STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER: Pine Grove Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE: 126 N. San Gabriel Blvd. San Gabriel, CA 91775	

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) was free from the use of physical restraints (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) in accordance with the facility policy. On 10/3/24, Certified Nurse Assistant (CNA) 3 wrapped Resident 1's torso (the main part of the body that contains the chest, stomach, pelvis, and back) with a white sheet as an abdominal binder (a wide compression belt that encircles the stomach) preventing resident's normal access to his torso. This deficient practice had the potential to negatively affect Resident 1's physical and psychological wellbeing and quality of life. Cross reference with F609. Findings: During a review of Resident 1's Admission Records indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (stroke - damage to the tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 1's History and Physical Examination (H&P) dated 4/27/24, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 7/30/24, indicated Resident 1 was cognitively (a mental process of acquiring knowledge and understanding) impaired. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for upper body dressing and personal hygiene and was totally dependent on staff for lower body dressing, shower/bathe self, and toilet hygiene. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent review of the facility's record titled Progress Notes, dated 10/8/24 at 18:36 PM, indicated on 10/3/24 at 11:15 PM, the progress notes indicated, Resident 1's torso was wrapped with a white sheet as an abdominal binder (a wide compression belt that encircles the stomach). The progress notes indicated, Resident 1 tend to self-scratch, so the nursing staff was trying to prevent this from occurring and the incident took place while charge nurse was making her round. During a telephone interview with CNA 3 on 10/10/24 at 1:32 PM, CNA 3 stated she used the white sheet to tuck Resident 1's stomach to prevent the resident's access to her abdominal area and from scratching herself, or pulling her gastrostomy tube (G-tube, a small tube that is surgically inserted through the abdominal wall and into the stomach to provide nutrition, fluids and medicine), and/or pull the incontinent brief. During a concurrent interview with License Vocational Nurse (LVN) 2 on 10/10/24 at 2:14 PM. LVN 2 stated, Resident 1 was confused and had episodes of trying to pull the resident's G-tube and incontinent brief. LVN 2 stated she observed a white sheet wrapped around Resident 1's stomach on 10/3/24 at 11:15 PM. LVN 2 stated CNA 3 confirmed to LVN 2 that CNA 3 used the white sheet to wrap Resident 1's abdominal area/ torso to prevent the resident from accessing the resident's abdominal area. During a concurrent record review of Resident 1's medical record and interview with Registered Nurse (RN) 1 on 10/10/24 at 3:25 PM, RN 1 stated Resident 1 had episodes of removing or pulling out her G-tube, and the resident had the tendency to scratch herself. RN 1 stated the CNA 3 was not supposed to wrap Resident 1's torso with a white sheet as a convenience to prevent resident from pulling out the resident's G-tube or scratching self. During an interview with the Administrator (ADM) on 10/10/24 at 4:18 PM, the ADM stated the staff should follow facility policies to obtain physician's order, assessment, and consent for the use of physical restraint if needed. The ADM stated, any restraints should be a medical necessity, and not as a convenience to the staff. During review of the facility's policy and procedure titled, Restraints, dated 3/27/24, the purpose of the policy was to ensure that all restraints were used properly and only when necessary for residents in the facility. The policy indicated that the facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. Restraints required a physician order and were used as a last resort to be used only when deemed necessary by the Interdisciplinary Team (IDT, a group of health care professional with various areas of expertise who work together toward the goals of their residents), and in accordance with the resident's assessment and Plan of Care.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44018 Based on interview and record review, the facility failed to report the suspected abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) and physical restraint (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) of resident to the long-term care (LTC) ombudsman (advocates for residents of nursing homes), Law Enforcement, and State Survey Agency State Survey Agency within 2 hours after the allegation oh physical restraint occurred for one of two sample residents (Resident 1) in accordance with the facility's Restraint prevention policy by failing. This deficient practice had the potential to place Resident 1at risk for further abuse and delay of investigation. Cross reference with F604. Findings: During a review of Resident 1's Admission Records indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (stroke - damage to the tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). During a review of Resident 1's History and Physical Examination (H&P) dated 4/27/24, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 7/30/24, indicated Resident 1 was cognitively (a mental process of acquiring knowledge and understanding) impaired. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for upper body dressing and personal hygiene and was totally dependent on staff for lower body dressing, shower/bathe self, and toilet hygiene. During a concurrent interview with License Vocational Nurse (LVN) 2 on 10/10/24 at 2:14 PM. LVN 2 stated Resident 1 was confused and had episodes of trying to pull her G-tube (a flexible, soft tube that's surgically inserted into a person's stomach to provide nutrition and medication) and incontinent brief. LVN 2 stated she observed a white sheet wrapping around Resident 1's stomach while she was making round on 10/3/24 at 11:15 PM. LVN 2 stated CNA 3 confirmed that CNA 3 used the white sheet to wrap Resident 1's stomach to prevent the resident's access to the resident's abdominal area. LVN2 stated, she immediately reported the incident to the Registered Nurse (RN) 1. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with RN 1 on 10/10/24 at 3:25 PM, RN 1 stated the incident happened on 10/3/24, at 11:15 PM, Certified Nursing Assistant (CNA) 3 wrapped Resident 1's torso (main part of the body that contains the chest, abdomen {stomach}, Pelvis, and back) with a white sheet to prevent Resident 1's access to the resident's abdominal area and from removing the incontinent brief. RN 1 stated LVN 2 did report the allegation of physical restraint/ abuse to Resident 1 however, RN 1forgot to report it to the Administrator (ADM). During an interview with the ADM of the facility on 10/10/24 at 4:18 PM, Admin stated she was informed of an alleged physical restraint to Resident which happened on 10/3/24 during the staff meeting on 10/8/24 at 6:36 PM. The ADM stated the staff should have reported the incident to the ADM immediately, so she could report the incident to the State Survey Agency within two (2) hours per facility policy, however, RN 1 forgot to do it. During a review of the facility's policy and procedure titled, Restraints dated 3/27/24, indicated that the facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. Restraints require a physician order and are used as a last resort to be used only when deemed necessary by the Interdisciplinary Team (IDT, a group of health care professional with various areas of expertise who work together toward the goals of their residents), and in accordance with the resident's assessment and Plan of Care. During a review of the facility's policy and procedure titled, Abuse Prevention and Management dated 6/12/24, indicated use of physical or chemical restraints for discipline or convenience was defined as using such restraints when they were not required to treat the resident's medical symptoms. The policy also indicated allegations of abuse, or reasonable suspicion of a crime were to be reported to the ADM or designated representative immediately. The ADM or designated representative would notify law enforcement, by telephone immediately, or as soon as practicably possible, but no longer than two (2) hours of an initial report and send a written SOC341 report to the long-term care (LTC) ombudsman, Law Enforcement, and State Survey Agency within 2 hours.