| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555213 | A. Building<br>B. Wing | 04/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cedar Pine Post Acute | 1640 N. Fair Oaks Avenue<br>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.

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide an accurate report detailing suspected presence of contraband (any item that is illegal to possess) for one (1) resident (Resident 1) as indicated in the facility's policy and procedure.This deficient practice had the potential to compromise or impede the protection of all the residents which could affect residents' physical, emotional, mental wellbeing and lead to irreversible results or death. Findings:During a review of Resident 1's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including but not limited to fibromyalgia (chronic disorder characterized by widespread musculoskeletal pain, fatigue, sleep disturbances), cervical disc displacement (herniated disc in the neck, the soft, jelly-like center of a spinal disc pushes out through a tear in its outer ring), and hypertension (high blood pressure). During a review of Resident 1's General Acute Care Hospital's (GACH) History and Physical (H&P), dated 3/29/2026, the H&P indicated Resident 1 had a fall last night while in the shower. The H&P indicated Resident 1 was alert and oriented. The H&P indicated Resident 1 was able to move all extremities. During a review of Resident 1's belonging list, dates 4/8/2026, indicated Resident 1 did not allow Certified Nurse Assistant 1 (CNA 1) to check Resident 1's black purse. During a review of Facility's initial report to State Agency (SA) on 4/9/2026, indicated Police Officer instructed facility staff not to touch the resident's belongings and have the door closed. Licensed Vocational Nurse 1 (LVN 1) were interviewed and inspected Resident 1's belongings, and Police officer found a small container with unknown substance. During a review of Police Department report dated 4/9/2026, timed 1:53 AM, indicated PD report indicated an offense of suspicious circumstance. PD report indicated facility staff locating apparent methamphetamine (highly addictive illegal stimulants that strongly affect the brain) inside Resident 1's backpack. PD report indicated LVN 1 unzipped Resident 1's backpack top middle pocket and pointed at a clear container. Police officer picked up the clear container and observed to be a white crystalline substance. During an interview on 4/14/2026 at 7 AM with CNA 1, CNA 1 stated that 4/8/2026, NOC shift (11 PM - 7 AM), CNA 1 was assigned to Resident 1. CNA 1 stated that she rendered care to Resident 1 around midnight and found a semi clear and hard substance stuck at Resident 1's right lower back. CNA 1 stated that she thought it was just a piece of cracked menthol candy. CNA 1 stated that after Resident 1 passed away, LVN 1 showed her a container with hard semi clear substance, and she told LVN 1 that she found the same substance at Resident 1's body during care. CNA 1 stated that the substance she found was like the substance that is inside the container that LVN 1 showed her. During an interview on 4/14/2026 at 7:35 AM with LVN 1, LVN 1 stated that he found the container with unknown substance in Resident 1's belongings when he was looking for Resident 1's family contact details. LVN 1 stated that he showed the container to the staff in his shift, and CNA 1 told him that she seen similar substance stuck in Resident 1's skin when rendering care. LVN 1 stated that she reported it to LVN 2 as well but did not report to the Administrator (ADM) or the Director of Nursing regarding CNA 1's observation of the substance stuck at Resident 1's skin. LVN 1 stated he initially reported to ADM and the DON that it was the Police Officer who found the container of unknown substance in Resident 1's belongings and changed his statement yesterday to correct that it<br>(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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was him who found the container with unknown substance that he thought to be salt. During an interview on 4/14/2026 at 1:06 PM with the DON, the DON stated that the initial report of Police officer founding a container of unknown substance was wrong. The DON stated that they based their report on what LVN 1 told them on 4/9/2026. The DON stated that LVN 1 was interviewed prior to reporting the incident to SA on 4/9/2026. The DON stated that the facility concluded their investigation with LVN 1's new statement that it was him who found the bottle with unknown substance. The DON stated that direct resident care staff which the CNA assigned to Resident 1 was not and should have been interviewed regarding the incident. The DON stated that she only found out today that CNA 1 has knowledge regarding the unknown substance. The DON stated she could have conducted better follow-up interviews for Resident 1 and staff involved, and she should have done an in-depth investigation. The DON stated if she did a thorough follow up interview, she could have identified other staff involved. The DON stated the investigation conducted was inaccurate and confusing because of missing information. During a review of Facility's P&P titled Contraband, revised 1/2025, the P&P indicated, all staff shall immediately report to Administrator (ADM) and/or Director of Nurses (DON) and/or designee and ADM, DON and designee shall immediately investigate suspected presence of contraband or illegal imports/goods/weapons in the facility. During a review of Facility's P&P titled Unusual Occurrence Reporting, revised on 1/2025, the P&P indicated a written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to state agency within 48 hours of reporting the event or as required by federal and state agencies. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an accurate and complete record for two (2) of 2 sampled residents (Resident 1 and 2) as indicated in the facility's policy and procedure (P&P) when: The facility failed to complete and accurately document Resident 1's neurological evaluation flow sheet (a standardized clinical documentation tool used to frequently monitor, record, and assess a patient's neurological status).The facility failed to complete Resident 1's fall risk assessment on 4/8/2026.The facility failed to accurately document Resident 2's neurological evaluation flow sheet.This deficient practice had the potential to result in miscommunication and improper delivery of care and inaccurate information of the care provided to Resident 1 and 2.Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including but not limited to fibromyalgia (chronic disorder characterized by widespread musculoskeletal pain, fatigue, sleep disturbances), cervical disc displacement (herniated disc in the neck, the soft, jelly-like center of a spinal disc pushes out through a tear in its outer ring), and hypertension (high blood pressure). During a review of Resident 1's General Acute Care Hospital's (GACH) History and Physical (H&P), dated 3/29/2026, the H&P indicated Resident 1 had a fall last night while in the shower. The H&P indicated Resident 1 was alert and oriented. The H&P indicated Resident 1 was able to move all extremities. During a review of Resident 1's fall risk assessment dated [DATE], it indicated Resident 1 was categorized as low risk for fall (score of nine). The fall risk assessment was reviewed with incomplete documentation/no answer to the following details: Ambulation/elimination statusGait/balanceSystolic blood pressureThe fall risk assessment evaluation indicated total fall risk score (score and acuity level will automatically be calculated based on response to the questions above). Score of 10 or higher indicated high risk for fall, and score of zero to nine (9) indicated low risk for fall. During a review of Resident 1's Neurological Evaluation Flow Sheet dated 4/8/2026, it indicated an instruction of initial assessment followed by every 15 minutes for four times, every 30 minutes for four times, every hour for two times, and once per shift (eight hours) for 72 hours. The Neurological Evaluation Flow Sheet indicated Resident 1 was initially assessed on 4/8/2026 at 5:30 PM. The Neurological Evaluation Flow Sheet indicated the following documented times of assessment:5:45 PM6 PM6:15 PM6:30 PM7 PM7:30 PM8 PM8:30 PM9 PM9:30 PM10 PM The Neurological Evaluation Flow Sheet indicated an instruction for respiratory patterns to use the following:N - Normal, easy, quiet breathing.BR - Bradypnea - slow less than 10 breaths per minute.C - [NAME] Stokes - period of deep breathing alternating with regular recurring periods of apnea (a common, serious disorder where breathing repeatedly stops and starts during sleep).B - Blots breathing - periods of deep or shallow breathing alternating with irregularity recurring periods of apnea.T - Tachypnea - rapid shallow more than 24 breaths per minute.H - Hyperventilation - rapid deep loud breathing.The Neurological Evaluation Flow Sheet indicated a documentation of three (3) over 10 for respiratory pattern on 4/8/2026 at 5:30 PM. The Neurological Evaluation Flow Sheet indicated a documentation of zero (0) over 10 for respiratory patterns on 4/8/2026 at 5:45 PM to 9:30 PM. During a concurrent record review and interview on 4/10/2026 at 2:59 PM with Registered Nurse 1 (RN 1), Resident 1's fall risk assessment dated [DATE] was reviewed. RN 1 stated Resident Fall risk assessment has incomplete assessment. RN 1 stated assessment for ambulation/elimination status, gait/balance, systolic blood pressure has not and should have been answered to have an accurate total score. RN 1 stated the score of 9 was not accurate, if all the questions were answered, the score would have totaled to 10 or higher which will make Resident 1 high risk for fall. RN 1 stated Resident 1 already has a history of fall before being admitted here in the facility, Resident 1 had fallen from home and had a fall in GACH as well. During a concurrent record review and interview on 4/10/2026 at 3:03 PM with RN 1, Resident 1's Neurological (continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Evaluation Flow Sheet dated 4/8/2026 was reviewed. RN 1 verified Resident 1's Neurological Evaluation Flow Sheet dated 4/8/2026 has a documented time of initial assessment at 5:30 PM, followed by 5:45 PM, 6 PM, 6:15 PM, 6:30 PM, 7 PM, 7:30 PM, 8 PM, 8:30 PM, 9 PM, 9:30 PM and 10 PM. RN 1 stated the 10 PM column has blank assessment. RN 1 stated the last documented assessment was the column before 10 PM, which is 9:30 PM. RN 1 verified the there was no neurological assessment for Resident 1 on 4/8/2026 at 10:30 PM. RN stated it should have been done every one hour. RN 1 stated there was no documented evidence that Resident 1 refused neurological assessment. RN 1 stated that the documented times for assessment should have initial assessment of 5:30 PM, followed by 5:45 PM, 6 PM, 6:15 PM, 6:30 PM, 7 PM, 7:30 PM, 8 PM, 8:30 PM, 9:30 PM, and 10:30 PM. RN1 verified that the documented respiratory patterns was wrong since the licensed nurses did not follow the instructions that was indicated in the Neurological Evaluation Flow Sheet. RN 1 stated it was important to follow the instructions on the frequency of assessment as indicated on the Neurological Evaluation Flow Sheet to ensure safety. RN 1 added that if the instructions on the Neurological Evaluation Flow Sheet were not followed, the assessment would be wrong, and care for Resident 1 would be different. During a concurrent record review and interview on 4/10/2026 at 3:20 PM with RN 2, Resident 1's Neurological Evaluation Flow Sheet dated 4/8/2026 was reviewed. RN 2 verified Resident 1's Neurological Evaluation Flow Sheet was inaccurately documented. RN 2 stated the respiratory patterns were mistakenly documented with three and zero, and the instructions were not followed. RN 2 also verified that the last documented assessment was 9:30 PM, and the next column has only a documentation of 10 PM, with blank assessment. RN 2 stated it was important to check and follow time indicated in the neurological evaluation flow sheet to assess if there was a change of condition. During a concurrent record review and interview on 4/10/2026 at 3:51 PM with Director of Nursing (DON), Resident 1's Neurological Evaluation Flow Sheet dated 4/8/2026 was reviewed. The DON stated neurological assessment or neuro check was conducted to assess if residents were alert and oriented and were at their previous baseline condition. The DON stated when conducting neuro check, the following were also assessed: Pupils Equal, Round, Reactive to Light and Accommodation, vital signs, extremities and resident responsiveness. The DON stated a neuro check was performed when a resident had an unwitnessed fall or fall with head injury. The DON stated there should be no instances that a neuro check is not be done after an unwitnessed fall since it was important to have a record and identify changes in resident status, and to immediately inform the Doctor of the change of condition to prevent a decline in residents health status. The DON stated a neuro check must be done to monitor any head injury, bleeding, or swelling to the brain or the change in a resident's level of consciousness. The DON verified Resident 1's Neurological Evaluation Flow Sheet dated 4/8/2026 was incomplete and with inaccurate documentation. The DON stated the last documentation was at 9:30 PM column, and the next column with a documented time of 10 PM time has no documented assessment of neuro check. During a concurrent record review and interview on 4/10/2026 at 3:53 PM with the DON, Resident 1's fall risk assessment dated [DATE] was reviewed. The DON stated Resident 1's Fall risk assessment has incomplete assessment. The DON stated assessment for ambulation/elimination status, gait/balance, systolic blood pressure has not and should have been answered to have an accurate total score. The DON stated if Resident 1's fall risk assessment was done completely, the score would have been over 10, which is high risk for fall. The DON stated incomplete assessment is wrong documentation and can lead to wrong treatment which might cause harm to any residents. 2. During a review of Resident 2's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including but not limited to anemia (a condition where the body does not have enough healthy red blood cells), muscle weakness, and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 2/7/2026, the MDS indicated Resident 2's cognitive (ability to think and reason) skills for daily decision making was severely impaired<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | (never/rarely made decisions). The MDS indicated Resident 2 required setup or clean-up assistance (helper sets up or cleans up) with eating and oral hygiene. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) with upper body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 2 required substantial assistance (helper does more than half the effort) with toileting hygiene, shower and lower body dressing. The MDS indicated Resident 2 one number of falls since admission. During a review of Resident 2's Neurological Evaluation Flow Sheet dated 3/19/2026 to 3/21/2026, The Neurological Evaluation Flow Sheet indicated an instruction for respiratory patterns to use the following:N - Normal, easy, quiet breathing.BR - Bradypnea - slow less than 10 breaths per minute.C - [NAME] Stokes - period of deep breathing alternating with regular recurring periods of apnea.B - Blots breathing - periods of deep or shallow breathing alternating with irregularity recurring periods of apnea.T - Tachypnea - rapid shallow more than 24 breaths per minute.H - Hyperventilation - rapid deep loud breathing.The Neurological Evaluation Flow Sheet indicated a documentation of letter R on all the boxes for respiratory patterns from 3/19/2026 to 3/21/2026.During a concurrent record review and interview on 4/10/2026 at 3:05 PM with RN 1, Resident 2's fall risk assessment dated [DATE] to 3/21/2026 was reviewed. The DON verified the documented respiratory patterns were inaccurate because the licensed nurses documented R instead of following the instructions. RN 1 stated letter R was not indicated in the instructions on how to document respiratory patterns. During an interview on 4/10/2026 at 3:55 PM with the DON, Resident 2's fall risk assessment dated [DATE] to 3/21/2026 was reviewed. The DON verified documented respiratory patterns were inaccurate because the licensed nurses documented R instead of following the instructions. The DON added that if the instructions on the neurological assessment was not followed, change of condition will not be known, and it can lead to resident's decline that can lead to hospitalization or death. During a review of Facility's P&P titled Charting and Documentation, revised on 4/2024, the P&P indicated documentation in the medical record will be objective, complete and accurate. The P&P also indicated to ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical record. |