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	02/13/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent sexual abuse (non-consensual sexual contact of any type with a resident) for one of two sampled residents (Resident 1) on 2/11/2026 in the facility's hallway. On 2/11/2026, Visitor (Visitor 1) witnessed Resident 2's hand was inside Resident 1's pants. This failure can result in Resident 1 and 2 experiencing emotional trauma (response to deeply distressing or disturbing events) or psychological trauma (damage to the mind that occurs as a result of a severely distressing event).Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1's diagnoses included dementia (progressive brain disorder that slowly destroys memory and thinking skills), hyperlipidemia (a condition in which there are high levels of fat particles in the blood), and hypertension (high blood pressure). The admission Record indicated Resident 1 was not self- responsible and the party responsible is Resident 1's Representative 1 (RR1). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 11/21/2025, the MDS indicated Resident 1's cognitive skills (processes of thinking and reasoning) for daily decision making were severely impaired. The MDS indicated Resident 1 requires partial moderate assistance (the helper does less than half the effort) for sit to stand (the ability to a standing position from sitting), walk 10 feet (ft.-unit of measurement) once standing the ability to walk at least 10 ft, in a room, corridor or similar space once standing. The MDS also indicated Resident 1 required partial moderate assistance to wheel 50 ft. with two turns using a wheelchair. During a review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR, tool used by health care professionals when communicating about critical changes in a resident's status), dated 2/11/2026 at 3PM, the SBAR indicated Resident 1 was at risk for emotional distress related to alleged inappropriate touching. The SBAR also indicated the charge nurse received a report from a witness (Visitor 1) that Resident 1 was being touched inappropriately by Resident 2 while sitting in their wheelchair in the hallway. During a review of Resident 1's Change in Condition Evaluation dated 2/11/2026 at 2:41 PM, the change in condition evaluation indicated Resident 1 was at risk for emotional distress related to alleged inappropriate touching. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE]. Resident 2's diagnoses included muscle weakness, gait mobility, dysphagia (difficulty swallowing). The admission Record indicated Resident 2 was not self- responsible and the party responsible is Resident Representative 2 (RR2). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 2 requires partial moderate assistance on sit to stand, walk 10 ft once standing. During a review of Resident 2's SBAR dated 2/11/2026 at 3PM, the SBAR indicated there was an allegation of inappropriate sexual behavior towards Resident 1 as manifested by inappropriate touching. During a review of Resident 2's Change in (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Condition Evaluation dated 2/11/2026 at 2:57 PM, the Change in Condition Evaluation indicated Resident 2 was being monitored for inappropriate behavior manifested by touching of Resident 1. During an interview on 2/12/2026 at 10:50 AM, with Visitor 1, Visitor 1 stated, on 2/11/2026 (unable to recall time), after leaving Room A and walking down the hallway going to the nurse's station, Visitor 1noticed 2 wheel chairs side by side, there was Resident 1 in the wheelchair closest to the wall and Resident 2 next to Resident 1 in the other wheelchair. Visitor 1 also stated, she noticed the male (Resident 2) had his hand down the front inside of the female (Resident 1) pants and was moving his hand. During an interview on 2/12/2026 at 11:28 AM with License Vocational Nurse (LVN 1), LVN 1 stated, on 2/11/2026 at around 3PM, Visitor 1 went to the nursing station 2 and reported to LVN 1 that Resident 2's hand was inside Resident 1's pants. During a concurrent interview on 2/12/2026 at 3:42 PM with the Director of Nursing (DON) and the Administrator (ADM), the ADM stated they (ADM and DON) reviewed the video footage from the surveillance camera at the hallway near nursing station 2 which was recorded on 2/11/2026 at approximately between 2:45 PM to 3 PM. ADM stated the video showed Resident 1 and 2 sitting side by side while they were in their wheelchair along the hallway. ADM also stated the video footage also showed Resident 2 attempting to place his hand under and in front of Resident 1's pants. ADM also stated they were not able to prevent Resident 2's sexual inappropriate touching. ADM further stated residents should not be touched on their private parts by staff or other residents especially if without consent. During an interview on 2/13/2026 at 12 PM, with House Keeping (HK1), HK 1 stated on 2/11/2026 around 3 PM, Visitor 1 told him (HK1) something about Resident 2 was touching Resident 1 while pointing towards Resident 1 and 2. HK 1 stated he did not fully understand what Visitor 1 was saying regarding the two residents, so he did not report it to the nurse or other staff. During a concurrent observation and interview on 2/13/2026 at 1:43 PM, with the DON and ADM, the video footage dated 2/11/2026 was reviewed. ADM stated, at 2:21:38 PM, the video showed Visitor 1 exiting Room A while Residents 1 and 2 were sitting in their wheelchair beside each other (Resident 1 closer to the wall). ADM stated, at 2:21:46 PM, Resident 1 swayed Resident 2's hand away. The ADM stated that at 2:21:56 PM, Visitor 1 was speaking with HK1. The ADM also stated Resident 2's hand exact location was not visible in the video footage. During a concurrent interview on 2/13/2026 at 4:56 PM with the DON and ADM, ADM stated everyone is a mandated reporter and staff are required to report even if it is an alleged abuse so the facility can investigate properly. ADM also stated the facility was not able to prevent Resident 2 from touching Resident 1 inappropriately. ADM further stated Residents 1 and 2 did not have consent to touch, especially in the private area or for any sexual interaction with another resident in the facility. ADM also stated that if sexual inappropriate touching was not consensual, it was considered sexual abuse. During a record review of the facility's policy and procedures (P&P) titled, Abuse and Neglect (fail to care properly) dated 2022, it indicated the facility does not condone any form of resident abuse. The P&P also indicated the purpose of the policy was to address the health, safety, welfare, dignity and respect of residents.