

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Beach Creek Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 645 South Beach Blvd. Anaheim, CA 92804	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the abuse investigation protocol was followed for one of three sampled residents (Resident 1) reviewed for abuse. * The facility failed to ensure CNA 1 was suspended immediately when Resident 1 reported to the facility staff of allegation of abuse against CNA 1. Resident 1 reported CNA 1 being rough during the provision of care. * The facility failed to report the result of the investigation to the CDPH, L&C Program, Orange District Office within five working days. These failures had the potential to put vulnerable residents at increased risk for abuse and/or delay in providing the necessary care. Findings: Review of the facility's P&P titled Abuse Investigation and Reporting dated 10/2022 showed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigation will also be reported. Under the section role of the administrator showed the administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. Further review of the P&P showed the administrator (or designee) will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five working days of the occurrence of the incident. Review of SOC 341 dated 11/28/25, showed on 11/28/25 at 1020 hours, the DON received a report from staff and Resident 1 of rough handling by assigned CNA on 11/27/25 in the evening shift. The SOC 341 further showed Resident 1 was alert oriented and had no injury. Medical record review for Resident 1 was initiated on 12/9/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 11/14/25, showed Resident 1 was able to make his own decisions. Review of Resident 1's MDS assessment dated [DATE] , showed Resident 1 was cognitively intact and required substantial assistance from staff for his activities of daily living. On 12/9/25 at 1506 hours, an interview was conducted with LVN 1. LVN 1 stated on 11/27/25 at around 2100 hours, CNA 1 asked for assistance while providing care to the Resident 1. LVN 1 stated Resident 1 had a long-term skin issue on his back and she observed CNA 1 was being rough while cleaning Resident 1. LVN 1 stated Resident 1 asked CNA 1 to stop and CNA 1 then stopped. However, LVN 1 further stated Resident 1 reported to her that he asked CNA 1 to stop providing care multiple times and CNA 1 did not stop before LVN 1 came to the room. LVN1 stated she then reported the incident to RN 1. On 12/9/25 at 1527 hours, an interview was conducted with RN 1. RN 1 stated on 11/27/25 at around 2100 hours, LVN 1 reported to her that CNA 1 was being rough to Resident 1 while providing care, and Resident 1 also reported to LVN 1 that he asked CNA 1 to stop providing care multiple times and CNA 1 did not stop before LVN 1 came to the room. RN 1 stated she then changed the assignment for CNA 1 and did not assign Resident 1 to CNA 1. When asked if CNA 1 continued to work for the facility with other residents after the incident, RN 1 stated CNA 1 continued to work that shift with other residents until her shift ended on 11/27/25 at 2300 hours. RN 1 stated the above incident was an allegation of abuse against CNA 1 and the process was to report the incident to the Administrator and suspend the accused staff pending investigation. RN 1 stated she should have reported the incident to the Administrator right away and suspended CNA 1 pending investigation. RN 1 acknowledged by not suspending CNA 1 pending investigation put the other residents at risk for further abuse. 2. On 12/9/25, at 1555 hours, an interview was conducted with the Administrator . The Administrator stated the facility had completed the investigation and determined the above allegation LVN 1 reported was unsubstantiated; however, the Administrator stated the facility did not submit the result of the investigation to CDPH L&C Program Orange District Office within five working days. The Administrator stated it was missed. On 12/20/25 at 0944 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p>		