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	06/26/2026

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 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 interview and record review, the facility failed to develop an individualized resident-centered care plan (CP, a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs)for four (4) of 23 sampled residents (Residents 16, 22, 35 and 73) in accordance with the facility's policy and procedure (P&P) by failing to have a care plan for:Resident 22's use of Montelukast (Singulair, a medication used to treat lung inflammation which has potentially dangerous side effects)Resident 73's use of a low air loss mattress (LALM, mattress overlay used to relieve pressure from a resident's back and help wounds heal).Resident 35 to have activities in accordance with the resident's activity assessment.Resident 16's noncompliance (when a resident does not follow a prescribed treatment plan) with fluid restriction as indicated on the physician's order by collecting water at his bedside. This deficient practice had the potential to cause Resident 16, 22, 35 and 73's care goals to not be met and care needs not be addressed, which could negatively affect the residents' overall well-being. Findings: 1. During a review of Resident 73's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness and stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the sacrum (lower end of the spinal area at the base of the spine). During a review of Resident 73's Minimum Data Set (MDS- a resident assessment tool), dated 5/26/2026, the MDS indicated Resident 73 had intact cognitive (ability to think and process information) skills for daily decision making. The MDS indicated Resident 73 was dependent (helper does all the effort) for showering, toileting hygiene, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 73 required supervision (helper provides verbal cues) for eating, and oral hygiene. The MDS indicated Resident 73 required substantial assistance (helper does more than half the effort) for upper body dressing. During a concurrent observation and interview on 6/23/2026 at 9:34 AM with Licensed Vocational Nurse 1 (LVN) 1, Resident 73 was observed in his room lying on a LALM. LVN 1 verified Resident 73 was lying on a LALM. During a concurrent interview and record review on 6/23/2026 at 9:40 AM with LVN 1, Resident 73's CPs, dated 4/1/2026 to 6/23/2026 were reviewed. LVN 1 stated Resident 73 does not have a CP for the use of LALM. LVN 1 stated that Resident 73 should have a CP for the use of LALM to monitor and determine whether the interventions are effective towards reaching a care goal. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/26/2026 at 11:57 AM with the Director of Nursing (DON), the facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised 1/2025 was reviewed. The P&P indicated: A comprehensive, person-centered CP that includes measurable objectives and timetables to meet the resident's physical and functional needs is developed and implemented for each resident. The comprehensive, person-centered CP describes the services that are to be furnished to attain or maintain the resident's highest practicable well-being. The CP reflects currently recognized standards of practice for problem areas and conditions. The DON stated it was important to follow the resident's plan of care of a resident and meet the needs of a resident. The DON stated that a LALM should have a CP to let licensed staff know how to care for a LALM, monitor its effectiveness and ensure it is used properly to prevent wounds. 2. During a review of Resident 22's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and cardiomegaly (enlarged heart). During a review of Resident 22's MD dated 6/7/2026, the MDS indicated Resident 22 had intact skills for daily decision making. The MDS indicated Resident 22 was independent for eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 22 required supervision for showering. During a review of Resident 22's Order Summary Report, dated 4/19/2026, the Order Summary Report indicated Resident 22 was ordered Singulair. During a review of Resident 22's Medication Regime Review (MRR, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication), dated 5/1/2026 to 5/18/2026, the MRR indicated that Resident 22 was receiving montelukast and required monitoring for a black box warning (BBW; serious, life threatening side effects). The MRR indicated to monitor for these behaviors in the care plan. During a concurrent interview and record review on 6/26/2026 at 8:39 AM with Registered Nurse Supervisor 1 (RNS 1), Resident 22's CPs, dated 2/28/2026 to 6/26/2026 were reviewed. RNS 1 stated Resident 22 does not have a CP for monitoring the BBW side effects of montelukast. RNS 1 stated that Resident 22 should have a CP for BBW monitoring to prevent Resident 22 from experiencing life-threating side effects that could lead to worsening conditions and possible hospitalization. During an interview on 6/26/2026 at 12:11 PM with the DON, the DON stated that a medication with a BBW needs a CP to monitor for side effects and to ensure the resident does not experience serious side effects. 3. During a review of the admission Record, the admission Record indicated Resident 35 was initially (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to encounter for attention to gastrostomy (a medical visit or procedure focused on the care, maintenance, or management of a gastrostomy tube [G-tube-an artificial opening in the stomach used for feeding or medication delivery]), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35 was severely impaired (never/rarely made decisions) with cognitive skills for daily decision making. The MDS indicated Resident 35 was dependent on the staff for the activities of daily living such as eating, oral hygiene, toilet hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 35's Activity Assessment (evaluates a resident's background to design personalized, person-centered activity programs), dated 3/10/2026, the Activity Assessment indicated Resident 35 has adequate vision and hearing. The Activity Assessment indicated Resident 35's past activity interests were to listen to music. The Activity Assessment indicated Resident 35's activity interest includes music, watching television (TV) and talking/conversing. During observation in Resident 35's room on 6/23/2026 at 12:09 PM, Resident 35 was observed asleep, in bed, no TV or radio was observed near Resident 35. During observation in Resident 35's room on 6/23/2026 at 1:26 PM, Resident 35 was observed awake, in bed, no TV or radio was observed near Resident 35. During a concurrent record review on 6/26/2026 at 10:52 AM, an interview with MDS nurse (MDSN), Resident 35's care plan was reviewed. MDSN stated Resident 35 did not and should have had a care plan regarding the specific activities appropriate for Resident 35. MDSN stated that it was important to reflect the specific activities and appropriate interventions on the care plan for the entire care team to know the specific activities for Resident 35. During an interview on 6/26/2026 at 10:55 AM with Activity Director (AD), the AD verified Resident 35 has no care plan for activities. The AD stated Resident 35's care plan for activities should include in-room activities such as providing TV or radio to listen to music and talking/conversing activities. During a review of Facility's P&P titled, Care Plan - Comprehensive Person- Centered), revised in January 2025, the P&P indicated facility develops and implements a comprehensive, person-centered care plan for each resident. The P&P also indicated the ca re plan interventions are derived form a thorough analysis of the information gathered as part of the comprehensive assessment. 4. During a review of Resident 16's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and end stage renal dialysis (ESRD - irreversible kidney failure) and dependence on renal (kidney) dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed). During a review of Resident 16's Order Summary Report, dated 5/20/2025, the Order Summary Report indicated fluid restriction of 1,000 cubic centimeters (cc- a measure of volume in the metric system) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	per day: Nursing: 260 cc total 60 cc – 11 PM to 7 AM 100 cc – 7 AM to 3 PM 100 cc – 3 PM to 11 PM Dietary: 740 cc total Breakfast - 300 cc Lunch - 240 cc Dinner – 200 cc During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 16 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathing self, partial/moderate assistance (helper does less than half the effort) with personal and oral hygiene and setup or clean-up assistance (helper sets up or cleans up) with eating. The MDS also indicated Resident 16 was on a therapeutic diet (a specialized meal plan prescribed by a healthcare provider or registered dietitian to manage, treat, or prevent a specific medical condition). During an observation in Resident 16's room on 6/23/2026 at 12:22 PM, six (6) full cups (a small, round open container used for drinking liquids; a measure of volume equal to approximately 236.59 cc) of water and a bottle of soda were observed on Resident 16's bedside table. During an observation in Resident 16's room on 6/24/2026 at 12:41 PM, four (4) full cups of water and a bottle of soda were observed on Resident 16's bedside table. During a concurrent observation in Resident 16's room and interview on 6/25/2026 at 10:53 AM with Registered Nurse Supervisor 1 (RNS 1), 4 full cups of water and 1 bottle of soda were observed on Resident 16's bedside table. RNS 1 stated Resident 16 is on a fluid restricted diet, and he should not have more than the prescribed amount of water at his bedside for him to drink. RNS 1 stated the 4 cups of water should not be there, but Resident 16 was noncompliant and kept more than the prescribed amount of fluid at his bedside. RNS 1 also stated when Resident 16 receives fluid from the kitchen with his meals, he does not send them and keeps them at bedside and that is why they accumulate (gradually collect) at his bedside. During a concurrent observation in Resident 16's room and an interview on 6/25/2026 at 10:53 AM with RNS 1, 4 full cups of water and 1 bottle of soda were observed on Resident 16's bedside table. RNS 1 stated Resident 16 is on a fluidˆrestricted diet and should not have more than the prescribed amount of fluid accessible at his bedside. RNS 1 stated the 4 cups of water should not have been present at bedside but explained that Resident 16 has been noncompliant with his fluid restriction and keeps more than the prescribed amount of fluid at his bedside. RNS 1 further stated that when Resident 16 receives fluids from the kitchen with his meals, he does not return them and instead (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	keeps them at his bedside, which leads to an accumulation (gradually collection) of fluids. During a concurrent interview and record review on 6/25/2026 at 11:15 AM with RNS 1, Resident 16's electronic medical chart, dated 5/20/2025 through 6/25/2026, was reviewed. The electronic medical chart failed to indicate a care plan for Resident 16's noncompliance of keeping more than the prescribed amount of fluid at his bedside. RNS 1 stated there was no care plan developed for Resident 16's behavior of noncompliance but one should be in place. RNS 1 stated a care plan was needed to implement interventions to prevent Resident 16 from drinking excessive amounts of fluid at any time, which could put his health at risk for fluid overload (a condition when there is too much fluid in your body). During an interview on 6/26/2026 at 11:26 AM with the DON, the DON stated Resident 16 needed a care plan for keeping more than the prescribed amounts of fluid at bedside. The DON stated the care plan would include interventions of educating Resident 16 of risks and informing the dialysis staff and doctor when Resident 16 is noncompliant with fluid restrictions. During a review of the facility's P&P titled, Care Plans, Comprehensive Person- Centered, dated 1/2025, the P&P indicated a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P also indicated the comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including the right to refuse treatment. The P&P also indicated assessments or residents are ongoing and care plans are revised as information about the resident and the residents' conditions change.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure three (3) of three sampled residents (Residents 57, 76 and 82) reviewed for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) were provided care and services to maintain independence, functional status, good grooming and personal hygiene by failing to:1. Provide feeding assistance to Resident 57 on 6/24/2026, during lunch meal. 2. Ensure Resident 76's fingernails on both hands were not long.3. Ensure Resident 82's fingernails on both hands were not long, jagged, and dirty. These deficient practices have the potential for Residents 57, 76 and 82 to develop skin issues/complications and had the potential to result in a negative effect on residents' quality of life and wellbeing.Findings: 1. During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was originally admitted to the facility on [DATE]. The admission record also indicated Resident 57's diagnoses included dementia (a progressive state of decline in mental abilities), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry). During a review of Resident 57's Minimum Data Set (MDS – a resident assessment tool), dated 6/13/2026, the MDS indicated Resident 57 has severely impaired (never/rarely made decisions) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 57 required partial/moderate assistance (helper does less than half the effort) with eating and oral hygiene. The MDS indicated Resident 57 required substantial/maximal assistance (helper does more than half the effort. helper lifts or holds trunks or limbs and provides more than half the effort) with upper body dressing. The MDS indicated Resident 57 was dependent (helper does all the of the effort) with toileting, showering, lower body dressing, and putting on/taking off footwear. During a review of Resident 57's care plan focusing on Resident 57's risk for further decline in Activities of Daily Living (ADL), initiated on 6/9/2026, the care plan interventions indicated encourage to continue participating in performing ADLs within capability including but not limited to combing hair, dressing, and feeding. During a review of Resident 57's care plan focusing on ineffective airway clearance related to chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), initiated on 6/11/2026, the care plans intervention indicated to keep head of bed elevated to 90 degrees to facilitate breathing. During an observation on 6/23/2026 at 1:35 PM, in Resident 57's room, Resident 57 was observed sitting on wheelchair, currently watching television (TV) with lunch tray on top of a bedside table in front of Resident 57. During a concurrent observation on 6/24/2026 at 12:50 PM and interview with Physical Therapist Assistant (PTA), in Resident 57's room, Resident 57 was observed eating lunch meal in bed without a staff assisting the resident. Resident 57 was observed having hard time reaching out the lunch meal that is on top of the bedside table across the bed. The head of the bed was observed to be low and should have been positioned higher to have a better positioning during meals. PTA stated the head of (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed was not raised to 90 degrees to have a sitting position. During a concurrent observation on 6/24/2026 at 12:54 PM and interview with Certified Nurse Assistant 2 (CNA 2), in Resident 57's room, Resident 57 was observed eating lunch meal in bed without a facility staff assisting the resident. CNA 2 stated Resident 57 is alert and that CNA 2 can leave the resident alone because the resident can eat by herself. During an interview on 6/26/2026 at 8:08 AM with MDS Nurse (MDSN), the MDSN stated Resident 57 required partial assistance during meals. MDSN stated Resident 57 was not positioned correctly and should have been positioned 90 degrees in bed on 6/24/2026 during lunch meal. MDSN also stated when Resident 57 was only being given the lunch tray without ensuring Resident 57 was properly positioned, the staff really did not provide the needed assistance for Resident 57. During an interview on 6/26/2026 at 8:50 AM with Physical Therapist (PT), he (PT) stated all residents should be assisted with proper positioning during meals as part of the care the resident needed from staff members. PT stated Resident 57 needs to maintain an upright posture during meals promotes easier swallowing and prevents aspiration (accidentally breathing food, liquid, saliva, or stomach contents into the airway and lungs rather than swallowing them). During a review of the facility's P&P titled, Assisting the Resident with in-room meals, revised on January 2026, the P&P indicated the resident should be positioned so his or her head and upper body are as upright as possible and with the head tipped slightly forward. If the resident is served his or her meal in bed, use wedges and pillows to achieve a nearly upright position. 2. During a review of Resident 76's admission Record, the admission Record indicated Resident 76 was admitted to the facility on [DATE], Resident 76's diagnoses included cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area) affecting left non-dominant side, 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) and hypertension (high blood pressure) During a review of Resident 76's MDS), dated [DATE], the MDS indicated Resident 76 had intact cognitive skills for daily decision making. The MDS indicated Resident 57 required substantial/maximal assistance in toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, and sit-to- stand. The MDS also indicated Resident 76 needed partial moderate assistance in upper body dressing, personal hygiene, roll left and right, sit to lying, and lying to sitting on side of bed. During an observation on 6/23/2026 at 9:31AM inside Resident 76's room, Resident 76 was lying on his bed, with the head of the bed (HOB) elevated 60-degree angle (a unit for measuring angles, where a full circle is 360 degrees) while reading a newspaper. Resident 76's left hand was contracted (a condition where the fingers or palm of the hand become permanently bent or curled). Resident 76's fingernails on both hands were long. During an observation and interview on 6/24/2026 at 9:03 AM inside Resident 76's room, Resident 76 was awake and lying on his bed and watching the news on the resident's cellphone. Resident 76 showed his long fingernails on his both hands and stated, I wanted it to be cut. During a concurrent observation and record review on 6/24/2026 at 2:50 PM with CNA 4, inside Resident 76's room. CNA 4 stated Resident 76 has long fingernails on both hands. CNA 4 stated they (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility staff need to cut it so the residents will not scratch themselves and have a skin breakdown. CNA 4 also stated the facility staff have to keep the resident's fingernails short so microorganisms will not be living under their nails and it must be done every week or as needed. CNA 4 stated the facility needs to keep Resident 76 fingernails short so the resident cannot hurt himself because the resident has a contracted left hand and might accidentally poke or scratch himself. During an interview on 6/26/2026 at 10:11 AM with Director of Staff Development (DSD), DSD stated Resident 76's fingernails on both hands were really long and if Resident 76's left hand has long fingernails, it can cause skin breakdown because the resident has contracture on that hand. DSD also stated the facility staff should make sure the staff trims the residents' fingernails to prevent infection and skin breakdown. During a concurrent interview and record review on 6/26/2026 at 1:04 PM with the Director of Nursing (DON), Resident 76's Care Plan (CP) for ADLs dated 8/7/2025 was reviewed. The CP interventions did not indicate providing grooming and personal hygiene. The DON stated Resident 76's CP interventions were incomplete because it is missing to provide the resident grooming and personal hygiene. The DON stated the staff needs to trim the resident's fingernails at least twice per week to maintain cleanliness and prevent infection. The DON also stated Resident 76's long fingernails can cause skin breakdown and the resident can have infection. 3. During a review of Resident 82's admission Record, the admission Record indicated Resident 82 was admitted to the facility on [DATE]. Resident 82's diagnoses included lymphedema (a chronic disease marked by the increased collection of lymphatic fluid in the body, causing swelling, which can lead to skin and tissue changes), cellulitis (a bacterial infection that enters your skin and tissue through a wound) on bilateral lower extremities, gastroenteritis (inflammation of the stomach and intestines, causing pain, vomiting and diarrhea) and generalized muscle weakness. During a review of Resident 82's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 82 requires supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity) when eating, oral hygiene, and personal hygiene. The MDS indicated Resident 82 also needed partial/ moderate assistance in upper body dressing, roll left and right, sit to lying, and lying to sitting on the side of the bed. The MDS indicated Resident 82 requires substantial/maximal assistance with toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, sit to stand, and chair/ bed-to-chair transfer. During a concurrent observation and interview on 6/23/2026 at 9:41 AM inside Resident 82's room, Resident 82 was sitting up on his bed and watching videos on his cellphone. Resident 82 showed his fingernails, they were long, jagged, with yellowish discoloration with blackish brown debris under the fingernails. Resident 82 stated I wanted to cut my long fingernails. They were dirty and discolored. It had dirt and it was long. I told the staff last Friday, but they told me they did not have the fingernail cart, which was not available on the weekend. During a concurrent observation and interview on 6/24/2026 at 9:07 AM inside Resident 82's room, Resident 82 was sitting up on his bed. Resident 82 stated my fingernails were still the same, they were still long and dirty. During a concurrent observation and interview on 6/24/2026 at 2:58 PM with CNA 4 inside Resident 82's room, Resident 82 showed his fingernails, they were long, jagged, with yellowish discoloration (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with blackish brown debris underneath the fingernails. CNA 4 stated Resident 82's fingernails were very dirty, the fingernails were long, jagged and discolored, and also had blackish debris under the fingernails. CNA 4 stated the facility staff need to cut Resident 82's fingernails short because there might be microorganisms living under the resident's fingernails. During an interview on 6/26/2026 at 10:10 AM with the DSD, DSD stated Resident 82's fingernails were long, jagged and dirty, they have brownish debris under the nails. DSD stated the staff did not check the resident's fingernails daily the staff should have offered to cut Resident 82's fingernails because it was dirty and it could cause infection. During a concurrent interview and record review on 6/26/2026 at 12:52 PM with DON, Resident 82's Care Plan (CP) for ADLs dated 6/22/2026 was reviewed. The CP interventions did not indicate providing grooming and personal hygiene. The DON stated the CP was incomplete because it is missing interventions such as grooming and offering to cut Resident 82's long fingernails as part of the resident's personal hygiene. The DON stated, Resident 5's fingernails were long and dirty; it can cause infection because microorganism/ bacteria can live under the resident's fingernails and the staff should have checked it daily. During a concurrent interview and record review on 6/26/2026 at 12:55 PM with DON, the facility's Policy and Procedure (P&P) titled, Nail Care dated 1/2025 was reviewed. The P&P indicated to promote cleanliness, safety, and neat appearance of all residents. The DON stated the staff did not follow the policy because Resident 82's fingernails were long and dirty, and the staff did not promote cleanliness for the residents. During a review of the facility's P&P titled, Activities of Daily Living, supporting dated 2001, the P&P indicated, residents will be provided with care, treatment, and services as appropriate to maintain or improve the resident's ability to carry out ADL. The P&P also indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, including appropriate support and assistance with hygiene, mobility (the capacity to move or be moved freely and easily) and dining.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the low air loss mattress (LALM- a specialized medical mattress designed to prevent and treat pressure ulcer [wound that occurs as a result of prolonged pressure on a specific area of the body] by maintaining a cool, dry environment through constant airflow, which helps regulate temperature and moisture) was on the correct setting for two (2) of four (4) sampled residents (Resident 5 and 35) in accordance with the physician's orders and LALM operator's manual instructions. This deficient practice placed Residents 5 and 35 at risk of development of new pressure ulcers, poor wound healing and deterioration (something once in good condition is now weakened, worn out, or otherwise in decline) of current pressure ulcers. Findings: 1. During a review of the admission Record, the admission record indicated Resident 35 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to encounter for attention to gastrostomy (a medical visit or procedure focused on the care, maintenance, or management of a gastrostomy tube [G-tube-an artificial opening in the stomach used for feeding or medication delivery]), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 35's Minimum Data Set (MDS- a resident assessment tool), dated 3/30/2026, the MDS indicated Resident 35 was severely impaired (never/rarely made decisions) with cognitive skills for daily decision making. The MDS indicated Resident 35 was dependent (helper does all of the effort) from the staff for the activities of daily living such as eating, oral hygiene, toilet hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 35's weight summary dated from 4/1/2026 to 6/23/2026, the resident's weight indicated the resident's weight on 6/10/2026 is 158 pounds (lbs.). During a review of Resident 35's Braden scale for predicting pressure sore risk (a tool used in healthcare to assess a resident's risk of developing pressure ulcers by evaluating six factors: sensory perception, moisture, activity, mobility, nutrition, and friction/shear), dated 3/21/2026, timed at 8:53 AM, it indicated Resident 35 was moderate risk for developing pressure ulcer. During an observation in Resident 35's room on 6/23/2026 at 12:09 PM, observed Resident 35 resting in bed with LALM setting at approximately 225 lbs. During an observation in Resident 35's room on 6/23/2026 at 1:26 PM, observed Resident 35 resting in bed with LALM setting at 225 lbs. During a concurrent observation and interview with Treatment Nurse (TN) in Resident 35's room on 6/24/2026 at 2:58 PM, observed Resident 35 resting in bed with LALM setting at 225 lbs. TN verified, the LALM setting was incorrect because Resident 35's weight is not 225 lbs. TN stated Resident 35 is high risk on developing pressure ulcer, and Resident 35 would benefit from the use of LALM if it is in the correct setting. TN stated the CNAs do not touch the settings for the LALM because that responsibility falls on the licensed nurses since the reason for the LALM is to help reduce the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure on the resident's skin and prevent pressure ulcer from getting worse or developing a new pressure ulcer. TN stated, LAL mattress settings are set by the treatment nurse, but the charge nurses check it too. We know how to place the settings because it is according to the resident's weight. During an interview on 6/24/2026 at 3:26 PM with Registered Nurse Supervisor 1 (RNS 1), RNS 1 stated LALM setting should be based on the resident's weight. RNS 1 stated not setting the LALM correctly according to the directions in the LALM manual or physician's orders will not help the residents' wounds or skin condition since the LALM was to prevent skin damage or relieve pressure from the resident's skin. RNS 1 stated, If the settings are off, the LALM may not have enough pressure relief and that will cause more harm than good to the resident. It does not help the resident to have a hard mattress, that can cause skin breakdown, and it can be a potential for infection, especially if the resident is incontinent. The whole use for the LALM is to prevent any further damage to the resident's skin. During a record review of Facility's Brand 2's LALM manual, the manual operation guide indicated to set according to the weight of the patient. 2. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE]. The admission record indicated Resident 5's diagnoses included cirrhosis of the liver (is permanent scarring that damages your liver and interferes with its functioning) and history of stage II pressure ulcer (is one that has progressed to affect both the top and bottom layers of the skin but has not yet affected the fatty tissue beneath) of the left buttock, and anxiety disorder (mental health condition marked by persistent excessive worry, fear, or nervousness that interferes with daily life), During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 5 was dependent in oral hygiene, toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying-to-sitting on the side of the bed, and chair/ bed-to-chair transfer, and tub/ shower transfer. The MDS also indicated Resident 5 was at risk for pressure ulcers. During a record review of Resident 5's weight summary dated 6/10/2026, the summary indicated Resident 5's weight was 152 lbs. During an observation on 6/23/2026 at 10:14 AM inside Resident 5's room, Resident 5 was sleeping, and lying on a LALM which was set at 260 lbs. During an observation on 6/23/2026 at 12:52 PM inside Resident 5's room, Resident 5 was awake and lying on a LALM which was set at 260 lbs. During a concurrent observation and interview on 6/24/2026 at 8:59 AM inside Resident 5's room, Resident 5 was awake and watching television while lying on the LALM which was set at 260 lbs. Resident 5 stated the bed (LALM) was hard and it hurts his back a little bit. During a concurrent observation and interview on 6/24/2026 at 1:02 PM inside Resident 5's room, Resident 5 was lying on the LALM set at 260 lbs. Licensed Vocational Nurse 3 (LVN 3) stated, the LALM was set incorrectly because the LALM was set up 260 lbs. and not according to Resident 5's (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weight. During a concurrent observation and interview on 6/24/2026 at 1:04 PM with RNS 1 inside Resident 5's room, Resident 5 was lying on the LALM set at 260 lbs. RNS 1 stated Resident 5's LALM was set at 260 lbs., the LALM was too firm for Resident 5. RNS 2 stated, Resident 5 weight last 6/10/2026 was 152 lbs. and the LALM should be set according to the resident's weight so the LALM is not too firm for the resident. RNS 1 stated, Resident 5 can develop pressure ulcers if LALM set incorrectly and it defeats the purpose of avoiding pressure on the residents' pressure points (bony areas of the body). During a concurrent interview and record review on 6/24/2026 at 3:03 PM with TN, Resident 5's Braden Scale Assessment (BSA) dated 4/21/2026 was reviewed. The BSA indicated Resident 5 was at high risk for developing pressure ulcers. TN stated Resident 5 was high risk for developing pressure ulcers and if the resident's LALM was set incorrectly and higher than Resident 5's weight the LALM will be too hard, and the resident can develop new pressure ulcers, and can contribute to the worsening of the resident's current pressure ulcer. During a concurrent interview and record review on 6/26/2026 at 12:23 PM with the Director of Nursing (DON), Resident 5's Physician Order (PO) dated 5/24/2026 was reviewed. The PO indicated may have LALM for skin maintenance. The DON stated the PO was incomplete, it should have included LALM set up should be based on the resident's weight. During a concurrent interview and record review on 6/26/2026 at 12: 23 PM with the DON, Resident 5's Care Plan (CP) for left buttock stage II pressure ulcer, dated 4/5/2026, was reviewed. The CP indicated in the interventions, may have LALM for skin maintenance. The DON stated Resident 5's CP interventions were incomplete because it should have included the use of LALM, indication for use and LALM set up based on Resident's weight, and this is to ensure that interventions were properly implemented. During a concurrent interview and record review on 6/26/2026 at 12:25 PM with the DON, the facility's Policy and Procedure (P&P) titled Air Loss Mattress revised on 7/2012 was reviewed. The P&P indicated: Air pressure of the air loss mattress will be adjusted based on the resident's weight to serve the purpose. The facility staff will maintain the air pressure that will suit and meet the needs of the Resident to serve the purpose of healing enhancement. The DON stated the licensed staff were not following the policy if the LALM of Resident 5 and 35 was set up incorrectly, it defeats the purpose to maintain the skin integrity of the residents and the residents can develop a new pressure ulcer.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary proper care and services for two (2) of two sampled residents (Resident 7 and Resident 48) reviewed for indwelling catheter (a tube that allows urine to continuously drain from the bladder) as indicated in the facility's policy and procedure (P&P) by failing to ensure:Resident 7's indwelling catheter drainage tubing (connects a flexible tube inside the body to an external collection bag) has no sediments (a build-up of waste that collect in the urine tube or drainage bag) and catheter care was provided in accordance with the physician's order.Indwelling catheter care was provided for Resident 48 for 12 days in accordance with the resident's care plan and physician's order.This deficient practice increased the risk of blockage and urinary tract infections (UTI- an infection in any part of the urinary system) for Resident 7 and placed Resident 48 at risk for developing discomfort, urine leakage, infection, and a decreased quality of life Findings: 1. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included retention of urine, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and absence of right and left leg below knee. During a review of Resident 7's Minimum Data Set (MDS- a resident assessment tool), dated 6/15/2026, the MDS indicated Resident 7 has independent (decisions consistent/reasonable) cognition (thought process and ability to reason or make decisions) for daily decision making. The MDS indicated Resident required supervision (helper provides verbal cues) with eating. The MDS indicated Resident 7 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 7 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower and lower body dressing. The MDS also indicated Resident 7 had an indwelling catheter. During a review of Resident 7's Care Plan focusing on Resident 7's risk for UTI related to indwelling foley catheter use, initiated on 6/8/2026, the Care Plan interventions included the following: Foley care every shift and after each bowel movement. Observe urine output for foul odor, sediments, color, amount, note abdominal pain and distention. During a review of Resident 7's Order Summary Report, dated 6/24/2026, the Order Summary Report indicated the following physician orders: Indwelling catheter care: wash with water and soap around urinary meatus (the opening at the tip of the penis) every shift and as needed, ordered on 6/8/2026. Flush foley catheter (a thin, flexible tube threaded through the urethra into the bladder to continuously drain urine) with 50 milliliters (ml, unit of measurement) normal saline (a saltwater solution) weekly (Monday) and as needed, ordered on 6/15/2026. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/23/2026 at 12:08 PM, in the dining room, Resident 7's indwelling catheter tubing was observed with sediments. During a concurrent observation and interview on 6/24/2026 at 9:56 AM, in Resident 7's room, Resident 7's indwelling catheter tubing was observed with sediments. Resident 7 stated they (facility staff) check and clean it sometimes. During a concurrent record review and interview on 6/26/2026 at 11:22 AM, with Registered Nurse 2 (RN 2), Resident 7's treatment administration record (TAR) for June 2026 was reviewed. RN 2 stated Resident 7's indwelling catheter care was not completed every shift in accordance with the physician's order. RN 2 stated that the following dates and shift have no documentation in the TAR under the indwelling catheter care: 6/9/2026 night shift (11 PM – 7 AM) 6/10/2026 evening shift (3 PM – 11 PM) and night shift. 6/14/2026 day shift (7 AM – 3 PM) and night shift. 6/15/2026 night shift. 6/21/2026 day shift. RN 2 stated Resident 7's TAR has missing documentation for indwelling care for total of five shift for the month of June 2026, RN 2 stated if it was not documented, it was not done. RN 2 stated that it is important for Resident 7's indwelling foley to be cared for every shift to prevent infection. During the same interview record review and interview on 6/26/2026 at 11:22 AM, with RN 2, Resident 7's treatment administration record (TAR) for June 2026 was reviewed. RN 2 stated that Resident 7's foley catheter has a documentation in the TAR that it was flushed on 6/22/2026 (Monday) and has no documentation of as needed flushing. RN 2 verified Resident 7's indwelling foley catheter tubing has sediments on 6/23/2026, and it should have been flushed to prevent blockage. During an interview on 6/26/2026 at 3 PM with Director of Nursing (DON), the DON stated Resident 7's indwelling catheter tubing should be free from sediments, and it should have been flushed in accordance with the physician's order. The DON stated the licensed nurses are responsible for providing indwelling catheter care and the DON did not know why there are multiple days and shifts that indwelling catheter care was not provided to Resident 7 as indicated in the TAR. During a review of the facility's P&P, titled, Incontinent Care, revised on January 2025, the P&P indicated to remove urine or feces from skin, to cleanse and lubricate skin, and to provide dry, odor free perineal care system. During a review of facility's P&P titled Policy and Procedure on Urinary Tract Infection,, revised on January 2025, the P&P indicated facility will provide the needed care and services to resident with diagnosis of UTI, and minimize, if possible, reoccurrence of the same. During a review of facility's P&P titled Catheter Care,, revised on January 2025, the P&P indicated to improve hygiene, and reduce infection by ensuring that catheter care is done every shift to residents (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	who are using foley catheter, The P&P also indicated to observe the urine for any sediments or change in color and to notify Doctor for any sediments noted in the urine flow. 2. During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), disorder of kidney (organ that removes waste and extra water from the blood) and ureter (one of two muscular tubes that carry urine from the kidneys to the bladder [an organ that stores urine]) and UTI During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48 had moderately impaired cognitive for daily decision making. The MDS indicated Resident 48 required substantial/maximal assistance with toileting hygiene, shower/bathing self, supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity and setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. The MDS also indicated Resident 48 had an indwelling catheter. During a review of Resident 48's Order Summary Report, dated 11/24/2025, the Order Summary Report indicated an indwelling catheter size 16 French (Fr- a scale used that measures the external diameter of the foley catheter tube) with seven (7) to 10 cubic centimeters (cc- a measurement of volume) balloon attached to gravity drainage bag for retention of urine. The Order Summary Report also indicated indwelling catheter care: wash with water and soap around urinary meatus (the external opening where urine exits the body from the urethra) every shift and as needed. During a review of Resident 48's Risk for UTI Related to Foley Catheter (indwelling catheter) Use, revised 11/24/2025, the care plan indicated for indwelling catheter care every shift and cleanse with soap and water around the urinary meatus. During a concurrent interview and record review on 6/25/2026 at 12:57 PM wit Treatment Nurse (TN), Resident 48's Treatment Administration Records (TAR), dated 5/1/2026 through 5/31/2026 and 6/1/2026 through 6/25/2026 were reviewed. The TARs indicated no catheter care was provided every shift on 5/9/2026, 5/20/2026, 5/22/2026, 5/26/2026, 5/27/2026, 5/31/2026, 6/3/2026, 6/9/2026, 6/14/2026, 6/20/2026, 6/21/2026 and 6/24/2026. TN stated Resident 48 has an indwelling catheter and the resident needs to receive catheter care every shift to prevent UTIs. TN stated Resident 48 is at a high risk to develop a UTI, and the catheter care decreases the bacteria that can enter the resident's bladder and/or indwelling catheter and cause a UTI. TN also stated if catheter care is not documented as done, the facility cannot ensure it was provided. During an interview on 6/26/2026 at 11:44 AM with the Director of Nursing (DON), the DON stated catheter care is provided to prevent infections. The DON stated a UTI can cause drainage, fever, confusion and hospitalization, so catheter care was very important and needed to be done every shift as in accordance with the physician's order. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person – Centered, revised 1/2025, the P&P indicated a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three (3) of 3 sampled residents (Resident 6, 16 and 18) reviewed for dialysis (a lifesaving treatment for residents with a kidney failure), who were receiving hemodialysis (process of removing waste products and excess fluid from the body) treatment were provided dialysis care and services in accordance with the facility policy by failing to ensure: Resident 6's dialysis arteriovenous (AV) fistula (vascular access in patients receiving regular hemodialysis) was assessed on 6/10/2026, 6/12/2026, 6/17/2026, and 6/19/2026 (4 days).Resident 16's urine output was monitored and recorded every shift.Resident 18's output was monitored and recorded every shift and the resident's weekly laboratory test was completed as ordered by the physician. These deficient practices have the potential for unnoticed or missed excessive bleeding and infection on Resident 6 dialysis AV fistula and placed Residents 16 and 18 at risk to experience complications of ESRD and negatively affect their physical, mental and psychosocial (the dynamic, interlocking relationship between an individual's psychological state and their social environment) health. Findings: 1. During a review of Resident 6'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 end stage renal disease (ESRD, irreversible kidney failure), anemia (a condition where the body does not have enough healthy red blood cells), and dementia (a progressive state of decline in mental abilities). During a review of Resident 6's Care Plan focused on the resident's diagnosis of ESRD, risk for complications related to hemodialysis, initiated on 4/23/2026, the Care Plan indicated staff intervention included the following: Assess access site on left upper arm AV shunt. Assess skin around access site, noting redness, swelling, local warmth, exudate and tenderness. Check for bruit (whooshing sound heard over an artery, usually with a stethoscope, indicating turbulent blood flow, often due to a narrowing or obstruction) and thrill (palpable vibration felt over an artery, also indicating turbulent blood flow). Monitor signs and symptoms of bleeding from the access site. Palpate skin around shunt (AV fistula) for warmth. During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 5/5/2026, indicated Resident 6's cognitive (ability to think and reason) skills for daily decision making was modified independence (some difficult in new situations only). The MDS indicated Resident 6 required supervision (helper provides verbal cues) with eating and oral hygiene. The MDS indicated Resident 6 required partial/moderate assistance (helper does less than half the effort) with upper body dressing and personal hygiene. The MDS indicated Resident 6 required substantial/maximal assistance (helper does more than half the effort) with shower, lower body dressing and putting on/taking off footwear. The MDS also indicated Resident 6 is on hemodialysis while a resident in the facility. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's Order Summary Report dated 6/24/2026, the Order Summary Report indicated hemodialysis, every Tuesday, Thursday, and Saturday, ordered on 6/7/2026. During a concurrent record review and interview on 6/24/2026 at 2:34 PM, with Licensed Vocational Nurse 2 (LVN 2), Resident 6's Nurse's Dialysis Communication Record, dated 6/10/2026, 6/12/2026, 6/17/2026, and 6/19/2026 were reviewed. The form indicated under the post dialysis check which included dialysis access site, AV shunt check was not completed on 6/10/2026 and 6/12/2026. LVN 2 stated the Nurse's Dialysis Communication Record was not filled out completely when the resident returned from dialysis on 6/10/2026, 6/12/2026 afternoon The form indicated under pre dialysis assessment which included access site, AV shunt was not completed on 6/17/2026 and 6/19/2026. LVN 2 stated the dialysis communication record's post dialysis check for Resident 6 should be completed by the charge nurse upon resident's return from dialysis to know the status of the resident and the resident's AV shunt. LVN 2 stated dialysis communication record's pre dialysis assessment for Resident 6 should be completed by the charge nurse who is assigned to Resident 6 before leaving the facility for dialysis to know the status of the resident and the resident's AV shunt. LVN 2 stated it was important to properly assess resident, document accurately, and complete the Nurse's Dialysis Communication Record to make sure that residents will receive the proper care. LVN 2 added charge nurses need to check vital signs (clinical measurements of pulse rate, temperature, respiration rat and blood pressure) and the resident's dialysis access site such as the AV shunt needs to be observed or assessed and document it in the nurse dialysis communication form. During a concurrent record review and interview on 6/24/2026 at 3:27 PM, with Registered Nurse Supervisor 1 (RNS 1), Resident 6's Nurse's Dialysis Communication Record, dated 6/10/2026, 6/12/2026, 6/17/2026, and 6/19/2026 were reviewed. RNS 1 stated the Nurse's Dialysis Communication Record was not filled out completely on 6/10/2026, 6/12/2026, 6/17/2026, and 6/19/2026. The post dialysis check which included dialysis access site, AV shunt check was not completed on 6/10/2026 and 6/12/2026. RNS 1 stated assessing resident before and after dialysis is important to make sure Resident 6's dialysis AV shunt is not bleeding, no signs of infection and it is working well. RNS 1 stated, it was important to properly assess the residents and complete the Nurse's Dialysis Communication Record to ensure that residents will receive proper care. During a review of facility's Policy and Procedure (P&P) titled, Dialysis, dated January 2015, the P&P indicated the facility shall maintain an ongoing communication with the dialysis center's staff to coordinate the care and services of each resident receiving dialysis treatment with ESRD. The P&P indicated communication method to coordinate the resident's condition, treatment plan and response, with the dialysis center's staff shall be dialysis communication form. The P&P also indicated that licensed nurses shall document condition prior to treatment, and upon resident's return from the treatment. 2. During a review of Resident 16's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), ESRD and dependence on renal (kidney) dialysis. During a review of Resident 16's Order Summary Report (active as of 6/24/2026), the Order Summary Report indicated for Resident 16 to receive dialysis one time a day every Tuesday, Thursday, Saturday related to ESRD, ordered on 2/1/2025. During a review of Resident 16's Care Plan for Risk for Complication related to Hemodialysis, initiated (continued on next page)

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 2/1/2025, the care plan indicated to monitor intake and output every shift. During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 16 required substantial/maximal assistance with toileting hygiene, shower/bathing self, partial/moderate assistance with personal and oral hygiene and set-up or clean-up assistance (helper sets up or cleans up) with eating. The MDS also indicated Resident 16 was on a therapeutic diet (a specialized meal plan prescribed by a healthcare provider or registered dietitian to manage, treat, or prevent a specific medical condition) and received dialysis. During a concurrent record review and interview on 6/24/2026 at 2:42 PM with LVN 1, Resident 16's Intake & Output Record, dated 5/22/2026 through 6/23/2026, and Resident 16's electronic medical chart from 5/22/2026 through 6/23/2026 were reviewed. Both records did not indicate Resident 16's urine output was monitored and recorded on 5/28/2026 for the 11 PM to 7 AM shift. LVN 1 stated there was no documented urine output for Resident 16 during this shift and there should have been per facility policy and the resident's care plan. 3. During a review of Resident 18's admission Record, the admission Record indicated Resident 18 was originally admitted to the facility on [DATE] with diagnoses that included ESRD, dependence on renal dialysis and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 18's Risk for Complication related to Hemodialysis care plan, revised 8/26/2025, the care plan indicated to monitor intake and output every shift and laboratory as ordered. During a review of Resident 18's Order Summary Report, (active orders as of 6/25/2026), it indicated for Resident 18 to receive dialysis one time a day every Monday, Wednesday, and Friday related to ESRD, ordered 10/1/2025.The Order Summary Report also indicated for complete blood count (CBC- a standard blood test used to evaluate your overall health and detect a wide range of disorders) and basic metabolic panel (BMP- a routine blood test that measures your body's fluid balance, electrolyte levels, metabolism, and kidney function) every Thursday for ESRD, starting 1/22/2026. During a review of Resident 18's MDS, dated [DATE], the MDS indicated Resident 18 had intact cognitive skills for daily decision making. The MDS indicated Resident 18 was independent (resident completes the activity by themselves with no assistance from a helper) with eating, oral, toileting and personal hygiene, dressing and shower/bathing self. The MDS also indicated Resident 18 was on a therapeutic diet and received dialysis. During a concurrent record review and interview on 6/24/2026 at 2:51 PM with LVN 1, Resident 18's Intake & Output Record, dated 5/22/2026 through 6/23/2026, and Resident 18's electronic medical chart from 5/22/2026 through 6/23/2026 were reviewed. Both records did not indicate Resident 18's output was monitored and recorded from 11 PM to 7 AM shift on 5/27/2026, 5/28/2026, 6/2/2026, 6/4/2026 and from 7 AM to 3 PM shift on 5/31/2026. LVN 1 stated there was no documented urine output for Resident 18 during these shifts and there should have been per facility policy. During an interview on 6/25/2026 at 10:53 AM with RNS 1, RNS 1 stated for per facility policy, all residents who receive dialysis should have their intake and urine output (I&O) monitored and documented in the resident's medical records each shift. RNS 1 stated it was necessary to monitor the I&O of these residents to ensure they residents are not receiving too much fluid, coordinate with dialysis staff the status of the resident and ensure the appropriate care is provided. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/2026 at 11:20 AM with the Director of Nursing (DON), the DON stated Resident 18receiving dialysis should have I&O monitoring every shift to ensure Resident 18 is receiving the fluid restriction as ordered and the monitoring needs to be documented and recorded in the resident's medical record. The DON stated if I &O monitoring was not done, the resident would be at risk for fluid overload (occurs when the body retains too much water and sodium) where the resident may experience congestion (refers to an abnormal or excessive accumulation of bodily fluids. This could be localized inflammation in the nasal passages, or fluid retention in organs like the lungs), edema (swelling) and distress. During an interview and record review on 6/25/2026 at 3:21 PM with RNS 1, Resident 18's laboratory test records dated 1/1/2026 through 6/25/2026 were reviewed. Resident 18 laboratory test records indicated a CBC and BMP was completed monthly for Resident 18 and did not indicate it was done weekly. RNS 1 stated Resident 18's CBC and BMP were done monthly and not as ordered by the physician which is weekly. RNS 1 stated the order should have been followed or clarified with a new order. RNS 1 stated laboratory test should have been done as ordered because Resident 18 received dialysis and his labs can fluctuate due to the resident's kidneys not working properly. During an interview on 6/26/2026 at 11:32 AM with the DON, the DON stated Resident 18 had an order for weekly laboratory test (CBC and BMP) that were not completed by the facility. The DON stated it was important for Resident 18's laboratory test to be done as ordered to make sure the resident's blood levels are addressed, assessed and reported to the MD as necessary. The DON added, if the laboratory tests are not completed, the staff would not know if there were any problems that needed to be addressed and the residents could experience symptoms related to abnormal laboratory levels. During a review of the facility's P&P titled, Dialysis, revised 1/2015, the P&P indicated licensed nurses shall document the intake monitoring of fluid restriction if ordered. During a review of the facility's policy and procedure (P&P) titled Intake and Output (I&O), revised 8/2025, the P&P indicated it was the policy of the facility to maintain an intake and output record when needed to monitor residents for adequate fluid balance and dialysis residents I&O monitoring is indefinite unless ordered by the medical doctor (MD) to discontinue. The P&P also indicated licensed staff will document fluids consumed in appropriate area of I&O sheet for each shift.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to promote dignity and respect for two (2) of 23 sampled residents (Resident 71 and 72) reviewed for dignity, in accordance with the facility's policy when: On 6/23/2026 and 6/24/2026, facility staff did not ensure Resident 71 was not drooling while in the dining room and hallway, where the resident was visible to the visitors and other residents while the resident is in the dining room and in the hallway. 2. On 6/24/2026 and 6/25/2026, facility staff did not ensure Resident 72's meal trays were served within the facility's scheduled mealtimes. These deficient practices have the potential to affect Residents 71 and 72 sense of self-worth and self-esteem, which could negatively impact their emotional and mental well^being Findings:1. During a review of Resident 71's admission Record, the admission Record indicated Resident 71 was admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included hemiplegia (paralysis of one side of the body) hemiparesis (weakness on one side of the body) cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area) affecting left non-dominant side, dysphagia (difficulty swallowing), diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels), and hypertension (high blood pressure) During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 5/3/2026, the MDS indicated Resident 2 has severely impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 2 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in eating, toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, lying to sitting on side of bed and tub/ shower transfer. During a review of Resident 71's Minimum Data Set (MDS, a resident assessment tool) dated 5/15/2026, the MDS indicated Resident 71 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 71 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds the trunk or limbs, and provides more than half the effort) when eating, oral hygiene, upper body dressing, roll left and right, sit to lying, lying to sitting on the side of the bed. It also indicated Resident 71 also was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, chair/ bed-to-chair transfer and tub/ shower transfer. During an observation on 6/23/2026 at 12:35 PM in the dining room, Resident 71 was sitting on her wheelchair while at the back of the dining room. Resident 71 was drooling on her shirt and holding a rolled hand towel on her contracted (a condition where the fingers or palm of the hand become permanently bent or curled) left hand. Licensed Vocational Nurse 4 (LVN 4) stated Resident 71's shirt was already wet from the resident's' drool. Resident 71 lunch tray was not on the table while other residents were already eating their lunch. During an observation on 6/24/2026 at 1:09 PM in the hallway, Resident 71 was sitting in her wheelchair, and the resident was drooling and dripping on the resident's chin. There were visitors and residents passing by in the hallway while Resident 71 was sitting in the hallway. During a concurrent observation and interview on 6/24/2026 at 1:12 PM in the hallway with Certified Nursing Assistant (CNA 4), CNA 4 stated Resident 71 was drooling. CNA 4 stated it was not okay that Resident 71 was drooling in the hallway because of dignity, and the facility staff need to make sure Resident 71 is always clean. During an interview on 6/26/2026 at 10:09 AM with Director of Staff Development (DSD), DSD stated the staff were not supposed to let Resident 71 drool on the resident's shirt, particularly when the resident is in the dining room and/ or hallway. DSD stated the staff should wipe the resident's mouth frequently to maintain Resident 71's dignity. 2. During a review of Resident 72's admission Record, the admission Record indicated (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 72 was admitted to the facility on [DATE]. Resident 72's diagnoses included diabetes, hypertension, left foot hallux valgus (bunion- is a condition in which the big toe migrates laterally toward the second toe) and dysphagia (difficulty swallowing). During a review of Resident 72's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were intact. The MDS indicated Resident 72 was independent (resident completes the activity by themself with no assistance from a helper) when eating. The MDS indicated Resident 72 also needed 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) in toileting hygiene, upper and lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/ bed-to-chair transfer, and walking 10 feet. During an interview on 6/24/2026 at 12:44 PM with Resident 72, Resident 72 stated Where is my food, it is almost 1 PM. It was never on time, never. The meal trays were always late. My breakfast arrived at 8:05 AM this morning, it was not on time. Some of the residents received their meals at 7:30 AM. During a concurrent observation and interview on 6/24/2026 at 12:48 PM with CNA 5 inside Resident 72's room, CNA 5 stated for the resident's lunch time the facility staff started giving out trays around 12:15 PM. CNA 5 stated Resident 72's lunch tray was served at 12:48 PM, and it was considered late. CNA 5 stated Resident 72 complained that the resident's meal tray was late and if the meal tray was always late, the resident can feel disrespected and feel frustrated. During an interview on 6/25/26 at 8:01 AM inside Resident 72's room, Resident 72 stated that she received her meal tray for breakfast at 8 AM. Resident 72 stated she ate dinner at 5:25 PM last night and it was almost 15 hours from her last meal. During an interview on 6/25/2026 at 8:02 AM with CNA 6, CNA 6 stated Resident 72 just got the resident's breakfast tray around 8 AM. CNA 6 stated the breakfast tray has to be served around 7:15 AM or the residents will feel hungry and to ensure the food is kept warm. If Resident 72's meal tray was always late, Resident 72 would feel left out and upset. During a concurrent observation and interview 6/25/2026 at 1:16 PM with Resident 72 inside Resident 72's room, Resident 72 was eating her lunch tray. Resident 72 stated she just received her lunch tray less than 10 minutes ago, and whatever system the facility has in the kitchen it was not working, because the resident's meal tray was always late. During an interview on 6/25/2026 at 1:21 PM with Dietary Supervisor (DTS), DTS stated if meal trays were served to the residents later than the posted time the residents can feel hungry, angry or upset. During an interview on 6/26/2026 at 1:10 PM with the Director of Nursing (DON), the DON stated Resident Mealtimes are from 7:15 AM to 7:45 AM for breakfast and 12:15 PM to 12:45 PM for lunch. he DON stated that if residents' meal trays are served after the allotted mealtime, the food can become cold and residents may feel disrespected. The DON explained that delays can cause residents to feel hungry and upset, and Resident 72 could feel frustrated while waiting for her tray. During an interview and record review on 6/26/2026 at 1:12 PM with the DON, the facility's Policy and Procedure (P&P) titled, Meal Times, revised on 12/2014 was reviewed. The P&P indicated the dietary department will provide accurate, efficient and consistent meal service with attractive food served at the appropriate temperature and in a pleasant atmosphere. The DON stated the staff were not following the policy because Resident 72 meal trays were always served late, the food can get cold. During a review of the facility's P&P titled, Quality of Life- Dignity/ Privacy, revised 8/2025, 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, and feelings of self-worth and self-esteem. The P&P indicated residents are treated with dignity and respect at all times and staff are expected to promote dignity and assist residents.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light (device used by residents to call staff for assistance) was within reach for one (1) of three (3) sampled residents (Resident 43) reviewed for environment in accordance with the facility's policy and procedure (P&P).This deficient practice has the potential to place Resident 43 at risk of not having his needs met and not receiving medical care in an emergency. Findings:During a review of Resident 43's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness, human immunodeficiency virus (HIV; a virus that compromises the body's ability to fight diseases), and dementia (a progressive state of decline in mental abilities). During a review of Resident 43's Minimum Data Set (MDS- a resident assessment tool) dated 4/14/2026, the MDS indicated Resident 43 had severely impaired cognitive (ability to think and process information) skills for daily decision making. The MDS indicated Resident 43 was dependent (helper does all the effort) for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 43 required substantial assistance (helper does more than half the effort) for upper body dressing and personal hygiene. The MDS indicated Resident 43 required partial assistance (helper does less than half the effort) for eating and oral hygiene. During a concurrent observation in Resident 43's room and interview on 6/23/2026 at 9:04 AM, Resident 43 was observed lying on his bed. Resident 43 stated that he cannot find his call light. During a concurrent observation and interview on 6/23/2026 at 9:05 AM with Certified Nursing Assistant 1 (CNA1), Resident 43 was observed in bed with his call light tucked behind his back. CNA 1 stated that the call light was tucked under Resident 43's back. CNA 1 stated that if Resident 43 cannot locate his call light, he is unable to call for help when in distress. CNA 1 stated that Resident 43 could experience a medical emergency, such as difficulty breathing, and would not receive timely assistance if his call light is not within reach. CNA 1 stated that Resident 43's condition could worsen if he is unable to call for help. During a concurrent interview and record review on 6/26/2026 at 11:54 AM with the Director of Nursing (DON), the facility's P&P titled, Call Light/Bell, revised 1/2025 was reviewed. The P&P indicated:It is the policy of this facility to provide the resident a means of communication with nursing staff.The call light is to be immediately within reach when a resident is in bed.The DON stated that the policy indicated the call light must be in reach while the resident is in bed. The DON stated that it is important for the call light to be in reach of residents so they may be able to call for help and get assisted, especially during an emergency.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a clean, comfortable, sanitary, and homelike environment for one (1) of three (3) sampled residents (Resident 57) reviewed for environment. On 6/23/2026, Resident 57's room was observed with a pillow and clothes on the floor near the trash can, a used/soiled diaper on the floor in front of Resident 57, and a green hairbrush on the resident's lunch tray. This deficient practice caused an unsanitary and unsafe environment and had the potential for Resident 57 to be placed at risk of infection and/ or injury.Findings:During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was originally admitted to the facility on [DATE]. The admission record also indicated Resident 57's diagnoses included dementia (a progressive state of decline in mental abilities), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry). During a review of Resident 57's Minimum Data Set (MDS - a resident assessment tool), dated 6/13/2026, the MDS indicated Resident 57 has severely impaired (never/rarely made decisions) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 57 required partial/moderate assistance (helper does less than half the effort) with eating and oral hygiene and Resident 57 required substantial/maximal assistance (helper does more than half the effort. helper lifts or holds trunks or limbs and provides more than half the effort) with upper body dressing. The MDS indicated Resident 57 was dependent (helper does all the of the effort) with toileting, showering, lower body dressing, and putting on/taking off footwear. During a review of Resident 57's care plan focusing on Resident 57's risk for further decline in Activities of Daily Living (ADL), initiated on 6/9/2026, the care plan indicated an intervention to provide safe and uncluttered environment. During a review of Resident 57's care plan focusing on medications of schizoaffective disorder, manifested by throwing food and utensils at staff/floor, initiated on 6/11/2026, the care plan indicated an intervention to monitor behavior of throwing food/utensils at staff/floor every shift. During dining observation on 6/23/2026 at 1:35 PM, in Resident 57's room, Resident 57 was observed sitting on wheelchair, watching television (TV) with lunch tray on top of a bedside table in front of Resident 57. Scattered clothes and a pillow were observed on the floor near a trashcan on the front right side of Resident 57's. Used/soiled diaper that is coiled with Resident 57's pants on the floor was observed in front of Resident 57's wheelchair, and a green hairbrush was observed on top of Resident 57's lunch tray. During an interview on 6/24/2026 at 1:06 PM, with Registered Dietitian (RD), RD stated Resident 57 did not have a clean and clutter free environment on 6/23/2026 and the resident should have a clean and clutter free environment. RD stated all residents should be provided with clean and safe environment because it could potentially be a hazard and is not homelike for the resident. During an interview on 6/26/2026 at 8:06 AM with Registered Nurse 2 (RN 2), RN 2 stated all residents' rooms should always be clean and sanitary to prevent infection. RN 2 stated Resident 57 was not clean and should have been provided with a clean and homelike environment during lunch meal on 6/23/2206. There were a pillow and clothes scattered on the floor near the trashcan, Resident 57's used diaper was on the floor in front of Resident 57's wheelchair, and a hairbrush was on Resident 57's lunch tray. During a review of Facility's Policy and Procedure (P&P) titled Homelike Environment, dated 2001, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The P&P indicated the facility staff, and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. The characteristics included the following:Clean, sanitary, orderly environment.Clean bed and bath linens that are in good condition.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide podiatry (prevention, diagnosis, and treatment of disorders affecting the foot, ankle, and lower limb) services for one (1) of 1 sampled resident (Resident 82) as indicated in the physician's order and facility's policy and procedure. This deficient practice had the potential for Resident 82 to develop foot and skin issues/complications and had the potential to negatively affect the resident's quality of life and self-esteem.Findings:During a review of Resident 82's admission Record, the admission Record indicated Resident 82 was admitted to the facility on [DATE]. Resident 82's diagnoses included lymphedema (a chronic disease marked by the increased collection of lymphatic fluid in the body, causing swelling, which can lead to skin and tissue changes), cellulitis (a bacterial infection that enters the skin and tissue through a wound) of the bilateral lower extremities, gastroenteritis (inflammation of the stomach and intestines, causing pain, vomiting and diarrhea), and generalized muscle weakness During a review of Resident 82's Minimum Data Set (MDS, a resident assessment tool), dated 6/29/2026, the MDS indicated the resident's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making were moderately impaired. The MDS indicated Resident 82 required supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 82 also needed 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, roll left and right, sit to lying, and lying to sitting on the side of the bed. The MDS indicated Resident 82 required substantial/maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) with toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, sit to stand, and chair/ bed-to-chair transfer. During a concurrent observation in Resident 82's room and interview on 6/23/2026 at 9:39 AM, Resident 82 was sitting up in bed watching videos on his cellphone. Resident 82 showed his bilateral lower extremities, which showed thick, yellowish toenails on both feet. Resident 82 stated, I wanted to see a podiatrist. I informed all the staff. I wanted him (podiatrist) to check my feet and cut my toenails; they are long, thick, and growing upward. I cannot reach them. During an interview on 6/23/2026 at 9:45 AM, Resident 82 stated that a podiatrist visited the facility on 6/20/2026. The podiatrist saw his roommate but did not speak with Resident 82. Resident 82 stated that he asked Registered Nurse Supervisor 2 (RNS 2) if the podiatrist could speak with him, but RNS 2 said no, which made him feel frustrated. Resident 82 stated he simply wanted the podiatrist to examine his feet and provide information. During an interview on 6/25/2026 at 11:03 AM, RNS 2 stated the podiatrist came to the facility on Saturday, 6/20/2026. Resident 82 asked her to request that the podiatrist check his feet and speak with him. RNS 2 asked the podiatrist, but Resident 82 was not on the list of residents scheduled to be seen. RNS 2 stated she did not endorse Resident 82's request to the next shift and did not inform Resident 82 that he was not included on the podiatry list for that day. Resident 82 had thick, long, yellowish toenails on both feet. During an interview on 6/25/2026 at 11:09 AM, RNS 2 stated she did not inform any other staff of Resident 82's podiatry request and did not document it in the communication book. RNS 2 stated she did not initiate a podiatry consultation request for Resident 82 and did not follow up with the Social Services Director (SSD). RNS 2 stated that if a resident requests a consultation, it must be endorsed to the SSD, or the resident will not be seen by the podiatrist. During a concurrent interview and record review on 6/26/2026 at 12:58 PM with the Director of Nursing (DON), Resident 82's Care Plan (CP) for podiatry consult dated 6/18/2026 was reviewed. The CP interventions indicated:Provide evaluation for referralPodiatry consult, as neededInstruct/show resident the proper techniqueUtilize medication for infection as orderedPerform with assist The DON stated the licensed staff should have left a follow-up note for the SSD in the (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communication book for Resident 82 to be seen by the podiatrist to avoid delay of treatment. During a concurrent interview and record review on 6/26/2026 at 1:01 PM with the DON, the facility's Policy and Procedure (P&P) titled, Ancillary Services dated 8/2024 was reviewed. The P&P indicated to ensure that all ancillary services provided to residents are safe, appropriate. timely, and compliant with applicable federal, state0 and local laws and regulations. These services may include but are not limited to:Physical therapy (PT, is a medical treatment used to restore functional movements, such as standing, walking, and moving different body parts),Occupational therapy (OT, use of self-care and work and play activities to promote and maintain health, prevent disability, increase independent function, and enhance development) Speech therapy (evaluates and treats communication disorders, cognitive-communication issues, and swallowing difficulties)Pharmacy Services (compounding and dispensing of medications. It also includes more modern services related to health care including clinical services, reviewing medications for safety and efficacy, and providing drug information with patient counselling)Laboratory Services Radiology/ImagingPodiatryOptometry (the practice or profession of examining the eyes for visual defects and prescribing corrective lenses),and Dental (the care and treatment of teeth) ServicesThe P&P also indicated ancillary services must be provided within reasonable time frames. The DON stated there was a miscommunication among staff and that RNS 2 did not timely communicate the information, resulting in a delay in podiatry services for Resident 82. This delay negatively affected Resident 82's emotions and self˜esteem.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide oxygen therapy (treatment that provides supplemental, or extra oxygen) as indicated in the physician's order for one (1) of one sampled residents (Resident 5) reviewed for respiratory and oxygen in accordance with the facility's policy and procedures (P&P). This deficient practice had the potential to place Resident 5 at risk for shortness of breath (SOB) or hyperoxia (breathing excess oxygen) which could trigger oxygen toxicity (or poisoning, is damage to the lungs that happens from breathing in too much oxygen. It can cause coughing, trouble breathing, and even death in severe cases) that can lead to irreversible damages of health and/or death.Findings:During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE]. The admission record indicated Resident 5's diagnoses included cirrhosis of the liver (is permanent scarring that damages your liver and interferes with its functioning) and history of stage II pressure ulcer (is one that has progressed to affect both the top and bottom layers of the skin but has not yet affected the fatty tissue beneath) of the left buttock, and anxiety disorder (mental health condition marked by persistent excessive worry, fear, or nervousness that interferes with daily life). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool) dated 4/13/2026. The MDS indicated Resident 5 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 5 was dependent in oral hygiene, toileting hygiene, shower/ bathe self, lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying-to-sitting on the side of the bed, and chair/ bed-to-chair transfer, and tub/ shower transfer. During a review of Resident 5's Physician Orders dated 4/1/2026, the PO indicated Oxygen at 2 liters per minute (lpm, unit of measurement) via nasal cannula (a lightweight, flexible tube used to deliver supplemental oxygen to people with breathing difficulties) continuously for SOB, respiratory distress, can titrate to 5 lpm via nasal cannula or mask, to monitor for oxygen saturation (SpO2, is a measurement of how much oxygen your blood is carrying as a percentage of the maximum it could carry. Normal value is 95% to 100%) if greater than (>) 92% to check oxygen saturation every shift. During an observation on 6/23/2026 at 10:15 AM inside Resident 5's room, Resident 5 was sleeping and using an oxygen machine (oxygen concentrator, a medical device that gives extra oxygen by taking and filtering air from the surroundings) that was set at more than (>) 5 lpm via nasal cannula. During a concurrent observation and interview on 6/23/2026 at 10:20 AM with Licensed Vocational Nurse 3 (LVN 3) inside Resident 5's room, oxygen machine was set at more than 5 lpm, and the oxygen machine was beeping and had an orange light on. LVN 3 came inside the room and looked at Resident 5's oxygen machine and stated Resident 5's oxygen level was higher than 5 lpm. During an interview on 6/24/2026 at 12:58 PM with LVN 3, LVN 3 stated Resident 5's oxygen machine was set incorrectly yesterday (6/23/2026 at 10:20 AM), and it was set up more than 5 lpm. LVN 3 did not answer when asked what would happen to Resident 5 if the resident was receiving oxygen for >5lpm. During an interview on 6/24/2026 at 1:01 PM with Registered Nurse Supervisor RNS 1 (RNS 1), RNS 1 stated the oxygen setting was higher than 5 lpm, Resident 5 will possibly feel drowning from receiving too much oxygen. During a concurrent observation and interview on 6/24/2026 at 1:03 PM with the Director of Nursing (DON) inside Resident 5's room, the DON stated Resident 5's oxygen machine was set up incorrect, it was more than 5 lpm. The DON stated Resident 5's lungs can possibly collapse from receiving too much oxygen. The DON also stated the licensed staff should check the oxygen machine every time they do rounds, when they give medicine and every 2 hours. During a concurrent interview and record review on 6/26/2026 at 12:35 AM with the DON, Resident 5's Treatment Administration Record (TAR, is a structured document used to track the administration of medications, treatments, or interventions, ensuring accuracy, safety, and compliance in patient care) dated 6/1/2026 to 6/26/2026 was reviewed. The TAR indicated no (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation of Resident 5's oxygen saturation and level of oxygen administered every shift on the following dates:6/7/2026, 6/9/2026, 6/10/2026, 6/14/2026, 6/15/2026 for the night shift, 6/8/2026, 6/9/2026, 6/10/2026 for evening shift and6/14/2026 for morning shiftThe DON stated the licensed staff should be monitoring Resident 5's oxygen saturation and level of oxygen administered every shift and should be documented it in the TAR. The TAR had incomplete documentation from the staff, the TAR was missing oxygen saturation documentation and the level of oxygen administered to the resident. If the TAR was inaccurate and incomplete, the licensed staff did not follow the physician's order. If the licensed staff were not following PO, they did not monitor Resident 5's oxygen saturation every shift, and there's no documentation that the correct amount of oxygen was being given to the resident. During a concurrent interview and record review on 6/26/2026 at 12:41 PM with the DON, Resident 5's Care Plan (CP) for continuous oxygen therapy dated 4/1/2026 was reviewed. The CP interventions did not include goals and interventions such as assessments, monitoring signs and symptoms (s/s) respiratory distress like shortness of breath and monitoring oxygen saturation every shift. The DON stated the CP interventions were incomplete because they were missing goals and interventions. The DON stated the CP interventions should include assessments, monitoring signs and symptoms (s/s) respiratory distress like shortness of breath, monitoring of the resident's oxygen saturation every shift and checking oxygen setting. During a concurrent interview and record review on 6/26/2026 at 12:46 PM with the DON, the facility's Policy and Procedure (P&P) titled Oxygen Administration revised on 10/2010 was reviewed. The P&P indicated after completing oxygen set up or adjustment, the following information should be recorded in the resident's medical record:the rate of oxygen flow, route and rationalethe frequency and duration of the treatment.All assessment data obtained before, during and after the procedure.The DON stated the licensed staff did not follow the policy because there were no documentation and monitoring of Resident 5's oxygen saturation and level of oxygen administered to the resident every shift.

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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 six (6) sampled residents (Resident 23 and 2) observed during medication administration as indicated on the physician's order and facility policy and procedure (P&P) when:1. Licensed Vocational Nurse 3 (LVN) 3 failed to administer Resident 23's levetiracetam (Keppra, medication used to prevent seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), metformin (medication used to control blood sugar levels), and escitalopram (Lexapro; medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]) on time.This deficient practice had the potential to cause Resident 23's medical conditions to not be treated effectively.2. LVN 2 failed to administer Resident 2's metoprolol (medication to treat or prevent hypertension [high blood pressure]) with breakfast on 6/25/2026.This deficient practice had the potential to result in damaging Resident 2's esophagus (muscular tube that connects the throat to the stomach) and irritating the resident's stomach lining which may cause nausea, cramps, vomiting, or diarrhea (condition of having loose, watery stool at least three or more times in a single day, or more frequently). Findings: 1. During a review of Resident 23's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures). During a review of Resident 23's Minimum Data Set (MDS- a resident assessment tool), dated 5/25/2026, the MDS indicated Resident 23 had intact cognitive (ability to think and process information) skills for daily decision making. The MDS indicated Resident 23 was dependent (helper does all the effort) for eating, oral hygiene, toileting hygiene, showering, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 23's Physician's Orders, dated 1/31/2025 to 6/26/206 the Physician's Orders indicated the following: Keppra 750 milligrams (mg, unit of measure for medications) 2 times a day for epilepsy, ordered on 2/25/2026. Lexapro 10 mg one time a day for major depressive disorder, ordered on 4/8/2025. Metformin 500 mg one time a day for diabetes, ordered on 10/24/2025. During a review of Resident 23's Medication Administration Record (MAR; a record of medications ordered for a resident which includes time medications are due), dated 6/1/2026 to 6/30/2026, the MAR indicated Resident 23 was ordered Keppra, metformin and Lexapro and they are to be administered at 9 AM every day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/25/2026 at 10:12 AM with LVN 3, LVN 3 was observed getting ready to administer medications to Resident 23 in Resident 23's room. LVN 3 stated that Resident 23's Keppra, Lexapro and metformin were due at 9 AM but she is going to give them late. LVN 3 stated that medications can be given one hour after the time they are due and that it has been over an hour since the medications were due. LVN 3 stated that medications will not treat the resident's conditions effectively if they are given late. During a concurrent interview and record review on 6/26/2026 at 12:14 PM with the Director of Nursing (DON), the facility's P&P titled, P&P in Medication Administration, revised 1/2025 was reviewed. The P&P indicated: Medications shall be administered in accordance with our established P&P Medications must be administered within one hour before or after administration time per MD order. The DON stated medications must be administered at the latest, one hour after they are due. The DON stated that a resident's medical conditions will not be controlled if medications are given late. The DON stated that if a resident has DM, their blood sugar might not be controlled. The DON stated that if a resident has epilepsy, they may have seizures. The DON stated that if a resident has depression, they may feel more depressed. 2. During a review of Resident 2's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE], with diagnosis of muscle weakness, hypertension (high blood pressure), and atherosclerotic heart disease (ASHD, occurs when fat builds up restricts blood flow to the heart). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had modified independence (some difficulty in new situations only) with cognitive skills for daily decision making. The MDS indicated Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 2 was dependent on toileting hygiene, shower, lower body dressing, and putting on/taking off footwear. During a review of Resident 2's Order Summary Report, dated 6/24/2026, the Order Summary Report indicated a physician's order, dated 4/16/2026 for metoprolol extended release 25 milligrams (mg, unit of measurement), by mouth, one time a day for hypertension, hold for systolic blood pressure (top or higher number in blood pressure reading) less than 110 and heart rate less than 60. It also indicated to give with breakfast. During a review of Resident 2's Nurse Progress Notes, dated 6/25/2026 timed 2:58 PM, documented by Licensed Vocational Nurse 2 (LVN 2), the Nurse Progress Notes indicated metoprolol was administered at 9:44 AM instead of 7:15 AM. Awaiting response from doctor. During a medication administration observation in Resident 2's room on 6/25/2026 at 9:44 AM, LVN 2 administered metoprolol 25 mg oral tablet to Resident 2 without breakfast or any food. During an interview on 6/25/2026 at 9:50 AM with LVN 2 , LVN 2 stated she did not administer (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2's metoprolol medication with breakfast meal and did not offer food or snack during metoprolol medication administration to Resident 2. During an interview on 6/25/2026 at 11:13 AM with Registered Nurse 2 (RN 2), RN 2 stated that LVN 2 did not administer Resident 2's, metoprolol medication with breakfast. RN 2 stated it was important to administer medication as ordered to get the full benefit of the medication and to prevent stomach upset. During an interview on 6/25/2026 at 2:50 PM with RNS 1, RNS 1 stated medications that were ordered to be given with food should be followed because these medications might cause stomach upset or medication might not be effective. RNS 1 stated Resident 2's metoprolol medication order should have been given with breakfast meal at 7:15 AM. During a review of the facility's Policy and Procedure (P&P) titled, Policy and Procedure in Medication Administration, revised on January 2025, the P&P indicated all medications will be administered following the scheduled medication administration routine unless otherwise specified by doctor which is different from routine medication administration schedule.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a Medication Regimen Review (MRR, also known as a Drug Regimen Review-is a structured, comprehensive evaluation of all medications a resident is taking, conducted typically by a pharmacist to ensure medications are appropriate, safe, effective, and used correctly) to identify and follow up on an irregularity (includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy) for two (2) of five (5) sampled residents (Resident 22 and Resident 57) reviewed for unnecessary medications in accordance with the facility's policy and procedure (P&P) by failing to ensure: 1. Resident 22 was monitored for the use of montelukast (a medication to treat lung inflammation), including required monitoring for its black box warning (BBW, serious, life-threatening side effects). 2. Resident 57's Donepezil hydrochloride (HCL) (Aricept, a medication used to treat the symptoms of dementia [a progressive state of decline in mental abilities]) order had the correct indication for use. These deficient practices increased Residents 22 and 57's risk to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to their medication therapy, potentially leading to impairment or decline in their mental, functional, and psychosocial wellbeing. Findings: 1. During a review of Resident 22's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and cardiomegaly (enlarged heart). During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool), dated 6/7/2026, the MDS indicated Resident 22 had intact cognitive (ability to think and process information) skills for daily decision making. The MDS indicated Resident 22 was independent for eating, oral hygiene, toileting hygiene, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MD indicated Resident required supervision (requires oversight, encouragement, or cueing from staff) for showering. During a review of Resident 22's Order Summary Report, dated 4/19/2026, the Order Summary Report indicated Resident 22 was ordered montelukast. During a review of Resident 22's MRR, dated 5/1/2026 to 5/18/2026, the MRR indicated that Resident 22 was receiving montelukast and required monitoring for a black box warning. The MRR indicated to monitor for these behaviors in the care plan. During a concurrent interview and record review on 6/26/2026 at 8:39 AM with Registered Nurse Supervisor 1 (RNS 1), Resident 22's care plans, dated 2/28/2026 to 6/26/2026 were reviewed. RNS 1 stated Resident 22 does not have a CP for monitoring the BBW side effects of montelukast. RNS 1 stated that Resident 22 should have a CP for BBW monitoring to prevent Resident 22 from experiencing life threating side effects, worsening conditions and possible hospitalization. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/26/2026 at 12:11 PM with the Director of Nursing (DON), the facility's P&P titled, Medication Regimen Reviews (MRR), dated 2001 and the facility's P&P titled, Black Box Warning (BBW), (undated) was reviewed. The MRR P&P indicated: The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medications errors and other irregularities such as inadequate monitoring for adverse consequences and potentially significant medication related adverse consequences or actual signs and symptoms that could represent adverse consequences. The BBW P&P indicated: The BBW is utilized for safe drug prescribing and administration to residents. A BBW means that medical studies indicate that the drug carries a significant risk of serious or even life-threatening adverse effects. The DON stated that MRR recommendations for BBW side effects monitoring must be followed to prevent the resident from having serious life-threatening side effects as mentioned in the policy. 2. During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was originally admitted to the facility on [DATE]. The admission record also indicated Resident 57's diagnoses included dementia, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry). During a review of Resident 57's MDS, dated [DATE], the MDS indicated Resident 57 has severely impaired (never/rarely made decisions) cognitive skills for daily decision making. The MDS indicated Resident 57 required partial/moderate assistance (helper does less than half the effort) with eating and oral hygiene. The MDS indicated Resident 57 required substantial/maximal assistance (helper does more than half the effort. helper lifts or holds trunks or limbs and provides more than half the effort) with upper body dressing. The MDS indicated Resident 57 was dependent (helper does all the of the effort) with toileting, showering, lower body dressing, and putting on/taking off footwear. The MDS indicated a diagnosis of dementia. During a review of Resident 57's Order Summary Report dated 6/25/2026, timed 4:31 PM, the Order Summary Report indicated an order on 6/9/2026 for Donepezil HCL oral tablet 5 milligrams (mg, unit of measurement), give 1 tablet by mouth at bedtime for cognitive impairment (problems with memory, learning, concentration, or decision-making). During a review of a facility's record titled, Consultant Pharmacist's Medication Regimen Review, dated 6/24/2026, the record indicated listing of residents reviewed with no pharmacy consultant (PC, provides expert guidance on medication therapy, facility operations, and regulatory compliance) recommendation between 6/1/2026 and 6/24/2026. Resident 57 was included in the list of residents (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed without any pharmacy consultant recommendations. During a concurrent record review and interview on 6/26/2026 at 8:34 AM with Registered Nurse 2 (RN 2), Resident 57's donepezil HCL order dated 6/9/2026 was reviewed. RN 2 verified Resident 57 has an order for donepezil for cognitive impairment, ordered on 6/9/2026. RN 2 stated the diagnosis of cognitive impairment as an indication for the use of donepezil HCL was incorrect because it should have been for Resident 57's diagnosis of dementia. RN 2 stated the facility's PC conducted the medication regimen review with no recommendation for Resident 57. RN 2 stated, Resident 57's donepezil HCL order did not and should have a clarification of order recommendation from the PC. During a concurrent record review and interview on 6/26/2026 at 11:51 AM with RNS 1, Resident 57's donepezil order dated 6/9/2026 was reviewed. RNS 1 verified Resident 1 has an order for donepezil HCL for cognitive impairment, ordered on 6/9/2026. RNS 1 stated that having an accurate diagnosis as the indication for any medication is essential to ensure the resident receives the correct medication for the correct purpose. RNS 1 stated This should have been captured in the MRR. The pharmacy consultant should have a recommendation to clarify the order, to indicate the diagnosis of dementia. During a concurrent record review and interview on 6/26/2026 at 11:54 AM with the facility PC, Consultant Pharmacist's Medication Regimen Review, dated 6/24/2026 and Resident 57's donepezil order dated 6/9/2026 was reviewed. PC verified that he reviewed Resident 57's medication orders with no recommendation. PC stated that Resident 57 has diagnosis of dementia, and not cognitive impairment. PC stated that he should have had a recommendation to clarify the order of donepezil, to indicate the diagnosis of dementia. During a review of Facility's P&P titled, Medication Regimen Review, dated 2001, the P&P indicated MRR report contains the identified irregularity and the pharmacist recommendation. The P&P also indicated an irregularity refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences. During a review of Facility's P&P titled, Policy and Procedures on Unnecessary Drugs, revised on July 2012, the P&P indicated to carry out medications as Doctor's order with medication dosage, route, frequency and diagnosis to justify medication used.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident 57) were free from unnecessary drug (any drug when used without adequate indications for its use by failing to have accurate indication for the use of donepezil hydrochloride (prescription medication used to treat the symptoms of dementia [a progressive state of decline in mental abilities]). This deficient practice had the potential to place Residents 57 at risk for significant adverse (harmful) consequences from the use of unnecessary drug.Findings: During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was originally admitted to the facility on [DATE]. The admission record also indicated Resident 57's diagnoses included dementia, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry). During a review of Resident 57's Minimum Data Set (MDS - a resident assessment tool), dated 6/13/2026, the MDS indicated Resident 57 has severely impaired (never/rarely made decisions) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 57 required partial/moderate assistance (helper does less than half the effort) with eating and oral hygiene. The MDS indicated Resident 57 required substantial/maximal assistance (helper does more than half the effort. helper lifts or holds trunks or limbs and provides more than half the effort) with upper body dressing. The MDS indicated Resident 57 was dependent (helper does all the of the effort) with toileting, showering, lower body dressing, and putting on/taking off footwear. The MDS indicated a diagnosis of dementia. During a review of Resident 57's Order Summary Report dated 6/25/2026, timed 4:31 PM, the Order Summary Report indicated an order on 6/9/2026 for donepezil hydrochloride (HCL) (Aricept) oral tablet 5 milligrams (mg, unit of measurement), give 1 tablet by mouth at bedtime for cognitive impairment (problems with memory, learning, concentration, or decision-making). During a concurrent record review and interview on 6/26/2026 at 8:33 AM with Registered Nurse 2 (RN 2), Resident 57's donepezil HCL order dated 6/9/2026 was reviewed. RN 2 verified Resident 57 has an order for donepezil for cognitive impairment, ordered on 6/9/2026. RN 2 stated the diagnosis of cognitive impairment as an indication for the use of donepezil HCL was incorrect because it should have been for Resident 57's diagnosis of dementia. RN 2 stated that it was important to have the correct diagnosis or use of a medication to ensure it is being administered appropriately. During a concurrent record review and interview on 6/26/2026 at 11:50 AM with Registered Nurse Supervisor 1 (RNS 1), Resident 57's donepezil order dated 6/9/2026 was reviewed. RNS 1 verified Resident 57 has an order for donepezil HCL for cognitive impairment, ordered on 6/9/2026. RNS 1 stated that having an accurate diagnosis as the indication for any medication is essential to ensure the resident receives the correct medication for the correct purpose. During a review of Facility's Policy and Procedure (P&P) titled, Policy and Procedures on Unnecessary Drugs, revised on July 2012, the P&P indicated to carry out medications as Doctor's order with medication dosage, route, frequency and diagnosis to justify medication used.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 rate was less than five (5) percent (%). Four (4) medication errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/ manufacturer's specifications / accepted professional standards and principles) out of 27 total opportunities (observed administered medications) for error, to yield an overall medication error rate of 14.81 % for two (2) of six (6) sampled residents (Resident 2 and Resident 23) observed for medication administration.1. Licensed Vocational Nurse 3 (LVN) 3 failed to administer Resident 23's levetiracetam (Keppra, medication used to prevent seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), metformin (medication used to control blood sugar levels), and escitalopram (Lexapro, medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]) on time on 6/25/2026 in accordance with the physician's order and facility's policy and procedure (P&P).This deficient practice had the potential to cause Resident 23's medical conditions to not be treated effectively.2. LVN 2 failed to administer Resident 2's metoprolol (medication to treat or prevent hypertension [high blood pressure]) with breakfast on 6/25/2026 in accordance with the physician's order and P&P. This deficient practice had the potential to result in damaging Resident 2's esophagus (muscular tube that connects the throat to the stomach) and irritating the resident's stomach lining which may cause nausea, cramps, vomiting, or diarrhea (condition of having loose, watery stool at least three or more times in a single day, or more frequently). Findings: 1. During a review of Resident 23's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures). During a review of Resident 23's Minimum Data Set (MDS- a resident assessment tool), dated 5/25/2026, the MDS indicated Resident 23 had intact cognitive (ability to think and process information) skills for daily decision making. The MDS indicated Resident 23 was dependent (helper does all the effort) for eating, oral hygiene, toileting hygiene, showering, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 23's Physician's Orders, dated 1/31/2025 to 6/26/206 the Physician's Orders indicated the following: Keppra 750 milligrams (mg, unit of measure for medications) 2 times a day for epilepsy, ordered on 2/25/2026. Lexapro 10 mg one time a day for major depressive disorder, ordered on 4/8/2025. Metformin 500 mg one time a day for diabetes, ordered on 10/24/2025. During a review of Resident 23's Medication Administration Record (MAR; a record of medications (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered for a resident which includes time medications are due), dated 6/1/2026 to 6/30/2026, the MAR indicated Resident 23 was ordered Keppra, metformin and Lexapro and they are to be administered at 9 AM every day. During a concurrent observation and interview on 6/25/2026 at 10:12 AM with LVN 3, LVN 3 was observed getting ready to administer medications to Resident 23 in Resident 23's room. LVN 3 stated that Resident 23's Keppra, Lexapro and metformin were due at 9 AM but she is going to give them late. LVN 3 stated that medications can be given one hour after the time they are due and that it has been over an hour since the medications were due. LVN 3 stated that medications will not treat the resident's conditions effectively if they are given late. During a concurrent interview and record review on 6/26/2026 at 12:14 PM with the Director of Nursing (DON), the facility's P&P titled, P&P in Medication Administration, revised 1/2025 was reviewed. The P&P indicated: Medications shall be administered in accordance with our established P&P Medications must be administered within one hour before or after administration time per MD order. The DON stated medications must be administered at the latest, one hour after they are due. The DON stated that a resident's medical conditions will not be controlled if medications are given late. The DON stated that if a resident has DM, their blood sugar might not be controlled. The DON stated that if a resident has epilepsy, they may have seizures. The DON stated that if a resident has depression, they may feel more depressed. 2. During a review of Resident 2's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE], with diagnosis of muscle weakness, hypertension (high blood pressure), and atherosclerotic heart disease (ASHD, occurs when fat builds up restricts blood flow to the heart). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had modified independence (some difficulty in new situations only) with cognitive skills for daily decision making. The MDS indicated Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating. The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 2 was dependent on toileting hygiene, shower, lower body dressing, and putting on/taking off footwear. During a review of Resident 2's Order Summary Report, dated 6/24/2026, the Order Summary Report indicated a physician's order, dated 4/16/2026 for metoprolol extended release 25 milligrams (mg, unit of measurement), by mouth, one time a day for hypertension, hold for systolic blood pressure (top or higher number in blood pressure reading) less than 110 and heart rate less than 60. It also indicated to give with breakfast. During a review of Resident 2's Nurse Progress Notes, dated 6/25/2026 timed 2:58 PM, documented by Licensed Vocational Nurse 2 (LVN 2), the Nurse Progress Notes indicated metoprolol was administered at 9:44 AM instead of 7:15 AM. Awaiting response from doctor. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication administration observation in Resident 2's room on 6/25/2026 at 9:44 AM, LVN 2 administered metoprolol 25 mg oral tablet to Resident 2 without breakfast or any food. During an interview on 6/25/2026 at 9:50 with LVN 2, LVN 2 stated she did not administer Resident 2's metoprolol medication with breakfast and did not offer food or snack during metoprolol medication administration to Resident 2. During an interview on 6/25/2026 at 11:13 AM with Registered Nurse 2 (RN 2), RN 2 stated that LVN 2 did not administer Resident 2's, metoprolol medication with breakfast. RN 2 stated it was important to administer medication as ordered to get the full benefit of the medication and to prevent stomach upset. During an interview on 6/25/2026 at 2:50 PM with Registered Nursing Supervisor 1 (RNS 1), RNS 1 stated medications that were ordered to be given with food should be followed because these medications might cause stomach upset or medication might not be effective. RNS 1 stated Resident 2's metoprolol medication order should have been given with breakfast meal at 7:15 AM. During a review of the facility's Policy and Procedure (P&P) titled, Policy and Procedure in Medication Administration, revised on January 2025, the P&P indicated all medications will be administered following the scheduled medication administration routine unless otherwise specified by doctor which is different from routine medication administration schedule.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow its policy and procedure (P&P) to ensure two (2) of six (6) sampled residents (Resident 23 and 2) observed during medication administration were free from significant medication errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/ manufacturer's specifications / accepted professional standards and principles, which may have cause the resident discomfort or jeopardize health and safety) when:1. Licensed Vocational Nurse 3 (LVN) 3 failed to administer Resident 23's levetiracetam (Keppra, medication used to prevent seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), metformin (medication used to control blood sugar levels), and escitalopram (Lexapro, medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]) on time on 6/25/26 as indicated on the physician's order.This deficient practice had the potential to cause Resident 23's medical conditions to not be treated effectively.2. LVN 2 failed to administer Resident 2's metoprolol (medication to treat or prevent hypertension [high blood pressure]) with breakfast on 6/25/2026 as indicated on the physician's order. This deficient practice had the potential to result in damaging Resident 2's esophagus (muscular tube that connects the throat to the stomach) and irritating the resident's stomach lining which may cause nausea, cramps, vomiting, or diarrhea (condition of having loose, watery stool at least three or more times in a single day, or more frequently). Findings:1. During a review of Resident 23's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures). During a review of Resident 23's Minimum Data Set (MDS- a resident assessment tool), dated 5/25/2026, the MDS indicated Resident 23 had intact cognitive (ability to think and process information) skills for daily decision making. The MDS indicated Resident 23 was dependent (helper does all the effort) for eating, oral hygiene, toileting hygiene, showering, upper/lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 23's Physician's Orders, dated 1/31/2025 to 6/26/206 the Physician's Orders indicated the following:Keppra 750 milligrams (mg, unit of measure for medications) 2 times a day for epilepsy, ordered on 2/25/2026.Lexapro 10 mg one time a day for major depressive disorder, ordered on 4/8/2025.Metformin 500 mg one time a day for diabetes, ordered on 10/24/2025. During a review of Resident 23's Medication Administration Record (MAR; a record of medications ordered for a resident which includes time medications are due), dated 6/1/2026 to 6/30/2026, the MAR indicated Resident 23 was ordered Keppra, metformin and Lexapro and they are to be administered at 9 AM every day. During a concurrent observation and interview on 6/25/2026 at 10:12 AM with LVN 3, LVN 3 was observed getting ready to administer medications to Resident 23 in Resident 23's room. LVN 3 stated that Resident 23's Keppra, Lexapro and metformin were due at 9 AM but she is going to give them late. LVN 3 stated that medications can be given one hour after the time they are due and that it has been over an hour since the medications were due. LVN 3 stated that medications will not treat the resident's conditions effectively if they are given late. During a concurrent interview and record review on 6/26/2026 at 12:14 PM with the Director of Nursing (DON), the facility's P&P titled, P&P in Medication Administration, revised 1/2025 was reviewed. The P&P indicated:Medications shall be administered in accordance with our established P&P.Medications must be administered within one hour before or after administration time per MD order.The DON stated medications must be administered at the latest, one hour after they are due. The DON stated that a resident's medical conditions will not be controlled if medications are given (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	late. The DON stated that if a resident has DM, their blood sugar might not be controlled. The DON stated that if a resident has epilepsy, they may have seizures. The DON stated that if a resident has depression, they may feel more depressed.

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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 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 an accurate and complete medical records for one (1) of 23 sampled residents (Resident 73) in accordance with the facility's policy and procedures (P&P) by failing to document Resident 73's use of low air loss mattress (LALM, designed to distribute the resident's body weight over a broad surface area and help prevent skin breakdown).This deficient practice has the potential to cause Resident 73 to receive inappropriate care. Findings:During a review of Resident 73's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness and stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of sacrum (lower end of the spinal area at the base of the spine). During a review of Resident 73's Minimum Data Set (MDS- a resident assessment tool) dated 5/26/2026, the MDS indicated Resident 73 had intact cognitive (ability to think and process information) ability. The MDS indicated Resident 73 was dependent (helper does all the effort) for showering, toileting hygiene, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 73 required supervision (helper provides verbal cues) for eating, and oral hygiene. The MDS indicated Resident 73 required substantial assistance (helper does more than half the effort) for upper body dressing. The MDS did not indicate Resident 73 was using a pressure reducing device for bed. During a concurrent observation and interview on 6/23/2026 at 9:34 AM with Licensed Vocational Nurse (LVN) 1, Resident 73 was observed in his room on a LALM. LVN 1 stated Resident 73 is on a LALM. During a concurrent interview and record review on 6/23/2026 at 9:36 AM with LVN 1, Resident 73's Order Summary Report dated 4/1/2026 to 6/22/2026 and Resident 73's Nursing Progress Notes dated 4/1/2026 to 6/22/2026 were reviewed. LVN 1 stated Resident 73 does not have an order for LALM and the progress notes did not indicate LALM was used for the resident, but the resident is using a LALM (LVN 1 unable to recall since when). LVN 1 stated LALM use requires an attending physician (MD) order because it is a special treatment for pressure ulcer prevention. During a concurrent interview and record review on 6/26/2026 at 12:05 PM with the Director of Nursing (DON), the facility's P&P titled, Policy and Procedure on Air Loss Mattress, revised 7/2012 was reviewed. The P&P indicated:The purpose of this procedure is to ensure that resident skin integrity is maintained and to aid in healing pressure ulcer.LALM will be applied on the resident's bed as MD order.The DON stated that the policy indicated the use of a LALM requires an MD order. The DON stated it is important to have an order for the LALM so it can be used properly and prevent wounds from getting worse. During a concurrent interview and record review on 6/26/2026 at 12:08 PM with the DON, the facility's P&P titled, Physician Orders and Telephone Orders, revised 8/2025 was reviewed. The P&P indicated:Physician's orders shall be obtained prior to the initiation of any medication or treatment.All orders must be specific and complete.All orders must be specific and complete will all the necessary details to carry out the prescribed order without any questions.The DON stated LALM order should have been obtained for Resident 73 prior to starting the resident on the treatment and the use of the LALM should have been documented in the resident's medical records whether in the resident's progress notes or in the treatment administration record from when the resident was placed on LALM. During a review of the facility's P&P titled, Policy and Procedure on Documentations, revised 1/2025, indicated:It is the policy of the facility to document all pertinent data and information of each resident in their respective medical record.Approaches and interventions are documented in order to help residents minimize problems and in the final course achieve resident goals.

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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 interview and record review, the facility failed to ensure infection prevention measures (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed for two (2) of 23 sampled residents (Residents 9 and 43) by failing to:1. Ensure Certified Nurse Assistant 3 (CNA 3) performed hand hygiene (cleaning hands with the use of alcohol-based hand rubs containing 60%-95% alcohol or hand washing with soap and water) during meal assistance with Resident 43.2. Ensure Resident 9's gastrostomy tube (G-Tube- a surgical opening fitted with a tube to allow feedings to be administered directly to the stomach common for people with swallowing problems) feeding pump (an electronic or battery-powered medical device designed to deliver liquid nutrition, hydration, or medications directly into a resident's stomach) was clean and sanitary during feeding administration. These failures have the potential for Residents 9 and 43 to be at risk for preventable infections related to cross contamination (the physical transfer of harmful bacteria, viruses, or allergens from one person, object, or food to another) from contaminated equipment and/or supplies during provided care and services.Findings:1. During a review of Resident 43's admission Record, the admission Record indicated Resident 43 was admitted to the facility on [DATE] with diagnoses that included adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), generalized muscle weakness and type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 43's Minimum Data Set (MDS- a resident assessment tool), dated 4/14/2026, the MDS indicated Resident 43 had severely impaired (never/rarely made decisions) cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 43 required partial moderate assistance (helper does less than half the effort) with eating and oral hygiene, and dependent (helper does all the effort to complete activity) with toileting, shower/bathing self and lower body dressing. During an observation on 6/23/2026 at 12:32 PM in the facility dining room, Certified Nurse Assistant 3 (CNA 3) was observed moving her (CNA 3's) eyeglasses from her eyes and raising them on her head and then pulling them from her head and down to her head without performing hand hygiene. CNA 3 was then observed grabbing Resident 43's food tray, taking it to Resident 43 and then removing the resident's food container lid and saran wrap (a thin, transparent plastic cling film used to seal and cover food) off the resident's 2 drinking cups. During an interview on 6/23/2026 at 1:07 PM with CNA 3, CNA 3 stated she moved her eyeglasses from her face and head and did not perform hand hygiene before assisting Resident 43 with the resident's food tray and should have performed hand hygiene. CNA 3 stated it was important to ensure hand hygiene is done for infection control to prevent infections or illness form bacteria that may spread. CNA 3 further stated, per facility protocol, hand hygiene should be done between each resident and if the facility staff touch themselves, including touching their hair and eyeglasses. During an interview on 6/26/2026 at 11:49 AM with the Director of Nursing (DON), the DON stated staff need to complete hand hygiene after touching residents, themselves (staff) or anything to prevent cross contamination with a resident's food, which could cause food borne illness (any illness resulting from eating contaminated/spoiled foods) with symptoms including nausea, vomiting, fever, abdominal pain, confusion and diarrhea. During a review of the facility's policy and procedure (P&P) titled, Preventing Foodborne Illness- Food Handling, dated 2001, the P&P indicated food will be stored, prepared and handled and served so that the risk of foodborne illness is minimized. 2. During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing), chronic kidney disease (CKD- a progressive condition where your kidneys are damaged and gradually lose their ability to filter waste and excess fluid from your blood) and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). During a (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	06/26/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident 9's Physician's Order, dated 6/11/2026, the Physician Order indicated Jevity 1.2 calories (cal) oral liquid (a nutritional supplement), give 60 milliliters (ml- a metric unit of measurement for volume)/ hour via G-tube related to encounter for attention to gastrostomy. 60ml/hr x 20 hours on at 2:00 PM off at 10:00 PM. During a review of Resident 9's MDS, dated 6/16/2026, the MDS indicated Resident 9 had severely impaired cognitive skills for daily decision making. The MDS also indicated Resident 9 was dependent with oral, personal and toileting hygiene, shower/bathing self and dressing. The MDS also indicated Resident 9 had a feeding tube. During a concurrent observation and interview on 6/25/2026 at 9:18 AM with Registered Nurse Supervisor (RNS) at Resident 9's bedside, Resident 9's G-Tube pump was observed with dried tan drops on the top and sides of the machine. RNS stated Resident 9's G-Tube pump had dried stains, the same color as the resident's Jevity feeding and the G-Tube pump should not have stains. RNS also stated Resident 9's G-Tube pump was dirty, but per facility policy, the G-Tube pump needed to remain cleaned to prevent bacteria from going to Resident 9. During an interview on 6/26/2026 at 11:29 AM with the DON, the DON stated staff need to maintain cleanliness of the G-Tube pump to prevent cross contamination from the dirty pump into the feeding and/or GT site of the resident. During a review of the facility's P&P titled, Enteral Nutrition (a method of delivering specialized liquid food directly into the gastrointestinal tract): General Guidelines, undated, the P&P indicated the pump, and pump stand should be kept clean by washing with a cloth and nonstaining germicidal agent.