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	11/26/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 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 ensure one (1) of three (3) sampled residents (Resident 1) was free from physical abuse (any intentional act causing injury or trauma to another person through bodily contact). Resident 1 had a change of behavior of screaming towards Resident 3 on 11/11/2025 and the facility did not have documented evidence the behavior was addressed. This resulted in Resident 2 hitting Resident 1 on the face on 11/12/2025.and Resident 1 sustained a scratch under the resident's right eye and redness on the right side of the nose. Findings:During a review of Resident 1's admission Record, the admission record indicated the resident was admitted to the facility on [DATE] with the following but not limited to diagnoses of dementia (a progressive state of decline in mental abilities), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), depression (a serious mood disorder characterized by persistent sadness and loss of interest, affecting how a person thinks, feels, and acts) and anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/8/2025, the MDS indicated the resident was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated, the resident is dependent (Helper does all of the effort. The MDS also indicated Resident 1 does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self but required substantial/maximal assistance (helper does more than half the effort. Helper lifts or hold trunk and provides more than half the effort) with lower body dressing, putting on/taking off footwear, and oral hygiene. The MDS indicated the resident required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds or supports trunk or limbs but provides less than half the effort) with eating, upper body dressing and personal hygiene. During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 11/12/2025, the SBAR indicated Resident 1 had a resident-to-resident altercation and had a scratch under the right eye and redness on the right side of the nose. During a review of Resident 1's Progress Notes, dated 11/12/2025 at 11:30 AM, the Progress Notes indicated Resident 1 stated he was hit by Resident 2 in the face. The progress notes indicated Resident 1 had a scratch under the resident's right eye and discoloration on the right side of the resident's nose. During an interview on 11/25/2025 at 12:48 PM, Treatment Nurse (TN) stated she heard Resident 1 screaming on 11/12/2022 around 10:30AM and when TN went into the resident's room and checked on Resident 1, the reisdent had a scratch under his right eye. During an interview on 11/25/2025 at 1:02 PM, Resident 1 stated Resident 2 hit Resident 1 in the face (unable to recall when). During an interview on 11/25/2025 at 1:28PM, Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 likes to get into other residents' personal space. CNA 1 also stated she did not report it, because everyone knows about Resident 1's behavior. During a review of Resident 2's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of muscle weakness and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness on one side of the body that can affect the arm, leg, hand, or face) of the right dominant side. During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident is moderately impaired in cognitive skills for daily decision making. The MDS also indicated, the resident required substantial/maximal assistance with shower/bathe self, lower body dressing, and putting on/taking off footwear but required partial/moderate assistance with oral hygiene, toileting hygiene, upper body dressing and personal hygiene. During an interview on 11/25/2025 at 1:20PM, Resident 2 stated, he did hit Resident 1 in the face (unable to recall when). During a review of Resident 3's admission Record, the admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of schizoaffective disorder, depression and anxiety. During a review of Resident 3's MDS, dated [DATE], the MDS indicated the resident was independent in cognitive skills for daily decision making. The MDS also indicated the resident was dependent on toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear but required substantial/maximal assistance with oral hygiene, upper body dressing and personal hygiene. During an interview on 11/25/2025 at 2:24 PM, Resident 3 stated, on 11/11/2025, Resident 1 was trying to get Resident