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	05/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to promote dignity and respect for two of three sampled residents (Resident 35 and Resident 5) for dignity and respect as indicated on the facility's policy by failing to ensure: 1. Resident 35 wore the resident's personal clothing. 2. Resident 5 was kept clean and without white colored food debris around the resident's mouth and a brown stain on the left upper should of the resident's gown. These deficient practices had the potential to negatively affect Resident 35 and Resident 5's self-worth, self-esteem and psychosocial (pertaining to the influence of social factors on an individual's mind or behavior) well-being. Findings: 1. During a review of Resident 35's admission Records, the admission Records indicated the Resident 35 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including hemiplegia (severe or complete loss of strength on one side of the body) and hemiparesis (loss of strength on one side of the body) following cerebral infarction (stroke - damage to the tissues in the brain due to a loss of oxygen to the area) affecting left non-dominant side, type 2 diabetes mellitus (a medication condition characterized by the body's inability to regulate blood sugar level), and insomnia (persistent problems falling and staying asleep). During a review of Resident 35's Minimum Data Set (MDS-resident assessment tool), dated 2/11/2025, the MDS indicated Resident 35's cognitive skill (mental action or process of acquiring knowledge and understanding for daily decision-making) for daily decision making was moderately impaired. The MDS also indicated Resident 35 was assessed to be dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff with eating, toileting hygiene, shower/bathe self, and lower body dressing. During a review of Resident 35's Personal Property Inventory Record (PPIR - a list of every item of value a person owns), dated 1/29/2025, PPIR indicated Resident 35 had seven (7) blouses, eleven (11) pants, and five (5) sweaters. (continued on next page)

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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/23/2025 at 9:45 AM in Resident 35's room, Resident 35 was observed wearing a hospital gown and was resting in bed. Resident 35 stated, No one bothered to ask what I wanted to wear. Certified Nursing Assistant (CNA - no identifier) dressed me up with hospital gown to make their jobs easier. Resident 35 further stated, They do not care about our feelings. During an observation on 5/23/2025 at 9:55 AM of Resident 35's closet, there were three blouses, and two pants were hung up, and two plastic bags full of clothes in the closet. During a concurrent observation and interview on 5/23/2025 at 9:57 AM in Resident 35's room with the CNA 4, CNA4 stated Resident 35 told CNA4 was not happy wearing a hospital gown. During an interview on 5/24/2025 at 2:23 PM with Administrator (ADM), ADM stated staff should preserve residents' dignity by giving them a choice of what to wear. During a review of facility's policy and procedures titled, Quality of Life - Dignity, revised dated 02/2022, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. 2. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures [are brief episodes of abnormal electrical activity in the brain that can cause a variety of symptoms, including involuntary movements, loss of consciousness, and changes in behavior]) and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 5's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 5 was dependent for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, sit to lying, lying to sitting on side of the bed, chair/bed-to-chair transfer and tub/shower transfer. The MDS also indicated Resident 5 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in eating and roll left and right. During an observation on 5/20/2025 at 9:42 AM, in Resident 5's room, Resident 5 was lying in bed, there were white colored food debris around the resident's mouth and a brown stain on the left upper shoulder of the resident's gown. During a concurrent observation and interview on 5/20/2025 at 10:54 AM with Licensed Vocational Nurse 3 (LVN 3) inside Resident 5's room, Resident 5 still has food debris on the resident's mouth and had a brown colored stain on the left upper shoulder of the resident. LVN 3 stated Resident 5's gown was not clean, it has brown stain on it, and the resident's mouth has some food particles. LVN 3 did not answer when asked if it is acceptable to have a dirty gown and food particles around the Resident 5's mouth. LVN 3 stated she will get the Certified Nurse Assistant (CNA) assigned to Resident 5, then left the room right away. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/20/25 at 10:56 AM with CNA 3, CNA 3 stated Resident 5's gown was not clean. CNA 3 stated Resident 5 had a brown stain on the resident's gown probably from the resident's nutritional drink. CNA 3 also stated, there was white colored dry skin around the resident's mouth, and it was dry skin. CNA 3 stated it is important to keep the residents clean so they can look presentable if the family comes in and if the residents were clean, it can make the resident feel good and puts them in good mood. During a review of the facility's Policy & Procedure (P&P) titled, Quality of Life-Dignity, revised 2/2022, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self- worth and self-esteem. The P&P indicated residents are always treated with dignity and respect.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow up on a resident's request on [DATE] to formulate an Advance Directive (legal document that provide instructions for medical care and only go into effect if you cannot communicate your own wishes) for one of three sampled residents (Resident 16). This failure resulted in a delay of seven (7) years in addressing Resident 16's request and had the potential for the staff not to carry out the resident's wishes regarding health care decisions during an emergency. Findings: During a review of Resident 16's admission Record, the admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis malignant neoplasm (cancer) of right breast and blindness on one eye. During a review of Resident 16's Minimum Data Set (MDS- resident assessment tool), dated [DATE], indicated Resident 16 had intact cognitive skills (ability to reason, think, and make decisions) for daily decision making. The MDS indicated Resident 16 required supervision (helper provides verbal cues and or touching as resident competes activity. Assistance may be provided throughout the activity or intermittently) for eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on taking off footwear, personal hygiene, rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfer, toilet and shower transfer, and walking ten feet. The MDS indicated Resident 16 required partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) to shower. During a review of Resident 16's Advanced Directive Acknowledgement, dated [DATE], and revised on [DATE], the Advance Directive Acknowledgement indicated Resident 16 expressed she had not executed an Advance Directive, but she wished to execute one. During a review of Resident 16's Progress Notes, dated [DATE], the Progress Notes written by the Social Services Worker (SSW), indicated Resident 16 had verbalized If the facility staff found me not breathing, I still want to have CPR (Cardiopulmonary Resuscitation- It is an emergency life-saving procedure that is performed when a person's heart has stopped beating effectively or they are not breathing) done but I do not want to be transferred to the hospital, I prefer to stay at the facility. During a review of Resident 16's Care Plan (CP- a tool that helps nurses and other care team members organize aspects of patient care according to a timeline, and allows them to think critically and holistically in a way that supports the patient's physical, psychological, social, and spiritual care), dated [DATE], the CP indicated Resident will have all forms of advance directives honored by facility staff, review and evaluation in 90 days and as indicated. Interventions: Re-address the advance directive status quarterly to update resident and family options to reinforce current directives. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:25 AM with Resident 16, Resident 16 stated she requested assistance in formulating an Advance Directive as early as [DATE], with follow up requests noted during care plan meetings in February 2025 after she was readmitted to the facility following an emergency evacuation. Resident 16 stated she required assistance filling out the form because she was blind on one eye and needed help filling out the form, and she did not wish to designate someone to make decisions for her because she was capable of making her own decisions. During an interview on [DATE] at 12:14 PM with the SSW, the SSW acknowledged Resident 16 had requested to complete an Advance Directive (AD) but stated she didn't have any children to designate as a decision maker. The SSW stated he usually reaches out to the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) via email and gives him a list of residents who wish to formulate an AD so that he can visit each resident and help them fill out and witness the form. The SSW stated he meets every three months with the interdisciplinary team (IDT- is a group of individuals from various professional disciplines who collaborate to achieve a common goal, such as providing patient care, conducting research, or solving complex problems. These teams leverage the diverse expertise and knowledge of their members to address the multifaceted nature of complex issues) to review the AD, but stated he failed to communicate with the Ombudsman regarding Resident 16, and had not gotten around to it. During an interview on [DATE] at 11:01 AM with the Director of Nursing (DON), the DON stated it is important to ensure residents formulate an AD if they wish to do so because if something happens to them where they are unable to make decisions for themselves, the facility can comply with the residents' wishes stated on the AD. The DON stated the AD is offered to everyone by social services, upon admission, IDT meetings which occur quarterly or as needed, and usually take about a week to formulate if the resident wishes to have one. The DON stated the AD can be witnessed by any alert-oriented person such as a visitor, another resident or the Ombudsman, except the facility staff. The DON stated the facility needed to revise the policy to include the Ombudsman's role in formulating the AD. During an interview on [DATE] at 12:26 PM with the Administrator, the Administrator stated the statement by the SSW reflects misinformation provided to Resident 16, as cognitively intact individuals are legally able to formulate an AD and make decisions regarding their own care preferences without a designee. The Administrator stated the Ombudsman could serve as a witness, or any other person that is not the facility staff and not having children does not constitute that they cannot fill out an AD. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, dated 9/2022, the P&P indicated inquiries from the community regarding advance directives are referred to the DON. Written information is provided upon request and includes, as a minimum, a summary of the state law outlining the rights of residents to formulate advance directives and a copy of the facility's policies governing advance directives. The staff development coordinator is responsible for ensuring that staff remains informed about the resident's rights to formulate advance directives. The IDT will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Residents have the option to execute their advance directives, and the facility staff will offer assistance in establishing advance directives. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician of significant changes in condition (a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions) for one of two sampled resident (Resident 51), who experienced eight (8) episodes of hypotension (low blood pressure when blood pressure is much lower than normal and varies from one person to another. This condition occurs when a person's blood pressure drops as little as 20 mmHg (millimeters of mercury- a unit of measurement to quantify the pressure exerted by blood against the walls of the arteries) reducing blood flow to the heart, brain, and other parts of the body) related to the use of Losartan Potassium-HCTZ (medication to treat high blood pressure). This deficient practice resulted in delayed treatment for repeated hypotensive episodes for Resident 51 placing him at risk of adverse outcomes (undesirable effects) such as falls, syncope (commonly known as fainting or passing out, is a temporary loss of consciousness caused by a sudden drop in blood flow to the brain), and organ hypoperfusion (a condition where there is inadequate blood flow to tissues and organs, leading to insufficient delivery of oxygen and nutrients). Findings: During a review of Resident 51's admission Record, the admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnosis of subdural hemorrhage (a collection of blood that accumulates between the brain and the inner lining of the skull), syncope (a temporary loss of consciousness caused by a sudden, temporary drop in blood flow to the brain) and collapse, end stage renal disease (ESRD- Condition in which the kidneys cease functioning on a permanent basis leading to the need for regular course of long-term dialysis or kidney transplant to maintain life) with dependence on renal (kidney) dialysis (a treatment that removes waste and excess fluid from the blood when the kidneys are no longer functioning properly), atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls), and atrial fibrillation (a common heart rhythm disorder characterized by an irregular, rapid heartbeat that starts in the upper chambers [atria] of the heart. This irregular electrical activity can cause the heart to pump blood inefficiently, leading to potential complications like blood clots, stroke, and heart failure). During a review of Resident 51's Minimum Data Set (MDS- resident assessment tool) dated 2/13/2025, indicated Resident 51 had intact cognition (ability to think, remember and make decisions) for daily decision making. The MDS indicated Resident 51 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for eating, required maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for toileting, showering, lower body dressing, putting on taking off footwear, supervision (helper provides verbal cues and or touching as resident competes activity. Assistance may be provided throughout the activity or intermittently) for oral hygiene, and partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) for upper body dressing, personal hygiene, rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, char bed transfer, toilet transfer and shower transfer. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 51's Order Summary Report for the month of 5/2025, the Order Summary report indicated to give one (1) tablet of Losartan Potassium-HCTZ by mouth in the morning related to hypertension and HOLD IF SYSTOLIC (the top number in a blood pressure reading, indicating the pressure in the arteries when the heart beats) BLOOD PRESSURE (BP) IS LESS THAN 110. This order was active on 2/12/2025 and discontinued on 5/21/2025. During a review of Resident 51's Weights and Vitals Exceptions, dated 5/23/2025, the record indicated Resident 51 had 8 episodes of BP with systolic below 110 mmHg on the following dates: 4/11/2025: BP 102/58 5/8/2025: BP 103/59 5/10/2025: BP 102/58 5/12/2025: BP 102/56 5/14/2025: BP 96/54 5/15/2025: BP 106/59 5/21/2025: BP 102/56 5/22/2025: BP 100/57 During a review of Resident 51's medical record, the medical record did not indicate that the physician was notified regarding any of these hypotensive episodes. There was no documentation of physician orders or interventions related to these events, nor evidence that the resident's responsible party was notified. During an interview on 5/21/2025 at 9:12 AM with Resident 51, Resident 51 stated he has dialysis every Monday, Wednesday, and Friday, and has been experiencing syncope during his dialysis treatments and when he is in his bed at the facility. Resident 51 stated he believed these symptoms started when he started taking a new blood pressure medication prescribed by the doctor and told Licensed Vocational Nurse (LVN) he feels like he is fainting when he is in his bed and at the dialysis center. During an interview on 5/21/2025 at 12:54 PM with LVN, the LVN stated Resident 51 had reported to her that he had passed out at the dialysis center and was experiencing symptoms of syncope. The LVN stated she had held Resident 51's blood pressure medication on 5/12/2025, 5/14/2025, 5/20/2025, and 5/21/2025 due to low blood pressure readings, but had failed to notify the physician and the responsible party .The LVN stated Resident 51's baseline systolic blood pressure is usually around 130-150 mmHg, and if Resident 51 was having symptoms of syncope licensed nurse should report these to the physician as it would be considered a change of condition. LVN confirmed that no calls were made to the physician, and no change of condition was documented in the medical record regarding Resident 51's low blood pressure readings. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2025 at 9 AM with the Director of Nursing (DON), the DON stated any change in a resident baseline is considered a change of condition and should be communicated to the physician immediately to help identify any underlying causes and provide timely and appropriate treatment. The DON stated hypotension is defined based on the patient's baseline blood pressure, and any deviation more than 10 mmHg from resident's baseline should be reported to the physician, as well as any medication that is held due to parameters that are out of range. The DON stated, despite reassessing the residents, any parameters that are below or above desired range should be communicated to the physician, and a Change of Condition (COC) should be documented by the licensed nurse. The DON stated not reporting Resident 51's symptoms of syncope and low blood pressure readings placed Resident 51 at risk for falls, heart rate abnormalities, confusion, and reduced blood flow to organs. During a review of the facility's policy and procedure titled Change of Condition dated 7/2022, indicated any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for care evaluation by the licensed nurse prior to end of assigned shift.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an accurate range of motion (ROM, means how far and in what direction you can move a joint or muscle) assessment on the Minimum Data Set (MDS, a resident assessment tool) for one (1) of 2 sampled residents (Resident 50) as indicated in the facility's policy. This deficient practice had the potential to result in an incorrect plan of care which could negatively affect the delivery of necessary care and services to Resident 50. Findings: During a review of Resident 50's admission Record, the admission Record indicated Resident 50 was admitted to the facility on [DATE] and re-admitted on [DATE]. During a review of Resident 50 History and Physical (H&P), dated 3/1/2025, the H&P indicated Resident 50's diagnoses that included cerebrovascular accident (CVA, stroke, loss of blood flow to a part of the brain) with bilateral lower extremity contractures (stiffening/ shortening at any joint, that reduces the joint's range of motion) and left upper extremity contractures, and hypertension (high blood pressure) During a review of Resident 50's MDS, dated [DATE], the MDS indicated the resident's cognitive skills (ability to understand and make decisions) for daily decision making was intact. The MDS indicated Resident 50 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathe self, lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, lying to siting on side of bed, chair/bed-to-chair transfer, and tub/shower transfer. The MDS also indicated Resident 50 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in oral hygiene, upper body dressing and personal hygiene. The MDS also indicated that there was no impairment in the Resident's functional limitation in ROM. During a record review of Resident 50's admission Nursing Assessment (ANA) dated 2/1/2025, the ANA indicated Resident 50 had left upper extremity and bilateral lower extremity contractures. During an observation and interview on 5/20/2025 at 10:13 AM inside Resident 50's room, Resident 50's sitting up on his bed with left upper extremity contracted on his chest. Resident 50 stated he cannot use his left hand because he has left side weakness. During an observation and interview on 5/21/2025 at 12:09 PM, inside Resident 50's room, Resident 50 was waving his right hand. Resident 50 was on right side-lying position with his left upper extremity placed across his chest and his left hand tucked under his right armpit. Resident 50 stated his arms were getting numb and asked to be repositioned. During a concurrent interview and record review on 5/22/2025 at 11:09 AM, with MDS Nurse (MDSN), the MDS Nurse stated Resident 50's MDS dated , 2/14/2025 indicated MDS functional limitation in ROM indicated no impairment. MDSN stated, Resident 50's MDS was inaccurately assessed. MDSN stated the MDS should have reflected an impairment on 1 side. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025 at 11:10 AM with MDSN, MDSN stated, It is important for the MDS to be accurate because it will be the basis of the plan of care for the resident. It was my fault, I overlooked. I should have checked the MDS thoroughly. During a review of the undated facility's Policy & Procedure (P&P) titled, Resident Assessment, the P&P indicated to assess Resident's physical, mental & psychosocial needs beginning on admission and thereafter, at least once in every quarter, annually, upon significant change in condition and on an as needed basis.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive resident centered care plan (a formal process that correctly identifies existing needs and recognizes a resident's potential needs or risks to achieve healthcare outcomes) in accordance with the facility's care plan policy for two (2) of 2 sampled resident (Residents 41 and 51) by failing to ensure: 1. Resident 41 had a care plan to address the resident's central venous catheter (a type of access used for hemodialysis [a procedure removing metabolic waste products or toxic substances from the bloodstream]). This deficient practice had the potential to not be able to provide the specific interventions such as monitoring Resident 41's access site for bleeding and infection, which could result in harm. 2. Resident 51 had a care plan to address use of a heart monitor. This deficient practice had the potential for Resident 51 not to receive specific interventions such as skin integrity check and monitoring of heart rhythm, which could result in delay of treatment and services. Findings: 1. During a review of Resident 41's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was re admitted on [DATE], with diagnoses of chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood effectively), anemia (a condition where the body does not have enough healthy red blood cells), and hypertension (high blood pressure). During a review of Resident 41's Minimum Data Set (MDS- a resident assessment tool), dated 2/20/2025, indicated Resident 41's cognitive (ability to think and reason) skills for daily decision making was independent (decisions consistent/reasonable). The MDS indicated Resident 41 required supervision (helper provides verbal cues) with eating, oral hygiene, toileting hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 41 goes to hemodialysis. During a review of Resident 41's Order Summary Report, , the Order Summary Report indicated an order of right upper chest tunnel dialysis catheter (a thin, flexible tube inserted into a large vein in the neck or chest, then tunneled under the skin for hemodialysis)site: Dressing change at the dialysis center during dialysis days and as needed in the facility when soiled and if there's bleeding, ordered on 3/31/2025. During a review of Resident 41's Care Plan regarding risk for complication related to hemodialysis, initiated on 3/31/2025, revised on 4/8/2025, the Care Plan indicated the following interventions: Avoid taking blood pressure or drawing blood samples in shunt extremity, initiated on 3/31/2025. (continued on next page)

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	555213	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Pine Post Acute	1640 N. Fair Oaks Avenue Pasadena, CA 91103

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Instruct patient not to sleep on side with shunt or carry packages, books, purse on affected extremity, initiated 3/31/2025. Palpate skin around shunt for warmth, initiated 3/31/2025. During a concurrent record review and interview on 5/22/2025 at 2:33 PM, Resident 41's care plan was reviewed with Licensed Vocational Nurse 2 (LVN 2), LVN 2 verified that the following interventions were not appropriate for Resident 41 because Resident 41 did not have a shunt for dialysis access: Avoid taking blood pressure or drawing blood samples in shunt extremity, initiated on 3/31/2025. Instruct patient not to sleep on side with shunt or carry packages, books, purse on affected extremity, initiated 3/31/2025. Palpate skin around shunt for warmth, initiated 3/31/2025. During an interview on 5/22/2025 at 3:31 PM with Registered Nurse 1 (RN 1), RN 1 stated Resident 41 has a central venous catheter dialysis access and not a shunt. RN 1 stated Resident 41's care plan should have indicated the correct dialysis access site because the care and monitoring for the right upper chest tunnel which was a central venous catheter was different from shunt care and monitoring. During a concurrent record review and interview with MDS Nurse (MDSN) on 5/22/2025 at 3:32 PM, Resident 41's care plan was reviewed. MDSN verified that Resident 41's care plan interventions were: Avoid taking blood pressure or drawing blood samples in shunt extremity. Instruct patient not to sleep on side with shunt or carry packages, books, purse on affected extremity. Palpate skin around shunt for warmth. MDSN stated that Resident 41's care plan was inaccurate because it indicated a shunt which Resident 41 never had. MDSN stated Resident 41 has a right upper chest tunneled central catheter, which was in accordance with the Resident 41's dialysis order. MDSN stated that it was important to reflect the right dialysis access and appropriate interventions on the care plan for the entire care team to know the specific care for Resident 41's dialysis access. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 51's admission Record, the admission Record indicated Resident 51 was admitted to the facility on [DATE] with diagnosis of subdural hemorrhage (a collection of blood that accumulates between the brain and the inner lining of the skull), syncope and collapse, end stage renal disease (ESRD- Condition in which the kidneys cease functioning on a permanent basis leading to the need for regular course of long-term dialysis or kidney transplant to maintain life) with dependence on renal (kidney) dialysis (a treatment that removes waste and excess fluid from the blood when the kidneys are no longer functioning properly), atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls), and atrial fibrillation (a common heart rhythm disorder characterized by an irregular, rapid heartbeat that starts in the upper chambers (atria) of the heart. This irregular electrical activity can cause the heart to pump blood inefficiently, leading to potential complications like blood clots, stroke, and heart failure). During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 had intact cognition (ability to think, remember and make decisions) for daily decision making. The MDS indicated Resident 51 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for eating, required maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for toileting, showering, lower body dressing, putting on taking off footwear, supervision (helper provides verbal cues and or touching as resident competes activity. Assistance may be provided throughout the activity or intermittently) for oral hygiene, and partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) for upper body dressing, personal hygiene, rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, char bed transfer, toilet transfer and shower transfer. During a concurrent observation and interview on 5/21/2025 at 9:12 AM with Resident 51 in Resident 51's room, Resident 51 was sitting on the side of his bed and stated he had a medical device on his chest but did not know what it was for. Resident 51 lifted his sweater to reveal an external round plastic device that was adhered to the center of his chest with the words Zio Patch (a small, adhesive patch that continuously monitors heart rhythm for up to 14 days. It's designed to be worn discreetly and comfortably, allowing patients to record their heart activity during normal daily routines, including sleeping, showering, and exercise. The device records every heartbeat and can help detect arrhythmia like atrial fibrillation, pauses, and fast heart rhythms) on it. Resident 51 stated he had this placed on 5/12/2025 by his cardiologist (a doctor who specializes in diagnosing, treating, and preventing diseases and conditions related to the heart and blood vessels) during a scheduled appointment and told the licensed nurse when he returned to the facility that he had a device placed on his chest, but no one explained to him what it was or how to take care of it. Resident 51 stated he had a heart attack five (5) months ago requiring heart surgery and also brain surgery due to a stroke (a condition when blood flow to the brain is blocked or there is sudden bleeding in the brain. The brain cannot get oxygen and nutrients from the blood. Without oxygen and nutrients, brain cells begin to die within minutes). Resident 51 stated the only thing he knew was that he had to remove and return the device by 5/26/2025. During an interview on 5/23/2025 at 10:36 AM with the MDS Nurse, the MDS Nurse confirmed the presence of the Zio Patch on Resident 51's chest and acknowledged that there was no care plan developed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/2025 at 11:04 AM with the Director of Nursing (DON), the DON stated that before and after residents go out of the facility such as to a physician's appointments, the charge nurse should conduct a thorough body assessment to determine vital signs, body checks, mental status, and note any new medications, orders, or treatments when they return back to the facility and carry out any interventions as well as update the care plan to guide nurses in caring for resident needs. The DON stated Resident 51 should have been provided with a thorough assessment to identify the Zio Patch and address it in the Care Plan to educate Resident 51 not to put lotion around the site, get it wet, assess for any skin integrity complications, and ensure the device was returned promptly as indicated by the physician. The DON stated the failure to develop a Care Plan for the Zio Patch represents a lack of comprehensive planning, which could result in missed arrhythmia detection, failure to monitor resident response, or device complications such as skin breakdown or malfunction. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, dated 1/2024, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical psychosocial afunctional needs is developed and implemented for each resident. Assessments of residents are ongoing, and care plans are revised as information about the residents and the resident's condition change.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist one of one sampled resident (Resident 46) who were unable to carry out activities of daily living (ADL) to maintain good grooming, and personal and oral hygiene by failing to assist Resident 46 with oral care. This failure placed Resident 46 at risk to develop dental caries (or tooth decay- a progressive destruction of bone or tooth), teeth and gum infections and/ or lung infection, that could lead to hospitalization. Findings: During a review of Resident 46's admission Records, the admission Records indicated Resident 46 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), mild, without behavioral disturbance; type 2 diabetes mellitus (a medication condition characterized by the body's inability to regulate blood sugar level); and gastroesophageal reflux disease (GERD- a digestive disorder, occurs when stomach acid flows back into the tube [esophagus] connecting the mouth and stomach). During a review of Resident 46's Minimum Data Set (MDS-a resident assessment tool), dated 5/8/2025, indicated Resident 46's cognitive skill (mental action or process of acquiring knowledge and understanding for daily decision-making) for daily decision making was impaired. The MDS also indicated Resident 46 was assessed to be dependent (helper does all of the effort, resident does none of the effort to complete the activity) staff with sit to stand, chair/bed-to-chair transfer, and toilet transfer. During an observation on 5/21/2025 at 1:23 PM in Resident 46's room, Resident 46 was observed to be awake and alert, and lying on her left side in the bed. Resident 46 was observed drooling on the corner of her mouth, with dried and cracked lips, tongue with yellow patch, and teeth yellowish in color. Resident 46 stated, Resident 46 did not receive daily oral care since admitted in the facility. During a concurrent observation and interview on 5/21/2025 at 1:27 PM in Resident 46's room with the Certified Nursing Assistant 1 (CNA 1), CNA1 stated Resident 46 did not get oral care regularly. CNA 1 stated, if Resident 46 received oral car daily then Resident 46 would not have yellow patch building up on the tongue, dry and chapped lips, and teeth that is yellowish in color. During an interview on 5/24/2025 at 2:26 PM with the Director of Nursing (DON), the DON stated oral hygiene should be done daily and as needed to prevent oral health problems such as gum disease and keep germs under control. During a review of facility's policy and procedure titled, Oral Hygiene, revised dated April 2024, indicated that facility to aid resident in cleaning their mouth, teeth, and gums, and removing particles of food, bacteria, and odors.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of two (2) of seven (7) sampled residents (Resident 50 and 51) as indicated on the facility policy and physician's order by failing to: 1. Administer Resident 50's carvedilol (a medicine used to treat hypertension [high blood pressure]) with food on 5/23/2025. 2. Administer Resident 51's sevelamer (a medicine to treat hyperphosphatemia [too much phosphate in the blood]) with food on 5/23/2025. This deficient practice had the potential to result in Residents 50 and 51 not obtaining the therapeutic level (medicine levels in your blood are in a range that is medically helpful but not dangerous) of the medication, which could lead to complications and harm to the residents. Findings: 1. During a review of Resident 50's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was re admitted on [DATE], with diagnosis of hypertension, osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and encephalopathy (a term for any disease or disorder of the brain that affects its function or structure). During a review of Resident 50's Minimum Data Set (MDS- a resident assessment tool), dated 2/14/2025, the MDS indicated Resident 50's cognitive (ability to think and reason) skills for daily decision making was independent (decisions consistent/reasonable). The MDS indicated Resident 50 required partial/moderate assistance (helper does less than half the effort) with eating. The MDS indicated Resident 50 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 50 was dependent on shower, lower body dressing, and put on/take off footwear. During a review of Resident 50's Order Summary Report dated, 5/23/2025, timed 11:08 AM, the Order Summary Report indicated an order of carvedilol oral tablet 3.125 milligrams (mg, unit of measurement), give 1 tablet by mouth one time a day related to hypertension. Give with food. Ordered on 2/1/2025. During a medication administration observation on 5/23/2025 at 8:32 AM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 prepared and administered the following six (6) medications: Lisinopril (medication to treat high blood pressure) 5 mg tablet. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Eliquis (medication to prevent and treat blood clots) 5 mg tablet. Carvedilol 3.125 mg tablet Iron (supplement used to treat or prevent anemia) tablet. Multivitamins with minerals tablet. Lactulose (medication used to treat constipation) solution 30 milliliters (ml, unit of measurement). Resident 50 was observed taking all 6 medications. LVN 1 did not offer food to Resident 50 during the entire medication administration, including when carvedilol was administered. During a concurrent record review and interview with LVN 1 on 5/23/2025 at 11:34 AM, Resident 50's electronic medication administration record was reviewed. LVN 1 verified that she did not administer carvedilol medication with food. During an interview on 5/23/2025 at 11:49 AM with Director of nursing (DON), the DON stated it was important to administer medication as ordered to get the full benefit of the medication and to prevent complications of inconsistent timing of medication administration. The DON stated, If medications were not administered on time, for example blood pressure medications, it can affect the blood pressure of the residents which can cause a change in the residents' condition. The DON stated, Resident 50's carvedilol order was to control the resident's blood pressure, and if it was not given timely, Resident 50 can develop uncontrolled high blood pressure and/ or chest pain that can cause complications such as death. 2. During a review of Resident 51's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was re admitted on 1/1302025, with diagnosis of end stage renal disease (ESRD, irreversible kidney failure), anemia (a condition where the body does not have enough healthy red blood cells), and syncope (temporary loss of consciousness). During a review of Resident 51's MDS, dated [DATE], Resident 51's cognitive skills for daily decision making was independent. The MDS indicated Resident 51 required supervision (helper provides verbal cues) with oral hygiene. The MDS indicated Resident 51 required partial/moderate assistance with upper body dressing and personal hygiene. The MDS indicated Resident 51 required substantial/maximal assistance with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 50 was dependent on eating. During a review of Resident 51's Order Summary Report dated, 5/23/2025, timed 11:04 PM, the Order Summary Report indicated an order of sevelamer oral tablet 800 mg, give 2 tablets by mouth three times a day for supplement. Give with meals. Ordered on 4/4/2025. During a medication administration observation on 5/23/2025 at 8:46 AM, LVN 2 prepared and administered the following medications in Resident 51's room with no breakfast meal observed at bedside. Sevelamer 800 mg, 2 tablets. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Amiodarone (medication used to control heart rate) 200 mg tablet. Nifedipine (medication to treat high blood pressure) 60 mg tablet. Lacosamide (used to treat seizure [(a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness)15 ml. Levetiracetam (used to treat seizure)10 ml. During an interview on 5/23/2025 at 9:25 AM with Resident 51, Resident 51 verified he was given his medications after breakfast meal. Resident 51 stated he had eaten breakfast when he got back from dialysis around 8 AM, and he was given medications almost 9 AM. During an interview on 5/23/2025 at 11:34 AM with Registered Nurse 1 (RN 1), RN 1 stated medications that was ordered to be given with meals should be followed because these medications might cause stomach upset if not given with food or medication might not be effective. During a review of facility's undated Policy and Procedure titled, Medication Administration, the Policy and Procedure indicated Drugs must be administered in accordance with the written orders of the attending physician.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its medication error (the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order; manufacturers specifications / accepted professional standards and principles) rate was less than five (5) percent (%). Two (2) medication errors out of 30 total opportunities for error, to yield an overall medication error rate of 6.67 % for two (2) of seven (7) sampled residents (Residents 50 and 51) observed for medication administration. This deficient practice had the potential to result in Residents 50 and 51 experiencing adverse medication effects (unwanted, uncomfortable, or dangerous effects that a medication may have) that could negatively affect the residents' health and well-being. Findings: 1. During a review of Resident 50's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was re admitted on [DATE], with diagnosis of hypertension, osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and encephalopathy (a term for any disease or disorder of the brain that affects its function or structure). During a review of Resident 50's Minimum Data Set (MDS- a resident assessment tool), dated 2/14/2025, the MDS indicated Resident 50's cognitive (ability to think and reason) skills for daily decision making was independent (decisions consistent/reasonable). The MDS indicated Resident 50 required partial/moderate assistance (helper does less than half the effort) with eating. The MDS indicated Resident 50 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 50 was dependent on shower, lower body dressing, and put on/take off footwear. During a review of Resident 50's Order Summary Report dated, 5/23/2025, timed 11:08 AM, the Order Summary Report indicated an order of carvedilol oral tablet 3.125 milligrams (mg, unit of measurement), give 1 tablet by mouth one time a day related to hypertension. Give with food. Ordered on 2/1/2025. During a medication administration observation on 5/23/2025 at 8:32 AM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 prepared and administered the following six (6) medications: Lisinopril (medication to treat high blood pressure) 5 mg tablet. Eliquis (medication to prevent and treat blood clots) 5 mg tablet. Carvedilol 3.125 mg tablet Iron (supplement used to treat or prevent anemia) tablet. Multivitamins with minerals tablet. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lactulose (medication used to treat constipation) solution 30 milliliters (ml, unit of measurement). Resident 50 was observed taking all 6 medications. LVN 1 did not offer food to Resident 50 during the entire medication administration, including when carvedilol was administered. During a concurrent record review and interview with LVN 1 on 5/23/2025 at 11:34 AM, Resident 50's electronic medication administration record was reviewed. LVN 1 verified that she did not administer carvedilol medication with food. During an interview on 5/23/2025 at 11:49 AM with Director of nursing (DON), the DON stated it was important to administer medication as ordered to get the full benefit of the medication and to prevent complications of inconsistent timing of medication administration. The DON stated, If medications were not administered on time, for example blood pressure medications, it can affect the blood pressure of the residents which can cause a change in the residents' condition. The DON stated, Resident 50's carvedilol order was to control the resident's blood pressure, and if it was not given timely, Resident 50 can develop uncontrolled high blood pressure and/ or chest pain that can cause complications such as death. 2. During a review of Resident 51's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was re admitted on 1/1302025, with diagnosis of end stage renal disease (ESRD, irreversible kidney failure), anemia (a condition where the body does not have enough healthy red blood cells), and syncope (temporary loss of consciousness). During a review of Resident 51's MDS, dated [DATE], Resident 51's cognitive skills for daily decision making was independent. The MDS indicated Resident 51 required supervision (helper provides verbal cues) with oral hygiene. The MDS indicated Resident 51 required partial/moderate assistance with upper body dressing and personal hygiene. The MDS indicated Resident 51 required substantial/maximal assistance with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 50 was dependent on eating. During a review of Resident 51's Order Summary Report dated, 5/23/2025, timed 11:04 PM, the Order Summary Report indicated an order of sevelamer oral tablet 800 mg, give 2 tablets by mouth three times a day for supplement. Give with meals. Ordered on 4/4/2025. During a medication administration observation on 5/23/2025 at 8:46 AM, LVN 2 prepared and administered the following medications in Resident 51's room with no breakfast meal observed at bedside. Sevelamer 800 mg, 2 tablets. Amiodarone (medication used to control heart rate) 200 mg tablet. Nifedipine (medication to treat high blood pressure) 60 mg tablet. Lacosamide (used to treat seizure [(a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness)15 ml. Levetiracetam (used to treat seizure)10 ml. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/2025 at 9:25 AM with Resident 51, Resident 51 verified he was given his medications after breakfast meal. Resident 51 stated he had eaten breakfast when he got back from dialysis around 8 AM, and he was given medications almost 9 AM. During an interview on 5/23/2025 at 11:34 AM with Registered Nurse 1 (RN 1), RN 1 stated medications that was ordered to be given with meals should be followed because these medications might cause stomach upset if not given with food or medication might not be effective. During an interview on 5/23/2025 at 11:34 AM with Registered Nurse 1 (RN 1), RN 1 stated medications that was ordered to be given with meals should be followed because these medications might cause stomach upset if not given with food or medication might not be effective. RN 1 stated breakfast meal is being served at 7 AM - 7:30 AM, resident should be offered food when administering sevelamer after breakfast meal is served. During a review of facility's undated Policy and Procedure titled, Medication Administration, the Policy and Procedure indicated Drugs must be administered in accordance with the written orders of the attending physician. It also indicated All medications will be administered following the scheduled medication administration for routine medication unless otherwise specified by Doctor which is different from the routine medication administration schedule.

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Cedar Pine Post Acute	1640 N. Fair Oaks Avenue Pasadena, CA 91103

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the facility's policy and procedure on disposal of discontinued medications when three (3) unidentified pills were observed on the floor of the medication storage room. This deficient practice increased the risk for residents to accidentally receive the medication that had become ineffective or toxic due to improper storage possibly leading to health complications, which may result to harm and hospitalization. Findings: During a concurrent observation on [DATE] at 9:38 AM, in the medication room, and interview with Infection Preventionist Nurse (IPN), IPN verified that there were 3 loose pills on the floor of the medication room. IPN described the following pills as: 1. Light purple in color, round. 2. Yellow in color, oblong. 3. White colored round pill. IPN was unable to determine what kind of pills were found on the floor. IPN stated the loose pills on the floor has the possibility of being kicked out of the medication room, and end up in the hallway, where residents could access and ingest the medications. During an interview on [DATE] at 11:48 AM with Registered Nurse 1 (RN 1), RN 1 stated having loose pills on the floor was not acceptable since the pills might end up in the hallway and be accessed by residents. RN 1 stated discontinued medications should be disposed in the container inside the medication storage room for incineration (burn). During a review of Facility's Policy and Procedure (P&P) titled, Disposal/Destruction of Expired or Discontinued Medications, revised [DATE], the P&P indicated the following: Facility staff should destroy and dispose of medications in accordance with Facility policy and Applicable Law. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility should place all discontinued or outdated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on interview and record review, the facility failed to assist one of one sampled resident (Resident 42) in obtaining dental services when the Social Service Director (SSD) did not follow up with the dental office regarding Resident 42 ' s eligibility for dental services. This failure resulted in Resident 42 feeling frustrated at not having his dental needs met and having difficulty chewing food. Findings: During a review of Resident 42 ' s admission Record, the admission Record indicated the facility admitted Resident 42 on 5/24/2024 and readmitted of 1/31/2025 with diagnoses including cerebral infarction (a condition where brain tissue dies due to lack of oxygen supplying the brain), anxiety disorder (a condition characterized by excessive and persistent worry, fear, and nervousness), and chronic pain syndrome (a condition where pain persist for a long time and can interfere with daily life activities). During a review of Resident 42 ' s Minimum Data Set (MDS - a resident assessment tool), dated 2/13/2025, the MDS indicated Resident 42 ' s cognitive (the ability to think and process information) skills for daily decision making were intact. During a review of Resident 42 ' s Order Summary Report (OSR), dated 5/22/2025, the OSR indicated a dental consult and follow treatment as needed was ordered on 1/31/2025. During a review of Resident 42 ' s Care Plan titled, Resident 42 experiences mouth pain related to health condition, poor oral hygiene, with an initiation date of 4/4/2025 and a revision date of 5/15/2025, the Care Plan indicated an intervention of Dental evaluation and intervention as needed. During an interview on 5/20/2025 at 11:27 AM with Resident 42, Resident 42 stated that he did not have teeth and would like to get some dentures. During an interview on 5/21/2025 at 2:19 PM with the SSD, the SSD stated when residents are admitted to the facility, the SSD would refer residents to the dentist if they needed to be seen. The SSD stated Resident 42 was on the 3/3/2025 list to be checked for eligibility with the dental office used by the facility. The SSD stated upon investigation today (5/21/2025) he realized Resident 42 had been overlooked by the dental office. The SSD stated it is the facility ' s policy to assist residents with dental services as it was important for their dignity and well-being. During an interview on 5/21/2025 at 2:42 PM with Resident 42, Resident 42 stated he would like to have dentures because he had trouble chewing his food. Resident 42 stated he asked facility staff (could not remember who) several times over the past three months to assist him in getting dentures. Resident 42 stated he is frustrated that he has not been able to get the dental assistance he requested. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025 at 11:07 AM with the Director of Nursing (DON), the DON stated it is the policy of the facility to make sure each resident receives dental care. The DON stated the SSD should have followed up with the dental office to make sure Resident 42 received dental care. The DON stated the importance of the resident seeing dental services is to honor the resident ' s rights and respect their dignity. During a review of the facility ' s undated policy and procedure (P&P) titled, Dental Services, the P&P indicated, Routine and emergency dental services are available to meet the resident ' s oral health services in accordance with the resident ' s assessment and plan of care Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide food that is palatable and attractive for one (1) out of 22 residents (Resident 19) based on the facility's policy. This deficiency has resulted Resident 19 being served his disliked foods which had the potential to negatively affect Resident 19's psychosocial (pertaining to the influence of social factors on an individual's mind or behavior) well-being. Findings: During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included morbid obesity (weight more than 100 pounds over your ideal body weight and experiencing severe health effects), Gastroesophageal reflux disease (GERD, happens when stomach acid flows back up into the esophagus and causes heartburn [a painful, burning feeling in the middle of your chest]) and major depressive disorder (or also called clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems). During a review of Resident 19's Minimum Data Set (MDS, a resident assessment tool) dated 2/14/2025, the MDS indicated the resident's cognitive skills (ability to understand and make decisions) for daily decision making was intact. The MDS indicated Resident 19 needed supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity) for eating, oral hygiene, upper body dressing, personal hygiene, roll left and right, sit to lying, lying to sitting on side of the bed, sit to stand and walk 10 feet. During a record review of Resident 19's Dietary notes dated 3/21/2025, Resident 19 does not always eat the food because of the taste, and sometimes too dry. During a concurrent observation and interview on 5/20/2025 at 12:52 PM with Resident 19 inside Resident 19's room, Resident 19 was sitting on his bed, while watching on his laptop and the resident's lunch tray was just sitting on the foot part of Resident 19's bed, the main dish plate was uncovered and has not been touched. The main dish plate had green beans, yellow squash and green peas that looked mushy/ pasty consistency. Resident 19 stated, Food was meh. I did not like it. It does not look appetizing Resident 19 stated did not each his lunch plate. During a concurrent observation and interview on 5/21/2025 at 12:47 PM with Resident 19, Resident 19's lunch tray has a piece of meat that looked dry and vegetables that looked mushy/ pasty. Resident 19 stated, the food does not look like appetizing. The barbeque pork was so dry looking similar to a cardboard. The vegetables were mushy, if they wanted to preserve the nutrients and flavor, they should steam it rather than boil and overcook it like this. I will just drink water and take a nap, and I will be fine. I already told them (unable to recall name of dietary staff) about it but still nothing changed. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/2025 at 12:50 PM with Resident 19, Resident 19 stated, it was like eating sandpaper. I cannot eat this dry food (barbeque pork). I like carrots and zucchini, but I hate overcooked vegetables, they should cook it right. If it was mushy, they should just throw blender and make it pureed. I want to eat healthy, but it was like eating garbage and that is what I feel about it. During an interview on 5/22/2025 at 12:14 PM with the Dietary Supervisor (DTS), DTS stated, Resident 19 often requests alternate menus like egg sandwich. Resident 19 wants Ceasar's salad, but I have to tell him that we do not carry some croutons. Resident 19 does voice out his concerns, and he was very particular with his food preferences. During an interview on 5/22/2025 at 12:19 PM with the DTS, DTS stated, Resident 19 likes his vegetables not overcooked, mushy and soft. Resident 19 was very particular with his vegetables. If the food was not cooked the way the resident requested it, the resident will not eat the food. They will not have the mood to eat it. During a review of the facility's policy & procedure (P&P) titled, Accommodation of Needs, revised 3/2021, the P&P indicated the resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. During a review of the facility's P&P titled, Food Preferences, dated 2023, the P&P indicated Resident's food preferences will be adhered to within reason.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 22 sampled resident (Resident 1) who required adaptive feeding equipment (modified utensils, accessories, glasses, and plates to help improve residents' comfort and independence) utilize a weighted spoon (specialized utensil with built up handle designed to assist residents with limited or weakened grasping strength) and plate guard (unique spill guard which prevents food from accidentally being pushed off the plate) during meal, as indicated on the physician's order. This deficient practice placed Resident 1 at risk for further decline in physical functioning and decline to perform self-feeding skills. Findings: During a review of Resident 1's admission Record indicated the resident admitted to the facility on [DATE] and got readmitted on [DATE], with diagnoses including but not limited to dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 2/8/2025, indicated Resident 1 was dependent (helper does all the effort) with eating, oral hygiene, toileting hygiene, shower, and upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During a review of the Resident 1's Order Summary Report dated 5/22/2025, timed 2:28 PM, the Order Summary Report indicated the following orders: Kitchen to provide plate guard for resident to perform self-feeding task. Ordered on 3/13/2025. Kitchen to provide weighted spoon for resident to perform self-feeding task. Ordered on 3/21/2025. During a review of Resident 1's Care Plan, initiated on 4/3/2025 indicated Resident 1's has nutritional problem. Staff intervention included for Occupational Therapist (healthcare professional who helps people of all ages overcome challenges with daily activities) to screen and provide adaptive equipment for feeding as needed. During an observation on 5/22/2025 at 12:38 PM, Resident 1 was in dining room and was being fed by Restorative Nursing Assistant 1 (RNA 1). Resident 1's meal tray was observed to have a plate guard and black colored spoon which was different from other residents' spoon. RNA 1 was using the black colored spoon to feed Resident 1. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/2025 at 3:07 PM with MDS Nurse (MDSN), MDSN verified that she observed RNA 1 feeding Resident 1 today during lunch meal in the dining room. MDSN verified that RNA 1 was the one using the weighted spoon while feeding Resident 1. MDSN stated RNA 1 needed to feed Resident 1 because he can't feed himself. MDSN stated that Resident 1's spoon is heavy and special, unlike another resident's spoon. During an interview on 5/23/2025 at 10:11 AM with Occupational Therapists (OT), OT stated that Resident 1 has an order of plate guard and weighted spoon for all meals since March of this year. OT stated that this assistive device would promote Resident 1's ability to self-feed and independence. OT stated that if Resident 1 is unable to use the assistive device during meals, nurses should communicate to them, and evaluation will be done to Resident 1 if assistive devices during meals is still appropriate. OT stated that she did not know that Resident 1 was being assisted by staff during meals. During an interview on 5/23/2025 at 11 AM with the Director of Nursing (DON), the DON stated that Resident 1 has an order to have plate guard and weighted spoon during meals. The DON stated assistive devices for meals are supposed to be used by residents and not staff. During a review of Facility's Policy and Procedure (P&P) titled, Assistive Devices and Equipment, revised January 2020, the P&P indicated Facility maintains and supervises the use of assistive devices and equipment for residents. It also indicated certain devices and equipment that assist with resident mobility, safety and independence are provided for residents. These may include specialized eating utensils and equipment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with its policy and procedure by failing to label food items in the refrigerators, and freezers in the kitchen with item name, date opened and used by date and discard one (1) expired food items. These deficient practices had the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness (example food poisoning with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and can lead to other serious medical complications and hospitalization. Findings: During a concurrent observation and interview on 5/20/2025 at 8:01 AM with [NAME] 1, Refrigerator #2 had a 1-gallon (gal, unit of volume) container of Thousand Island dressing with no label of open date. [NAME] 1 stated, I just opened it yesterday, I just forgot to put the opened date. We need to write down the open date and used by date so we will know when it will be expired. During a concurrent observation and interview on 5/20/2025 at 8:05 AM with Dietary Staff 1 (DS 1), Refrigerator #2 had 3 cups of vanilla pudding with used by date of 5/18/2025. DS 1 stated, We (kitchen staff) should have thrown them away yesterday (5/19/2025) because it is already considered spoiled. It can make the residents sick. During a concurrent observation and interview on 5/20/2025 8:11 AM with DS 1, Freezer # 2 has a tray full of ice cream cups with no date and label of use by date and/ or expiration date. DS 1 stated, We need to put the dates on the ice cream cups so we will know until what date we can still serve it (ice cream). During a review of the facility's policy & procedure (P&P) titled, Labeling and Dating of Foods dated 2023, the P&P indicated all food items in the storeroom, refrigerator, and freezer need to be labeled and dated. The P&P indicated newly opened food items will need to be closed and labeled with an open date and used by date that follows the various storage guidelines. The P&P also indicated all prepared foods need to be covered, labeled, and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement its policy and procedure on infection control for four (1) of 22 sampled residents (Resident 30) when staff did not use personal protective equipment (PPE, used to prevent or minimize exposure and to protect from potential transmission of biological agents that can be transferred from person to person by direct and indirect contact) while rendering wound care to Resident 30 who was on enhanced barrier precaution (EBP, use of PPE beyond anticipated blood and body fluid exposures) on 5/23/2025. This deficient practice had the potential to result in a widespread infection in the facility that could compromise the health of the residents, visitors, and staff. Findings: During a review of Resident 30's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was re admitted on [DATE], with diagnosis of hypertension (high blood pressure), pain, and epilepsy (a brain disease where nerve cells don't signal properly, which causes seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]). During a review of Resident 30's Minimum Data Set (MDS- a resident assessment tool), dated 2/14/2025, indicated Resident 30'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 30 required supervision (helper provides verbal cues) with eating. The MDS indicated Resident 30 required partial/moderate assistance (helper does less than half the effort) with personal hygiene. The MDS indicated Resident 30 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene and upper body dressing. The MDS indicated Resident 30 was dependent with toileting hygiene, shower, lower body dressing, and putting on/taking off footwear. During a concurrent record review and interview on 5/23/2025 at 8:53 AM, Resident 30's electronic treatment administration record was reviewed with Registered Nurse 2 (RN 2). RN 2 stated Resident 30 has the following treatment orders: Amlactin (a brand of lotion, to treat dry skin) lotion to both feet every day for dry scaly skin. Right lateral (the side of the body) heel stage 1 (reddened skin and does not turn white when pressed on). Clean with normal saline, pat dry. Apply A and D (vitamin) ointment. Cover with abdominal pad and wrap with kerlix (a type of bandage roll used for wound care) every day and as needed. Ordered on 5/13/2025, until 5/27/2025. During an observation on 5/23/2025 at 9:20 AM, RN 2 entered Resident 30's room. RN 2 did not don (put on) isolation gown PPE prior to entering Resident 30's room. During a treatment administration observation on 5/23/2025 at 9:22 AM, with RN 2 and Certified Nursing Assistant 2 (CNA 2), RN 2 was observed removing Resident 30's old treatment dressing in Resident 30's right foot. CNA 2 was observed lifting Resident 30's foot from bed. Both RN 2 and CNA 2 are touching Resident 30's bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/23/2025 at 9:25 AM, RN 2 and CNA 2 was observed with RN 1, RN 1 verified RN2 and CNA2 were not wearing PPE while rendering wound treatment to Resident 30. RN 1 stated RN 2 and CNA 2 did not follow enhanced barrier precaution (EBP, use of PPE beyond anticipated blood and body fluid exposures) as indicated on the facility's policy. RN 1 stated that RN2 and CNA 2 should wear proper PPE which included isolation gown, gloves and mask when taking care of Resident 30. RN 1 added that wearing PPE is important to protect Resident 30 who has a wound. RN 1 stated staff giving care to him should wear the proper PPE for infection control. During an interview on 5/23/2025 at 11:50 AM with the Director of Nursing (DON), the DON stated that Resident 30 has a treatment order for his right foot, and EBP should be implemented when rendering direct care. The DON stated that EBP is to protect residents from infections and viruses. During a review of Facility's Policy and Procedure titled, Enhanced Barrier Precautions, revised 4/2025, indicated the following: EBPs are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDRO, bacteria that have become resistant to certain antibiotics) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: ¢ dressing. ¢ bathing/showering. ¢ (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transferring. ¢ providing hygiene. ¢ changing linens. ¢ wound care (any skin opening requiring a dressing).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 22 sampled residents (Resident 42) had a call light (a device used to call for assistance) within reach. This failure had the potential to result in Resident 42 being unable to call for assistance resulting to unmet needs and possibly being injured when trying to reach the call light. Findings: During a review of Resident 42's admission Record, the admission Record indicated the facility admitted Resident 42 on 5/24/2024 and readmitted on [DATE] with diagnoses including cerebral infarction (a condition where brain tissue dies due to lack of oxygen supplying the brain), anxiety disorder (a condition characterized by excessive and persistent worry, fear, and nervousness), and chronic pain syndrome (a condition where pain persist for a long time and can interfere with daily life activities). During a review of Resident 42's Minimum Data Set (MDS - a resident assessment tool), dated 2/13/2025, the MDS indicated Resident 42's cognitive (the ability to think and process information) skills for daily decision making were intact. The MDS indicated Resident 42 had upper and lower extremity impairment on one side and required partial to moderate assistance with eating. The MDS indicated Resident 42 was dependent (a helper does all the effort to complete the activity) with oral hygiene, toileting hygiene, bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and all mobility tasks. During an observation on 5/20/2025 at 11:20 AM in Resident 42's room, Resident 42 was observed lying in bed. The call light for Resident 42 was lying on the floor beneath the bed. During an interview on 5/20/2025 at 11:23 AM with Certified Nurse Assistant 1 (CNA1), CNA 1 stated the call light for Resident 42 was out of reach of the resident and should be within reach so the resident could call for help if needed. CNA 1 stated Resident 42 could possibly fall out of bed and could get hurt if the call light was out of reach. During an interview on 5/22/2025 with Licensed Vocational Nurse 1 (LVN1), LVN 1 stated it is the policy of the facility for call lights to be within reach of the residents to maintain safety and prevent falls. During an interview on 5/22/2025 with the Director of Nursing (DON), the DON stated call lights should be within reach of the residents. The DON stated if the call light is on the floor, the resident may get hurt while trying to reach for the call light. During a review of Resident 42's Care Plan titled, Resident 42 is at risk for further decline in activities of daily living related to hemiplegia and hemiparesis (mild to complete paralysis on one side of the body) following cerebral infarction affecting left non dominant side ., with an initiation date of 1/31/2025 and a revision date of 2/10/2025, the Care Plan indicated an intervention to Keep call light within easy reach and answer promptly. (continued on next page)

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	05/23/2025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s undated policy and procedure (P&P) titled, Call Light/Bell, the P&P indicated, It is the policy of this facility to provide the resident a means of communication with nursing staff Call light only be out of reach during resident care to prevent injury during the time when residents are out of bed but would immediately be within reach after care or when resident is back to bed .place the call device within resident ' s reach before leaving room.