

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Cedar Pine Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent sexual abuse (non-consensual sexual contact of any type with a resident) for two (2) of 2 sampled residents (Resident 1 and 2) on 12/18/2025 in the facility's hallway. On 12/18/2025, Orientee of Dietary (OD) and Certified Nursing Assistant (CNA 1) witnessed Resident 1 pulled down his (Resident 1) pants and pulled out his (Resident 1) penis. Resident 2 then performed oral sex (one partner uses the tongue, mouth or throat to excite the other partner's sex organs) to Resident 1. This failure resulted in Resident 1 and 2 to sexual abuse potentially risking emotional trauma (response to deeply distressing or disturbing event) or psychological trauma (damage to the mind that occurs as a result of a severely distressing event) placing other residents in the facility at risk for sexual abuse. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1's diagnoses included cocaine dependence (addictive disorder characterized by compulsive and uncontrollable drug seeking, continued drug use despite negative consequences.), unsteadiness of the feet, and muscle weakness. The admission records also indicated Resident 1 was self- responsible (able to make decisions for himself). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 11/13/2025, the MDS indicated Resident 1's cognitive skills (processes of thinking and reasoning) for daily decision making were moderately impaired. The MDS indicated Resident 1 needs partial moderate assistance on (the helper does less than half the effort) on roll left and right (the ability to roll from lying on back to left and right side and return to lying back on the bed) and walk 10 feet (ft.-unit of measurement) once standing the ability to walk at least 10 ft. in a room, corridor or similar space. During a review of Resident 1's Situation, Background, Assessment and Recommendation (SBAR, tool used by health care professionals when communicating about critical changes in a resident's status), dated 12/18/2025 at 2:25 PM, it indicated there was a situation of inappropriate sexual activity by the hallway. During a review of Resident 1's nurses progress notes dated 12/18/2025 at 2:40 PM, the nurses progress notes indicated on 12/18/2025 at 2:25 PM the Director of Dietary (DD) and OD came to the nurses station and reported incident to charge nurse that the OD was outside standing in the patio area, facing towards the facility entrance building and witnessed (from the glass window) Resident 1 pulled down his pants and pulled out his penis. The progress notes also indicated, OD witnessed Resident 2 perform oral sex to Resident 1. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE]. Resident 2's diagnoses included schizoaffective disorder (a mental illness that causes loss of contact with reality), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), hypertension (high blood pressure). The admission Record indicated Resident 2 was not self-responsible and the responsible party is Resident Representative 1. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making is cognitively intact skills for daily decision making were intact. The MDS indicated Resident 2 needs substantial maximal assistance (helper does more than half the effort) on roll left and right, walk 10 ft. once standing the ability to walk at least 10 ft. in a room, corridor or similar space. During a review of Resident 2's SBAR dated 12/16/2025 at 10:52 AM, the SBAR indicated Resident 2 with episode of throwing feces to the hallway, attempts to touch or kiss the staff and residents' hands, and wander (the act of a resident with cognitive impairment moving around in the facility without appreciation for personal safety, potentially entering into harm's way) into other residents' room. During a review of Resident 2's care plan initiated on 12/16/2025 the care plan indicated Resident 2 has socially inappropriate / disruptive behavioral symptoms as evidenced by: touching and kissing hands of staff and residents. The care plan indicated an intervention included to observe socially inappropriate, disruptive behavior when around others. During a review of Resident 2's nurses progress notes dated 12/18/2025 at 4:13 PM, the nurses progress notes indicated at approximately 2:15 PM, CNA 1 saw Resident 2 with Resident 1 having oral sex in the hallway. CNA 1 was coming from outside (not indicated where) and saw Resident 1 and 2 having oral sex then CNA 1 knock on the glass door and Resident 1 immediately pulled his pants up and walked away. During a record review of facility's incident written statement from date 12/18/2025 indicated on 12/18/2025 at 2:15 PM OD witnessed Resident 1 pulled down his pants and pulled out his penis, then Resident 2 performed oral sex to Resident 1 at the hallway. During a record review of facility's Resident Interview Form dated 12/18/2025 at 3:33 PM indicated Resident</p>		