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	07/01/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident #1), who was non-weight bearing on his/her left leg and required the use of a Hoyer (mechanical lift) for transfers, received adequate assistance to prevent accidents when Certified Nurse Aide (CNA) A and Certified Medication Technician (CMT) B performed an assisted transfer without the use of a mechanical lift or gait belt. The resident reported pain during the transfer and sustained a fractured fibula (calf bone). The sample was 7. The census was 52 The Administrator was notified on 07/01/26 of the past non-compliance, which occurred on 05/05/26. Nursing staff were in-serviced on resident transfers. The deficiency was corrected on 05/14/26. Review of the facility's Total Mechanical Lift policy, revised 06/2020, showed:-Purpose: A mechanical lift is used appropriately to facilitate transfers of residents;-Policy:-Nursing staff will be trained to use the mechanical lift;-At least two people are present while resident is being transferred with the mechanical lift. Review of the facility's Transfer of Residents policy, revised 06/2020, showed:-Purpose: To provide the form of transfer best suited to the residents' needs and to maintain resident safety during the procedure;-Policy:-A Licensed Nurse and/or the Director of Rehabilitation Services assess and determine lifting and transfer requirements and the procedure used for each resident. The procedure is recorded in the resident's care plan;-Residents must be lifted or transferred according to the determined procedure;-Residents who require assistance in transferring will be transferred using a gait/transfer belt or with a lift;-Members of the nursing staff are trained to use good body mechanics, knowing the properprocedures and properly operating assistive devices;-Mechanical lift procedures are used on any resident unable to independently pivot or transfer. Review of the facility's Gait Belt policy, revised 06/2020, showed:-Purpose: To provide assistance to clinical staff when moving a resident from one place to another and to increase the safety of residents by allowing clinical staff members to grip it and keep the resident from falling;-Policy: A gait belt may be used for residents who are too weak to walk or stand alone, or requires assistance during transfers;-Procedure: The gait belt is only used to assist with transfer or movement. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 04/18/26, showed:-Cognitively intact;-Lower extremity impairment on one side;-Dependent on assistance with sit to stand and chair/bed-to-chair transfers;-Diagnoses included periprosthetic fracture around the internal prosthetic left knee joint, unsteadiness on feet, other lack of coordination, and need for assistance with personal care. Review of the resident's care plan, in use at the time of survey, showed:-Focus: Resident is at risk for falls related to history of falls, gait/balance problems, incontinence, psychoactive drug use, denial of safety needs, need for assistive devices for locomotion, and vision/hearing problems;-Interventions included on 03/20/26, changed to mechanical lift assist x 2. Review of the facility's investigation showed:-A typed statement for the resident, transcribed by Administrator, dated 05/06/26, showed on 05/05/26, CNA A entered his/her room with CMT B. The resident was a Hoyer lift and non-weight bearing on his/her left leg, but CNA A insisted him/her to stand for the transfer. CMT B asked if they should use a Hoyer lift, but CNA A said no because the resident could (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	do it and was faking. As they stood him/her up, the resident said it hurt and CNA A responded, Well, you are hurting my back. CNA A made the resident fully transfer to bed bearing weight;-A typed statement for CNA A, transcribed by the Administrator, dated 05/06/26, showed CNA A entered the resident's room with CMT B. CNA A noticed the resident was sliding out of his/her chair. The resident was a Hoyer lift transfer, but the Hoyer lift was dead, so CNA A asked CMT B to assist in transferring the resident to bed. CNA A explained he/she didn't want the resident to fall and CNA A knew they weren't supposed to do it, but they were going to do a two-person transfer the resident. The resident did not complain of pain during the transfer;-A typed statement for CMT B, transcribed by Administrator, dated 05/07/26, showed CNA A asked CMT B to assist in transferring the resident due to him/her sliding out of his/her chair. CMT B went into the room and assisted CNA A in transferring the resident. They utilized a two-person transfer. CMT B was unaware the resident was a Hoyer lift transfer. The Hoyer lift was charging at the time of transfer;-An undated summary, showed on 05/06/26, the resident came to the Administrator's office to report that on 05/05/26 at 8:30 P.M., CNA A and CMT B entered his/her room and transferred him/her to the bed utilizing a two-person transfer. The resident required a Hoyer lift for transfers and was non-weight bearing on his/her left leg. Instead of utilizing the Hoyer lift, CNA A assisted the resident to stand, CMT B stated to CNA A, Shouldn't we use the Hoyer? CNA A told CMT B that they could two-person transfer the resident and stated that the resident could stand on his/her own and that the resident was faking. As they assisted him/her to stand, the resident complained that they were hurting him/her. CNA A then replied, Well, you are hurting my back. The transfer was completed and the resident was placed into bed. The resident's roommate was unable to give any kind of corroborating statement due to his/her limited cognition. The aides involved in the transfer were identified as CNA A and CMT B. Both CNA A and CMT B admitted that they transferred the resident utilizing a two-person transfer. Both denied there being any inappropriate communication between CMT B and the resident such as, You are faking, or rudeness. CNA A admitted that he/she was aware that the resident was non-weight bearing and required a Hoyer lift for transfers. CMT B denied knowing the resident's need for a Hoyer lift or that he/she was non-weight bearing on his/her left leg. CMT B stated that at no time did CNA A and CMT B discuss the resident required a Hoyer lift. CMT B just trusted CNA A and completed the transfer without further investigation. Skin assessment revealed bruising to the resident's left ankle. An x-ray on his/her left ankle was ordered. Results showed the resident had a left ankle fracture. The resident was sent to the emergency room (ER) following results. After completing investigation, it was determined that the resident was transferred incorrectly utilizing a two-person transfer and that the resident suffered a fracture to his/her left ankle, but the facility did not find that either aide intentionally caused harm or injury to the resident. Review of the resident's skin assessment, dated 05/06/26, showed:-Does the resident have any skin impairments: Yes;-Left knee (front) bruising and swelling, no open areas;-Left lower leg (front) bruising and swelling, no open areas;-Left ankle (outer) bruising and swelling, no open areas;-Left toes bruising and swelling, no open areas. Review of the resident's May 2026 progress notes, showed:-On 05/06/26 at 11:15 A.M., x-ray ordered due to concerns of worsening deformity of left knee joint;-On 05/06/26 at 2:59 P.M., patient complained of pain to left foot, foot was warm to touch, swelling and slight bruising noted. X-ray was ordered;-On 05/07/26 at 6:53 A.M., resident had an acute distal fibular shaft fracture. Physician gave orders to send to emergency room for further evaluation. Review of the resident's hospital Discharge summary, dated [DATE], showed diagnoses included closed fracture (broken bone that does not pierce the skin) of left ankle. During an interview on 06/29/26 at 12:51 P.M., the resident said he/she required a Hoyer lift for transfers. CNA A and CMT B came to his/her room to transfer. CMT B asked if they should use a Hoyer lift. The employees were on both sides of him/her and picked him/her up by lifting underneath his/her arms. The staff did not use a gait belt. They stood him/her up and turned him/her, and that was how his/her left ankle broke. It was hard to tell that it was broken because his/her left leg was broken prior to this. The resident was not sliding out of his/her chair at the time of the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	transfer. The resident told the staff his/her physician said to use a Hoyer lift and CNA A said, You know the resident, he/she is just faking it. That hurt the resident's feelings. During an interview on 06/30/26 at 11:23 A.M., the Assistant Director of Nursing (ADON) said the resident reported the improper transfer to CNA D on the morning of 05/06/26, then CNA D brought the resident to the Administrator. The resident reported that he/she was hurt by CNA A. The resident said he/she was not sliding out of his/her chair at any time. CNA A stepped to the door and requested help and CMT B came to assist. CNA A told CMT B the Hoyer was dead and CNA A told CMT B that they needed to do a two-person assist transfer before the resident fell. The resident said CNA A never went to look for a Hoyer lift. CNA A and CMT B transferred the resident by standing and pivoting him/her, even though the resident was non-weight bearing and should not have been standing. The ADON said the resident was non-weight bearing because he/she has a fracture to his/her left knee. The resident complained of pain in his/her left leg. The ADON did a skin assessment on the resident and found bruising and swelling to the resident's left knee and ankle. The ADON reported this information to the physician and obtained an order for an x-ray to left knee and left ankle. The x-ray results came back with a left ankle fracture and the resident was sent to the hospital for evaluation and treatment. During an interview on 06/30/26 at 3:32 P.M., the Interim Administrator and Interim Director of Nursing (DON) said the staff know a resident's transfer status by checking the resident's Kardex (quick-reference to a resident's specific care requirements) or care plan. If a resident is listed as a Hoyer lift transfer, they expected staff to use the Hoyer for all transfers. It was not appropriate to do a two-person assisted transfer without a Hoyer lift, if the resident was listed as a Hoyer. The facility had three Hoyer lifts in the facility on 05/05/26. If one Hoyer lift was dead, they expected staff to use one of the other two Hoyer lifts that were available. If all Hoyer lifts were dead, they expected the staff to charge the Hoyer and use the Hoyer lift for the transfer after it was charged. If the resident was sliding down in their wheelchair, they expected staff to reposition the resident in the wheelchair, wait until the Hoyer lift was charged, and then transfer the resident with the Hoyer. When staff performed one or two-person assisted transfers, they expected staff to use a gait belt during the transfers. They expected staff to follow the resident's Kardex and care plan for transfer status. They expected staff to be knowledgeable of and to follow facility policies. During an interview on 06/30/26 at 3:45 P.M., Physician E, the resident's primary care physician (PCP), said he/she expected staff to follow the resident's Kardex and care plan for transfer status. He/She expected staff to be knowledgeable of and to follow facility policies and procedures. 3011397