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	05/06/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain clinical records in accordance professional standards and practices and facility's Policy and Procedure (P&P) for one (1) of six (6) sampled residents (Resident 1) by failing to accurately document the administration of narcotics (drug or controlled substance that affects the mood or behavior and if consumed for nonmedical purposes or not prescribed by the doctor can cause serious harm) count in the narcotic drug record (narcotic count sheet is a document used to document and track the administration of controlled substance to ensure accurate dispensing and administration of medications, as well as to provide a record of how much of a controlled substance has been used and when).This deficient practice had the negative impact on the delivery of services and lead to potential harm or irreversible harm to the residents.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 right shoulder rotator cuff tear (involves damage to the muscles and tendons holding the shoulder joint in place, causing pain, weakness, and limited motion, particularly when lifting the arm or sleeping), anxiety(a normal, temporary response to stress or danger, often causing feelings of apprehension, tension, and physical symptoms like a racing heart) and depression (a common, serious medical illness causing persistent sadness, loss of interest, and decreased energy, affecting how you feel, think, and behave).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/16/2026, the MDS also indicated the resident is moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunks or limbs but provides less than half the effort) with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear but 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 upper body dressing and personal hygiene. The MDS indicated the resident receives scheduled and as needed medication. The MDS also indicated that the resident has occasional pain.During a review of Resident 1's Physician Order, dated 4/3/2026, the Physician Order indicated Oxycodone Hydrochloride (HCL) (a potent, semi-synthetic opioid analgesic medication used to treat severe, ongoing pain) Oral Tablet 5 milligrams (mg - unit of measure) Give 1 tablet by mouth every 6 hours as needed for pain of (5-10/10 pain rating scale; 0 being no pain and 10 being the worst pain) unrelieved by non-opioids.During a review of Resident 1's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 5/2026, the MAR indicated Oxycodone HCL was not given on 5/5/2026.During a concurrent observation and interview on 5/5/2026 at 12PM of Cart 1, Licensed Vocational Nurse 1 (LVN 1) and Surveyor 1 were doing a narcotic count. LVN 1 stated the narcotic count for Resident 1's Oxycodone HCL is not correct and there was a discrepancy in the counting done that morning. Observed was 18 tablets in the bubble pack and the narcotic sheet indicated there should be 19 tablets left.During a concurrent observation (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

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	05/06/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and interview on 5/5/2026 at 12:05PM of Resident 1's Oxycodone narcotic count, Director of Nursing (DON) stated the count does not match and there is one missing.During an interview on 5/5/2026 at 1:10PM in Resident 1's room, Resident 1 stated he got his Oxycodone HCL pain medication around 6am this morning. Resident 1 also stated it was given by a male nurse.During an interview on 5/5/2026 at 3:19PM, LVN 2 stated Resident 1's pain was 10/10 on the pain scale and LVN 2 gave Resident 1 his Oxycodone pain medication 6 am this morning, LVN 2 also stated he forgot to document in the MAR and narcotic sheet that Resident 1 received his oxycodone pain medication but he should have documented in the MAR and narcotic sheet when administering Oxycodone HCL to Resident 1.During an interview on 5/5/2026 at 3:30PM, DON stated LVN 2 should have documented in the MAR and narcotic sheet but LVN2 did not document in the MAR or narcotic sheet. DON also stated documentation is to ensure no narcotics are missing and the narcotic count is accurate.During a review of the facility's P&P titled Policy and Procedure in Medication Administration, revised 1/2025, the P&P indicated medications must be immediately charted following the administration by the license nurse who administered the medication.During a review of the facility's P&P titled Charting and Documentation, revised 1/2025, the P&P indicated entries in the clinical record must be accurate, legible, clear and timely. Documentation of procedures and treatments will include care-specific details such as the assessment data obtained during the treatment, how the resident tolerated the procedure/treatment and the signature and title of the individual documenting.During a review of the facility's P&P titled Policies and Procedures on Controlled Drugs Count Records, revised 1/2025, the P&P indicated nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document in the controlled drugs-count record.