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	01/30/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41459 Based on observation, interview, and record review, the facility failed to ensure a care plan was developed and implemented to address a personal monitoring device used to measure blood glucose levels, for one of 15 residents (Resident 14). This failure had the potential for staff to not be aware of Resident 14 care needs and provide appropriate treatment related to the blood sugar monitoring device. Findings: On January 28, 2025, at 3:20 p.m., Resident 14 was observed at the nurse's station trying to get the attention of the nursing staff due to his Dexcom (brand name of a blood glucose monitoring device inserted under the skin) monitor showing an increase in blood sugar. On January 29, 2025, at 4:30 p.m., an interview was conducted with Resident 14. Resident 14 stated he would show the staff his personal blood glucose monitor when his blood sugar would increase or decrease. Resident 14 stated his blood sugar increased and licensed nursing staff would not give insulin (medication that helps regulate blood sugar levels) until the licensed nurse performed the blood sugar check at 4:30 p.m. Resident 14 stated he had a personal blood glucose monitoring device inserted under the skin that could monitor the blood glucose levels. Resident 14 stated the device would alarm if the blood sugars increased or decreased. Resident 14 stated he should get the blood glucose device inserted under his skin every 10 days. On January 29, 2025, a review of Resident 14's Admission Record, indicated, Resident 14 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (the body has trouble controlling blood sugar). A review of Residents 14's Medication Administration Record, included a physician order, dated January 8, 2025, which indicated, .Dexcom G7 Sensor Miscellaneous (Continuous Glucose System Sensor) Inject 1 application subcutaneously in the evening every 10 day(s) for blood sugar checks. Change Dexcom G7 Sensor every 10 days . Further review of Resident 14's record indicated there was no care plan developed to address the use of the personal blood glucose monitoring device. (continued on next page)

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 29, 2025, at 5:40 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the licensed nurses should compare the blood sugar results from Resident 14's Accu-Check with the Dexcom monitor reading. The DON stated there was no care plan for the use of the Dexcom . The DON stated there should be a care plan to address the use of the Dexcom device for Resident 14. A review of the policy and procedure titled Comprehensive Resident Centered Care Plan, dated January 2022, indicated, .It is the policy of this facility that the interdisciplinary team (IDT - a group of healthcare professionals) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframe to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment .within 48 hours of the resident's admission, the facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person centered care .the baseline care plan will include the minimum healthcare information necessary to properly care for the resident including, but not limited to: initial goals based on admission orders .physician orders .dietary orders .therapy orders .social services orders .and PASARR recommendations, if applicable . the residents comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments .

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41459 Based on observaton, interview, and record review, the facility failed to ensure care and treatment was provided according to the physicians orders and plan of care, for two of 15 residents (Residents 14 and 286) when: 1. For Resident 14 and 286, the blood sugar levels were outside of the parameters and; 2. For Resident 14, the blood pressure (B/P - force exerted by blood against the walls of the arteries) was not monitored prior to administering the medication to treat high blood pressure. These failures had the potential for a delay in care and treatment and could cause a decline in the residents overall health condition. Findings: 1a. On January 28, 2025, at 3:20 p.m., Resident 14 was observed at the nurses station trying to get the attention of the nursing staff due to his Dexcom (brand name of a blood glucose monitoring device inserted under the skin) monitor showing an increase in blood sugar. On January 29, 2025, at 4:30 p.m., an interview was conducted with Resident 14. Resident 14 stated he would show the staff his personal blood glucose monitor when his blood sugar would increase or decrease. Resident 14 stated his blood sugar increased and licensed nursing staff would not give insulin (medication to help regulate blood sugar levels) until the licensed nurse performed the blood sugar check at 4:30 p.m. Resident 14 stated he had a personal blood glucose monitoring device inserted under the skin that could monitor the blood glucose levels. Resident 14 stated the device would alarm if the blood sugars increased or decreased. A review of Resident 14's Admission Record, indicated, Resident 14 was admitted to the facility on [DATE], with diagnoses which included, diabetes mellitus (the body has trouble controlling blood sugar). A review of Resident 14's Minimum Data Set (MDS - a resident assessment tool), indicated Resident 14 had a Brief Interview for Mental Status (BIMs - short cognitive screening test) score of 15 (cognitively intact). A review of Resident 14's Medication Administration Record, included a physician order, dated January 14, 2025, which indicated, .Insulin Lispro (medication which regulates blood sugar) Injection Solution 100 unit/ml (milliliter - unit measurement), insulin Lispro Inject as per sliding scale: if 150 - 200 = 2 units; 201-250 = 4 units; 251- 300 = 6; 301- 350 = 8; 351- 400 = 10; 401- 450 = 12; 451- 500 = 14 units over 500 administer 14 units and notify md (physician), subcutaneously (beneath the skin) before meals and at bedtime for diabetes mellitus . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 14's Progress Notes, for the month of January indicated, a blood sugar level of 500 on January 14, 2025, at 4:30 p.m. A further review of Resident 14's record indicated, there was no notification provided to the physician on January 14, 2025 at 4:30 p.m. when Resident 14's blood sugar level was 500. On January 30, 2025, at 4:06 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the blood sugar of 500 on January 14, 2025, at 4:30 p.m., was not reported to Resident 14's physician and should have been. 1b. A review of Resident 286's Admission Record, indicated Resident 286 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus. A review of Resident 286's Minimum Data Set (MDS - a resident assessment tool), dated January 27, 2025, indicated Resident 286 had a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). A review of Resident 286's Physician Order, dated January 23, 2025, indicated, .Insulin Aspart (medication used to decrease blood sugar levels) Injection Solution (Insulin Aspart) Inject as per sliding scale: if 70 - 150 = 0; 151 - 200 = 2U; 201-250 = 4U; 251-300 = 6U; 301-400 = 10U BS (blood sugar) over 400 call Medical Doctor (MD - physician) subcutaneously before meals and at bedtime for diabetes mellitus . A review of Resident 286's Medication Administration Record, for the month of January 2025, indicated a blood sugar level of 442, on January 23, 2025, at 9 p.m. Further review of Resident 286's record indicated there was no documented evidence the physician was notified of Resident 286's blood sugar level of 442 (above 400), on January 23, 2025, at 9 p.m. On January 30, 2025, at 5:02 p.m., an interview and concurrent record review was conducted with the DON. The DON stated if the blood glucose level is above 400, the licensed nurse should give 10 units of insulin and notify the physician. The DON further stated the physician was not contacted when Resident 286 blood sugar level was 442 on January 23, 2025, at 9 p.m. A review of the policy and procedure titled, Diabetes Mellitus - Resident Management, revised January 2025, indicated, .medication management .follow physician's order for glucose monitoring .specific resident need . notify the residents physician when blood sugars are out of range per orders . 2. A review of Resident 14's Admission Record, indicated Resident 14 was admitted to the facility on [DATE], with diagnoses which included heart failure. A review of Resident 14's Physician Order, dated December 27, 2024, indicated, Lisinopril (medication used to treat high blood pressure) Oral Tablet 20mg (milligram - unit of measurement). Give 1 tablet by mouth in the evening for Hypertension (pressure in blood vessels is to high) HOLD if SBP (systolic blood pressure) is < (less than) 110. A review of the Medication Administration Record, dated January 2025, indicated, Resident 14 SBP was not taken prior to administering Lisinopril on January 2, 5, 10, 11, 13, 14, 15, 16, 18, 19, 20, 21, 22, 25, 26, 27, 28, and 30, 2025 (18 days). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 30, 2025, at 5:58 p.m., an interview and concurrent record review was conducted with the DON. The DON stated licensed nurse should check and document the resident's blood pressure prior to administering lisinopril for Resident 14. The DON stated licensed nursing need to follow the physician orders to know if it was appropriate to administer the medication according to the parameters ordered by the physician. The DON stated if lisinopril was given when the blood pressure is below the parameters, the resident could experience adverse effects from a low blood pressure. A review of the policy and procedure titled Medication Administration, dated January 2025, indicated . administering unit doses and previously prepared drugs .take vital signs if required .hold drugs if indicated .

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46393 Based on observation, interview, and record review, the facility failed to ensure provision of pharmacy services met the needs of the residents, when Resident 18 was missing documentation for the administration of a controlled substance (CS - those with high potential for abuse and addiction) medications, during the medication cart inspection. The CS medication was signed out of the Controlled Medication Count Sheet (an inventory sheet that keeps record of the usage of controlled medications) but not documented on the Medication Administration Records (MAR) to indicate it was administered to the resident. Additionally, the CS medication was wasted (not administered to the resident and discarded) without two licensed nurses' documentation on the count sheet according to the facility's policy for Resident 18. These failures resulted in inaccurate accountability of CS medications, which had the potential for misuse or diversion. Findings: On January 27, 2025, Resident 18's record was reviewed. Resident 18 had a physician's order, dated November 16, 2024, for hydrocodone-acetaminophen (Norco, a potent controlled medication for pain) 5/325 mg, 1 tablet by mouth every 8 hours as needed for severe pain. On January 27, 2025 at 10:53 a.m., during an interview with Licensed Vocational Nurse (LVN) 1, she stated the facility's process for CS medication administration was as follows: - Ask the resident about pain location; - Check the Count Sheet to find out when pain medication was last given; - Pour pain medication (remove from locked drawer of medication cart); - Sign Count Sheet and MAR at the same time; and - If the pain medication was not given or refused by a resident, need to waste with another nurse witness and both nurses needed to sign the Count Sheet. On January 27, 2025, at 10:58 a.m., during a concurrent interview and record review with LVN 1, a review of Resident 18's Controlled Medication Count Sheet, for Norco 5/325 mg and the Medication Administration Record, for the months of November and December 2024, indicated Norco was signed out from the count sheet but was not documented as administered on the MAR on the following dates and times: - November 29, 2024, at 20:57 (8:57 p.m.); - December 8, 2024 at 21:15 (9:15 p.m.); (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- December 18, 2024 at 21:24 (9:24 p.m.); - December 20, 2024 at 21:04 (9:04 p.m.); and - December 26, 2024 at 05:20 (5:20 a.m.). In a concurrent interview, LVN 1 acknowledged one Norco 5/325 mg tablet for Resident 18 was unaccounted in November 2024 and four Norco 5/325 mg tablets were unaccounted in December 2024. Additionally, Resident 18's Count Sheet for Norco 5/325 mg indicated one tablet was wasted on December 21, 2024 at 21:04 (9:04 p.m.) and did not have a second nurse witness documented on the Count Sheet. LVN 1 stated the nurse should have had another nurse sign on the Count Sheet as a witness for the wasted Norco 5/325 mg tablet. On January 28, 2025 at 2:08 p.m. during an interview with the Director of Nursing (DON), the DON stated the expectation during CS medication administration was for the nursing staff to have immediately document on the count sheet and in the MAR. The DON confirmed the discrepancies and acknowledged the missing documentations in the MAR for the dates and times as listed above for Resident 18. The DON stated the administrations should have been documented on the MAR. Additionally, the DON stated the expectation for wasting CS medications was for two licensed nurses to co-sign. The DON stated nursing staff must document wasted on the Count Sheet with two licensed nurse initials every time. The DON said, [Nurses] Cannot destroy [CS medication] without a witness. The DON confirmed and acknowledged the Norco 5/325 mg tablet was wasted without two licensed nurses' initials on December 21, 2024, at 21:04 (9:04 p.m.) for Resident 18. The DON stated documentation of CS medication was important to prevent diversion and to ensure residents received the medication but not double dosed if too soon to be given. The DON stated following the process for wasting CS medication was important for accountability and transparency to prevent diversion. A review of the facility's policy and procedure titled Medication Administration, dated August 2021, indicated, . The staff administering the medication must record such information on the resident's MAR before administering the next resident's medication . During a review of the facility's P&P, titled Controlled Medications - Storage and Reconciliation, dated January 2022, the P&P indicated, When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: date and time of administration; amount administered; signature of the nurse administering the dose, completed after the medication is actually administered .When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It must be destroyed in the presence of two licensed nurses and the disposal documented on the accountability record, on the line representing that dose .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46393 Based on interview and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities during the monthly medication regimen review (MRR), for one of five residents reviewed for unnecessary medications (Resident 10), when Resident 10 received sertraline (brand name for Zoloft, medicatuion used to treat depression) without an appropriate indication and/or clinical justification for its use. This failure had the potential for medications not being optimized for best possible health outcome, and unnecessary or prolonged use of medications which could lead to medication adverse effects for the residents. Finding: On January 29, 2025, a review of Resident 10's clinical record indicated Resident 10 was initially admitted to the facility on [DATE] and recently readmitted on [DATE] with diagnoses which includes major depressive disorder (depression). A review of Resident 10's medical record indicated she had received sertraline prescribed for depression on December 7, 2021 to November 5, 2024. A review of Resident 10's medical record included a physician's order, dated November 6, 2024, which indicated sertraline 150 milligrams (mg - unit of measurement) by mouth one time a day for chronic pain. A review of Resident 10's medical record indicated a current physician's order dated January 23, 2025 for sertraline 150 mg by mouth one time a day every Monday, Wednesday, Friday, Sunday for chronic pain and one time a day every Tuesday, Thursday, Saturday for chronic pain. On January 29, 2025 at 4:07 p.m., during a concurrent interview and record review with the Director of Nursing (DON). The DON stated the physician orders indicated sertraline was initially prescribed for depression on December 7, 2021 to November 5, 2024 and the indication was changed to chronic pain on November 6, 2024 to January 23, 2025. When asked if there was documentation of the clinical justification for the new indication chronic pain, the DON stated she would follow-up. During the same interview, the DON stated the facility's psychotropic medication administration and monitoring process was as follows: - Upon admission of a resident with psychotropic medications, the facility needed to ensure the resident had a physician's order for the psychotropic medication with an accurate diagnosis and corresponding behavior manifestation; - If the physician's order was unclear, nursing staff needed to clarify with the physician; (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Psychotropic medications were reviewed monthly, or more often if needed, by the Interdisciplinary team (IDT) which included the Social Services Director, the DON or designee, the Activities Director, and other staff involved in the residents' care; and - All psychotropic medications were reviewed by a psychiatric provider and the Consultant Pharmacist (CP). A review of the CP's monthly MRRs for Resident 10 on November 25, 2024, December 31, 2024, and January 18, 2025, indicated there were no recommendations from the CP related to the sertraline indication change from depression to chronic pain. On January 29, 2025 at 5:33 p.m., during a follow-up interview with the DON, the DON confirmed there was no documentation in Resident 10's medical record of the clinical justification for the new sertraline indication of chronic pain on November 6, 2024 and stated there should have been documentation. Additionally, the DON stated the CP should have identified the indication change and reported the irregularities during the MRRs on November 25, 2024, December 31, 2024, and January 18, 2025. On January 30, 2025 at 2:33 p.m., during a telephone interview with the CP, the CP stated the MRR process was as follows: - Medications for all residents were reviewed monthly, including review of the MAR, laboratory results, diagnoses, and documentation of clarifications; and - If medication changes or adjustments were needed, the CP sent the documented recommendations to the facility. During the same telephone interview, the CP stated she did not identify or report when the sertraline indication was changed from depression to chronic pain for Resident 10 during the MRRs on November 25, 2024, December 31, 2024, and January 18, 2025. The CP acknowledged the irregularity should have been identified and reported. A review of the facility's policy and procedure titled Medication (Drug) Regimen Review (MRR), revised January 2022, indicated, .The MRR includes identification of irregularities, medication-related errors, adverse consequences, and use of unnecessary drugs .Unnecessary drug is defined as medications ordered .without adequate indications for its use .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46393 Based on interview and record review, the facility failed to ensure, one of five residents reviewed for unnecessary medications (Resident 10), was free from unnecessary psychotropic (drugs that affects brain activities associated with mental processes and behavior) medications when Resident 10 was administered sertraline (brand name Zoloft, used to treat depression) without an appropriate indication and/or clinical justification for its use. This failure resulted in unnecessary medications for Resident 10, which increased the potential for medication interactions, adverse reactions, and unidentified risks associated with the use of sertraline that included but not limited to sexual dysfunction, diarrhea, nausea, and seizures. Finding: On january 29, 225, a review of Resident 10's clinical record indicated she was initially admitted to the facility on [DATE] and recently readmitted on [DATE] with diagnoses including major depressive disorder (depression). A review of Resident 10's medical record indicated she had received sertraline prescribed for depression on December 7, 2021 to November 5, 2024. A review of Resident 10's medical record included a physician's order, dated November 6, 2024, for sertraline 150 milligrams (mg - unit of measurement) by mouth one time a day for chronic pain. A review of Resident 10's medical record indicated a current physician's order dated January 23, 2025 for sertraline 150 mg by mouth one time a day every Monday, Wednesday, Friday, Sunday for chronic pain and one time a day every Tuesday, Thursday, Saturday for chronic pain. On January 29, 2025 at 4:07 p.m., during a concurrent interview and record review with the Director of Nursing (DON), Resident 10's medical record and sertraline physician orders, dated December 7, 2021 to January 23, 2025, were reviewed. The physician orders indicated sertraline was initially prescribed for depression on December 7, 2021 to November 5, 2024 and the indication was changed to chronic pain on November 6, 2024 to January 23, 2025. When asked if there was documentation of the clinical justification for the new indication chronic pain, the DON stated she would follow-up. During the same interview, the DON stated the facility's psychotropic medication administration and monitoring process was as follows: - Upon admission of a resident with psychotropic medications, the facility needed to ensure the resident had a physician's order for the psychotropic medication with an accurate diagnosis and corresponding behavior manifestation; - If the physician's order was unclear, nursing staff needed to clarify with the physician; (continued on next page)

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Psychotropic medications were reviewed monthly, or more often if needed, by the Interdisciplinary team (IDT) which included the Social Services Director, DON or designee, the Activities Director, and other staff involved in the residents' care; and - All psychotropic medications were reviewed by a psychiatric provider and the Consultant Pharmacist. On January 29, 2025 at 5:33 p.m., during a follow-up interview with the DON, the DON confirmed there was no documentation in Resident 10's medical record of the clinical justification for the new sertraline indication chronic pain on November 6, 2024 and stated there should have been documentation. On January 30, 2025 at 10:33 a.m., during an interview with the Social Services Director (SSD), the SSD stated the facility's psychotropic medication review process was as follows: - The day after an admission, any resident with psychotropic medications were reviewed to ensure the appropriate medication orders were obtained; and - Psychiatric consults were scheduled with the appropriate provider if needed. During the same interview, the SSD reviewed Resident 10's medical record and sertraline orders dated December 7, 2021 to January 23, 2025. The SSD acknowledged sertraline was initially prescribed for depression on December 7, 2021, and the indication was changed to chronic pain on November 6, 2024. The SSD stated there was no documentation of an initial psychiatric assessment on November 5, 2024 (the day the resident was admitted) or on November 6, 2024 (the day after admission). Additionally, the SSD reviewed the LN [Licensed Nurse] - Psychoactive Medication Evaluation, dated November 6, 2024 and confirmed the evaluation did not indicate why sertraline indication was changed to chronic pain. The SSD stated there should have been documentation in Resident 10's medical record of the clinical justification for the new sertraline indication chronic pain on November 6, 2024. The SSD stated the Interdisciplinary Team (IDT) had a meeting on December 16, 2024 to review Resident 10's reported issues from the weekend and did not discuss the sertraline indication change from depression to chronic pain. On January 30, 2025, at 2:21 p.m., during a follow-up interview with the DON, she stated it was important for psychotropic medications to have a clear indication and documented clinical justification for use to ensure appropriate monitoring for effectiveness and to ensure the resident was provided the correct medication. A review of the facility's policy and procedure titled Psychotropic Drug Use, dated August 2017, indicated, . The Licensed Nurses shall review the classification of the drug, the appropriateness of the diagnosis, and its indication/behavior monitors and related adverse side effects prior to verification of admission orders the Attending Physician .Upon initial comprehensive assessment, the Social Services designee shall review new admissions for any psychiatric, mood or behavior disorders, mental and psychosocial difficulties, and/or physician's orders for psychotropic medications. These residents will be referred to the facility's Psychotropic Drug Review Committee and/or the Psychiatrist to ensure .Psychotropic medication was prescribed to treat a specific diagnosed condition as documented in the clinical record . (continued on next page)

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	01/30/2025

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for sertraline, revised August 2023, indicated, Indications and Usage .indicated for the treatment of .Major depressive disorder (MDD) in adults .Obsessive-compulsive disorder (OCD) in adults and pediatric patients 6 years and older .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41459 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food practices were provided, when: 1. Lettuce and stalks of celery were found in the walk-in refrigerator, open to air; 2. A small container of elbow macaroni was not dated or labeled; and 3. One tin container was placed on top of another tin container touching cut up watermelon. These failures had the potential to cause growth of harmful bacteria in food served to a medically compensated population. Findings: 1. On January 27, 2025, at 9:47 a.m., during the initial kitchen tour with the Dietary Manager (DM), small heads of lettuce and stalks of celery were found in unsealed plastic bags observed to be open to air stored in the walk-in refrigerator. On January 27, 2025, at 10:20 a.m., an interview was conducted with the Dietary Manager (DM). The DM stated the lettuce and celery were in the walk-in refrigerator exposed to air and should not be exposed to air. A review of the facility's policy and procedure titled Storing Produce, dated 2023, indicated, .When storing vegetables that should remain crisp, such as lettuce and other leafy greens, fresh herbs, celery, green peppers, broccoli, and asparagus, they will stay fresh longer if you place them in a sealed bag or container . keeping fresh vegetables tightly wrapped with as little air in the bag/container as possible will keep them fresh longer . 2. On January 27, 2025, at 10:34 a.m. an observation was conducted in the dry storage area where a small container of elbow macaroni was found undated and unlabeled. On January 27, 2025, at 10:36 a.m., an interview with the DM was conducted. The DM stated all the containers should be dated and labeled. A review of the policy and procedure titled Labeling and Dating of Foods, 2023, indicated, .All food items in the storeroom, refrigerator, and freezer need to be labeled and dated based on established procedures for either food safety or product rotation .the individual opening or preparing a food shall be responsible for date marking at the time of processing and/or storage .the use by date will incorporate the open date .the use by date signifies the date in which food must be consumed or discarded . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On January 29, 2025, at 10:15 a.m., during a follow up observation in the kitchen, the dietary aide was observed preparing fruit for lunch. The Dietary Aide (DA) was observed cutting watermelon and putting in a tin container. The DA was observed to stack another tin container with whole fruit inside on top of the tin container with watermelon and was touching the watermelon. On January 29. 2025, at 10:15 a.m., an interview was conducted with the DA. The DA stated one container fell inside the container with the watermelon. On January 29, 2025, at 10:19 a.m., an interview was conducted with the Certified Dietary Manager (CDM) who stated the watermelon was contaminated and needed to be discarded. A record review of the policy and procedure titled Food Preparation, 2023, indicated, .consider all raw product as contaminated .handle it with methods designed to reduce existing contamination or to prevent cross contamination to other products .keep raw and cooked foods separate .use separate cleaned and sanitized cutting boards, utensils, and knives when moving between working with raw and cooked foods .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41459 Based on observation, interview, and record review the facility failed to ensure infection control practices were followed when the Certified Nursing Assistant (CNA) was observed not to perform hand hygiene prior to and after passing out lunch trays. This failure had the potential for staff to spread infection to residents who are already medically compromised. Findings: On January 29, 2025, at 11:48 a.m., CNA 1 was observed passing out lunch trays without washing or sanitizing his hands. On January 29, 2025, at 12:00 p.m., an interview was conducted with CNA 1. CNA 1 stated he should have washed and sanitized his hands prior to touching the lunch tray and after placing the tray with the resident. On January 30, 2025, at 10:23 a.m., an interview was conducted with the Infection Preventionist (IP). The IP stated during meal distribution prior to touching plates, staff should wash or sanitize their hands before and after handling each tray and after every three residents, the staff should wash their hands. A review of the policy and procedure titled Hand Hygiene, 2023, indicated, .use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after direct contact with residents .before and after entering isolation precaution settings .before and after eating or handling food .before and after assisting a resident with meals .