STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555445	A. Building B. Wing	07/29/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 implement the P&P to ensure the reporting of a reasonable suspicion of a crime in accordance with Section 1150B for one of four sampled residents (Resident 1). * The facility failed to ensure Resident 1's sexual abuse allegation by a facility staff was reported timely to the CDPH L&C Program. This failure had the potential for abuse to go unreported and uninvestigated timely at a facility with a highly vulnerable resident population. Findings: Review of the facility's P&P titled Abuse Investigation and Reporting (undated) showed all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility administrator, or his/her designee, to the following persons or agencies:a. The State licensing/certification agency responsible for surveying/licensing the facility;b. The local/State Ombudsman;c. The Resident's Representative (Sponsor) of Record;d. Adult Protective Services (where state law provides jurisdiction in long-term care);e. Law enforcement officials;f. The resident's attending physician; andg. The facility medical director. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than two hours if the alleged violation involves abuse, has resulted in serious bodily injury or if the alleged violation does not involve abuse and has resulted in serious bodily injury. On 7/23/25, the CDPH L&C Program received an SOC 341 from the facility showing Resident 1 alleged LVN 1 leading the resident's elbow in between LVN 1's legs. Review of the facility's SOC 341 - Report of Suspected Dependent/Elder Abuse dated 7/23/25, showed the facility reported an abuse allegation to the CDPH, L&C Program on 7/23/25 at 1620 hours. The report showed Resident 1 alleged LVN 1 led the resident's elbow in between LVN 1's legs. Medical record review for Resident 1 was initiated on 7/25/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 4/26/25, showed the resident had the capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed the resident had a BIMS score of 12, indicating moderate cognitive impairment. On 7/25/25 at 0805 hours, an interview was conducted with Resident 1. Resident 1 stated the alleged abuse incident with LVN 1 occurred on 7/18/25. Resident 1 stated she was sitting in her wheelchair by her doorway and rubbing her abdomen in a circular motion. Resident 1 stated when she was rubbing her abdomen, her elbow was positioned outside of her wheelchair. Resident 1 stated LVN 1 then positioned her vagina on the resident's elbow. Resident 1 stated she laughed during the incident because she did not know how to react at the time. However, Resident 1 stated she did not feel good about the incident with LVN 1. Resident 1 further stated LVN 1 left the room but returned. LVN 1 then straddled her legs around Resident 1's legs and thrusted against the resident. Resident 1 stated she did not know what to say during the incident, but she felt bad and laughed about it. However, Resident 1 stated she felt violated by LVN 1. Resident 1 stated she told CNA 1 about the incident with LVN 1. On 7/25/25 at 0945 hours, an interview was conducted with CNA 1. CNA 1 verified Resident 1 informed her of the incident wherein LVN 1 positioned her vagina on the resident's elbow and LVN 1 thrusted against Resident 1. CNA 1 further stated Resident 1 was laughing and asked about LVN 1's sexual orientation. CNA 1 stated she informed LVN 1 about Resident 1's allegations on Friday 7/18/25. CNA 1 further stated on the following day, Resident 1 felt serious about the incident with LVN 1 and stated she would file a complaint with the State Agency. On 7/25/25 at 1018 hours, an interview was conducted with LVN 1. LVN 1 denied the allegations of Resident 1. LVN 1 stated CNA 1 had asked her about Resident 1's allegations on Friday 7/18/25, but LVN 1 denied the incident occurred. LVN 1 stated RN 1 had asked her if she touched Resident 1's vagina on Saturday 7/19/25. LVN 1 further stated the CNAs were asking her about her sexual orientation because of what Resident 1 had reported. When asked, LVN 1 stated she did not report the allegation to the supervisor because she was the alleged perpetrator. LVN 1 added she did not know how to report the allegations to when she was involved. On 7/29/25 at 1336 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.