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	03/13/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure bathrooms on the second floor were cleaned routinely, affecting one of 18 sampled residents (Resident #10). The sample was 18. The census was 53 Review of the facility's Housekeeping policy, dated 8/2020, showed:-Purpose: To ensure that the facility is clean, sanitary, and in good repair at all times so as to promote the health and safety of residents, staff, and visitors;-Policy: All rooms of the facility are kept clean and as free as possible of germs and other contaminating agents at all times, while maintaining a pleasant and homelike atmosphere for our residents;-Procedure: The housekeeping department is responsible for completing the daily, weekly, and monthly cleaning procedures. 1. Observations of the second floor bathrooms, on 3/9/26 at 9:57 A.M., showed:-The toilet in the bathroom by the emergency exit door had brown and yellow matter on the seat. A strong bowel movement (BM) odor permeated from the bathroom;-The shower room floors had various dark stains. Small hairs were on the ground of the shower in various areas. The toilet seat had brown matter smeared on it;-The bathroom across from the nurse's station had a strong BM odor. The toilet seat dirty with dark matter smeared on it. The toilet contained toilet paper with a brown substance in it. Observations of the second floor bathrooms on 3/12/26, showed:-At 8:35 A.M., the shower room toilet unflushed with toilet paper and urine in the toilet and on the seat. The shower floor had various hairs and dark matter stains;-At 11:24 A.M., the shower room toilet had brown smears on it and a strong BM odor. The floor of the shower had hair and various dark matter stains. 2. Review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 2/14/26, showed:-Diagnoses included multiple sclerosis (MS, autoimmune disease) and insomnia;-Cognitively intact. During an interview on 3/9/26 at 9:20 A.M., the resident said the bathrooms on the second floor are dirty and are not cleaned often enough. There is only one shower room open and the shower is dirty sometimes. 3. During an interview on 3/13/26 at 8:16 A.M., Licensed Practical Nurse (LPN) G said he/she expected the toilets and showers on the second floor to be clean for residents to use them. The housekeeping staff is responsible for cleaning the bathrooms. He/She did not believe there were enough housekeeping staff and that is why the bathrooms are often dirty. 4. During an interview on 3/13/26 at 1:53 P.M., Housekeeper H said there is normally one housekeeper assigned to clean the second floor. Bathrooms are expected to be cleaned on each housekeeping shift. He/She expected the toilets and showers to be clean. 5. During an interview on 3/13/26 at 4:43 P.M., the Administrator and Director of Nursing (DON) said they expected bathrooms to be clean to prevent infection control issues. They expected showers and toilets to be clean. The housekeeping staff were responsible for cleaning the bathrooms at least once a day and as needed. 27924362788490

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure physician orders were followed by not accurately coding one resident (Resident # 8's) medication as not given on the medication administration record (MAR) and by failure to document if one resident (Resident #7's) medications, treatments, and skin assessments were completed on the MAR. In addition, the facility failed to ensure that skin assessments were completed as physician ordered for two residents (Residents #5 and #48). The resident sample is 18. The census was 53.Review of facility's physician order policy, last revised, June 2020, showed: -Purpose: This will ensure that all physician orders are complete and accurate; -Procedure: -A licensed nurse will transcribe telephone orders with date, time, and signature of the person receiving the orders; -Orders will include a description complete enough to ensure clarity of the physician plan of care; -Whenever possible, the licensed nurse receiving the order will be responsible for documenting and implementing the order; -Medication and treatment orders will be transcribed onto the appropriate resident administration record; -Documentation pertaining to physician orders will be maintained in the resident's medical record, current month's administration will be maintained in the medication administration record and the treatment administration record (TAR). 1. Review of Resident #8's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 12/13/25, showed: -Cognitively intact; -Diagnoses included anxiety, depression and bipolar disorder (a mental disorder that cause severe mood swings). Review of the resident's MAR dated March 2026, showed; -An order dated, 2/20/26, clonazepam (anxiety medication) 0.5 milligrams (mgs), give one tablet every evening at 4:00 P.M.; -Clonazepam 0.5 mg documented as administered on 3/12/26 at 4:00 P.M. Review of the resident's controlled drug administration record, showed the resident's clonazepam 0.5 mg was last documented as administered on 3/11/26 at 4:00 P.M. and 11 tablets remained. During an interview on 3/13/26 at 7:50 A.M., the resident said he/she did not receive his/her (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clonazepam dose on 3/12/26 at 4:00 P.M. The resident said he/she tried to tell the night shift staff that he/she did not receive his/her clonazepam. The staff member informed the resident that the clonazepam was documented as administered. The resident said he/she did not sleep all night due to not receiving his/her clonazepam dose. During observation and interview on 3/13/26 at approximately 8:20 A.M., the nurses' medication cart narcotic box was opened by Licensed Practical Nurse (LPN) A. The resident's card of clonazepam 0.5 mg showed 11 tablets remaining. LPN A said he/she worked 3/12/26 and thought he/she had given the resident his/her clonazepam. LPN A said he/she must have signed it off as given in the electronic medical record but did not actually give the clonazepam. During an interview on 3/13/26 at 3:50 P.M., the Director of Nursing (DON) said she expected the staff to accurately document a medication was administered on the resident's MAR and on the controlled substance sheet. She expected staff not to just click off that the medication was given and pay attention to what medication is being administered. 2. Review of Resident #7's medical record, showed: -admitted : 5/17/24; -Diagnoses included: Dementia, high blood pressure, high cholesterol, dysphasia (swallowing difficulty), seizures, depression, hemiplegia (paralysis of one side of the body), and major depressive disorder. Review of the March 2026 electronic physician order sheet (ePOS), showed: -An order, dated 12/22/25, for Lorazepam Intensol Oral Concentrate 2 milligrams (mg)/milliliters (ml), give 0.25 ml every six hours for anxiety; -An order, dated 12/30/25, to observe resident closely for significant behaviors: 0-No Behaviors, 1-Agitation, 2-Anxiety, 3-Nervousness, 4-Compulsiveness, 5-Physical Aggression, 6-Combative, 7-Excitation/Irritability, 8-Verbal Aggression, 9-Panic, 10-other; every shift for Anxiety/Agitation. Code the appropriate number that reflect any and all behaviors. Notify Physician if a behavior increases or a new behavior is noted. -An order, dated 12/30/25, to observe resident closely for significant side effects: 0-No Side effects,1-Dizziness, 2-Drowsiness, 3-Confusion, 4-Fatigue, 5-Syncope (feeling faint due to blood flow change), 6-Dysathea (speech disorder), 7-Nightmares, 8-Agitation, 9-Tremors, 10-Ataxia (uncoordinated movement), 11-Mania (extreme sustained high energy), 12-Blurred Vision, 13-Other; every shift for anxiety. Code the appropriate number that reflect any and all side effects. Notify Physician if any side effects are noted. -An order, dated 6/23/25, to assist resident with dressing and undressing every shift related to limitations from diagnosis of hemiplegia and hemiparesis (weakness on one side of the body) following cerebral infarction (a type of stroke) affecting left dominant side every shift; -An order, dated 6/16/25, for weekly skin assessments every day shift every Thursday. Complete under assessment tab; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 4/22/25, for anti-itch 0.5-0.5% lotion. Apply to both upper extremities (BUE) topically every shift for pruritus (severe, persistent itching); -An order, dated 4/22/25, for [NAME] Cream moisture (barrier cream). Apply to peri-area (between the genital and anal areas) topically two times a day for preventative skin treatment. Review of the resident's MAR, dated 2/1/26 through 2/28/26, showed: - An order, dated 12/22/25, for Lorazepam Intensol Oral Concentrate 2 mg/ml, give 0.25 ml every six hours for anxiety; -Documentation showed, seven out of the 112 opportunities were blank. Review of the resident's nurse's administration record (NAR), dated 2/1/26 through 2/28/26, showed: -An order, dated 12/30/25, to observe resident closely for significant behaviors: 0-No Behaviors, 1-Agitation, 2-Anxiety, 3-Nervousness, 4-Compulsiveness, 5-Physical Aggression, 6-Combative, 7-Excitation/Irritability, 8-Verbal Aggression, 9-Panic, 10-other; every shift for Anxiety/Agitation. Code the appropriate number that reflect any and all behaviors. Notify Physician if a behavior increases or a new behavior is noted. -Documentation showed, four out of the 56 opportunities were blank; -An order, dated 12/30/25, to observe resident closely for significant side effects: 0-No Side effects,1-Dizziness, 2-Drowsiness, 3-Confusion, 4-Fatigue, 5-Syncope, 6-Dysathea,7-Nightmares,8-Agitation,9-Tremors,10-Ataxia,11-Mania,12-Blurred Vision,13-Other; every shift for anxiety. Code the appropriate number that reflect any and all side effects. Notify Physician if any side effects are noted. -Documentation showed, four out of the 56 opportunities were blank; -An order, dated 6/23/25, to assist resident with dressing and undressing every shift related to limitations from diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left dominant side every shift; -Documentation showed three out of the 56 opportunities were blank; Review of the resident's treatment administration record (TAR), dated 2/1/26 through 2/28/26, showed: -An order, dated 6/16/25, for weekly skin assessments every day shift every Thursday. Complete under assessment tab; -Documentation showed, two out of the four opportunities were blank; -An order, dated 4/22/25, for anti-itch 0.5-0.5% lotion. Apply to BUE topically every shift for pruritus; -Documentation showed, four out of the 56 opportunities were blank; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 4/22/25, for [NAME] Cream moisture. Apply to peri-area topically two times a day for preventative skin treatment; -Documentation showed, four out of the 56 opportunities were blank. Review of the resident's NAR, dated 3/1/26 through 3/11/26, showed: - An order, dated 12/22/25, for Lorazepam Intensol Oral Concentrate 2 mg/ml, give 0.25 ml every six for anxiety; -Documentation showed, three out of the 40 opportunities were blank. Review of the resident's TAR, dated 3/1/26 through 3/11/26, showed: -An order, dated 6/16/25, for weekly skin assessments every day shift every Thursday. Complete under assessment tab; -Documentation showed one out of the one opportunity was blank; -An order, dated 4/22/25, for anti-itch 0.5-0.5% lotion. Apply to both BUE topically every shift for pruritus; -Documentation showed three out of the 20 opportunities were blank; -An order, dated 4/22/25, for [NAME] Cream moisture. Apply to peri-area topically two times a day for preventative skin treatment; -Documentation showed three out of the 20 opportunities were blank. 3. Review of Resident #5's quarterly MDS, dated [DATE], showed: -Diagnoses included diabetes, hearing loss, and schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves); -Cognitively intact. Review of the resident's MAR, dated March 2026, showed: -An order, dated 7/10/25, for weekly skin assessment to be completed on Wednesday night shifts; -The skin assessment for 3/4/26 and 3/11/26 were not documented as completed. Review on 3/12/26, of the resident's electronic medical record (EMR), showed: -The most recent skin assessment under the assessments tab was dated 2/19/26. 4. Review of Resident #48's quarterly MDS, dated [DATE], showed: -Diagnoses included dementia, diabetes, and bipolar disorder; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Moderately impaired cognition. Review of the resident's MAR, dated March 2026, showed: -An order, dated 7/11/25 for weekly skin assessments to be completed on Monday evening shift; -The skin assessment for 3/2/2026 and 3/9/26 were not documented as completed. Review on 3/12/26, of the resident's EMR, showed the most recent skin assessment under the assessments tab was dated 2/24/26. 5. During an interview on 3/13/26 at 3:56 P.M., the Administrator and DON said they would expect weekly skin assessments to be completed if there is an order from the physician. The skin assessments are to be completed in the assessment's tab in the EMR and documented as completed in the resident's MAR. They would expect medication to be administered per the physicians' orders. They would expect the nurse to document why the medication was not administered and notify the physician. 2792436

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure activities of daily living (ADL, bathing, dressing, eating, transferring and toileting) care was provided for four of 18 sampled residents. The facility failed to ensure one resident was toileted in a timely manner (Resident #28), failed to ensure two residents received at least two showers a week and were assisted by staff (Residents #4 and #38), and failed to ensure one resident was assisted with unwanted facial hair removal (Resident #5). The census was 53. Review of the facility's showering a resident policy, undated, showed:-Purpose: a shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors;-Policy: residents are offered a shower at a minimum of once weekly and given per resident request. Review of the facility's perineal (care to the surface area between the thighs, extending from the pubic bone to tail bone) care policy, dated 6/2020, showed:-Purpose: To maintain cleanliness of the genital area, to reduce odor, and to prevent infection or skin breakdown;-Policy: Perineal care is provided as part of a resident's hygienic program, a minimum of once daily and per resident need. 1. Review of Resident #28's quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated, 12/22/25, showed:-Severe cognitive impairment;-Impairment on one side of upper and lower extremity;-Dependent on staff for toilet hygiene, bathing, personal hygiene, upper and lower body dressing;-Requires maximum assist rolling left and right;-Frequently incontinent of bowel and bladder;-Diagnoses included dementia, depression and hemiplegia (weakness to one side of the body). Review of the resident's care plan, in use at the time of survey, showed:-Focus: the resident has self-care ADL performance deficit related to hemiplegia, dementia and pain.-Interventions: the resident is totally dependent of staff for toilet use, personal hygiene, dressing, transfers and bathing. Observation and interview on 3/10/26 at 12:45 P.M., showed the resident lay in bed, eating his/her lunch tray. The resident had a strong odor of urine, and when he/ she raised his/her left arm, the resident had strong body odor. Certified Medicine Technician (CMT) J administered the resident medication. At 12:55 P.M., the Certified Nursing Assistant (CNA) B and CNA I came into the room and turned the resident to his/her left side. The resident's brief, two quilted bed pads and fitted sheet were saturated with urine. CNA B said, Whew, that's a lot when the resident was turned. The resident had an open wound to his/her right buttock and an open wound on his/her left buttock with no dressing. CNA B said the last time he/she checked on the resident was around 8:00 A.M. CNA B said he/she did not want to disturb the resident this morning because he/she was sleeping and frequently is in pain. During an interview on 3/11/26 at 12:15 P.M., Licensed Practical Nurse (LPN) A said all incontinent residents should be checked on and repositioned every two hours. During an interview on 3/13/26 at 11:17 A.M., CMT J said all incontinent residents should be checked on every two hours. Resident #28 should have been changed and gotten out of bed at the beginning of the shift. During an interview on 3/13/26 at approximately 2:00 P.M., CNA I said incontinent residents should be checked every two hours and the resident has never refused care for him/her. During an interview on 3/14/26 at 3:50 P.M., the Director of Nursing (DON) said she expected staff to check on all incontinent residents to be checked on every two hours. 2. Review of Resident # 4's, quarterly MDS, dated , 12/25/25, showed:-Cognitively intact;-Requires partial to moderate assistance from staff for bathing, personal hygiene and toilet hygiene;-Frequently incontinent of bladder and occasionally incontinent of stool;- Diagnoses included stroke, dementia, diabetes, kidney failure and depression. Review of the resident's care plan in use at the time of survey, showed:- Focus: the resident has self-care ADL performance deficit related to Parkinson's disease, myasthenia gravis (an auto immune disease that causes muscle weakness) and refuses assistance;-Interventions: the resident requires toilet and personal hygiene assistance. The resident uses a walker and requires supervision to partial assistance from staff. Observation and interview on 3/9/26 at 9:20 A.M., showed the resident lay in bed and had a strong body odor, uncombed, oily hair, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and an unshaven face with approximately one half an inch of facial hair. The resident said he/she would walk to the shower room down the North Hall using his/her walker. The shower room was usually cluttered with equipment and the resident said he would try to move the equipment but usually wasn't able to. The resident finds the obstructed shower room to be a deterrent to take a shower. He/She has asked staff to help him/her getting set up in the shower, but they never do. The resident said he/she was incontinent of urine and frequently was incontinent of stool and would like to take a shower. The resident said his/her poor hygiene added to his/her depression. Observation on 3/10/26 at 8:10 A.M., and 3/11/26 at approximately 10:00 A.M., showed the resident lay in bed and had a strong body odor, uncombed, oily hair, and an unshaven face with approximately one half an inch of facial hair. During an interview on 3/11/26 at approximately 12:00 P.M, CNA K said the resident didn't really want any help with his/her showers. CNA K said the resident did his/her own thing. He/She was not aware that the resident was having difficulty getting his/her showers completed. CNA K was aware that the resident was incontinent of urine and stool but said the resident provided his/her own care. During an interview on 3/14/26 at 3:50 P.M., the DON said everyone that lives in the facility requires assistance from staff with their hygiene needs including Resident # 4. All residents are expected to be clean, dry and odor free. 3. Review of Resident #38's annual MDS, dated [DATE], showed:-Diagnoses included type two diabetes, schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), and cerebral palsy (group of disorders affecting a person's ability to move and maintain balance and posture),-Severe cognitive impairment. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: the resident has an ADL self-care performance deficit;-Goal: the resident will maintain current level of function in through the review date;-Interventions: personal hygiene/oral care: maximum assistance from staff needed. Review on 3/12/26, of the resident's MAR, dated 3/2026, showed:-An order, dated 12/2/25, showers scheduled every Monday and Thursday evening shift;-On 3/2/26 and 3/9/26, the resident's showers were not marked as given. Observation on 3/9/26 at 10:05 A.M., showed the resident in bed awake. The resident had a strong sweat like odor emitting from him/her. Observation on 3/12/26 at 1:17 P.M., showed the resident in bed awake watching tv. The resident had a strong sweat like odor emitting from him/her. During an interview on 3/13/26 at 8:21 A.M., LPN G said Resident #38 was not resistive to care. He/She would expect the resident to receive his/her scheduled showers and to be odor free. During an interview on 3/13/26 at 4:45 P.M., the Administrator and DON said they would expect residents to receive their scheduled showers and showers as needed. They said Resident #38 was not resistive to care. 4. Review of Resident #5's quarterly MDS, dated [DATE], showed:-Diagnoses included type two diabetes, hearing loss, and schizophrenia;-Cognitively intact. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: resident has an ADL self-care performance deficit;-Goal: resident will maintain current level of function in bed mobility, transfers, eating, and dressing through the review date;-Interventions: personal hygiene/oral care: dependent on one staff with personal hygiene and oral care. Observation on 3/9/26 at 10:00 A.M., showed the resident in bed awake. The resident's chin had long white curly hairs. Observation on 3/10/26 at 7:25 A.M., showed the resident walking out of his/her room to go to the dining room for breakfast. The resident's chin had long white curly hairs. During an interview on 3/10/26 at 7:35 A.M., the resident said he/she wanted his/her chin hairs removed. During an interview on 3/13/26 at 8:21 A.M., LPN G said both CNAS and LPNs could assist residents with removing unwanted facial hair. He/She would expect staff to ask the resident their grooming preference during showers. During an interview on 3/13/26 at 1:56 P.M., CNA F said during showers or bed baths CNAs could remove the resident's unwanted facial hair. During an interview on 3/13/26 at 4:45 P.M., the Administrator and DON said nursing staff should assist residents with removing unwanted facial hair. They would expect staff to ask both the male and female residents. 2792436

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess resident activity preferences and to provide an ongoing activity program that supports residents in their choices of activities (Residents #2, #4, #5, #10, #16, #25, and #48). In addition, the facility failed to provide one to one (1:1) activities to three residents who were identified as having the potential to benefit from them (Residents #6, #7, and #9). The sample was 18. The census was 53. Review of the facility's Activities Program policy, dated 6/2020, showed:-Purpose: To encourage residents to participate in activities to make life more meaningful, to stimulate and support physical and mental capabilities to the fullest extent, and to enable the resident to maintain the highest attainable social, physical and emotional functioning;-Policy: The facility provides an activity program designed to meet the needs, interests, and preferences of residents. The activities are varied and work to address the needs and interests identified through the assessment process. The activity program may address areas including, but not limited to social activities, indoor and outdoor activities, activities away from the facility, religious programs, opportunity for resident involvement for planning activities, creative activities, educational activities, and exercise activities;-Procedure: Activities are developed for individual, small group, and large group participation. The activity schedule is posted, in large print, in a location accessible to residents, their family, and staff;-The initial activity assessment is completed by the Director of Activities or his or her designee within seven days of admission. After completion of the initial Activity Assessment and the Minimum Data Set (MDS, a federally mandated assessment tool completed by facility staff), an individualized care plan will be developed and implemented for each resident. 1. Observation of the main dining room on 3/9/26 at 1:05 P.M., showed Mardi Gras decorations hanging on the wall and resident birthdays for February 2026 posted on a bulletin board. Observations of the North hall near the main dining room, on 3/9/26 at 1:00 P.M., and 3/10/26 at 7:15 A.M. and 3/12/26 at 9:13 P.M., showed an activity calendar for February 2026 posted on a bulletin board. Observations on 3/10/26 at 8:56 A.M., 10:26 A.M., and 12:45 P.M., showed no activities provided to residents. Observations on 3/11/26 at 2:20 P.M., 3:44 P.M., 4:04 P.M., and 5:17 P.M., showed no activities provided to residents. Observations on 3/12/26 at 9:09 A.M., 10:11 A.M., 11:23 A.M., and 1:15 P.M., showed no activities provided to residents. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included anxiety, depression, bipolar disorder (a mental disorder that causes extreme mood swings), schizophrenia (a mood disorder that distorts reality) and post-traumatic stress disorder (PTSD, a mental condition that is triggered by experiencing or witnessing traumatic events). Review of the resident's care plan, in use at the time of survey, showed no documentation related to the resident's activity participation or preferences. Review of the resident's medical record, showed no activity assessment. Observation on 3/9/26 at 9:41 A.M., showed an activity calendar, dated February 2026, outside of the resident's bathroom door. During an interview, the resident said there are no activities taking place. It had been about two weeks since the last Activities Director left. He/She comes out for activities only when it interests him/her, which isn't very often. He/She pays for a car ride out of his/her personal money to go to Wal-Mart, just to get out of this place. 3. Review of Resident #4's quarterly MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included stroke, dementia, diabetes, kidney failure, and depression. Review of the resident's care plan, in use at the time of survey, showed no documentation related to the resident's activity participation or preferences. Review of the resident's medical record, showed no activity assessment. Observation on 3/9/26 at 9:20 A.M., showed the resident in bed and the room was dark. During an interview, the resident said he/she does nothing all day long. He/She goes to dialysis and that is the only time he/she goes out anywhere. He/She would like to participate in something that he/she is interested in. He/She used to put large puzzles together. The facility used to have a small bus that would take residents places, and he/she thought it would be nice to (continued on next page)

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	265828	A. Building B. Wing	03/13/2026

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have that again. Observation on 3/9/26 at 9:20 A.M. and 3/11/26 at 5:15 P.M., showed an activity calendar dated February 2026, posted on the outside of the resident's bathroom door. 4. Review of Resident #5's quarterly MDS, dated [DATE], showed:-Diagnoses included diabetes, hearing loss, and schizophrenia;-Cognitively intact. Review of the resident's care plan, in use at the time of survey, showed no documentation related to the resident's activity participation or preferences. Review of the resident's medical record, showed no activity assessment. During an interview on 3/9/26 at 10:00 A.M., the resident said there are not enough activities provided. He/She wants more activities to be provided. 5. Review of Resident #10's quarterly MDS, dated [DATE], showed:-Diagnoses included multiple sclerosis (MS, autoimmune disease) and insomnia;-Cognitively intact. Review of the resident's care plan, in use at the time of survey, showed no documentation related to the resident's activity participation or preferences. Review of the resident's medical record, showed no activity assessment. During an interview on 3/9/26 at 9:10 A.M., the resident said there are not enough activities provided and he/she would like more. 6. Review of Resident #16's quarterly MDS, dated [DATE], showed:-Diagnoses included hypertension (high blood pressure), insomnia, and anemia (increase in number of red blood cells);-Cognitively intact. Review of the resident's care plan, in use at the time of survey, showed no documentation related to the resident's activity participation or preferences. Review of the resident's medical record, showed no activity assessment. During an interview on 3/9/26 at 8:56 A.M., the resident said there are not enough activities provided. There are not enough activity staff to do activities. 7. Review of Resident #25's quarterly MDS, dated [DATE], showed:-Diagnoses included diabetes, bipolar disorder, depression, and hypertension;-Cognitively intact. Review of the resident's care plan, in use at the time of the survey, showed:-Focus: The resident is independent in activity attendance and chooses what to participate in;-Interventions: Invite the resident to scheduled activities. Provide with activities calendar. Notify resident of any changes to the calendar of activities. During an interview on 3/9/26 at 9:54 A.M., the resident said there are not enough activities. He/She would like more activities to keep him/her from being bored. 8. Review of Resident #48's quarterly MDS, dated [DATE], showed:-Diagnoses included dementia, diabetes, and bipolar disorder;-Moderately impaired cognition. Review of the resident's care plan, in use at the time of survey, showed no documentation related to the resident's activity participation or preferences. Review of the resident's medical record, showed no activity assessment. During an interview on 3/9/26 at 9:52 A.M., the resident said the facility did not have enough activity staff to conduct activities. He/She would like more activities and is bored most of the time. 9. During an interview on 3/13/26 at approximately 1:30 P.M., the Activity Director said her first day working for the facility was on 3/9/26. The activity calendar for March 2026 had not been made yet, and it was still in the process of being created. She expected activities to be scheduled and provided to residents. She expected a current activity calendar to be given to the residents and posted where they can read it. 10. During an interview on 3/13/26 at 4:21 P.M., the Administrator and Director of Nursing (DON) said they expected activities to be offered and provided to residents. They expected an up-to-date activity calendar to be given to each resident and posted in areas where the residents can see it. They expected resident care plans to reflect the resident's activity preferences. The Activity Director is responsible for conducting the activity assessment upon admission to the facility and annually. 11. Review of Resident #6's comprehensive MDS, dated [DATE], showed:-Cognitively intact;-Diagnoses included dementia, bipolar disorder, hypertension, and malnutrition. Review of the resident's care plan, in use at the time of survey, showed no documentation related to the resident's activity participation or preferences. Review of the facility's 1:1 Activity List, undated, showed the resident scheduled to receive 1:1 activities on Wednesdays and Saturdays. Review of the resident's medical record, showed no documentation of activities offered or provided to the resident. Observations of the resident throughout the survey, from 3/9/26 through 3/13/26, showed the resident not engaged in any 1:1 activities. 12. Review of Resident #7's quarterly MDS, dated [DATE], showed:-Severe cognitive impairment;-Diagnoses included Alzheimer's Disease, (dementia), stroke, dementia, (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hemiplegia (paralysis of the arm, leg, and trunk on the same side of the body), seizure disorder, malnutrition, and anxiety disorder. Review of the resident's care plan, in use at the time of survey, showed no documentation related to the resident's activity participation or preferences. Review of the facility's 1:1 Activity List, undated, showed the resident scheduled to receive 1:1 activities on Mondays and Thursdays. Review of the resident's medical record, showed no documentation of activities offered or provided to the resident. Observations of the resident throughout the survey, from 3/9/26 through 3/13/26, showed the resident not engaged in any 1:1 activities. 13. Review of Resident #9's quarterly MDS, dated [DATE], showed:-Short and long-term memory impairment;-Diagnoses included anxiety disorder, aphasia (communication disorder), seizure disorder, mild cognitive impairment, malnutrition, and Rett's syndrome. Review of the resident's care plan, in use at the time of survey, showed no documentation related to the resident's activity participation or preferences. Review of the facility's 1:1 Activity List, undated, showed the resident scheduled to receive 1:1 activities on Wednesdays and Saturdays. Review of the resident's medical record, showed no documentation of activities offered or provided to the resident. Observations of the resident throughout the survey, from 3/9/26 through 3/13/26, showed the resident not engaged in any 1:1 activities. 14. During an interview on 3/13/26 at approximately 1:30 P.M., the Activity Director said she had not started conducting 1:1 activities for the residents on the 1:1 Activity List. Residents #6, #7, and #9 are on the 1:1 Activity List and would benefit from 1:1 activities. 15. During an interview on 3/13/26 at 4:21 P.M., the Administrator and DON said they expected 1:1 activities to be provided to residents who have been determined to benefit from them. 2792436

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to offer and vaccinate eligible residents for pneumococcal pneumonia (pneumonia caused by bacteria) for two out of five residents reviewed (Resident #2 and Resident #27), and influenza (flu) vaccine for one out of five residents (Resident #4) sampled for immunizations. The census was 53.Review of the facility's Pneumococcal Disease Prevention policy, last revised, June 2020, showed:-Purpose: To ensure that the facility prevents and control the spread of pneumococcal disease in the facility;-Policy: -The facility will offer training to facility staff upon hire and inform residents on precautions and best practices to control the infection and spread pneumococcal disease in the facility; -The pneumococcal vaccine is recommended for all adults 65 ears of age and older; -Before offering the pneumococcal immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; -The resident or the legal representative has the opportunity to refuse immunization, with such refusal being noted in the resident's medical record; -The resident medical record includes documentation that indicated, at a minimum, the following: -That the resident or resident's legal representative was provided education regarding the benefit and potential side effects of pneumococcal immunization; -That the pneumococcal vaccination- informed consent or refusal will be placed in the resident's medical record; -That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contradictions or refusals. Review of the facility's Influenza Prevention and Control policy, last revised, June 2020, showed:-Purpose: To ensure that the facility prevents and controls the spread of influenza;-Policy: -The facility will offer training to facility staff upon hire and inform residents on precautions and best practices to control the infection and spread influenza in the facility; -Before offering the influenza immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; -Residents are offered an influenza immunization during the flu season annually, unless the immunization is contraindicated, or the resident has already been immunized; -The resident or the legal representative has the opportunity to refuse immunization, with such refusal being noted in the resident's medical record; -The resident medical record includes documentation that indicated, at a minimum, the following: -That the resident or resident's legal representative was provide education regarding the benefit and potential side effects of influenza immunization; -That the influenza vaccination- informed consent or refusal will be placed in the resident's medical record; -That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contradictions or refusals. 1.Review of Resident #2's medical record showed:-Diagnoses included heart failure, chronic obstructive pulmonary disease (COPD), a lung disease, and kidney disease;-No documentation the resident received the pneumococcal vaccine, and no documentation staff offered the vaccine or vaccine education to the resident. 2.Review of Resident #27's medical record showed:-Diagnoses included COPD and high blood pressure;-No documentation the resident received the pneumococcal vaccine, and no documentation staff offered the vaccine or vaccine education to the resident. 3. Review of Resident #4's medical record showed:-Diagnoses included kidney disease, Parkinson's disease, Myasthenia Gravis (an auto immune disease that affects the muscles), diabetes, and bladder cancer.-No documentation the resident received the influenza vaccine, and no documentation staff offered the vaccine or vaccine education to the resident. During an interview on 3/13/26 at 3:50 P.M., the Director of Nursing (DON), who is also the Infection Preventionist (IP), said all residents should be offered the influenza yearly. All residents should have the pneumococcal vaccine offered if eligible. Refusals of the vaccines and any education provided should be documented in the resident's medical record. All vaccines administered to the resident should be documented in the resident's medical record.