STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675230	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Grove Nursing Center	246 Haley Dr Center, TX 75935

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 5 residents (Resident #1) reviewed for supervision to prevent accidents. The facility failed to ensure Resident #1 was in safe position prior to incontinent care. Resident #1 rolled off her bed during incontinent care on 12/06/25.Resident #1 sustained a comminuted distal left femur fracture with apex posterior angulation and mild impaction (lower leg bone broken into multiple pieces tilted at an angle and slight displacement of the bone fragments) and a non-displaced fracture of the right distal femoral shaft(middle section of the femur-the bone breaks in one spot and remains aligned).This failure could place residents at risk of severe injuries.Findings included: Record review of Resident #1's undated face sheet indicated she was an [AGE] year-old female, admitted on [DATE], and her diagnoses included dementia (decline in mental abilities), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body following cerebral infarction (stroke), and cognitive communication deficit (difficulties in communication). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated she was usually able to make herself understood and usually understood others. She had severe cognitive impairment (BIMS-7). She was dependent for rolling left to right. There were no falls noted. Record review of Resident #1's care plan dated 07/28/25 indicated Resident #1 needed assist with ADLS. Interventions included total assistance X 1 or 2. Record review of Resident #1's care plan dated 07/28/25 indicated Resident #1 had potential for falls related to weakness and hemiplegia/hemiparesis. Intervention included assist with ADLS as needed and call light in reach. Record review of Resident #1's fall risk assessment dated [DATE] indicated she was at high risk for falls. Interventions included needed and desired items in reach/easy access, low bed, and reminders to use call light. Record review of Resident #1's electronic care record printed 12/09/25 (EHR effective 06/24/25) indicated she was dependent for bed mobility. The care record did not indicate number of staff required. Record review of Resident #1's electronic care record printed 12/10/25 (EHR effective prior to 06/24/25) indicated Resident #1 was total dependence for bed mobility with support of 1 staff. Record review of nurse note dated 12/06/25 at 6:02 a.m., completed by LVN N indicated CNA W called LVN N to Resident #1's room. CNA W reported while she was changing Resident #1, she turned Resident #1 on her side and Resident #1 continued to roll. She was not able to catch Resident #1 before she fell. Resident #1 complained 10/10 of leg and back pain. Resident #1 had a skin tea to left hand and discoloration to bilateral knees. 5:29 am EMT Transport notified. 5:35 am Family, MD, Administrator, DON, ADON notified of transport. 5:42 a.m. EMT in facility. 5:52 a.m. EMT left facility. Record review of Resident #1's incident report dated 12/06/25 at 5:20 a.m., completed by LVN N indicated CNA W called LVN N to Resident #1's room. CNA W reported while she was changing Resident #1, she turned Resident #1 on her side and Resident #1 continued to roll. She was not able to catch Resident #1 before she fell. Resident #1 complained 10/10 of leg and back pain. Resident #1 had a skin tea to left hand and discoloration to bilateral knees. Neglect and Abuse were ruled out. The physician, DON, and family were notified. Actions included being changed to 2-person assist. Record review of Resident #1's hospital records dated 12/06/25 indicated she sustained a comminuted distal left femur fracture with apex posterior angulation and mild impaction. Record review of Resident #1's hospital records dated 12/07/25 indicated a non-displaced fractur of the right distal femoral shaft. Record review of CNA W's personnel record indicated she was oriented to resident care on 01/21/25 and incontinent care and fall prevention on 02/13/25. During an interview on 12/09/25 at 9:55 a.m., the DON said she was made aware on 12/06/25 Resident #1 fell, had pain and was sent to the hospital. The hospital never called the facility to give report of their findings. On 12/08/25, the facility found out she had sustained a left leg fracture and during surgery the surgeon noticed Resident #1 had right foot and leg swelling and determined she also had a right leg fracture. Resident #1's family member came to the family on 12/08/25 and questioned how he sustained her injuries. The DON said she showed the family member the bed height was set up in the highest position and how she rolled out of the bed onto the floor. Resident #1 had no history of falls in the facility. Resident #1 was on an air mattress that was set based on her weight. She said she was not in a bariatric mattress because she did not meet the criteria of a BMI over 50. She said staff are trained on bed mobility. She said Resident #1 was a 1-person assist for bed mobility. Staff are aware of resident care requirements through the care plan and care record. She said the facility determined the air mattress probably factored into Resident #1's fall during care and the