STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055929	A. Building B. Wing	06/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Cove Care Center	1445 Superior Avenue Newport Beach, CA 92663

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to thoroughly investigate an abuse allegation for one of 18 final sampled residents (Resident 105). * Resident 105 reported a night shift staff came to the resident and made the resident feel uncomfortable, to the Case Manager. Resident 105 further reported the night nurse was unpleasant and was rude, to the ADON. This failure placed the resident at risk for potential ongoing abuse, delayed thorough investigation and potential lack of protection of the resident and other residents from potential abuse.Findings: Review of the facility's P&P titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 2001 showed the residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Investigate and report any allegations within timeframes required by federal requirements. On 6/9/26, the CDPH received a complaint with the following allegations: the graveyard nursing staff would wake Resident 105 up by kicking the bed (Resident 105 had a heart condition and the nurse thought it was funny, she was afraid to go to sleep because of fear of retaliation), the facility nurse lied about giving Resident 105 her heart medicine, and gestured to the resident as if she was crazy, Resident 105 would hear staff talking about the residents' personal information in the hallway, and the graveyard nursing staff refused to help the resident to use the restroom and made her wear a diaper, causing her to hold toileting until day shift started. On 6/17/26 at 0802 hours, a phone interview was conducted with Resident 105. Resident 105 stated she reported her complaint to the Case Manager and ADON. Resident 105 stated the ADON told her she would investigate her complaint. The resident further stated she insisted to be discharged from the facility because she could not go to sleep. Resident 105 stated she felt intimidated by the nurse (LVN 5) gestured his finger and circled it around his ear indicating she was crazy, when the resident inquired about her medication. Closed medical record review for Resident 105 was initiated on 6/16/26. Resident 105 was admitted to the facility on [DATE]. Review of Resident 105's H&P examination dated 4/14/26, showed the resident's cognition was normal. Review of Resident 105's MDS assessment dated [DATE], showed resident's BIMS score was 15 which indicated the resident's cognitive capacity was intact. Review of facility's Concern/Grievance Log (undated) showed Resident 105 reported a concern with the nurse's bedside manner. The resolution showed a grievance was offered but the resident refused. The resolved date was 4/21/26 with a comment to continue to check with the resident to confirm improvement. Review of the facility's Risk Management note dated 4/20/26, showed the ADON was summoned to the resident's room due to Resident 105's complaint regarding LVN 5 being rude to her, had an unpleasant personality and was not given her heart medication. Review of a note presented by the DON from a notebook of the Case Manager dated 4/20/26, showed Resident 105 mentioned the night shift nurse was rude to her. Review of the DON's notes presented by the DON dated 4/20/26, showed a list of staff names with 0 mark beside the staff names. The notes failed to show times the staff were interviewed, and had no statements regarding discussion of the investigation. The DON's notes (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	further showed a list of resident names with 0 marked beside the names. The notes failed to show times the residents were interviewed, and had no statements regarding discussion of the investigation. Review of Resident 105's medical record failed to show any documentation of Resident 105's allegation, and failed to show a psychosocial follow up was provided to the resident. On 6/17/26 at 0908 hours, an interview was conducted with the ADON. The ADON stated Resident 105 complained the night nurse was unpleasant, rude, not paying attention to her and had told her the resident did not receive her medication. The ADON stated she informed the DON and would investigate the concern. Review of the facility's SOC 341 dated 6/17/26, showed on 6/17/26 at 0945, the HFEN to the DON, Resident 105 informed CDPH about the following care concerns, including a staff being rude, not giving meds as ordered; a staff kicked her bed to wake her up; a staff gestured indicating that resident is crazy; and a staff told the alleged victim to go to her diaper when she asked for toileting assistance when resident was at the facility. On 6/17/26 at 0947 hours, an interview was conducted with the DON. The DON stated he was informed of Resident 105's complaint. The DON stated when he tried to talk to the resident, the resident had told him that she had already talked to the ADON. On 6/17/26 at 0959 hours, an interview was conducted with the Case Manager. The Case Manager stated Resident 105 verbalized to her that the night shift staff came to the resident and made the resident feel uncomfortable. On 6/17/26 at 1050 hours, an interview was conducted with the Administrator. The Administrator stated he was aware of the resident's concern with regards to a complaint regarding a nurse being rude from the tonality of the nurse and the resident's medication was not properly given. On 6/18/26 at 0945 hours, an interview and concurrent facility document review was conducted with the DON. The DON verified the above findings. The DON stated the case was not treated as abuse investigation because the resident stated she was fine and at the time, the resident stated she just wanted the administration know. On 6/18/25 at 1421 hours, a follow-up phone interview was conducted with Resident 105. Resident 105 stated she was not offered to file a grievance by the facility. Resident 105 further stated she had verbalized all the allegations she had made to the ADON. Resident 105 stated she was not asked by the facility how she was after she had complained and was not informed of the findings or outcome and the actions taken regarding the complaint she made to the ADON. 06/19/26 at 1420 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F609.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the plan of care for one of 18 final sampled residents (Resident 98) was followed and revised. * Resident 98's interventions for keeping the bed in a low position was not followed. * Resident 98's plan of care was not revised to show interventions for Resident 98 raising the bed on her own, per staff. These failures posed the risk of not providing appropriate care for Resident 98.Findings: On 6/17/26 at 0802 hours, Resident 98 was observed sitting up in her bed awake with her bed approximately one and one half feet above the floor. On 6/17/26 at 0835 hours, Resident 98 was observed in bed with her bed approximately one and one-half feet above the floor. On 6/17/26 at 0900 hours, Resident 98 was observed in bed, awake with her bed approximately one and one-half feet above the floor. On 6/17/26 at 1217 hours, an observation of Resident 98 and concurrent interview was conducted with CNA 3. Resident 98 was observed in bed awake with her bed approximately one and three quarters feet above the floor. CNA 3 was summoned to Resident 98's room for an interview. CNA 3 stated she last came into Resident 98's room on 6/17/26 at around 12 pm to change Resident 98's diaper. CNA 3 verified the bed was high and stated sometimes Resident 98 moved the bed with the bed remote. CNA 3 was observed leaning over Resident 98 to retrieve the bed remote and Resident 98's bed was observed moving towards Resident 98's window with Resident 98 on the bed and CNA 3 leaning on the bed. CNA 3 verified Resident 98's bed was not locked. Medical record review for Resident 98 was initiated on 6/17/26. Resident 98 was readmitted to the facility on [DATE]. Review of Resident 98's care plan for risk for falls initiated 6/3/26 and revised 6/16/26, showed the interventions including keeping the bed in a low position with the brakes locked. Review of Resident 98's post fall risk assessment dated [DATE], showed Resident 98 had an unwitnessed fall. Further review of this document showed Resident 98 stated she rolled out of bed but did not know how she rolled out of bed. Review of Resident 98's H&P examination dated 6/9/26, showed Resident 98's diagnoses included post status right total knee arthroplasty, open left knee wound, history of stroke, altered mental status post fall at the facility. On 6/18/26 at 0754 hours, Resident 98 was observed awake in bed with her bed about one and a half feet above the floor. On 6/19/26 at 0808 hours, an observation and concurrent interview was conducted with RN 1. RN 1 stated sometimes Resident 98 was alert and sometimes confused. RN 1 verified the interventions for Resident 98's fall included keeping the bed in low position. RN 1 was informed Resident 98 was observed with multiple incidents of her bed being approximately more than one foot from the floor. Per RN 1, this height to RN 1 was low bed position. When asked what low position meant to RN 1, RN 1 said low position meant one and half ft above the floor. RN 1 verified Resident 38's bed was about one and a half feet from the floor. When asked if the height of Resident 98's bed posed a fall risk for Resident 98, RN 1 acknowledged the height of Resident 98's bed posed a fall risk for Resident 98. RN 1 acknowledged Resident 98's care plan was not being followed and the interventions did not address Resident 98's raising the bed on her own. On 6/19/26 at 0829 hours, an interview was conducted with the DON. The DON was informed of above findings. Cross reference to F689.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure one of three final sampled residents (Resident 98) reviewed for accident hazards remained free of accidents. * Resident 98's bed was not kept in a low position. This failure posed the risk of Resident 98 suffering serious injuries from any future falls.Findings: On 6/17/26 at 0802 hours, Resident 98 was observed sitting up in her bed awake with her bed approximately one and one half feet above the floor. On 6/17/26 at 0835 hours, Resident 98 was observed in bed with her bed approximately one and one-half feet above the floor. On 6/17/26 at 0900 hours, Resident 98 was observed in bed, awake with her bed approximately one and one-half feet above the floor. On 6/17/26 at 1217 hours, an observation of Resident 98 and concurrent interview was conducted with CNA 3. Resident 98 was observed in bed awake with her bed approximately one and three quarters feet above the floor. CNA 3 was summoned to Resident 98's room for an interview. CNA 3 stated she last came into Resident 98's room on 6/17/26 at around 12 pm to change Resident 98's diaper. CNA 3 verified the bed was high and stated sometimes Resident 98 moved the bed with the bed remote. CNA 3 was observed leaning over Resident 98 to retrieve the bed remote and Resident 98's bed was observed moving towards Resident 98's window with Resident 98 on the bed and CNA 3 leaning on the bed. CNA 3 verified Resident 98's bed was not locked. Medical record review for Resident 98 was initiated on 6/17/26. Resident 98 was readmitted to the facility on [DATE]. Review of Resident 98's initial fall risk assessment dated [DATE], showed Resident 98 had a moderate risk for falls. Review of Resident 98's care plan for risk for falls initiated 6/3/26, showed interventions including keeping the bed in a low position with the brakes locked. Review of Resident 98's fall risk assessment dated showed 6/4/26, showed Resident 98 had a high risk for falls Review of Resident 98's post fall risk assessment dated [DATE], showed Resident 98 had an unwitnessed fall. Further review of this document showed Resident 98 stated she rolled out of bed but did not know how she rolled out of bed. Review of Resident 98's H&P examination dated 6/9/26, showed Resident 98's diagnoses included post status right total knee arthroplasty, open left knee wound, history of stroke, altered mental status post fall at the facility. On 6/18/26 at 0754 hours, Resident 98 was observed awake in bed with her bed about one and a half feet above the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 6/19/26 at 0808 hours, an observation and concurrent interview was conducted with RN 1. RN 1 stated sometimes Resident 98 was alert and sometimes confused. RN 1 verified the interventions for Resident 98's fall included keeping the bed in low position. RN 1 was informed Resident 98 was observed with multiple incidents of her bed being approximately more than one foot from the floor. Per RN 1, this height to RN 1 was low bed position. When asked what low position meant to RN 1, RN 1 said low position meant one and half ft above floor. RN 1 verified Resident 38's bed was about one and a half feet from the floor. When asked if the height of Resident 98's bed posed a fall risk for Resident 98, RN 1 acknowledged the height of Resident 98's bed posed a fall risk for Resident 98. On 6/19/26 at 0829 hours, an interview was conducted with the DON. The DON was informed of above findings. Cross reference to F657.