or reprisal.the behavior of staff.make prompt efforts to resolve grievances that the resident may have.facility's grievance official is responsible for overseeing the grievance process and for receiving and tracking grievances.coordinating with state and federal agencies.reasonable expected time frame for completing review of the grievance.Grievance Official evaluates and investigates the concern and takes immediate action to resolve the concern and prevent further potential violations of any resident's right while the alleged violation is being investigated.responds to the individual expressing the concern within (3) three working days of the initial concern to acknowledge receipt and describe steps taken toward resolution.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure transmission-based precautions (additional infection control measures used for patients with suspected or confirmed highly transmissible pathogens) were implemented according to the facility's policy and procedure, for two of three residents reviewed (Residents A and B).This failure had the potential for Residents A and B to be exposed to further infections.Findings:On March 11, 2026, at 8:45 a.m., an unannounced visit was conducted for the investigation of infection prevention and control.On March 11, 2026, at 9:20 a.m., an interview with the Infection Preventionist (IP) was conducted. The IP stated there are several residents on enhanced barrier precautions (EBP - Infection control measures used in nursing homes to minimize the spread of infections during high contact care-requiring staff to wear gowns and gloves) and a few residents on contact isolation (mandatory use of gloves and gowns upon room entry and removed before exiting the room) at this time in the facility.On March 11, 2026, at 12:15 p.m., a concurrent observation and interview were conducted with the Certified Nurse Assistant (CNA). The CNA entered Resident A and Resident B's room, which had the sign on door indicating, Contact Isolation. The CNA was observed applying gloves to deliver the meal tray to Resident A, removed her gloves, and grabbed another meal tray from another CNA in the hallway and delivered the meal tray to Resident B. The CNA was observed to have not put on a gown when she was serving Residents A and B's meal tray. The CNA was observed not to perform hand hygiene between caring for the two residents. The CNA came out of the room and stated only Resident A is on contact isolation. The CNA stated she should have worn gown and gloves when serving Resident A's meal tray and should have used hand hygiene (washing hand with soap and water or using an alcohol-based sanitizer) before taking Resident B's meal tray to her.On March 11, 2026, at 12:30 p.m., an interview was conducted with the IP. The IP stated the CNA should have followed proper infection prevention and control protocol, she should have worn gown and gloves when she helped Resident A, and performed hand hygiene before helping Resident B.On March 11, 2026, at 12:40 p.m., a review of Resident A's medical record was conducted. Resident A was admitted to the facility on [DATE] with diagnoses which included osteomyelitis (bacterial infection of the bone causing swelling, fever, tissue damage), bacteremia (presence of bacteria in the blood in an immunocompromised individual), and MRSA (Methicillin-resistant Staphylococcus aureus-a type of bacteria that is resistant to several antibiotics).A review of Resident A's Order Summary Report, included a physician's order, dated March 3, 2026, which indicated, TRANSMISSION BASED PRECAUTIONS CONTACT ISOLATION.On March 11, 2026, at 4 p.m., a review of Resident B's medical record was conducted. Resident B was admitted to the facility on [DATE], with diagnosis which included dementia (impaired ability to remember, think, or make decisions) and bipolar disorder (mental health condition characterized by extreme mood swings).A review of the facility's policy and procedure titled IPCP (Interprofessional Collaborative Practice) Standard and Transmission-Based Precautions, dated March 2025, indicated, .implement infection control measures to prevent the spread of communicable diseases.contact precautions.are used with a known infection that is spread by direct or indirect contact with the resident or the resident's environment.personal protective equipment (PPE): wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment.Don (put on) PPE before room entry doff (remove) before room exit; change before caring for another resident.A review of the policy and procedure titled Infection Prevention and Control Program, dated January 2026, indicated, .decrease the risk of infection to residents and personnel. Recognize infection control practices while providing care.ensure compliance with state and federal regulations related to infection control.prevent and control the spread of infection.investigate, control and prevent infections in the facility.hand hygiene and appropriate use of personal protective equipment (PPE-specialized clothing [gloves, gowns, masks, goggles] used to prevent the spread of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infections).facility personnel will conduct themselves and provide care in a way that minimizes the spread of infection.facility personnel will wash their hands after each direct resident contact for which hand washing is indicated by acceptable professional practice.A review of the facility's undated policy and procedure titled Infection Prevention-Hand Hygiene, indicated, .all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.before and after direct contact with residents.after removing gloves.before and after entering isolation precaution settings.before and after assisting a resident with meals.the use of gloves does not replace hand washing/hand hygiene.gloves should be used.when in contact with a resident, or the equipment or environment of a resident, who is on contact precautions.