

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 04/23/2026
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)
<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to administer the intravenous (IV, administering fluids or medications directly into a vein using a needle or tube, allowing for immediate entry into the bloodstream) hydration (the process of supplying water to maintain adequate fluid levels in the body) for one (1) of two (2) sampled residents (Resident 1) on 4/10/2026, in accordance with the physician's order, care plan, and facility policy. This failure had the potential to put Resident 1 at risk for dehydration (a condition occurs when the body loses more fluids than it takes in, leading to an insufficient amount of water for normal bodily functions) and complications that can lead to hospitalization and death. Findings: During a review of Resident 1's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] with diagnoses including malignant (harmful, or dangerous to health) neoplasm (an abnormal, new growth of tissue in the body) of lungs and bones, neoplasm related pain and malnutrition. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 4/11/2026, the MDS indicated Resident 1's cognitive (ability to think and reason) skills for daily decision making was modified independence (some difficulty in new situations only). The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with eating and oral hygiene. The MDS indicated Resident 1 required substantial/moderate assistance (helper does less than half the effort) with upper body dressing and personal hygiene. The MDS indicated Resident 1 was dependent on toileting hygiene, shower, lower body dressing, and putting on/taking off footwear. During a review of Resident 1's Physician's Order, dated 4/10/2026, the Physician's Order indicated peripheral IV hydration of normal saline (NS, a saltwater solution), give over four hours, on 4/10/2026, 4/11/2026, and 4/12/2026. During a concurrent record review and interview on 4/23/2026 at 8 AM with Registered Nurse 1 (RN 1), Resident 1's medical records were reviewed. RN 1 stated the order on 4/10/2026 of IV hydration was not administered until 4/11/2026 at around 11 AM. RN 1 stated she initiated the peripheral IV line on 4/11/2026 because when she started her shift (7 AM to 3 PM), it had been endorsed to her that the order last night had not been carried out. RN 1 stated that Resident 1 did not have an IV line in place when she started her shift on 4/11/2026. During an interview on 4/23/2026 at 11:48 AM with the Director of Nursing (DON), the DON stated she was not aware that the IV hydration on 4/10/2026 was not administered until 4/11/2026. The DON stated the IV hydration order was important because Resident 1 has a change of condition of hypotension (abnormally low blood pressure) on 4/9/2026. The DON stated administering IV hydration would have increased Resident 1's blood pressure. During a review of undated Facility's P&P titled Policy and Procedure for IV, the P&P when an IV order is received, call or fax pharmacy with IV orders. The P&P also indicated, of the fluids and medications ordered are available from emergency kit (e-kit) supply, initiate infusion therapy as ordered in timely manner.</p>

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to reconcile the General Acute Care Hospital's (GACH) Discharge Medications List and carry out a physician's order to administer long-acting insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) for one (1) of two (2) sampled residents (Resident 2) as indicated on the facility policy and procedure (P&P). This deficient practice resulted in Resident 2 experiencing hyperglycemia (a condition where there's too much glucose in the blood) placing Resident 2 at risk for various serious complications such as ketoacidosis (DKA, a complication of diabetes in which acids build up in the blood to levels that can be life-threatening), dehydration (a condition occurs when the body loses more fluids than it takes in, leading to an insufficient amount of water for normal bodily functions), confusion (a state of reduced awareness and impaired thinking), and coma (a state of prolonged unconsciousness where a person is alive but unresponsive to their surroundings) and transfer to GACH on 4/10/2026. Findings: During a review of Resident 2's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control) with hyperglycemia (high blood sugar), End Stage Renal Disease (ESRD-irreversible kidney failure), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 3/27/2026, the MDS indicated Resident 2's cognitive skills for daily decision making was modified independence. The MDS indicated Resident 2 required supervision or touching assistance (helper provided verbal cues) with eating. The MDS indicated Resident 2 required partial/moderate assistance with oral hygiene. The MDS indicated Resident 1 was dependent on toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS also indicated Resident 2 received insulin injections. During a review of Resident 2's GACH's Discharge Medications List, dated 2/23/2026, the GACH's Discharge Medications List indicated an order of insulin glargine (long-acting, man-made insulin used once daily to control high blood sugar in adults and children with diabetes), inject 20 units (unit of measurement) subcutaneously (method of administering medication into the fatty tissue layer just below the skin) every 24 hours. During a review of Resident 2's Order Summary Report as of 3/15/2026, the Order Summary Report indicated an order of insulin lispro (insulin used to treat diabetes that is designed to work quickly-usually within 15 minutes of injection-to manage blood sugar spikes immediately before or after meals), inject nine (9) units SQ before meals for DM, hold if blood sugar is less than 100 milligrams per deciliter (mg/dl, unit of measurement), rotate sites of injection. Ordered on 3/14/2026. During a review of Resident 2's Order [NAME] report as of 4/21/2026, indicated an order of insulin glargine SQ, inject 10 unit SQ at bedtime for DM, ordered on 4/17/2026. During an interview on 4/22/2026 at 1:47 PM with Resident 2, in resident's room, Resident 2 stated he's been taking long-acting insulin for more than 20 years now. Resident 2 stated he's been managing his diabetes at home for a while now. Resident 2 stated that at home, he has been injecting himself with a long-acting insulin together with a short acting insulin depending on his blood sugar result. Resident 2 stated here in the facility, he was only receiving the short acting insulin which is being injected to him after the staff checked his blood sugar and this is before meals. Resident 2 added the facility had recently started giving him the long-acting insulin days after his readmission on [DATE]. During a concurrent record review and interview on 4/23/2026 at 10:45 AM with RN 1, Resident 2's medication administration records for March and April 2026 were reviewed. RN 1 verified Resident 2 did not have an order for long-acting insulin which is glargine since admission of 3/14/2026 and was only ordered on 4/17/2026. RN 1 stated that she noticed Resident (continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2's blood sugar was always high as reflected on the electronic medication administration record (EMAR) for the month of March and April 2026, that is why RN 1 notified Resident 2's Doctor on 4/17/2026. During an interview on 4/23/2026 at 11:55 AM with the DON, the DON stated Resident 2's Discharge Medications List from GACH on 3/14/2026 of insulin glargine was not and should have been carried out upon admission to the facility. The DON stated insulin glargine is a long-acting insulin that works with maintaining blood sugar levels within normal limits, in addition to an order of short acting insulin of lispro. The DON stated Resident 2 did not have insulin glargine order on 3/14/2026, and it was only ordered on 4/17/2026. The DON stated the licensed nurse who admitted Resident 2 to the facility on 3/14/2026 did not completely follow the Discharge Medications List order from GACH. During a review of Facility's P&P titled, Admission, revised on 1/2025, the P&P indicated under the licensed nurse procedure, to notify physician of admission and verify transfer and admission orders. During a review of Facility's P&P titled, Medication Administration, revised on 1/2025, the P&P indicated drugs must be administered in accordance with the written orders of the attending physician.</p>		