STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555213	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Pine Post Acute	1640 N. Fair Oaks Avenue Pasadena, CA 91103

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 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 interview and record review, the facility failed to create and implement a comprehensive person-centered care plan for one (1) of two (2) sampled residents (Resident 1) to address Resident's 1's diagnosis of alcohol dependence (also known as alcohol use disorder [[NAME]], a chronic disease characterized by a compulsive need to drink alcohol despite negative consequences).This failure resulted in Resident 1 going out on pass (OOP - a non-medical visit outside of the facility most commonly used for visits with family or friends) from the facility on 7/15/2025 at 11:45 AM and not returning. The facility was notified by the local police on 7/15/2025 at 10:51 PM that Resident 1 was found at the general acute care hospital (GACH) emergency department. Findings:During a review of Resident 1's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of alcohol abuse (drinking in a manner, situation, amount, or frequency that could cause harm to the person who drinks or to those around them) with intoxication (the condition of having physical or mental control markedly diminished by the effects of alcohol or drugs) and hypotension (the pressure of blood circulating around the body is lower than normal). During a review of Resident 1's History and Physical Examination (H&P), dated 6/18/2025, the H&P indicated Resident 1 had a diagnosis of alcohol abuse.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/29/2025, the MDS indicated the resident had an intact cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 1 needed partial/moderate assistance (helper does less than half the effort) with walking 10 feet, chair/bed-to-chair transfers, going from a sitting position to standing, rolling left and right in bed, putting on/taking off footwear and lower body dressing (the ability to dress and undress below the waist). Resident 1 needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with upper body dressing (the ability to dress and undress above the waist), personal hygiene and eating. During a review of Resident 1's Nurses Note dated 7/15/2025 timed at 5:41 PM by Registered Nurse 2 (RN 2), Resident 1's Nurses Note indicated RN 2 had called Resident 1's friend (listed on the face sheet as alternate contact) to inform them that Resident 1 had not returned to the facility from his OOP from that morning and was inquiring if they knew Resident 1's whereabouts. Resident 1's friend informed RN 2 that they had not spoken to or seen Resident 1. RN 2 then informed MD of situation on 7/15/2025 at 5:47 PM. During a review of Resident 1's Nurses Note, dated 7/15/2025, timed at 8:49 PM by RN 2, Resident 1's Nurses Note indicated that Resident 1 had not returned from his OOP from 11:45 AM on 7/15/2025 and indicated the following timeline: 7:44 PM: RN 2 notified the DON and ADM that Resident 1 had not come back from being OOP. 9:27 PM: Called Resident 1's friend a second time to see if they had any update on Resident 1. Resident 1's friend had not heard anything from Resident 1. 9:30 PM: RN 2 contacted the local police to report resident's status. 9:43 PM: RN 2 left a message for the California Department of Public Health (CDPH). 10:02 PM: the local police department arrived at the facility to investigate and (local police) left around 10:12 PM. 10:51 PM: the local police called the facility to inform them that Resident 1 was found at the general acute care hospital (GACH) emergency department (ED) and were on their way to check on the resident. 10:56 PM: RN 2 contacted GACH ED and spoke with Resident 1's assigned nurse who stated Resident 1 was seen lying down in the street with bottles of alcohol around him and was transported to ED around 7:13 PM and was being treated for alcohol intoxication and hypotension and might be admitted to the GACH. During a review of Resident 1's GACH Discharge summary, dated [DATE], the GACH Discharge Summary indicated Resident 1 was found unconscious outside by Emergency Medical Services (EMS) after drinking approximately 48 ounces (oz) of beer. Resident 1 had no recollection of events prior to coming to the ED. However, he had been staying at a Skilled Nursing Facility (SNF) and got a one day pass to leave, which is when he bought the alcohol and consumed it. During an interview on 7/30/2025 at 11:40 AM with RN 2, RN 2 stated, on 7/15/2025 around 5 PM, she had called Resident 1's friend to see if he knew where Resident 1 was since he had not returned. RN 2 stated after the local police visited the facility and left, RN2 then received a call from local police letting RN 2 know the local police had found Resident 1 in the GACH EDDuring an interview on 7/30/2025 at 1:43 PM with RN 1, RN 1 stated she obtained an OOP order from MD for Resident 1 on 7/14/2025. MD was made aware that Resident 1 was AAOx4, self-responsible and ambulatory without assist. RN 1 stated she did not relay to the MD that Resident 1 had a history of alcohol dependence During a concurrent interview and