STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Crest Nursing Center	3067 W Orange Avenue 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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47476 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary services and adequate supervision for one of two sampled residents (Resident 1) to prevent the elopement. * The facility failed to ensure the front door alarm was activated when no one was monitoring the front entrance, resulting in Resident 1 going out of the facility undetected. This failure had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Emergency Procedure - Missing Resident revised 8/2018 showed the residents at risk for wandering and/or elopement will be monitored, and the staff will take necessary precautions to ensure their safety. Medical record review for Resident 1 was initiated on 4/29/24. Resident 1 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 1's Change in Condition Evaluation dated 1/27/24, showed Resident 1 was found in the facility's parking lot walking around with stable gait. Resident 1 was redirected to go inside the facility and cooperative. Review of Resident 1's Elopement Risk assessment dated [DATE], showed yes to these following questions: - If Resident 1 paces, wanders, tries to get out of the door, finds family or friends, perceives they need to be doing something other than what they are doing. - If Resident 1 is at risk for elopement. Review of Resident 1's Care Plan initiated on 1/27/24, showed a care plan problem addressing Resident 1's risk for wandering and elopement. The interventions included to monitor the resident closely and keep the environment safe. Review of Resident 1's MDS dated [DATE], showed Resident 1 had severe cognitive impairment. (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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NAME OF PROVIDER OR SUPPLIER Anaheim Crest Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3067 W Orange Avenue Anaheim, CA 92804	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Psychological Progress Notes dated 4/3/24, showed Resident 1 was pacing in the hallways, liked to walk and see what other people were doing, and then kept himself busy by watching TV. Review of Resident 1's Progress Notes dated 4/20/24 at 2100 hours, showed at 1930 hours, Resident 1 was seen in the front lobby watching TV and assisted back to the room. Resident 1 was offered snacks and adjusted comfortably in bed with the call light within reach. However, at 2100 hours, during the evening med pass, Resident 1 was noted not in his room. Review of Resident 1's Change in Condition Evaluation dated 4/20/24 at 2232 hours, showed the charge nurse was doing rounds and noted Resident 1 was not in his room. The facility initiated the room/restroom checks and was not able to find Resident 1. The facility initiated a Code Yellow (a term used to indicate an emergency procedure for a missing resident) and searched the facility and surrounding areas. Review of Resident 1's Hospital H&P Examination dated 4/21/24 at 0109 hours, showed Resident 1 presented with altered mental status and was found in the parking lot with soft restraints on his wrist. Further review of the hospital's notes showed Resident 1 had a localized abrasion to his right periorbital (around the eye) area with surrounding swelling. Review of Resident 1's Skin/Wound Note dated 4/25/24, showed Resident 1 was seen by the wound physician. Resident 1 had the right lateral eyebrow laceration, measuring 3 cm (length) x 0.5 cm (width) with six sutures and the right cheek trauma wound (abrasion), measuring 1 cm x 5 cm, with dry scab. On 4/29/24 at 0904 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated the facility had door alarms on all the facility exit doors. The Maintenance Director stated the doors could be opened from the inside but could not be opened from the outside. The Maintenance Director stated the nursing staff or the janitor was responsible for locking and turning on the alarm for the front entrance door between 1930 to 2000 hours. On 4/29/24 at 1052 hours, an interview was conducted with LVN 2. LVN 2 stated Resident 1 could walk by himself and would sometimes walk in the hallway outside the room and sit next to the lobby door but had not tried to exit the facility before. LVN 2 verified Resident 1 would wander in the facility and stated Resident 1 was not an elopement risk. LVN 2 stated after Resident 1 eloped, Resident 1 had a new injury to the eyebrow area upon returning to the facility. On 4/29/24 at 1122 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated Resident 1 could ambulate independently. RN 1 reviewed Resident 1's elopement evaluation conducted on 1/27/24, and verified Resident 1 was at risk for elopement. RN 1 stated Resident 1 would walk and sit in the front lobby. RN 1 stated they monitored Resident 1 with visual checks. RN 1 stated she was not aware if Resident 1 had attempted to leave the facility prior to 4/20/24. RN 1 stated Resident 1 returned to the facility after elopement with a new laceration to his right eyebrow with sutures and an abrasion to his right cheek. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/24 at 1203 hours, an interview was conducted with LVN 1. LVN 1 stated she was the charge nurse for Resident 1 on the day he eloped from the facility on 4/20/24. LVN 1 stated Resident 1 would walk independently; and after dinner, she saw Resident 1 in the lobby watching TV at 1930 hours. LVN 1 stated she asked Resident 1 to go back to his room and he was adjusted in bed with the bedside table across him so he could eat. LVN 1 stated when she started passing her medication at 2100 hours, she checked Resident 1's room and Resident 1 was not there. LVN 1 stated they searched for Resident 1 and called a Code Yellow. LVN 1 stated Resident 1 had not tried to leave the facility in the past and did not consider Resident 1 at risk for elopement. LVN 1 stated she was responsible for turning on the alarm and locking the front entrance door and she would set the alarm on at 2000 hours or 2100 hours. LVN 1 verified she had not set the front entrance door alarm on that day when Resident 1 eloped through the front entrance door. LVN 1 stated no one was monitoring the front entrance door at the time Resident 1 eloped from the facility. On 4/29/24 at 1306 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 1 could walk around independently and would seldomly walk around to the dining room, hallways, and lobby. CNA 1 stated Resident 1 had not attempted to leave the facility prior and was not an elopement risk. On 4/29/24 at 1420 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated Resident 1 would independently walk around and had episodes of wandering. The DON stated Resident 1 wandered into the facility parking lot on 1/27/24. The DON verified Resident 1 was a risk for elopement which was first identified on 1/27/24. The DON stated the interventions for preventing elopement were visual monitoring and the door alarms prior to Resident 1's elopement. The DON was notified of the interviewed staff not aware of Resident 1's previous wandering episode to the facility parking lot and the facility staff did not consider Resident 1 at risk for elopement. The DON stated she would need to in-service the staff. The DON verified Resident 1 had exited through the front entrance door after 1800 hours when no one was monitoring the front lobby.