STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055056	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Grove Healthcare & Wellness Centre, LP	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide adequate intervention such as bed alarm (a safety device, often for the elderly or those with dementia, that alerts caregivers when a person tries to get out of bed), to monitor/document sleeping pattern and inform the resident's physician of any insomnia (trouble falling asleep or staying asleep) or anxiety (natural feeling of worry, fear, or unease, often a physical and emotional reaction) for one (1) of two (2) sampled residents (Resident 1) who was assessed as at risk for fall. This deficient practice resulted in Resident 1 sustaining a fall in the resident's room on 12/31/2025 around 5:30 AM. Resident 1 was found on the floor on the right side of the bed and was assessed to have a small abrasion (a superficial skin injury, also known as a scrape) measuring 2 centimeters (cm, unit of measurement) on the left forehead.Findings: During a review of Resident 1's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), hypertension (HTN-high blood pressure), and legal blindness (severe vision loss). During a review of Resident 1's Fall Risk Evaluation, dated 11/12/2025, the Fall Risk Evaluation indicated Resident 1 was at risk for fall. The Fall Risk Evaluation indicated the following:Level of consciousness / mental status = Intermittent confusion (experiencing temporary, recurring periods where you can't think clearly)Ambulation / elimination status = Bed bound / Incontinent (involuntary leakage of urine or stool).Vision status = Poor During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 11/12/2025, the MDS indicated Resident 1's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 1 has impairment on both upper extremities, and one side impairment on lower extremity. Resident 1 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with rolling left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed. The MDS indicated Resident 11 has no history of falls. During a review of Resident 1's Care Plan (CP), revised on 11/18/2025, it indicated Resident 1 has coronary artery disease (fatty buildup narrows or blocks the arteries) related to hypercholesterolemia (having abnormally high levels of fats in your blood) and HTN. The CP intervention indicated to monitor/document sleeping pattern and inform the resident's physician of any insomnia or anxiety. Give sedatives (a drug or substance that calms you down) as ordered. During a review of Resident 1's CP, revised on 11/18/2025, it indicated Resident 1 is at risk for falls. The CP indicated the following interventions: If a resident is a fall risk, initiate fall risk precautions.May put bed to the lowest position every shift for safety and history of fall related to restlessness. During a review of Resident 1's CP initiated on 4/1/2025, and revised on 11/18/2025, it indicated Resident 1 is (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at risk for falls related to confusion, gait/balance problems, poor communication/comprehension, unaware of safety needs, and restlessness while in bed. The CP indicated interventions included the following:Anticipate and meet the resident's needs.Follow facility fall protocol.May put bed to the lowest position every shift for safety and history of fall related to restlessness. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR -a communication tool used by healthcare workers when there is a change of condition among the residents) summary for providers, dated 12/31/2025 at 2:11 AM, entered by Registered Nurse 1 (RN 1), it indicated Resident 1 was observed to be restless and grimacing (a facial expression in which your mouth and face are twisted in a way that shows disgust, disapproval, or pain). During a review of Resident 1's Transfer to Hospital Summary dated 12/31/2025, timed 6:08 AM, entered by RN 1, it indicated Resident 1 was found lying on the floor between the nightstand and the bed with the resident's face down. During a review of Resident 1's Change of Condition (COC) evaluation, dated 12/31/2025, timed 7:27 AM, entered by Licensed Vocational Nurse 1 (LVN 1), the COC evaluation indicated Resident 1 had a fall. The COC evaluation indicated Resident 1 with new COC of restlessness and constant moving in bed around 2 AM. The COC evaluation indicated at 5:30 AM, Resident 1 was found on the floor on the right side of the bed. The COC evaluation also indicated Resident 1 obtained a small abrasion measuring 2 cm on the left forehead. During a review of Resident 1's Interdisciplinary Team (IDT, a group of healthcare professionals) Progress notes, dated 1/2/2026, timed at 12:51 PM, it indicated Resident 1 had a fall on 12/31/2025. The IDT Progress notes indicated prior to the incident, Resident 1 was observed making moaning noises and exhibiting constant movement in bed despite repositioning and distraction attempts for comfort. The IDT Progress notes indicated that Resident 1 had been restless throughout the night, with constant body movement. The IDT Progress notes indicated a root cause for Resident 1's fall was most likely due to severe cognitive impairment, restlessness, and significant physical limitations. The IDT progress notes also indicated on the night of the fall, Resident 1 exhibited agitation, restlessness, and constant movement During an interview on 1/6/2026 at 12:20 PM with RN 1, RN 1 stated she was assigned to Resident 1 on 12/31/2026 when Resident 1 had a fall. RN 1 stated on that night, Resident 1 was restless, screaming, and constantly moving in bed. RN 1 stated at around 5:30 AM, CNA 1 called her to Resident 1's room where they observed Resident 1 on the floor, face down, on the right side of the bed, between the bed and the nightstand. During an interview on 1/6/2026 at 2:17 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 is able to move while in bed, Resident 1 does not use the call light, and is unable to verbalize needs. LVN 1 stated Resident 1 did not have a bed alarm and should have an order of bed alarm to alert staff when Resident 1 is no longer in a safe position to prevent the resident from falling from the bed. LVN 1 stated bed alarm is usually placed in the middle of the bed, and it will alarm when it detects weight change when resident lifts off the bed. During an interview on 1/6/2026 at 4:05 PM with CNA 2, CNA 2 stated he is familiar with Resident 1. CNA 2 stated Resident 1 is usually restless and does not sleep in the evening like other residents. CNA 2 stated Resident 1 usually move around while in bed. During a concurrent interview on 1/7/2026 at 8:10 AM with RN 1, and record review of Resident 1's medical records dated from 11/18/2025 to 1/7/2026 were reviewed RN 1 stated that on 12/31/2025, Resident 1 has no sedative order. RN 1 stated Resident 1 is usually awake, with moaning and screaming behavior at night. RN 1 stated that Resident 1 has care plan for CAD revised on 11/18/2025 with intervention to monitor/document the resident's sleeping pattern, to inform physician of any insomnia or anxiety, and to give sedatives as ordered. RN 1 stated there was no documented evidence that Resident 1's sleep pattern has been monitored. RN 1 stated there is no sedatives order, and the CP was not resident centered. RN 1 stated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if Resident 1's sleep pattern/anxiety has been monitored and documented, Resident 1's Physician could have ordered a medication to relieve Resident 1's anxiety, and inability to sleep which will help prevent Resident 1 to move around in bed and could have prevented the fall. RN 1 also added Resident 1 could have benefited from a bed alarm to alert staff that resident is no longer in a safe spot so the staff can intervene right away and prevent Resident 1 from falling. During a concurrent interview on 1/7/2026 at 8:30 AM with LVN 2 and record review of medical records, LVN 2 stated monitoring and documenting sleep pattern should have been ordered if it was in Resident 1's care plan to reflect in the medication administration record, where in licensed nurses would be documenting residents' hours of sleep. LVN 2 stated a bed alarm could have prevented Resident 1's fall if it was added in the plan of care and provided to the resident. During a telephone interview on 1/8/2026 at 9:20 AM with CNA 1, CNA 1 stated that on 12/31/2025, around 1 AM, Resident 1 has been more restless than usual. CNA 1 stated that Resident 1 squirms (twist the body from side to side, especially as a result of nervousness or discomfort) in bed and being repositioned frequently. During an interview on 2/8/2026 at 10:53 AM with Assistant Director of Nursing (ADON), ADON stated Resident 1's sleeping pattern was not monitored, and there was no documented evidence of Resident 1's sleep pattern. ADON stated since it is part of Resident 1's CP, it should have been ordered to reflect in Resident 1's MAR. During an interview on 12/8/2026 at 12:39 PM with ADON, she stated Resident 1 could have benefited the use of bed alarm to alert staff when the pressure was off, it will make the staff know that the resident is no longer in a good position in bed. ADON stated that when a resident does not get enough sleep at night place the resident to be restless that is why Resident 1 does a lot of moving around the bed. During a concurrent interview and record review on 2/8/2025 at 4 PM with the Director of Nursing (DON), Resident 1's medical records dated from 3/25/2025 to 12/31/2025 were reviewed. The DON stated Resident 1 has been at risk of falling because of cognitive problems, blindness and contractures. The DON stated Resident 1 had a fall on 3/25/2025 and a care plan was initiated on 4/1/2025 that Resident 1 is risk for falls related to confusion, balance problems, poor communication/comprehension, unaware of safety needs and restlessness while in bed. The DON verified that the CP did not indicate an intervention to address Resident 1's restlessness while in bed and the intervention to follow facility fall protocol was general and not resident- specific. The DON stated, Resident 1 had a CP for CAD that was revised on 11/18/2025 with intervention to monitor and document sleep pattern, and the DON verified the intervention was not implemented or was not done. During a review of facility's P&P titled, Person-Centered care Planning, revised on 4/24/2025, it indicated interventions are actions, treatments, procedures, or activities designed to meet an objective. It also indicated Person-centered care plan means making an effort to understand what is important to each resident with regard to daily routines and preferred activities and having an understanding of the resident's life before coming to reside in nursing facility. During a review of facility's Policy and Procedure (P&P) titled, Fall Management program, revised in 8/28/2025, the policy indicated the facility will implement an interdisciplinary fall prevention program that includes risk screening, individualized care planning, and targeted interventions. During a review of facility's P&P titled, Fall Management program, revised in 8/28/2025, the P&P indicated licensed nurse will develop a care plan according to the identified risk factors.