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 _____	C 11/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE CARE AND WELLNESS	3401 LEMON STREET RIVERSIDE, CA 92501

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey to investigate a complaint. Complaint number: CA00552013 Representing the California Department of Public Health: Surveyor 34388, HFEN The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Three deficiencies were issued for complaint number: CA00552013	F 000	**This document will serve as a credible allegation of our intent to correct deficient practices identified. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code.**	
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 315	F 315 ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Resident A discharged from the facility on 9/6/2017. ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by the identified practice. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;***	12/26/17

17 DEC 14 PM 3:20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Operations Manager — (X6) DATE: 12/14/17

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.

APOC JBa 34388 12/20/17

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F 315	Continued From page 1 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that the staff followed the facility's policy and procedure (P&P) for intake and output (fluid intake and urine output) documentation for one of four sampled residents (Resident A) in a universe of 34 when it was determined that the volume of output from the resident's Foley catheter (a thin sterile tube inserted into the bladder to drain urine) had not been documented. This failure had the potential for changes in hydration or kidney function to go unidentified. Findings: On September 12, 2017, at 8:50 a.m., an unannounced visit was made to the facility for the investigation of a complaint regarding quality care	F 315	DSD inservice to licensed staff on proper documentation of I&O will be conducted on 12/15/2017. Medical Records Director (MRD) will conduct regular audits on I&O documentation completion. ***How the facility plans to monitor its performance to make sure that solutions are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;*** Results of the audits conducted by MRD will be discussed in QA/QAPI meeting at least quarterly.	

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F 315	Continued From page 2 and treatment. On September 12, 2017, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on July 19, 2017, with diagnoses that included acute osteomyelitis of right femur (infection in bone), pressure ulcer stage 4 (injury to the skin and underlying tissue that is deep and reaches into muscle and bone), paraplegia (paralysis of the legs and lower body), neuromuscular dysfunction of the bladder (lack of bladder control), dehydration, and gastroenteritis and colitis (inflammation of the stomach or intestine due to infection). A review of Resident A's facility, "History and Physicals," (H&P) dated July 20, 2017, failed to indicate if the resident had capacity to understand and make decisions. Review of Resident A's document titled, "Physician Orders for Life Sustaining Treatment," (POLST) dated July 20, 2017, indicated, "Attempt Resuscitation/CPR," (lifesaving technique used in emergencies when breathing or heartbeat have stopped). The POLST further indicated that medical interventions were to include, "Full Treatment- primary goal of prolonging life by all medically effective means." Review of Resident A's facility document titled, "Order Summary Report," dated August 31, 2017, indicated an order dated July 19, 2017, for an "INDWELLING CATHETER 16FR (French- size of tubing)/10CC (cubic centimeter) BALLON	F 315		

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F 315	Continued From page 3 CLOSED DRAINAGE SYSTEM SECONDARY TO (sic) RELATED TO STAGE 4 TO RIGHT ISHIUM (lower and back part of the hip bone) as needed." Further review of Resident A's facility medical record found no documentation of intake or output. A request was made to the facility for documentation of Resident A's intake and output. A copy of the resident's intake was faxed by the facility and received on September 13, 2017. After review of the faxed documentation it was determined that there was no output documentation sent as had been requested. On September 14, 2017, at 11:10 a.m., a call was placed to the facility to again request output documentation for Resident A. At that time a phone interview was conducted with the Minimum Data Set nurse (MDS) (a nurse who conducts federally mandated assessments). The MDS nurse was asked about the facility's policy for documenting output for a Resident with a Foley catheter. The MDS nurse stated that there should have been output documented for the resident. The MDS nurse further stated that it was a normal process especially for residents with a Foley catheter to document output. The MDS nurse stated, "We have to monitor intake and output the entire stay." A request was made again for output documentation. Additional facility records for Resident A were	F 315		

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F 315	Continued From page 4 received from the facility and reviewed on September 15, 2017. No documentation of output was found. On September 19, 2017, at 11:02 a.m., a phone interview was conducted with the facility's Administrator (AD) and Director of Nursing (DON). The AD and DON were asked about output documentation for Resident A. The DON stated that the facility was "informally" documenting the output. The DON was asked if that was the facility policy. The DON stated that per the facility policy intake and output should have been recorded. Review of the facility policy titled, "Intake & Output Documentation," revised May 2007, indicated, "It is the policy of this facility that fluid intake and output shall be recorded for each resident with an indwelling Foley catheter...2. The intake and output (I&O) information is to be recorded at the end of each shift by a licensed nurse..."	F 315		
F 502 SS=D	ADMINISTRATION CFR(s): 483.50(a)(1) (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a laboratory test was performed	F 502	F 502 *How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Resident A discharged from the facility on 9/6/2017 date *How the facility will identify other residents having the potential to be*	12/26/17

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F 502	Continued From page 5 on the date ordered by the physician for one of four sampled residents (Resident A) in a universe of 34. This failure had the potential to negatively impact the physical well-being of the resident. Findings: On September 12, 2017, at 8:50 a.m.; an unannounced visit was made to the facility for the investigation of a complaint regarding quality care and treatment. On September 12, 2017, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on July 19, 2017, with diagnoses that included acute osteomyelitis of right femur (infection in bone), pressure ulcer stage 4 (injury to the skin and underlying tissue that is deep and reaches into muscle and bone), paraplegia (paralysis of the legs and lower body), neuromuscular dysfunction of the bladder (lack of bladder control), dehydration, and gastroenteritis and colitis (inflammation of the stomach or intestine due to infection). Review of Resident A's facility record found a physician order dated August 26, 2017, at 1:19 p.m., that indicated, "Stool culture for cdiff (Clostridium difficile- inflammation of the colon caused by the bacteria) one time only for cdiff until 08/27/2017 (sic) 23:59 Stool culture." Review of a facility progress note for Resident A, dated August 26, 2017, at 2:53 p.m., indicated,	F 502	***affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by the identified practice. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;*** DON inservice licensed staff on 12/14/17 regarding 24 hour chart check to audit follow through of physician orders. MRD will conduct regular audits of licensed staff 24 hour chart check of physician orders. ***How the facility plans to monitor its performance to make sure that solutions are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;*** Results of the audits conducted by MRD of the licensed staff physician order completed audits will be discussed in QA/QAPI meeting at least quarterly.	

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F 502	Continued From page 6 "...patient still having loose stools, doctor notified pending stool sample on 8/28/2017. Still (sic) on strict contact precautions for c-diff pending stool sample..." Review of a facility progress note for Resident A, dated August 26, 2017, at 3:36 p.m., indicated, "Patietn (sic) is status post antbiotic (sic) treatment for c.diff. Patient is noted to have continued lose (sic) stool consitent (sic) with C.diff. Physician notified and orders given for: Stool culture for cdiff one time only for cdiff until 08/27/2017, 23:59 Stool culture (sic) Continue contact precautions until stool culture results are reported. Start Date: 8/27/2017. End Date: 8/27/2017..." Further review of Resident A's facility record found a progress note dated August 27, 2017, at 2:39 p.m., that indicated no stool was collected. Review of a facility progress note for Resident A, dated August 27, 2017, at 3:43 p.m., indicated, "...patient continues on strict contact precautions for c-diff pending stool sample..." No documentation was found that indicated why the stool culture had not been obtained on August 27, 2017, as ordered by the physician. Review of a facility progress note for Resident A, dated August 29, 2017, at 1:03 p.m., indicated, "...with x2 (two times) episode of loose stool reported..."	F 502		

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F 502	Continued From page 7 Review of a Resident A's facility document titled, "Diagnostic Laboratories & Radiology," indicated the C. Difficile toxin was collected on August 30, 2017, at 2:15 a.m. Review of a facility progress note for Resident A, dated August 30, 2017, at 3:47 p.m., indicated, "Reported C-diff stool sample to MD (doctor). Stool is negative for C-diff at this time..." Further record review found no facility progress note that indicated when the actual stool sample had been obtained or why it had not been done on August 27, 2017, as ordered. On September 12, 2017, at 1:38 p.m., a concurrent interview and record review were conducted with the facility's Director of Nursing (DON). The DON was provided a copy of the physician's order for the stool sample to be collected on August 27, 2017, and provided the lab documentation that indicated it had not been done until August 30th. The DON was asked if it was the facility's policy to follow a physician's order and if an order had called for a lab to be done on August 27th should it have been done. The DON nodded stated, "Uh huh." Review of the facility policy titled, "Physician Order, Transcribing," revised May 2007, indicated, "...7. Lab orders are transferred to the Laboratory request computer and physician's order sheet...All lab orders will be verified by Unit	F 502		

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F 502	Continued From page 8 Nurse Manager. All labs are to be charted in Nursing Notes when drawn, including site where labs obtained...9. All new orders are to be documented in Nursing Notes..."	F 502		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F 514	F 514 ***How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Resident A discharged from the facility on 9/6/2017 date ***How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;*** All residents have the potential to be affected by the identified practice. ***What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;*** DSD inservice to licensed staff on 12/20/2017 regarding accurately monitoring vital signs and notification of change of condition to physician. DSD inservice to licensed staff on 12/20/2017 in regards to accurate and complete documentation. MRD will conduct regular audits of change of condition notification and of the complete and accurate medical record documentation by licensed staff. ***How the facility plans to monitor its performance to make sure that solutions***	12/26/17

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F 514	Continued From page 9 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to maintain complete and accurate clinical records for one of four sampled residents (Resident A) in a universe of 34, when: 1. A low blood pressure of 98/61 (average is 120/80) had been documented for three consecutive days without being rechecked or verified for accuracy; 2. A blood pressure had been documented as 79/58 and no documentation had been made that indicated it had been rechecked for accuracy or that the physician had been notified for a change of condition; 3. The resident's pressure ulcer (injury to the skin and underlying tissue) was inaccurately documented on facility medical records as a sacrococcyx (tailbone) wound instead of a right ischium (lower and back part of the hip) wound; 4. The resident's Treatment record (TAR) had missing documentation that indicated treatments were performed as ordered by the physician; and 5. The TAR was missing documentation for physician ordered monitoring of the indwelling catheter (a thin sterile tube inserted into the bladder to drain urine). Findings:	F 514	***are sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system;*** Results of the audits conducted by MRD of change of condition notification and the complete and accurate licensed staff documentation will be discussed in the QAPI/QA meeting at least quarterly.	

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F 514	Continued From page 10 On September 12, 2017, at 8:50 a.m., an unannounced visit was made to the facility for the investigation of a complaint regarding quality care and treatment. On September 12, 2017, a review of Resident A's facility medical record was conducted. Resident A was admitted to the facility on July 19, 2017, with diagnoses that included acute osteomyelitis of right femur (infection in bone), pressure ulcer stage 4 (injury to the skin and underlying tissue that is deep and reaches into muscle and bone), paraplegia (paralysis of the legs and lower body), neuromuscular dysfunction of the bladder (lack of bladder control), dehydration, and gastroenteritis and colitis (inflammation of the stomach or intestine due to infection). A review of Resident A's facility, "History and Physicals," (H&P) dated July 20, 2017, failed to indicate if the resident had capacity to understand and make decisions. The H&P further indicated, "DIAGNOSIS: chronic decubular (pressure ulcer) R (right) ischium..." Review of a facility progress note for Resident A, dated August 9, 2017, at 2:01 p.m., indicated, "...VITAL SIGNS: BP (blood pressure) 98/61-8/9/2017 (sic) 14:02 (2:02 p.m.) Position: Sitting r (right)/arm..." There was no documentation found that indicated the low BP was rechecked. Review of a facility progress note for Resident A, dated August 10, 2017, at 4:03 p.m., indicated,	F 514		

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F 514	Continued From page 11 "...VITAL SIGNS: BP 98/61- 8/9/2017 (sic) 14:02 Position: Sitting r/arm..." There was no documentation found that indicated the low BP was rechecked. Review of a facility progress note for Resident A, dated August 11, 2017, at 4:15 p.m., indicated, "...VITAL SIGNS: BP 98/61- 8/9/2017 (sic) 14:02 Position: Sitting r/arm..." There was no documentation found that indicated the low BP was rechecked. Review of a facility progress note for Resident A, dated August 24, 2017, at 11:33 p.m., indicated, "...vs: (vital signs) temp (temperature) 98.3 (sic) pulse 69 (sic) resp (respirations) 18 (sic) 79/58..." There was no documentation found that indicated the extremely low BP was rechecked or that the physician had been notified of a change in condition. Review of Resident A's facility record titled, "ORDER SUMMARY REPORT," dated August 31, 2017, indicated an order to, "CLEAN STAGE FOUR TO SACROCOCCYX WITH WOUND CLEANER, PAT DRY AND APPLY NPWT (negative-pressure wound therapy) Q3 (every 3) DAYS AND PRN (as needed), REASSESS X 21 (times 21) DAYS every 3 days (sic) every 3 days." Review of Resident A's TAR for July and August of 2017, indicated, "CLEAN STAGE FOUR TO SACROCOCCYX WITH WOUND CLEANER, PAT DRY AND APPLY NPWT Q3 DAYS AND PRN, REASSESS X 21 DAYS every 3 days (sic)	F 514		

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THE GROVE CARE AND WELLNESS	3401 LEMON STREET RIVERSIDE, CA 92501

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F 514	Continued From page 12 every 3 days." Further review of Resident A's TAR for the month of August 2017, found blank boxes for the physician ordered treatments to the sacrococcyx for Monday August 7th, Wednesday August 16th, and Friday August 25th. The blank boxes on the TAR indicated the treatments had not been performed as ordered. Review of Resident A's facility care plan with an initiated date of August 23, 2017, indicated, "Focus: Has pressure ulcer of Right Ischium..." The care plan further indicated, "Interventions...Administer treatments as ordered and monitor for effectiveness..." Review of Resident A's facility record titled, "ORDER SUMMARY REPORT," dated August 31, 2017, indicated the following order, "INDWELLING CATHETER URINE MONITORING Q (every) SHIFT FOR S/S (signs and symptoms) OF INFECTION SUCH AS FEVER..." Review of Resident A's TAR for the month of July 2017, found blank boxes for the physician ordered monitoring on Monday July 24th and Thursday July 27th for the PM (evening) shift. These blanks indicated the resident's catheter had not been monitored as ordered on those two dates in July. Review of Resident A's TAR for the month of	F 514		

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 _____	C 11/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE CARE AND WELLNESS	3401 LEMON STREET RIVERSIDE, CA 92501

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F 514	Continued From page 13 August 2017, found blank boxes for the physician ordered monitoring on August 5th, 6th and 15th for the NOC (night) shift, August 18th for the PM shift, and August 24th and 25th NOC shift . These blanks indicated the resident's catheter had not been monitored as ordered on those six dates in August. Review of Resident A's TAR for the month of September 2017, found a blank box for the physician ordered monitoring on the PM shift of Saturday September 2, 2017. This blank indicated the resident's catheter had not been monitored as ordered on that one date in September. On September 12, 2017, at 1:38 p.m., an interview was conducted with the Director of Nursing (DON). The DON was asked about Resident A's blood pressure that had been documented as 79/58 on August 24, 2017. The DON stated that the documentation was most likely a "typo." (mistake made in typed or printed text) On September 14, 2017, at 3:51 p.m., a phone interview was conducted with the author of the August 24th progress note that had documented the Resident A's blood pressure of 79/58. The LVN stated that the documentation "must have been a typo." On September 19, 2017, at 11:02 a.m., a phone interview was conducted with the facility's Administrator (AD) and DON. The AD and DON	F 514		

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 _____	C 11/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE CARE AND WELLNESS	3401 LEMON STREET RIVERSIDE, CA 92501

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F 514	Continued From page 14 were asked about the documentation of Resident A's blood pressure as 98/61 for three consecutive days without being rechecked. The DON stated that the blood pressure should have been rechecked. The AD and DON were then asked about the inaccurate documentation of the resident's pressure ulcer on facility records, about the blanks on the TAR and were asked the facility's expectation for accuracy and completeness in the medical record. The DON stated that it was expected that the staff document accurately. Review of the facility policy titled, "Documenting and Charting," revised May 2007, indicated, "It is the policy of this facility to provide: 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc...C. Do not leave blank lines..."	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
555613 Y1	A. Building B. Wing Y2	12/20/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GROVE CARE AND WELLNESS	3401 LEMON STREET RIVERSIDE, CA 92501

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0315 Reg. # 483.25(e)(1)-(3) LSC	Correction Completed 12/20/2017	ID Prefix F0502 Reg. # 483.50(a)(1) LSC	Correction Completed 12/20/2017	ID Prefix F0514 Reg. # 483.70(i)(1)(5) LSC	Correction Completed 12/20/2017
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Tracey Haeleme	1/8/18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
			HFES	

FOLLOWUP TO SURVEY COMPLETED ON	
11/27/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO