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	03/19/2026

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

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure competencies and skills sets to provide nursing and related services were completed for five (5) of 5 sampled nursing staff in accordance with the facility assessment and policy and procedures (P&P). This deficient practice has the potential to result in an increased risk for improper care provided to the residents which could negatively affect the residents' overall wellbeing.Findings:During a concurrent review and interview on 3/18/2026 at 2PM with the Director of Staff Development (DSD), Certified Nurse Assistant 1's (CNA 1) employee records were reviewed. The DSD stated CNA 1 was hired on 2/13/2025. The DSD stated the facility form titled Facility Support Assistant Onboarding Activities and Skills Observation Checklist is used to evaluate the competency of CNAs' skills upon hire. The DSD stated the skills competency log includes, but is not limited to, evaluating CNAs on activities of daily living, vital signs, feeding techniques, and residents' rights. The DSD verified that CNA 1's Facility Support Assistant Onboarding Activities and Skills Observation Checklist, dated 2/13/2025, was not conducted correctly. The DSD stated she signed off on the checklist without observing CNA 1's skills. The DSD stated she only verbally discussed the skills with CNA 1 on 2/13/2025 and signed off the checklist. The DSD stated CNA 1's skills should have been observed and validated to ensure CNA1 was competent in providing care to the residents. During a concurrent record review and interview on 3/18/2026 at 2:10 PM with the DSD, Restorative Nurse Assistant 1's (RNA 1) employee records were reviewed. The DSD stated RNA 1 was hired on 12/3/2025 as a CNA and transitioned to RNA on 2/18/2026. The DSD stated RNA 1's 16-hour clinical orientation, which was also used to evaluate competency, was incomplete, as all skills were signed off on 2/18/2026 without documentation of the method of skills validation. During a concurrent record review and interview on 3/18/2026 at 2:15 PM with the DSD, Licensed Vocational Nurse 1's (LVN 1) employee records were reviewed. The DSD stated LVN 1 was hired on 1/15/2025. The DSD stated LVN 1 did not have documented evidence of a completed skills competency evaluation upon hire and annually thereafter. The DSD stated it is important to evaluate licensed nurses' skills competency before releasing them from orientation to determine whether additional training is needed and to ensure residents' safety. The DSD stated the facility's form titled, Licensed Nurse Onboarding Activities Checklist, is used to evaluate the competency of licensed nurses upon hire and annually. The DSD stated the skills competency log includes, but is not limited to, evaluating licensed nurses on medication documentation and dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) care. During a concurrent record review and interview on 3/18/2026 at 2:17 PM with the DSD, LVN 2's employee records were reviewed. The DSD stated LVN 2 was hired on 1/24/2026. The DSD stated LVN 2 did not have documented evidence of a completed skills competency evaluation upon hire. The DSD stated all employees should complete and be deemed competent in the skills required of them upon hire and annually to ensure licensed nurses are capable of providing necessary care to residents. During a concurrent record review and interview on 3/18/2026 at 2:20 PM with the DSD, Registered Nurse 1's (RN 1) employee records were reviewed. The DSD stated RN 1 was hired on 7/29/2025. The DSD stated RN 1 did not have documented (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evidence of a completed skills competency evaluation upon hire. The DSD stated the Assistant Director of Nursing (ADON) is responsible for conducting skills competency evaluations for registered nurses upon hire and annually. During a concurrent record review and interview on 3/19/2026 at 12:23 PM with the ADON, the licensed nurses' employee records were reviewed. The ADON stated the competency skills evaluations were not and should have been completed for LVN 1, LVN 2, and RN 1. The ADON stated it was important to complete the skills competency upon hire and annually thereafter in accordance with the policy to ensure staff knew how to perform their assigned tasks for resident safety. The ADON stated that nursing practices are continually changing; therefore, annual skills evaluations are important to ensure that nurses remain updated in their skills and knowledge. During a review of the Facility Assessment, updated 1/1/2026, the Facility Assessment indicated that the assignments and tasks of each staff member are based on the needs of the facility and the residents. All assignments and tasks are also based on community standards. For more details regarding the individual tasks and assignments of each staff member, refer to their job descriptions, which are available upon request. During a review of the facility's P&P titled, Staff Competency Validation, revised on 3/28/2024, the P&P indicated that competency validation is completed to evaluate individual performance, evaluate group performance, meet regulatory standards, address problematic issues, and enhance performance reviews. Competency validation is a determination based on an individual's satisfactory performance of each specific element of their job description and the specific requirements of the area in which they are employed. The P&P also indicated that staff are required to complete competency validation based on their job description and assigned duties.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure garbage was properly disposed of in accordance with the facility's policy and procedure titled, Waste Management. This deficient practice had the potential to attract pests and rodents and may cause disease and other health issues to residents, staff, and the community.Findings: During a concurrent observation and interview on 3/16/2026 at 8:01 AM with the Dietary Supervisor (DS), in the facility's parking lot, two lidless/uncovered trash bins with wheels were filled with bags of trash placed next to three dumpsters. DS stated the two trash bins were filled with nursing trash and were not covered and the two trash bins should be covered. During a concurrent interview and record review on 3/19/2026 at 9:35 AM with Assistant Director of Nursing (ADON), the facility's Waste Management policy and procedure (P&P) dated 4/21/2022 was reviewed. The P&P indicated dispose of all regulated or potentially regulated waste, close and dispose regulated waste according to state and federal regulations and dispose bag into large, covered waste bin. ADON stated all trash should be transferred from the trash bins with wheels should have a cover and transfer the content into the dumpsters. ADON stated the trash bin was not supposed to be left outside uncovered exposing the garbage inside the trash bin. ADON stated this is an infection control issue since the trash was improperly disposed. ADON also stated stray animals and/ or rodents could get access to the trash and could cause a mess.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure vital (objective, measurable indicators of the body's most essential physiological functions, used to evaluate physical health, monitor illness, which includes blood pressure) were documented accurately for two (2) of three (3) sampled residents (Residents 5 and 82) reviewed for dialysis. This failure resulted in the facility not documenting blood pressure readings were taken in the correct arm for Residents 5 and 82 which can lead to potential harm and/ or injury to the residents. Findings: 1. During a review of Resident 5's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses of end stage renal disease (ESRD, irreversible kidney failure), and dependence on renal dialysis (hemodialysis; a life-sustaining medical treatment that filters waste products, toxins and excess fluids from the blood when the kidneys have failed). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment too), dated 3/10/2026, the MDS indicated Resident 5 has independent (decisions consistent) cognitive (person's ability to think, learn, remember, use judgement, and make decisions) skills for daily decision making. The MDS indicated Resident 5 was independent (Resident completes the activity by themselves with no assistance from a helper) with oral and toileting hygiene, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 5 required setup or clean-up assistance (helper sets up or cleans up, resident completes activity) with eating. The MDS indicated Resident 5 required supervision or touching assistance (helper provides verbal cues) with shower. In addition, the MDS indicated Resident 5 acquired arteriovenous fistula (AV fistula; a surgically created connection between an artery [high-pressure blood vessel] and a vein [low-pressure blood vessel], usually in the arm designed for hemodialysis). During a review of Resident 5's Order Summary Report dated 3/18/2026, Resident 5's Order Summary Report indicated an order initiated on 1/20/2025 for no blood pressure checks to AV fistula location (left upper arm) as appropriate. During a review of Resident 5's Care Plan, initiated on 6/24/2022 and revised on 3/15/2026, indicated Resident 5 needed hemodialysis related to ESRD. The care plan indicated intervention to not draw blood or take blood pressure in the arm with graft (AV fistula) (left arm). During an interview and record review on 3/19/2026 at 8:36 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 5's blood pressure (BP) vital sign documentation dated March 2026 was reviewed. Resident 5's BP vital sign documentation indicated Resident 5's blood pressure was taken on the left arm (extremity with AV fistula) on 3/1/2026, 3/2/2026, 3/3/2026, 3/4/2026, 3/5/2026, 3/6/2026, 3/7/2026, 3/9/2026, 3/11/2026, 3/13/2026, 3/14/2026, 3/15/2026, 3/16/2026, 3/17/2026 and 3/18/2026. LVN 1 admitted he is one of the licensed nurses who documented wrong site of where the blood pressure was taken. LVN 1 stated Resident 5's blood pressure was taken on right upper arm, and never in her (Resident 5) left upper arm because of the dialysis access. LVN 1 stated he mistakenly clicked the wrong site when documenting Resident 5's blood pressure in the resident's vital signs. LVN 1 stated it is not the facility's practice to document blood pressure that was taken from the arm with dialysis access, because it is wrong. LVN 1 added it is very important to maintain accurate documentation with resident's vital signs because it is used as part of the assessment (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	process to ensure residents are stable and to ensure appropriate care is being provided. During a concurrent interview and record review on 3/19/2026 at 9:11 AM with MDS Coordinator (MDSC), Resident 5's blood pressure (BP), vital sign documentation dated March 2026 were reviewed. Resident 5's BP vital sign documentation indicated Resident 5's blood pressure was taken on the left arm (extremity with AV fistula) on 3/1/2026, 3/2/2026, 3/3/2026, 3/4/2026, 3/5/2026, 3/6/2026, 3/7/2026, 3/9/2026, 3/11/2026, 3/13/2026, 3/14/2026, 3/15/2026, 3/16/2026, 3/17/2026 and 3/18/2026. MDSC stated Resident 5 had an AV fistula in her (Resident 5) left upper extremity and the documented BP readings that were taken on Resident 5's left arm were documented incorrectly. MDSC stated wrong documentation can lead to wrong treatment which might cause harm to any residents. 2. During a review of Resident 82's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of essential (primary) hypertension (HTN; high blood pressure that develops gradually over time without direct, known medical cause) and dependence on renal dialysis. During a review of Resident 82's History and Physical Examination (H&P), dated 3/12/2026, the H&P indicated the resident had the capacity to understand and make her own decisions and had ESRD and on hemodialysis every Tuesday, Thursday and Saturday with a right upper extremity AV fistula for dialysis access. During a review of Resident 82's Order Summary Report dated March 2026, Resident 82's Order Summary Report indicated an order initiated on 3/11/2026 for no blood pressure checks to AV fistula location (right arm) as appropriate.During a review of Resident 82's Care Plan dated 3/12/2026, Resident 82's Care Plan indicated Resident 82 needed hemodialysis related to renal failure and indicated an intervention to not draw blood or take blood pressure in the arm with graft (AV fistula). During a concurrent interview and record review on 3/18/2026 at 10:58 AM with Assistant Director of Nursing (ADON), Resident 83's BP vital sign documentation dated March 2026 were reviewed. Resident 83's BP vital sign documentation indicated Resident 83's blood pressure was taken on the right arm (extremity with AV fistula) on 3/12/2026, 3/14/2026, 3/15/2026 and 3/16/2026. ADON stated Resident 83 had an AV fistula in her right upper extremity and the documented BP readings on 3/12/2026, 3/14/2026, 3/15/2026 and 3/16/2026 were documented incorrectly because the BO was taken from the resident's left arm. ADON stated the correct laterality (preference for using one side of the body over the other) should have been documented for those BP readings because whatever is on the resident's chart reflects what was done and it is important to ensure charting is accurate. During a review of the facility's policy and procedure (P&P) titled, Completion & Correction, revised 1/1/2012, the P&P indicated its purpose is to ensure that medical records are complete and accurate, and entries will be complete, legible, descriptive and accurate.

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	055056	A. Building B. Wing	03/19/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not implement water testing samples (to collect and deliver for analysis a sample of water representative of the bulk of water being examined) to initially validate the facility's water management program control measures (actions that can be taken to reduce the potential of exposure to a hazard) to ensure the facility's water was free of waterborne (carried or transmitted by water and especially by drinking water) pathogens (any organism that can cause disease) such as legionella (a bacterium which cases legionnaires' disease [a severe form of pneumonia - lung inflammation usually caused by infection]). This failure resulted in the facility having no initial baseline validation for their water management program and had the potential to place the residents in the facility at risk for developing severe respiratory infection (pneumonia).Findings: During a concurrent interview and record review on 3/17/2026 at 12:10 PM with Property Manager (PM) and Maintenance Supervisor (MS) the Centers for Disease Control (CDC) toolkit titled, Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings, dated 6/24/2021 and the ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) Addendum to ASHRAE Standard [PHONE NUMBER] (defines types of buildings and devices that need a water management program) titled, Legionellosis: Risk Management for Building Water Systems, dated 6/23/2018 were reviewed. The CDC toolkit indicated, Your program team should establish procedures to confirm, both initially and on an ongoing basis that the water management program effectively controls the hazardous conditions throughout the building water systems. This step is called ?validation.' The ASHRAE Standard 188-201 indicated the Program Team shall establish procedures to confirm both initially and on an ongoing basis, that the Program is being implemented as designed. PM stated he understood the concept of validation of the water management program and further stated they have had no testing done for their water management program and have no initial validation for their controls. During an interview on 3/18/2026 at 7:38 AM with the Administrator (ADM), ADM stated there was no initial validation test done for the controls for their water management program. During an interview on 3/18/2026 at 1:57 PM with ADM, ADM stated the importance of initially validating the controls of their water management program is so they can ensure the program is working.During a review of the facility's policy and procedure (P&P) titled, Water Management, dated 12/22/2025, the P&P indicated, The facility will develop and utilize water management strategies, using the Core Elements of a Water Management Plan (WMP), to reduce the risk of growth and spread of Legionella and other opportunistic water-borne pathogens in facility water systems, and indicated its purpose, To minimize exposure to legionella and other water-borne pathogens to our residents, family members, staff and visitors. The P&P further indicated: Control Measures and Corrective ActionsFollowing national, state and local guidelines, the team will identify needed control measures based on the risk assessment performed, and how to monitor them.Verification and ValidationThe team will ensure the program is running as designed and effective. During a review of the Centers for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality/Survey and Certification Group letter titled, Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD) revised 7/6/2018, indicated, Surveyors will review policies and procedures and reports documenting water management implementation results to verify that facilities:Implement a water management program that considers the ASHRAE industry standard and the Centers for Disease Control (CDC) toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections and environmental testing for pathogens.Specify testing protocols and acceptable ranges for control measures and document the result of testing and corrective actions taken when control limits are not maintained. During a review of the CDC toolkit titled, Developing a Water Management Program to Reduce (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Legionella Growth & Spread in Buildings, dated 6/24/2021 was reviewed. The CDC toolkit indicated, Now that you have a water management program, you need to be sure that it is effective. Your program team should establish procedures to confirm, both initially and on an ongoing basis, that the water management program effectively controls the hazardous conditions throughout the building water systems. This step is called ?validation.' Environmental testing for Legionella is useful to validate the effectiveness of control measures. The program team should determine if environmental testing for Legionella should be performed and, if so, how test results will be used to validate the program. Factors that might make testing for Legionella more important include: Being a healthcare facility that provides inpatient services to people who are at increased risk for Legionnaires' disease. IP stated they had only had testing done initially in 2018 and did not do any water testing afterwards. IP further stated the importance of validating controls on an ongoing basis is to prevent legionella from happening in the facility. A review of ASHRAE Addendum to ASHRAE Standard [PHONE NUMBER] (defines types of buildings and devices that need a water management program) titled, Legionellosis: Risk Management for Building Water Systems, dated 6/23/2018, indicated the Program Team shall establish procedures to confirm, both initially and on an ongoing basis, that the Program is being implemented as designed. The resulting process is verification. The Program Team shall establish procedures to confirm, both initially and on an ongoing basis, that the Program, when implemented as designed, controls the hazardous conditions throughout the building water systems. The resulting process is validation. The Program Team shall determine whether testing for Legionella shall be performed and if so, how test results will be used to validate the Program. If the Program Team determines that testing is to be performed, the testing approach, including sampling frequency, number of samples, locations, sampling methods, and test methods, shall be specified and documented. The Program Team shall consider include the following as part of the determination of whether to test for Legionella:b. A healthcare facility provides in-patient services to at-risk or immuno-compromised population.

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	055056	A. Building B. Wing	03/19/2026

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide documented evidence or written notice of why a room change was required and failed to accommodate the request to be roomed together as a married couple from 5/5/2025 to 7/21/2025 for two (2) of 19 sampled residents (Residents 43 and 44) when they did not in accordance with the facility's policy and procedure titled Resident Rights. This failure resulted in violation of Residents 43 and 44 right to be notified of the reason why they needed to change rooms and had the potential to result in Residents 43 and 44 feeling sad, lonely and abandoned.1. During a review of Resident 43's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of paraplegia (the loss of movement and sensation in the lower half of the body, including both legs) and generalized (widespread) muscle weakness (decreased ability to use your muscles, making daily activities feel like they require extra effort). Resident 43's admission Record also indicated Resident Representative 1 (RP 1) was Resident 43's responsible party. During a review of Resident 43'S Minimum Data Set (MDS - a resident assessment tool), dated 2/24/2026, the MDS indicated the resident had moderate impairment with cognitive (ability to think, remember, and reason) skills for daily decision making. The MDS also indicated Resident 43 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with rolling left and right in bed, upper and lower body dressing (the ability to dress and undress above and below the waist), putting on/taking off footwear, personal hygiene and eating.2. During a review of Resident 44's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of unilateral (one side) primary osteoarthritis (weak and brittle bones due to lack of calcium and Vitamin D) of the right knee and generalized muscle weakness. During a review of Resident 44'S MDS, dated [DATE], the MDS indicated the resident was moderately impaired with cognitive skills for daily decision making. The MDS also indicated Resident 44 needed substantial/maximal assistance (helper does more than half the effort) with chair/bed-to-chair transfers and going from sitting to standing. In addition, the MDS indicated Resident 44 needed partial/moderate assistance (helper does less than half the effort) with walking 10 feet, going from lying down to sitting on the side of the bed and with putting on/taking off footwear and needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with upper and lower body dressing and eating. During an interview on 3/16/2026 at 2:49 PM with Responsible Party 1 (RP 1), RP 1 stated Residents 43 and 44 are married to one another and there have been times over the past year where the facility had separated Resident 43 and 44's room to accommodate other residents being admitted to the facility. RP 1 also stated she was not agreeable to the room change and had always expressed to the facility wanting Residents 43 and 44 to stay together since Resident 43 is bedridden and unable to call for help. RP 1 further stated, Resident 43 normally asks Resident 44 to notify facility staff when she (Resident 43) needs assistance since the resident cannot do it herself. During an interview on 3/17/2026 at 1:51 PM with RP 1, RP 1 stated there was a time in 2025 where Residents 43 and 44 were assigned separate rooms for 2 months. RP 1 also stated that she had mentioned to facility staff that she would prefer Residents 43 and 44 not be separated since Resident 43 is unable to call for help from facility staff without the help of Resident 44 (Resident 43's husband). During an interview on 3/18/2026 at 7:45 AM with Resident 44, Resident 44 stated when the facility had previously separated him and his wife, Resident 43, he was not notified prior to the new arrangement or the reason why he needs to be in a separate room with Resident 43.During an interview on 3/18/2026 at 11:13 AM with Assistant Director of Nursing (ADON), ADON stated there were times Residents 43 and (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	44 needed to be placed in a separate room and moved to different rooms to accommodate for the admission of a new resident who was under isolation (the physical separation of sick people with a contagious disease from those who are not sick). ADON stated prior to a room change, a room change notification needed to have been done with the resident(s) and/or their responsible party. ADON also stated it would be the Social Services Director (SSD) who would be in charge of contacting the resident's responsible party regarding the room change needed. During an interview on 3/18/2026 at 11:27 AM with ADON, ADON stated for every single room change, there needs to be a room change notification documentation done as well as a room change follow-up visit. During a concurrent interview and record review on 3/18/2026 at 11:30 AM with ADON, Residents 43's Electronic Medical Record (EMR; a digital, computer-based version of a patient's paper chart, containing their medical history, diagnosis and treatment plans) dated 8/27/2024 to 3/18/2026 and Resident 44's EMR dated 9/1/2024 to 3/18/2026 were reviewed. Residents 43 and 44's EMR indicated Residents 43 and 44, who were initially in the same room, were separated and moved to different rooms on 5/5/2025 and remained separated until 7/21/2025. Resident 43 and 44's EMR also indicated no room change notification documentation or progress note was found for 5/5/2025. ADON verified that Residents 43 and 44 were initially in the same room together and were separated and moved to different rooms on 5/5/2025 and remained separated until 7/21/2025. ADON also stated there was no room change notification to the residents or RP 1 nor progress note documented for both Residents 43 and 44 for their room change on 5/5/2025. During an interview on 3/18/2026 at 11:32 AM with ADON, ADON stated a documented room change notification is to let the resident's family and/or responsible party as well as the resident(s) know about the room change because the facility is their home and it is their right to receive written notice regarding the room change. ADON stated it is also important to notify the resident or resident's representative to help with the transition of the room change so that family and visitors know which room they will be going to and also stated if the resident(s) and/or responsible party is not agreeable to the change, the facility cannot force the room change upon the resident. ADON further stated if the facility has the rooms available, it is better for Residents 43 and 44 to stay together. During an interview on 3/18/2026 at 11:45 AM with SSD, SSD stated for any room change the resident and/or responsible party need to be notified and they (resident/ resident representative) have a right to refuse. SSD stated she was aware of RP 1's request that Residents 43 and 44 stay together. SSD stated for every room change there needs to be a room change notification documented, however, on 5/5/2026 SSD was busy and was not able to document a room change notification for Residents 43 and 44. SSD also stated there should have been a documented room change notification done for both residents to ensure their responsible party was notified and also to show it was explained why the room change was needed as well as giving the responsible party a chance to express their concerns and/or their refusal. SSD further stated a follow up room change visit and documentation should have been done to assess the residents' transition to their new rooms and stated there was no follow-up done after 5/5/2026 for both Resident 43 and 44. During a concurrent interview and record review on 3/18/2026 at 1:55 PM with the Administrator (ADM), the Facility Census dated 5/4/2025 and 5/5/2025 were reviewed. The Facility Census on 5/4/2025 indicated Residents 43 and 44 were both in room [ROOM NUMBER] and on 5/5/2025 Residents 43 and 44 were separated and moved to other rooms to accommodate a new resident being admitted with an isolation. ADM also stated the facility underwent room renovations starting on 5/6/2025. During an interview on 3/19/2026 at 11:56 AM with RP 1, RP 1 stated she was not provided with any written notice of the reason why a room change was necessary for Residents 43 and 44 on 5/5/2025. During a concurrent interview and record review on 3/19/2026 at 12:24 PM with ADM, the Facility Census dated 5/4/2025, 5/5/2025, 5/6/2025, 5/20/2025 and 5/27/2025 were reviewed. The Facility Census on 5/4/2025 indicated Residents 43 and 44 were both in room [ROOM NUMBER] and on 5/5/2025 Resident 43 and 44 were separated and moved to other rooms to accommodate a new resident being admitted with an isolation. The facility census on 5/27/2025 indicated an empty room available for (continued on next page)

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	03/19/2026

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents 43 and 44 to be moved back into the same room. ADM stated on 5/27/2025, they should have accommodated Residents 43 and 44 to be moved back into the same room and should not have had to wait until July 2025 to place both residents back into the same room. ADM also stated RP 1's request for Residents 43 and 44 to be together should have been accommodated especially for their (Resident 43 and 44) emotional support and also because Resident 44 watches over Resident 43 and calls for assistance for her. ADM further stated a written notice of the room change should have been provided to RP 1 to validate that they were educated on the reason why the room change was needed and to give RP 1 a chance to agree or disagree. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, revised 1/1/2012, the P&P indicated its purpose is to promote and protect the rights of all residents at the facility which includes a resident's right to share a room with a spouse, it that is mutually agreeable (and feasible). During a review of the facility's P&P titled, Resident Rights - Quality of Life, revised March 2017, the P&P indicated the facility staff keeps the resident informed and oriented to his/her environment and procedures are explained to the residents before they are preformed and the resident is told in advance if he/she is to be taken out of his/her usual or familiar surroundings. During a review of the facility's P&P titled, Room or Roommate Change, revised March 2018, the P&P indicated:When making a change in room or roommate assignment, the resident's needs and preferences are considered and will be accommodated to the extent practical.Prior to changing a room or roommate assignment, the resident, the resident's representative (if available), and the resident's new roommate will be provided with timely advance notice of such a change.The notice of a change in room or roommate assignment must be given in writing, and will include the reason(s) for such change.The facility will use SS-12-Form A-Notification of Room Change or SS-12-Form B Notification of Roommate Change to notify the resident, or the resident's representative of the room or roommate change.

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	055056	A. Building B. Wing	03/19/2026

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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** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 34) reviewed for restraint (restricting freedom of movement) was free from physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body; cannot be removed easily by the resident; and restricts the resident's freedom of movement or normal access to his/her body) by failing to conduct an assessment for the use of wheelchair and bed alarm (monitoring devices used in healthcare settings to detect when a person attempts to rise, triggering an alert for caregivers). This deficient practice had the potential to negatively affect Resident 34's physical and psychological wellbeing and quality of life.Findings: During a review of Resident 34's admission Record, the admission Record indicated an original admission to the facility on 3/9/2022, and readmission on [DATE]. Resident 34's diagnoses included difficulty in waking, dementia (a brain disorder that results in memory loss, poor judgment, and confusion), and history of falling. During a review of Resident 34's Minimum Data Set (MDS, a resident assessment too), dated 2/25/2026, the MDS indicated Resident 34 had severely impaired cognitive (person's ability to think, learn, remember, use judgement, and make decisions) skills for daily decision making. The MDS indicated Resident 34 required partial/moderate assistance (helper does less than half the effort) with eating and oral hygiene. The MDS indicated Resident 34 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower, upper and lower body dressing. During a review of Resident 34's Order Summary Report, dated 3/18/2026, timed 2:26 PM, indicated the following orders:May have bed pad alarm to alert staff when resident is getting out of bed without assistance. Every shift for safety precaution and history of fall Monitor bed pad alarm function and placement, Y= proper function and placement, N= not proper function or placement. Ordered on 3/15/2026.May have wheelchair alarm to alert staff when resident is getting out of the wheelchair without assistance. Every shift for safety precaution while up on wheelchair, monitor wheelchair alarm function and placement, Y= proper function and placement, N= not proper function or placement. Ordered on 3/15/2026. During an observation on 3/16/2026 at 1:47 PM, in the front lobby, Resident 34 was observed sitting in a wheelchair. Resident 34 was observed with a wheelchair alarm. During a concurrent review of Resident 34's restraint assessments and active orders and interview on 3/19/2026 at 10:15 AM with Registered Nurse 2 (RN 2), RN 2 stated Resident 34 has been using bed and wheelchair alarm for a while now and was discontinued when Resident 34 had a change of condition and was transferred out of the facility on 2/12/2026. RN 2 stated that Resident 34 was readmitted back to the facility on 2/18/2026. RN 2 stated that an order of bed and wheelchair alarm to alert staff when Resident 34 is getting up without assistance was obtained by the Director of Nursing on 3/15/2026. RN 2 stated that prior to use of bed and wheelchair alarm, the interdisciplinary team (IDT, a collaborative group of health professionals who work together to create a unified, person-centered care plan) should conduct restraint-physical evaluation for its use because it can be a form of restraint. RN 2 stated that the following are included in evaluation:Reason for restraintRestraint reduction strategies and alternatives attempted.Effectiveness of restraint.Recommendations from IDT.IDT membersCommunicationRN 2 stated Resident 34 did not and should have had an assessment for the use of bed and wheelchair alarm. RN 2 stated there was no documented evidence that the restraint-physical evaluation from 3/15/2026 to 3/19/2026 was conducted for Resident 34. RN 2 stated she had seen Resident 34 with wheelchair alarm. During a concurrent review of Resident 34's restraint assessments and active orders and interview on 3/19/2026 at 1:33 PM with Assistant Director of Nursing (ADON), ADON stated Resident 34 did not have a restraint-physical evaluation prior to the use of bed and wheelchair alarm, which was ordered on 3/15/2025. ADON stated a restraint assessment should have been (continued on next page)

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	055056	A. Building B. Wing	03/19/2026

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted before using the bed and wheelchair alarm to ensure that Resident 34 needed it, and it was not a form of restraint for the resident's safety. ADON stated that she had seen Resident 34 with a wheelchair while sitting in wheelchair. During a review of facility's Policy and Procedure (P&P) titled, Restraints, revised in 1/25/2024, the P&P indicated restraints require a physician order and are used as a last resort to be used only when deemed necessary by the IDT, and in accordance with the resident's assessment.

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	055056	A. Building B. Wing	03/19/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an accurate assessment of the Minimum Data Set (MDS, a resident assessment tool) for one of two sampled residents (Resident 9) to reflect the antipsychotic (drug that works by altering brain chemistry to help reduce psychotic symptoms like hallucinations [an experience which a person sees, hears, feels, or smells something that does not exist], delusions [fixed false beliefs], and disordered thinking) medication taken and Antipsychotic Medication Review (a structured, interprofessional evaluation of a resident's antipsychotic drug therapy to assess effectiveness, monitor side effects, and determine the need for continued use, dose reduction, or withdrawal). This deficient practice had the potential for the facility not to develop and implement an individualized care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives, interventions and timeframes to meet a resident's medical, nursing, and mental psychosocial needs) to monitor antipsychotic medication use and delivery of necessary care and services. Findings: During a review of Resident 9's admission Record, the admission record indicated Resident 9 was admitted to the facility on [DATE], with the diagnoses including but not limited to schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), and emphysema (a long-term lung condition that causes shortness of breath). During a record review of Resident 9's Order Summary Report, dated 4/10/2025, the physician order indicated Quetiapine Fumarate (antipsychotic medication used to treat schizophrenia) oral tablet 25 milligrams (mg, unit of measurement) - Give two tablets by mouth at bedtime for schizophrenia manifested by auditory hallucinations (hearing voice telling to harm herself). During a record review of Resident 9's Minimum Data Set, dated [DATE], the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was moderately impaired. The MDS indicated Resident 9 was taking an antipsychotic medication. The MDS also indicated Resident 9 did not receive antipsychotics (it prompted to skip over when the last gradual dose reduction [GDR, a stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued] was attempted and if the physician documented GDR as clinically contraindicated). During a record review of Resident 9's Care Plan, revised 2/13/2026, the Care Plan indicated Resident 9 used psychotropic medications (Quetiapine) related to behavior management, schizophrenia. The care plan also indicated the staff interventions were to consult with pharmacy, physician to consider dosage reduction when clinically appropriate at least quarterly, discuss with physician family re-ongoing need for use of medication, and review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. During a concurrent interview and record review on 3/19/2026 at 10:48 AM with the Minimum Data Set Coordinator (MDSC), Resident 9's MDS dated [DATE], MDSC stated Resident 9 was taking an antipsychotic medication. MDSC stated the Antipsychotic Medication Review was conducted for review when a resident took antipsychotic medication. MDSC stated Resident 9's MDS indicated Resident 9 currently did not receive any antipsychotic medication. MDSC stated the MDS was not accurate, and the answer should have been documented as yes antipsychotic were received on a routine basis only. MDSC stated the Antipsychotic Medication Review was done to review if there was a gradual dose reduction done within the past year or past six months or if there was any contraindication from the physician. MDSC stated if GDR was attempted for Resident 9, it should have been documented in Resident 9's MDS dated [DATE]. MDSC stated GDR for Resident 9 was done on 4/10/2025 and it should have been documented in the resident's MDS because this would allow the facility to be able to track any contraindication by the physician or if there was any dosage that could be adjusted. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment (continued on next page)

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	055056	A. Building B. Wing	03/19/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Instrument (RAI) Process, revised 10/4/2016, the P&P indicated to provide resident assessments that accurately depict the identify resident-specific issues and objective as required, while meeting state and federal guidelines and data submission requirements.

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	055056	A. Building B. Wing	03/19/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide one (1) of three (3) sampled residents (Resident 1) meal trays that were appetizing and palatable (agreeable to one's sense of taste). This failure had the potential to result in dissatisfaction, decreased food intake and placed Resident 1 at risk for unplanned weight loss.Findings:During a review of Resident 1's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of type two (2) diabetes mellitus (DM2; a disorder characterized by difficulty in blood sugar control and poor wound healing) with ketoacidosis (a life-threatening, emergency complication of DM occurring when the body lacks enough insulin [a hormone that acts as a key, unlocking cells to allow sugar {glucose} from food to enter and provide energy] to use glucose for energy) without coma (a state of deep, prolonged unconsciousness where a person is alive but unable to wake up, more, or respond to their surroundings, sounds or pain) and protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function). During a review of Resident 1'S Minimum Data Set (MDS - a resident assessment tool), dated 2/25/2026, the MDS indicated the resident was cognitively intact (ability to think, remember, and reason) with cognitive skills for daily decision making. The MDS also indicated Resident 1 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with chair/bed-to-chair transfers, going from sitting to standing and with putting on/taking off footwear. It indicated, Resident 1 needed substantial/maximal assistance (helper does more than half the effort) with upper and lower body dressing (the ability to dress and undress above and below the waist) and also needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with personal hygiene and eating.During a review of Resident 1's Order Summary Report dated March 2026, Resident 1's Order Summary Report indicated an order initiated on 3/3/2026 for consistent carbohydrate (CCHO; a diabetes management plan that involves eating plan that involves eating roughly the same amount of carbohydrates at the same times each day) standard portion diet with regular texture and thin consistency. During an interview on 3/16/2026 at 10:15 AM with Resident 1, Resident 1 stated the food he receives from the facility is bad and has no flavor and does not like to eat the food.During a food test tray (a quality assurance audit where a meal tray is selected, tracked, and evaluated for accuracy, temperature, safety, and palatability) on 3/18/2026 at 12:33 PM the tray itself did not look appetizing with the spinach on the plate being bland with no flavor. During the same food test tray on 3/18/2026 at 12:33 PM with Dietary Supervisor (DS), DS tasted the spinach and stated it was bland and it needed more flavor. DS stated she does not like food without any flavor and stated because residents who are older in age have a diminished ability to taste and the medications some of the residents take can also affect their ability to taste. DS also stated it is important that the food has good flavor or else the residents might not eat the food. DS further stated good flavor is the only way to ensure residents eat well because if not, there is a risk for the residents to lose weight. During a review of the facility's policy and procedure (P&P) titled, Dietary Department - General, revised 6/1/2014, the P&P indicated the primary objectives of the dietary department include preparation and provision of nutritionally adequate, attractive, well-balanced meals that are consistent with physician orders and maintenance of standards for quality of food.

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	055056	A. Building B. Wing	03/19/2026

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its hospice (care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure) agreement to coordinate care for one out of two sampled residents (Resident 42) reviewed for hospice by failing to develop an effective communication process for Resident 42's plan of care, hospice visitation, and physician's orders. This deficient practice had the potential for Resident 42 not to receive the hospice care and services necessary to promote comfort and quality of life.Findings:During a review of Resident 42's admission Record, the admission Record indicated an admission to the facility on [DATE]. Resident 42's diagnoses included aortic aneurysm (a dangerous, balloon-like bulge or weak spot in the wall of the aorta [the body's main artery that carries blood from the heart to the rest of the body], heart disease (any condition that affects the heart's structure or function, preventing it from working properly) and encounter for palliative care (specialized medical care focused on providing relief from the symptoms, pain, and stress of a serious illness to improve quality of life for both the patient and their family). During a review of Resident 42's Minimum Data Set (MDS, a resident assessment too), dated 12/31/2025, the MDS indicated Resident 42 had modified independence (some difficulty in new situations only) cognitive (person's ability to think, learn, remember, use judgement, and make decisions) skills for daily decision making. The MDS indicated Resident 42 required setup or clean-up assistance (helper sets up or cleans up) with eating. The MDS indicated Resident 42 required partial/moderate assistance (helper does less than half the effort) with oral hygiene. The MDS indicated Resident 42 required substantial/maximal assistance (helper does more than half the effort) with upper body dressing and personal hygiene. The MDS indicated Resident 42 was dependent (helper does all the effort) with toileting hygiene, lower body dressing, and putting on/taking off footwear. During a review of Resident 42's Plan of Care (POC) Summary, dated 3/19/2026, the summary indicated a physician's order, dated 1/202/26 to recertify patient to Hospice 1 for care from 1/20/2206 to 3/20/2026, with primary diagnosis of end stage heart failure (the final, most severe stage of heart failure where the heart is too weak to pump blood effectively, and standard treatments no longer work, it is marked by persistent, severe symptoms like severe breathlessness even while resting, and extreme fatigue) for symptom management and comfort focused care. Ordered on 1/20/2026. During a review of a Resident 42's Care Plan (CP), focusing on Resident 42's terminal prognosis related to abdominal aortic aneurysm (AAA, dangerous, often silent, bulge or swelling in the aorta [the main blood vessel supplying blood to the body-as it passes through the abdomen]), initiated 11/27/2024, and revised 3/15/2026, the CP indicated intervention included was to work cooperatively with hospice team to ensure the residents' spiritual, emotional, intellectual, physical and social needs are met. During an interview on 3/19/2026 at 9:19 AM with Registered Nurse 2 (RN 2), RN 2 stated Resident 42's care plans were developed based on active physician's order in electronic medical record. RN 2 stated that Resident 42 has a hospice binder located in Nursing Station 2. RN 2 stated that the facility practice was to transcribe (the accurate, manual copying of prescribed order details from a primary source onto a resident's medical records) all hospice orders to the facility's electronic medical records. RN 2 stated conflicting orders from the hospice binder and Resident 42's electronic medical records can cause confusion and potentially inaccurate, incomplete and unsafe hospice plan of care for Resident 42. RN 2 stated that Resident 42's hospice diagnosis of end stage heart failure was not in the care plan. RN 2 also added that the following hospice staff frequency of visits was not and should have been in the care plan.Master of Social Work (MSW, staff who provides essential psychosocial support, counseling, and resources to patients with terminal illnesses and their families) visit every recert to evaluate and identify psychosocial and emotional needs of patient and family. May send one extra visit per month (continued on next page)

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	055056	A. Building B. Wing	03/19/2026

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as needed and per patient/family request for symptom management. Ordered on 4/5/2025.Spiritual Counselor (SC, a Chaplain) visit once every recert for spiritual needs of patient and family. May send one extra visit per month per patient/family request for symptom management. Ordered on 4/4/2025.All personnel to visit patient face to face unless requested by patient/family. May do telephone visit via phone, or other technology options. Ordered on 4/1/2025.Hospice Aide (HA, a certified professional providing essential personal care, companionship, and comfort to patients) to visit patient two times a week for assistance with personal care needs. Ordered on 4/1/2025.RN visits every 14 days thereafter for ongoing comprehensive assessment and supervisory visits. Recertification assessment per schedule for skilled assessment and intervention. Ordered on 4/1/2025.Skilled Nurse visits once a week, and two as needed a week to promote comfort and symptom management and for change of condition. Ordered on 4/1/2025. During a concurrent record review of Resident 42's CP and interview on 3/19/2026 at 9:25 AM with MDS assistant, the MDS assistant stated that Resident 42's hospice frequency of visits was not and should have been in the care plan. MDS assistant stated that it was important to reflect hospice frequency of visits on the care plan for the entire care team to know the specific care for Resident 42 who is on hospice care. During a concurrent record review and interview on 3/19/2026 at 9:35 AM with the Director of Nursing (DON), Hospice 1's contract agreement, dated 8/20/2025 and Resident 42's hospice binder was reviewed. The DON stated Resident 42's electronic medical records were inconsistent with the records that are in Resident 42's hospice binder. The DON stated that facility did not develop Resident 42's hospice care plan. The DON stated this can lead to inconsistency of care that may cause harm to Resident 42. The DON stated the Hospice 1 Agreement indicated Both the plan of care and the nursing care plan developed by the agency will be part of the patient's record in the facility. Both of these will be developed in collaboration with the agency and the facility staff. The facility staff will notify the agency if there are any changes in the plan of care or the nursing care plan and make copies available to the agency personnel. The DON stated that the hospice care plan developed for Resident 42 was incomplete and does not and should have included all the orders that are indicated in Resident 42's POC summary filed in the hospice binder. During a review of the Contract Agreement between Hospice 1 and facility, dated 8/20/2025, the Contract Agreement indicated responsibilities of the agency and the provider in the admission, assessment, care planning, coordinating, supervising and evaluating the care and services provided, interdisciplinary group care conferences, development review revision, and review of the plan of care. The contract agreement also indicated the hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care. The hospice plan of care reflects the participation of the hospice, the facility, and the patient and family to the extent possible. Any changes in the hospice plan of care must be discussed with the patient or representative, and facility, and must be approved by the hospice before implementation. During a review of facility's Policy and Procedure (P&P) titled, Hospice Care of Residents, revised on 1/1/2012, the P&P indicated the hospice and facility will collaborate on a care plan for the resident. It also indicated all documentation concerning hospice services will be maintained in resident's medical record.

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	03/19/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light for one (1) of 1 sampled resident (Resident 83) reviewed for environment was within reach.This failure had the potential to put Resident 83 at risk for experiencing a delay in receiving assistance from facility staff which could lead to a fall or accident and unmet needs.Findings:During a review of Resident 83's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of unspecified sequelae of cerebral infarction (the lasting physical, cognitive [ability to think, remember and reason] or emotional impairments that remain after a stroke [blocked blood flow to the brain])and generalized (widespread) muscle weakness (decreased ability to use your muscles, making daily activities feel like they require extra effort). During a review of Resident 83's History and Physical Examination (H&P), dated 3/13/2026, the H&P indicated the resident had mild cognitive impairment and only able to make decisions for her basic needs. During a review of Resident 83's admission assessment dated , 3/11/2026, Resident 83's admission Assessment indicated resident 83's cognitive (mental action or process of acquiring knowledge and understanding) level as having moderate impairment (memory loss). The admission Assessment also indicated Resident 83 had no impairment with her upper extremity range of motion but had impairment on one side for her lower extremity range of motion. Resident 83 was also assessed to be bedfast (being confined to bed due to serious illness, injury or old age) all or most of the time. During a review of Resident 83's Care Plan, dated 3/13/2026, Resident 83's Care Plan indicated Resident 83 was noncompliant evidenced by attempts to get out of bed without assistance. The care plan also indicated Resident 83 did not consistently use the call light and had increased risk for falls with injury. Staff intervention included was to ensure the call light is within reach at all times.During a review of Resident 83's Care Plan, dated 3/18/2026, Resident 83's Care Plan indicated call light would be secured by wrapping it around the grab bar to maintain accessibility. The Care Plan also indicated a goal of Resident 83 maintaining safe access to the call light. During an observation on 3/16/2026 at 10:25 AM in Resident 83's room, Resident 83 was observed lying down in bed with her call light observed hanging off the right side of her bed on the floor on top of the fall mat (a cushioned floor pad designed to help prevent injury should a person fall). During a concurrent observation and interview on 3/16/2026 at 10:29 AM with Assistant Director of Nursing (ADON) in Resident 83's room, Resident 83 was observed turned onto her left side on the bed with both her legs attempting to come off the side of the bed and touching the floor and her call light was observed hanging of the right side of her bed on the floor on top of the fall mat. ADON stated Resident 83's call light was on the floor and out of her reach. During an interview on 3/18/2026 at 11:06 AM with ADON, ADON stated the purpose of a call light is so the resident can ask for assistance and if it is not within reach, there is a risk for a delay in staff providing assistance to the resident. During a review of the facility's policy and procedure (P&P) titled, Communication - Call System, revised 8/24/2024, the P&P indicated, The call alert device will be placed within the resident's reach.

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	03/19/2026

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

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq.ft. - unit of measurement) per resident in multiple resident bedrooms for 13 of 35 residents' rooms (Rooms 5, 7, 9, 11, 15, 16, 17, 18, 19, 20, 21, 22, and 23) in the facility. This deficient practice had the potential to affect the ability to provide care, safety, and a home-like environment for the residents.Findings: During a tour of the facility on 3/16/2026 at 10 :00 AM, 13 of 35 residents' rooms did not meet the minimum 80 sq. ft. per resident in multiple resident bedrooms. These are Rooms 5, 7, 9, 11, 15, 16, 17, 18, 19, 20, 21, 22, and 23. During a concurrent observation and interview on 3/16/2026 at 1:35 PM in room [ROOM NUMBER], one resident (Resident 3) was observed sitting on the edge of her bed, about to get up and ambulate with a walker. Resident 3 stated that the space in the room was adequate and that she has a walker, which allows her to move around without difficulty. Resident 3 also stated that staff have enough space to move around while providing care.During a concurrent review of the facility's client accommodation analysis and interview with the Administrator (ADM) on 3/18/2026 at 7:50 PM, the ADM stated the facility has 35 resident rooms. The ADM stated 13 of these rooms do not meet the requirement of 80 square feet per resident in multiple - resident bedrooms. The ADM stated that she will continue to request a room waiver because not meeting the required square footage does not affect the health and safety of the residents. The ADM also stated that there is enough space for staff to provide care for the residents. During a review of the facility's room waiver letter, dated 3/16/2026, the room waiver indicated the following:Room Sq. Ft. Bedsroom [ROOM NUMBER] - 226.9 sq. ft. - 3 bedsroom [ROOM NUMBER] - 222.24 sq. ft. - 3 bedsroom [ROOM NUMBER] - 226.9 sq. ft. - 3 bedsroom [ROOM NUMBER] 222.24 sq. ft. - 3 bedsroom [ROOM NUMBER] - 226.9 sq. ft. - 3 bedsroom [ROOM NUMBER] - 222.24 sq. ft. - 3 bedsroom [ROOM NUMBER] - 221.9 sq. ft. - 3 bedsroom [ROOM NUMBER] - 221.9 sq. ft. - 3 bedsroom [ROOM NUMBER] - 221.9 sq. ft. - 3 bedsroom [ROOM NUMBER] - 221.9 sq. ft. - 3 bedsroom [ROOM NUMBER] - 221.9 sq. ft. - 3 bedsroom [ROOM NUMBER]- 216.26 sq. ft. - 3 bedsroom [ROOM NUMBER] - 216.26 sq. ft. -3 bedsThe minimum square footage for a 3-bedroom is 240 sq. ft. During a review of the facility's room waiver letter, dated 3/16/2026, the facility's room waiver indicated a request for re-authorization of waivers for the following 13 resident 3-bed rooms floor areas ranging 216.26 to 226.9 square feet per room. These rooms are in accordance with the needs of residents, do not have an adverse effect on the residents' health and safety, nor impede the ability of any resident to attain his or her highest practicable well-being. During the survey from 3/16/2026 to 3/19/2026, rooms 5, 7, 9, 11, 15, 16, 17, 18, 19, 20, 21, 22, and 23 were observed with adequate ventilation and lighting. The residents in the rooms have bathroom and toilet facilities. The residents have privacy curtains around their beds, which assured privacy. There was adequate space for getting in and out of wheelchairs and residents were afforded sufficient freedom of movement in the rooms. The residents did not complain regarding the space in their room. There was enough space for the staff to provide care and enough storage for residents' belongings. Residents that were wheelchair bound were able to move in the room without difficulty. The Department would recommend the room waiver for Rooms 5, 7, 9, 11, 15, 16, 17, 18, 19, 20, 21, 22, and 23.