STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265828	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Grove Manor	4359 Taft Avenue Saint Louis, MO 63116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect each resident's right to be free from any physical restraint when Resident #2 was found by staff with the sleeves of his/her long sleeve shirt tied together at the end, preventing freedom of movement, and resulted in limiting normal access to the use of his/her hands. The census was 48.Review of the facility's Restraints policy, dated 6/2020, showed:-Purpose: Residents shall be provided an environment that is restraint-free, unless a restraint is necessary to treat a medical symptom in which case the least restrictive measures shall be used;-Physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. This may include bed rails, beds against walls, restrictive clothing, etc.;-The facility will ensure that restraints will not be imposed for purposes of discipline or convenience;-Restraints may only be used if/when the resident has a specific medial symptom that cannot be addressed by another less restrictive intervention and a restraint is required to treat the medical symptoms, protect the resident's safety, and help the resident attain the highest level of his/her physical or psychological well-being. During an interview on 12/18/25 at 1:00 P.M., the Interim Administrator said Resident #2 was found by the day shift Certified Nurse Assistant (CNA) today with his/her hands tied. The resident was wearing a long-sleeved shirt and was in bed. Review of Resident #2's annual Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 6/14/25, showed:-Resident is rarely/never understood;-Severely impaired cognitive skills for daily decision making;-Physical behavioral symptoms directed towards others occurred 1 to 3 days;-Other behavioral symptoms not directed towards other occurred 1 to 3 days;-Behavioral symptoms impact on resident: Significantly interferes with the resident's care;-Functional limitation in range of motion impairment on both sides, upper and lower extremity;-Dependent for eating, oral hygiene, toileting hygiene, shower/baths, upper and lower body dressing, putting on/taking off footwear, and personal hygiene;-Dependent to roll left and right, char/bed-to-chair transfers, and tub/shower transfers;-Not attempted/resident did not perform activity: sit to lying, lying to sitting on side of bed, sit to stand, toilet transfer, walk 10 feet;-Always incontinent of bowel and bladder;-Primary medical condition category: Non-traumatic brain dysfunction (damage to the brain from internal causes like stroke, infection, lack of oxygen (anoxia/hypoxia), tumors, or toxins, rather than an external impact (like a fall or blow);-Diagnoses included hemiplegia or hemiparesis (weakness and/or paralysis on one side of the body), malnutrition, and anxiety disorder. Review of the resident's medical record, showed:-An order dated 6/23/25 to assist resident with dressing and undressing every shift related to limitations from diagnosis of hemiplegia and hemiparesis following a stroke affecting the left side;-No documentation of any type of restraint used;-No order for any type of physical restraint. Review of the resident's quarterly MDS, dated [DATE], showed:-Severely impaired cognition;-Physical behavioral symptoms directed towards others occurred 1 to 3 days;-Rejection of care occurred 1 to 3 days;-Functional limitation in range of motion impairment on both sides, upper and lower extremity;-Dependent for eating, oral hygiene, toileting hygiene, shower/baths, upper and lower body dressing, putting on/taking off footwear, and personal hygiene;-Dependent to roll left and right, char/bed-to-chair transfers, and tub/shower transfer;-Not attempted/resident did not perform activity: sit to lying, lying to sitting on side of bed, sit to stand, toilet transfer, walk 10 feet;-Always incontinent of bowel and bladder;-Primary medical condition category: Non-traumatic brain dysfunction;-Diagnoses included hemiplegia or hemiparesis, non-Alzheimer's dementia, malnutrition, and anxiety disorder. Review of the resident's care plan, last revised on 10/22/25, showed:-The resident has potential to demonstrate physical and verbal behaviors related to dementia with psychotic disturbances;--Goal: Will not harm self or others;--Interventions included: When he/she becomes agitated intervene before agitation escalates. Engage calmly in conversations;-Activity of daily living (ADL) self care performance deficit related to Alzheimer's disease;--Goal: maintain current level of function;--Interventions included: 1-2 staff participation for bed mobility. Totally dependent on staff for bathing, bed mobility, personal hygiene and dressing;-The care plan did not direct staff to use any form of restraint;-The care plan did not address the resident's behavior of rubbing his/her scalp until the area was bald. During an interview on 12/18/25 at 1:11 P.M., CNA F said he/she was the CNA assigned to the resident on the day shift. His/Her shift started at 7:00 A.M., and he/she did not get report from the off going CNA from night shift. He/She did not need to provide care to the resident

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide cardiopulmonary resuscitation (CPR, life saving measures) effectively to include rescue breaths, to a resident when the supplies needed to run a code were not available on the crash cart. This resulted in a delay of up to 9 minutes from the time CPR was initiated until rescue breaths and oxygen could be administered, for one resident (Resident #1). Staff were not knowledgeable on how to work the suction machine, resulting in an occluded airway. In addition, staff failed to ensure Emergency Medical Services (EMS) was in the room and ready to take over compressions before stopping CPR. Eighteen residents were identified to be a full code. The census was 48. The Interim Administrator was notified on [DATE] at 2:50 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor onsite verification. Review of the facility's Medical Emergencies - Code Blue, policy, dated [DATE], showed:-Purpose: To ensure the prompt and effective response by facility personnel during medical emergencies through the use of the Code Blue procedure;-The facility will provide an appropriate level of response to the resident during medical emergency;-A medical emergency is defined as any of the following conditions requiring immediate medical intervention and the initiation of the Code Blue procedure:--Respiratory or Cardiac Arrest;-The facility will perform CPR in accordance with the guidelines set forth by the American Heart Association (AHA);-Once CPR is initiated, it will continue until paramedics arrive;-First Responder:--The first of facility personnel to arrive and find a resident with any of the above conditions will:---Call for help;---Send available staff to call a Code Blue and retrieve emergency medical equipment;---Assess the resident's level of consciousness, circulation, airway, and breathing; begin CPR according to current practice. Note: The first responder should not leave the victim to call for help unless absolutely necessary according to the situation;---When the second responder arrives, have the second responder place the cardiac arrest board under the resident and assist with two-rescuer CPR.-Subsequent Responder(s):--Activate the Emergency Response System - Call 911;--Direct all needed personnel to the Code Blue site;--Send a staff member to the entrance door to wait where the ambulance is expected to arrive;--The Registered Nurse (RN) to respond will lead the code unless responsibility is transferred to another licensed staff member;--Note: One person CPR will be maintained until there is a second responder available to begin two person CPR;---CPR will continue until the paramedics arrive and assume responsibility;-Licensed Nurse:--In the absence of an Attending Physician, it will be the responsibility of the first licensed staff member responding to the code to lead and coordinate the resuscitation efforts until paramedics arrive. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed:-Severe cognitive impairment; -Diagnoses included pressure ulcers (injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or friction), sepsis (infection in the blood), dysphagia (inability to swallow), and aphasia (inability to speak or understand). Review of the resident's care plan, in use at the time of survey, showed: -Focus: Full code;-Goal: Initiate CPR;-Interventions: Signed proper documents, consult nurse staff on changes in health. Review of the resident's electronic Physician Order Sheet, (ePOS), showed an order, dated [DATE], for full code status. During an interview on [DATE] at 2:53 P.M., Licensed Practical Nurse (LPN) B said usually night shift checks the crash cart, but he/she did not see a sign off sheet on the cart for verification. Review of the crash cart check list showed an Ambu bag (self-inflating resuscitator) with mask and oxygen tank listed as items that should be on the crash cart. Staff initialed all supplies available on [DATE]. Review of the AHA Adult Basic Life Support Algorithm for Healthcare Providers, dated 2020, showed:-Check for responsiveness;-Look for no breathing or only gasping and check pulse;-If no breathing or only gasping, pulse not felt: Start CPR;-Perform cycles of 30 compressions and two breaths. Use Automated External Defibrillator (AED) as soon as it is available. Review the AHA CPR Science Based Guidelines, dated 2025, showed:-CPR - is an emergency lifesaving procedure performed when the heart stops beating. Immediate CPR can double or triple chances of survival after cardiac arrest;-For healthcare providers and those trained: conventional CPR using chest compressions and mouth-to-mouth breathing at a ratio of 30 compressions to two breaths. In adult victims of cardiac arrest, it is reasonable for rescuers to perform chest compressions at a rate of 100 to 120 per minute and to a depth of at least 2.0 inches (5.0 centimeters) for an average adult. Observation on [DATE] at 2:20 P.M., showed during the resident's wound care, the Wound Doctor exited the room and the Director of Nursing (DON)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure treatment orders for wound care were appropriately transcribed, resulting in one resident (Resident #4) not receiving wound care as ordered by the physician. The sample was 7. The census was 48. Review of the facility's Physician's Orders policy, dated June 2020, showed:-Purpose: This will ensure that all physician orders are complete and accurate;-Orders will include a description complete enough to ensure clarity of the physician's plan of care;-Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order;-Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other health care disciplines will be transcribed onto the appropriate communication system for that discipline;-Documentation pertaining to physician orders will be maintained in the resident's medical record. Current month's administration records will be maintained in the medication administration record (MAR)/treatment administration record (TAR). Review of the facility's Wound Management policy, dated June 2020, showed:-Purpose: To provide a system for the treatment and management of residents with wounds including pressure and non-pressure injury;-A resident who has a wound will receive necessary treatment and services to promote healing, prevent infection and prevent new pressure injuries from developing;-Venous insufficiency ulcer - an open lesion of the skin and subcutaneous tissue of the lower leg, usually occurring in the pretibial (shin bone) area of the lower leg or above the medial ankle. Venous insufficiency ulcers may be caused by one (or a combination of) factor(s) including: loss of (or compromised) value function in the vein, partial or complete obstruction of the vein, and/or failure of the calf muscle to pump the blood;-Per attending physician's order, the nursing staff will initiate treatment and utilize interventions for pressure redistribution and wound management;-New pressure injuries or wounds will be documented in the 24-Hour Log;-Wound documentation will occur at a minimum of weekly until the wound is healed. 1. Review of Resident #4's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/11/25, showed:-Mild cognitive impairment; -Open lesions other than ulcers, rashes, or cuts noted;-Diagnoses included peripheral vascular disease (poor circulation), cognitive communication deficit (inability to understand or express impaired thinking), protein-calorie malnutrition (inadequate intake of protein and calories), infection of the skin and subcutaneous tissues (common bacterial on skin), diabetes, and kidney disease. Review of the resident's electronic Physician Order Sheet (ePOS), showed an order, dated 8/27/25, for tubi-grip (compression) socks to right lower extremity daily for swelling. Review of the nurse's progress notes, dated 12/5/25, showed:-At 10:00 A.M., staff documented the resident's leg was noted to have edema (swelling) +2, faint pedal pulse, and redness to right lower leg to halfway to top of foot. Resident had a recent diagnosis of cellulitis (bacterial infection causing inflammation) of the legs. Resident stated I know something is wrong with my foot. Physician notified and new order received to send resident out to emergency room (ER) upon return to facility from dialysis;-At 6:07 P.M., staff documented EMS arrived to transport the resident to the hospital for further evaluation of right leg. Resident alert and oriented times four (alert to person, place, time, and event) and refused to go to the hospital. Review of the resident's Wound Doctor progress notes, dated 12/11/25, showed:-Area to right medial shin, venous insufficiency ulcer: change dressing daily, cleanse with normal saline (sterile water). Primary treatment with betadine (antiseptic medication), dressing dry, and wrap with an Ace wrap (tight bandage);-Area to left anterior shin, diffused/scattered venous insufficiency ulcer: change dressing daily, cleanse with normal saline. Primary treatment with betadine, dressing dry, and wrap with an Ace wrap. Review of the resident's skin assessment, dated 12/12/25, showed right lower leg (front) with closed scabs, bruising, and redness. Left lower leg (front) with closed scabs, bruising and redness. Review of the resident's ePOS and MAR for December 2025, showed the Wound Doctor's orders from 12/11/25 for treatment to the resident's right medial shin and left anterior shin, were not added to the ePOS or MAR. Review of the resident's care plan, in use at the time of survey, showed no documentation related to the resident's wounds. Observation on 12/18/25 at 11:25 A.M., showed the resident had an irregularly shaped wound to the right inner mid-calf with defined and pink edges. The wound was scabbed over. The left upper leg had scrape-like marks that were scabbed. Both legs were without bandages, dressings, or tubi-socks. During an interview, the resident said he/she has wounds on his/her right toes, right shin, left shin, and buttocks. A doctor prescribed medication nine days go, but he/she has not received the medication. The resident believes his/her wounds are one to two months old. During an interview on 12/18/25 at 11:06 A.M., Licensed Practical

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free from significant medication errors when staff failed to prime pre-filled insulin pens before insulin administration for two residents (Residents #6 and #4). The sample was 7. The census was 48. Review of the facility's Medication Administration of Insulin policy, revised May 2014, showed: -Purpose: To provide guidelines for the safe administration of insulin to residents with diabetes;-The type of insulin, dosage requirements, strength, method of administration must be verified before administration, to assure that if corresponds with the order on the medication sheet and the physician's order;-The policy did not address the use of insulin pens. 1. Review of Resident #6's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/25/25, showed:-Cognitively intact;-Diagnoses included diabetes, obstructive sleep apnea (OSA), adult failure to thrive, obesity, and kidney disease. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident has diabetes and is insulin dependent;-Goal: Resident will have no complications related to diabetes through the review date;-Interventions included: Educated on diabetes chronic disease, monitor for hypoglycemia (low sugars)/hyperglycemia (high sugars) symptoms. Review of the electronic Physician Order Sheet (ePOS), showed an order, dated 4/22/25, for insulin aspart (short-acting insulin)100 Units (U)/milliliters (ml), inject 12 U subcutaneously before meals. Review of the manufacturer's guidelines for prefilled insulin pens, undated, showed:-Do an air shot before each injection. Before each injection, a small amount of air may collect in the cartridge. To avoid injecting air and ensure proper dosing, an air shot must be completed before each injection;-Turn the dose button to select four U with a new cartridge or one U with a cartridge already in use;-Hold the pen with the needle pointing up. Tap the cartridge holder gently with finger a few times to make sure any air bubbles collect at the top of the cartridge;-Keep the needle pointing up, press the dose button, all the way in, until a click is heard or felt. The display will return to zero. A drop of insulin must appear at the needle tip. If a drop of insulin at the needle tip is not seen, repeat the steps until a drop of insulin is at the needle tip;-It is very important that a drop of insulin is seen at the needle tip before injection. This will ensure accurate dosing. Observation on 12/18/25 at 8:32 A.M., showed License Practical Nurse (LPN) A sanitized his/her hands and put on a fresh pair of gloves. LPN A wiped the prefilled insulin pen with an alcohol pad and placed a needle onto the pen. LPN A did not prime the insulin pen. LPN A dialed the pen to 12 U and administered the insulin to the resident while he/she was halfway through eating breakfast. During an interview on 12/19/25 at 7:47 A.M., LPN A said he/she was unaware if he/she primed the insulin pen before administering the medication. 2. Review of Resident's #4's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnosis includes peripheral vascular disease (poor circulation), cognitive communication deficit (inability to understand or express impaired thinking), protein-calorie malnutrition (inadequate intake of protein and calories), infection of the skin and subcutaneous tissues (common bacterial on skin), diabetes, and kidney disease. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident has diabetes and requires hypoglycemic medication daily;-Goal: Resident will have no complications related to diabetes through the review date;-Interventions included: Educated on diabetes chronic disease, fasting serum blood sugars as ordered by doctor. Review of the ePOS, showed an order, dated 9/16/25, for Basaglar KwikPen (insulin glargine, long-acting insulin), subcutaneous solution pen-injector 100 U/ml, inject 15 U subcutaneous in the morning. Review of the manufacture's guidelines for KwikPen Pre-Filled Insulin Pen, dated November 2022, showed:-Prime before each injection;-Priming then pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly;-If the pen is not primed before each injection, you may get too much or too little insulin;-To prime the pen, turn the dose knob to two units. Hold the pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding the pen with needle pointing up. Push the dose knob in until it stops and 0 is seen in the dose window. Hold the dose knob in and count to five slowly. You should see insulin at the tip of the needle. Observation on 12/19/25 at 8:12 A.M., showed LPN B did not prime the insulin pen before administering the insulin to the resident. During an interview on 12/19/25 at 8:12 A.M., LPN B said he/she did not prime the insulin pen before using it on the resident. The purpose of priming first is to ensure the pen is functional prior to administering insulin. During an interview on 12/19/25 at 12:03 P.M., the Director of Nursing (DON) said he expects staff to prime insulin two units, per the