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	06/25/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to determine if it was safe for one nonsampled Resident (Resident 14) to self-administer the medication. * Resident 14 was observed with a medication at the bedside. Resident 14 had no physician's order, assessment, and a care plan for the self-administration of the medications. This failure had the potential for Resident 14 to administer the medication inaccurately. Findings: Review of the facility's P&P titled Self-Administration of Medication revised 2/2021 showed the residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. - As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. - If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and care plan. The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and/or decision-making status. -Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. On 6/22/25 at 0820 hours, during the initial tour of the facility, an observation, interview, and concurrent medical record review was conducted for Resident 14 with LVN 2. Resident 14 was observed sitting on his bed, and a medication cup containing a white cream was observed on the resident's bedside table. Resident 14 stated the nurse gave him the medication for his pain to apply later. Resident 14 stated the nurses usually would just leave the medication at the bedside and he would apply the medication later. LVN 2 verified that the medication was Diclofenac Sodium topical gel 1 % for pain. LVN 2 stated the licensed staff were not supposed to leave the medications at bedside. Medical record review for Resident 14 was initiated on 6/22/25. Resident 14 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident's 14 H&P examination dated 5/14/25, showed Resident 14 had the capacity to understand and make decisions. Review of Resident 14's Order Summary Report did not show a physician's order for Resident 14 to self-administer the medications. Review of Resident 14's plan of care did not show a care plan problem to address Resident 14's self-administration of the medications. Further review of Resident 14's medical record failed to show a physician's order to self-administer medications, nor was an assessment was completed for Resident 14 to safely self-administer a medication. On 6/24/25 at 1616 hours, an interview and concurrent medical record review for Resident 14 was conducted with DON. The DON verified Resident 14 had no physician's order, assessment, and care plan for the self-administration of any medications.

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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 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, medical record review, facility document review, and facility P&P review, the facility failed to ensure the call lights were within reach for two of 19 final sampled residents (Residents 40 and 50). This failure had the potential for Residents 40 and 50 not to receive care and assistance when needed. Findings: Review of the facility's P&P titled Answering the Call Light revised 9/2022 showed to ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor. 1. Medical record review for Resident 40 was initiated on 6/22/25. Resident 40 was admitted to the facility on [DATE]. Review of Resident 40's H&P examination dated 4/2/25, showed the resident had the capacity to understand and make decisions. Review of Resident 40's care plan titled Visual Function initiated on 4/8/25, showed the interventions included to keep the call light within reach. On 6/22/25 at 0840 hours, a concurrent observation and interview with Resident 40 was conducted in Resident 40's room. Resident 40 was observed lying in bed with the call light on the floor under and near the head of the bed. Resident 40 stated she could not find the call light, could not reach, and did not know why the call light was on the floor. On 6/22/25 at 0850 hours, a concurrent observation and interview with LVN 1 was conducted in Resident 40's room. LVN 1 verified Resident 40's call light was on the floor and not within resident's reach. LVN 1 further stated call lights should be accessible to the resident to ensure for resident safety and allow the resident to communicate with the staff when in need of assistance. 2. Medical record review for Resident 50 was initiated on 6/22/25. Resident 50 was admitted to the facility on [DATE]. Review of Resident 50's H&P examination dated 5/5/25, showed the resident had no capacity to understand and make decisions, neurologically the resident was weak and confused. Review of Resident 50's MDS assessment dated [DATE], showed Resident 50 had a BIMS score of 1 that meant the resident had severe impaired cognition. Review of Resident 50's care plan titled Fall Risk Prevention and Management dated 5/5/25, showed the interventions included for the call light to be within reach and the staff to answer promptly. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/2/25 at 0843 hours, a concurrent observation and interview with Resident 50 was conducted in Resident 50's room. Resident 50 was observed sitting up in bed eating breakfast and the call light was clipped to the wall. Resident 50 stated she did not know where the call light was and wanted to use the call light to ask for staff assistance. Resident 50 stated she could not reach the call light since it was clipped to the wall and did not know who had clipped the call light to the wall. On 6/22/25 at 0852 hours, a concurrent observation and interview with LVN 1 was conducted in Resident 50's room. LVN 1 verified Resident 50's call light was clipped to the wall and not within resident's reach. LVN 1 further stated the call light should be accessible to the resident to ensure for resident safety and allow the resident to communicate with the staff when in need of assistance. On 6/22/25 at 1500 hours, an interview with the DON was conducted. The DON verified the above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to develop the resident-centered care plans to reflect the individual care needs of two of 19 final sampled residents (Residents 34 and 48) * Resident 48's Care Plan addressing the resident's Mood and Behavioral Symptoms dated 1/29/24, did not include the interventions consistent with the interventions on the Informed Consent Renewal- Psychoactive Medications dated 5/11/25. * The facility failed to develop a comprehensive individualized care plan to address the interventions to address the PASARR (Preadmission Screening and Resident Review) Level II recommended interventions for Resident 34. These failures posed the risk of not providing the appropriate and individualized care to Residents 34 and 48 to meet the highest practicable mental health and well-being. Findings: 1. Review of the facility's P&P titled Care Planning- Interdisciplinary Team dated March 2022 showed a comprehensive, person-centered care plans are based on resident assessments and developed by the IDT. Review of Resident 48's medical records was initiated on 6/23/25. Resident 48 was admitted on [DATE]. Review of Resident 48's H&P examination dated 3/1/25, showed Resident 48 had no capacity to understand and make decisions. Review of Resident 48's MDS assessment Section D: Mood dated 3/19/25, showed the presence of the symptoms of mood distress and frequent observations of distressed mood symptoms. Review of Resident 48's Informed Consent - Psychoactive Medications dated 5/11/25, showed the Interventions and Assessment of Psychoactive Medications: Non- Pharmacological Approaches included as follows: - encourage exercise and activities of interest - empathetic listening - individualization of care choices - positive reinforcement - repositioning (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Social Service or Activity visits Further review of Resident 48's care plan failed to include the interventions that were included in the resident's psychoactive medications as shown above. On 6/24/25 at 1559 hours, an interview and concurrent medical record review was conducted with LVN 7. LVN 7 stated Resident 48, screams, and prefers to be called halmeoni (Korean for grandma), Resident 48 reportedly keeps quiet when called halmeoni. LVN 7 stated the staff puts the head up and repositions the resident, as part of the interventions to minimize Resident 48's screaming, etc. LVN 7 further stated she collaborated with the MDS Coordinator of the care plan interventions in place for Resident 48. However, the above interventions were not included in Resident 48's mood and behavior plan of care. On 6/24/25 at 1600 hours, a concurrent interview and medical record review were conducted with the MDS Coordinator. The MDS Coordinator reviewed Resident 48's Mood and Behavior care plan and verified the care plan did not include all the interventions outlined from the renewed Informed Consent form dated 5/11/25. The MDS Coordinator verified the above missing interventions. On 6/25/25 at 1525 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified the above findings. 2. Medical record review for Resident 34 was initiated on 6/22/25. Resident 34 was admitted to the facility on [DATE]. Review of Resident 34's Initial Preadmission screening (PAS) dated 4/6/21, showed Level 1 - Positive. Level I screen indicates the need for a PASRR Level II evaluation. Further review of Resident 34's PASRR letter dated 7/1/21, showed a Level 1 was screen was conducted at the facility and a followed by Level II PASRR evaluation on 6/30/21, was conducted by a psychologist from DHCS, reviewed the findings of the evaluation and made a determination for the most suitable setting for the resident care and any needs for specialized services. The following personalized care recommendations are based on the resident's medical and social history, strength and personal goals. Culture and religious preferences should be considered when providing care. - Psychotropic Medication and Education Monitoring - on going monitoring of current psychotropic medication or a recommendation of medication for psychiatric symptoms. Whenever possible, this service should be combined with education in the use of the medication and its side effects. - Mental Health Rehabilitation Activities - These include therapeutic community, dance, music, art, exercise, leisure, recreation, orientation, education and/or skill building activities. - Activities of Daily Living (ADL) Training/Reinforcement - Skill training and behavior reinforcement to improve your ability to dress, bathe, feed, toilet and groom yourself. - Supportive services - these are interactions between you and facility staff that encourage problem solving, socialization, reality orientation or focus on your therapeutic goals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Psychotherapy/Counseling - Individual and/or group and/or family treatment provided by a licensed mental health professional. Therapy may include a combination of strategies and techniques such as supportive, cognitive behavioral, psychodynamic, art/music, counseling, skills training, and existential therapies, among others. - Psychiatry Consultation -Psychopharmacological intervention and monitoring of mental conditions. Psychiatrists may consider the impact of medications on lipid profile and glucose metabolism, assess the risk and benefits of pharmacological interventions, evaluate the efficacy and necessity of psychiatric medications, make adjustments as needed, and address side effects. - Neuropsychology Consultation-Services to gain understanding of cognitive functioning, to clarify diagnosis, and to provide treatment direction. Review of Resident 34's H&P examination on 4/24/25, showed Resident 34 had no capacity to understand and make decisions. The H&P examination also showed Resident 34 had a past medical history including anxiety disorder, depressive disorder and bipolar disorder. Review of Resident 34's care plan failed to show an individualized care plan for the PASARR Level II recommendations. On 6/24/25 at 0851 hours, an interview and concurrent medical record review were conducted with the MDS Coordinator. The MDS Coordinator failed to showed a personalized care plan was developed for the PASARR Level II recommendation from the DHCS Psychologist. On 624/25 at 1116 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	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 interview, medical record review, and facility P&P review, the facility failed to revise the comprehensive care plans to address the individual care needs of two of 19 final sampled residents (Residents 26 and 48). * Resident 26 and 48's care plan interventions were not revised or modified related to skin care and cognitive function. This failure placed the residents at risk of not being provided appropriate, consistent, individualized care. Findings: Review of the facility's P&P titled Wound Care dated February 2024 showed all the assessment data (i.e. wound bed color, size, drainage, etc. obtained when inspecting the wound should be recoded in the resident's medical record. Review of the facility's P&P titled Care Planning- Interdisciplinary Team dated March 2022 showed Comprehensive, person - centered care plans are based on resident assessments and developed by the IDT. 1. Review of Resident 26's medical record was initiated on 6/24/25. Resident 26 was admitted on [DATE]. Review of Resident 26's Order Summary Report dated 6/24/25, showed physician's orders dated 1/25/25, to cleanse with normal saline and apply zinc oxide ointment, leave to open air every shift the left posterior thigh fragile skin, to the perineum extending to the bilateral groin fragile skin and to the right posterior thigh fragile skin. Review of Resident 26's TAR dated June 2025 showed the treatment order had been provided to Resident 26 every shift. Review of Resident 26's Skin Integrity Care Plan dated 10/30/24, showed interventions including the ordered treatment of zinc oxide to the left posterior thigh fragile skin, to the perineum extending to the bilateral groin fragile skin and to the right posterior thigh fragile skin. The interventions also included to provide the treatment as ordered and monitor for the effectiveness. Review of Resident 26's progress notes and skin assessments did not show documentation the effectiveness of the zinc oxide cream use was monitored or evaluated as per the care plan. On 6/25/25 at 746 hrs, a concurrent interview and medical record review was conducted with LVN 6. LVN 6 stated the nonpressure ulcer treatments were evaluated every Monday. If the treatment was to continue or needs changes, the result would be discussed with the Wound Care Physician and the changes would be made as needed. LVN 6 was asked who evaluated the effectiveness of the treatment, LVN responded, this is maintenance, so we continue. (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	On 6/25/25 at 755 hours, a concurrent interview and medical record review were conducted with LVN 4. LVN4 stated, this is a maintenance treatment, anytime we have maintenance treatment, we don't evaluate. LVN 4 further stated, we did not do reevaluation of fragile skin; we only do reevaluation on non-pressure every Monday, and this order is not considered as a non-pressure wound. On 6/25/25 at 954 hours, a concurrent interview and medical record review with the DON was conducted. The DON was asked when a treatment like zinc oxide was evaluated for effectiveness. The DON stated, no, we do not evaluate, it is maintenance treatment. The DON verified the zinc oxide cream use was not being evaluated for its effectiveness and the intervention to monitor for the effectiveness should not be included in the care plan interventions. The DON verified the care plan should be revised. 2. Review of Resident 48's medical records were initiated on 6/23/25. Resident 48 was admitted on [DATE]. Review of Resident 48's Care Plan on Risk for Psychosocial Well- being and Mood State Care Plan dated 1/12/24, showed the intervention included to encourage verbalization of feelings and listen to the resident attentively. Review of Resident 48's H&P dated 3/1/25, showed Resident 48 had no capacity to understand and make decisions. Review of Resident 48's MDS assessment Section C0100 dated 3/12/25, showed Resident 48 was rarely/never understood. On 6/23/25 at 1432 hours, an interview with the Activity Director was conducted. The Activity Director stated Resident 48 have shown declining interest in group activities. The Activity Director further stated Resident 48 was unable to verbalize the needs all the time, checked the Korean language book when Resident 48 verbalized something and the staff could not understood the resident. On 6/23/25 1557 hours, a concurrent interview and medical record review was conducted with the MDS Coordinator. The MDS Coordinator stated, the intervention to encourage verbalization of feelings is not realistic at this time and cannot be done, it needs to be updated. The MDS Coordinator verified the intervention was inaccurate to reflect Resident 48's present cognitive status. On 6/24/25 at 1559 hours, an interview with LVN 7 was conducted. LVN 7 stated Resident 48 did not really verbalize feelings and would scream and yell only. LVN verified the interventions outlined were to encourage verbalization of feelings and needed to be revised. On 6/25/25 at 1525 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified the above findings.

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	555445	A. Building B. Wing	06/25/2025

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F 0693 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary GT care and services for one of two final sampled residents (Residents 22) reviewed for enteral feeding. * The facility failed to ensure Resident 22's enteral water feeding bag was changed within 24 hours. This failure posed the risk of developing complications related to enteral feeding. Findings: Review of the facility's P&P titled Enteral Feedings - Safety Precautions revised 11/2018 showed to change the administration sets open-system enteral feeding at least every 24 hours, or as specified by the manufacturer. Medical record review for Resident 22 was initiated on 6/22/25. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's diagnosis information dated 3/7/22, showed Resident 22 had a medical history of dysphagia. Review of Resident 22's H&P examination dated 3/9/25, showed Resident 22 had no capacity to understand and make decisions. Review of Resident 22's Order Summary Report showed the following orders: - dated 4/30/25, to administer Diabetisource AC (enteral feeding formula) at 75 ml/hr for 20 hours to provide 1500 ml/1800 kcal via GT to start at 1400 hours until dose met. - dated 6/1/25, to administer free water at 50 ml/hr for 20 hours to provide 1000 ml in 24 hours start in 1400 hours On 6/22/25 at 0955 hours, an observation and concurrent interview for Resident 22 was conducted with LVN 2. Resident 22 was observed lying in bed with enteral feeding pump was observed with Diabetisource AC (enteral formula) bottle hanging from the feeding pump pole. The enteral formula bottle was labeled 6/22/25 at 0645 hours. The enteral feeding water bag was observed with 6/21/25 at 0500 hours when the bag was prepared. The LVN 2 verified the findings and stated the enteral feeding formula, and the water bag should be changed every 24 hours when starting the enteral feeding at 1400 hours. On 6/24/25 at 1606 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings.

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	555445	A. Building B. Wing	06/25/2025

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F 0694 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV access site for one of nonsampled residents (Resident 719) consistent with the professional standards of practice. * The facility failed to ensure Resident 719's PIV was correctly labeled. This failure posed the risk for the resident to develop complications related to the IV therapy. Findings: Review of the facility's P&P titled Peripheral IV Catheter insertion revised 2/2022 showed placed label on one side of catheter (not over insertion site). Include the date and time of catheter insertion, initials, length and gauge of catheter on the label. Documentation, the following information should be recorded in the residents' medical record: - The date and time of the procedure. - The number of venipuncture attempts (maximum of two). - The type, length and gauge of catheter, and type of antiseptic agent used. - The site of insertion (be specific to name of vein, area of limb). - The condition of the IV site. - Resident's response to procedure. - The signature and title of the person recording the data. On 6/22/25 at 0849 hours, during the initial tour of the facility, an observation and concurrent interview for Resident 719 was conducted with RN 1. Resident 719 was observed in bed awake with the peripheral IV line on the left antecubital area. The label showed a date of 6/20, no time and initial, and no length and gauge of the catheter was included in the label. The RN 1 verified the above findings. Medical record review for Resident 719 was initiated on 6/22/25. Resident 719 was admitted to the facility on [DATE]. Review of Resident 719's H&P examination dated 6/12/25, showed Resident 719 had the capacity to make decisions Review of Resident 719's Order Summary Report showed the following physician's order dated 6/12/25: - for piperacillin-sodium -tazobactam 3-0.375 gram (antibiotic) intravenously every eight hours for the left lower leg venous ulcer/cellulitis for 14 days. (continued on next page)

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	555445	A. Building B. Wing	06/25/2025

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F 0694 Level of Harm - Potential for minimal harm Residents Affected - Some	- to change the dressing every seven days and with every IV site change. Review of Resident 719's IV administration record for 6/2025, showed on 6/19/25 at 0900 hours, there was an entry on the dressing change every seven days and with a site change. Further review of the IV administration record failed to show Resident 719's IV site was changed on 6/20/25, which was inconsistent with the label on the IV site observed on 6/22/25. On 6/24/25 at 1606 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified there was no documentation on 6/20/25, on the PIV access on the nurse's note and IV administration record.

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	555445	A. Building B. Wing	06/25/2025

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F 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	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, medical record review, and facility P&P review, the facility failed to provide the respiratory services in a safe manner in accordance with the facility's P&P for one of one final sampled resident (Resident 38) reviewed for the respiratory care. This failure posed the risk for complications and negative health outcomes to the resident. Findings: Review of the facility's P&P titled Oxygen Administration revised 2/2024 showed to label or date the nasal canula when changed or replaced. Further review of the facility's P&P also showed to change the oxygen tubing weekly. Medical record review for Resident 38 was initiated on 6/24/25. Resident 38 was admitted to the facility on [DATE]. Review of Resident 38's H&P examination dated 4/26/25, showed Resident 38 had the capacity to understand and make decisions. The H&P also showed Resident 38 had a diagnosis of COPD. Review of Resident 38's Order Summary Report dated 6/24/25, showed a physician's order dated 6/16/25, for oxygen to titrate at a rate of 2-4 LPM via nasal canula as needed when the oxygen saturation level was less than 90%. On 6/24/25 at 1129 hours, an observation and concurrent interview for Resident 38 was conducted with RN 1. Resident 38 was observed sitting in the wheelchair in the hallway with a portable oxygen tank and the nasal canula tubing was in Resident 38's nostrils. RN 1 verified there was no date on Resident 38's nasal canula. RN 1 stated the nasal canula should be labeled with the date for the staff to know when the nasal canula should be changed to prevent potential respiratory infection. On 6/24/25 at 1600 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Crest Nursing Center	3067 W Orange Avenue Anaheim, CA 92804

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and facility document review, the facility failed to ensure the Nurse Staffing Information was posted daily, which included the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for the resident care per shift. This failure had the potential of not having the information available to the residents and the public in a timely manner. Findings: A concurrent observation and interview on 6/22/25 at 1345 hours, was conducted with RN 1 and LVN 1. RN 1 was asked to show where they posted the nursing staffing information (the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift). RN 1 stated the nursing staffing information was posted daily in the nursing station, but he could not locate it and someone might have taken it off the posting. LVN 1 was unable to locate the posting of the nursing staffing information. RN 1 and LVN 1 verified the findings.

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	555445	A. Building B. Wing	06/25/2025

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	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, medical record review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services when: * LVN 8 failed to administer Resident 520's zinc sulfate (supplement) as ordered by the physician. This failure had the potential to negatively affect the resident's well-being. Findings: Review of the facility's P&P titled Administering Medications revised 4/2023 showed the medications are administered in a safe and timely manner, and as prescribed. The medications are administered in accordance with the prescriber's orders including any required time frame. On 6/23/25 at 0915 hours, a medication administration observation for Resident 520 was conducted with LVN 8. LVN 8 prepared and administered the following medications to Resident 520: - one tablet of vitamin C (supplement) 500 mg; - one tablet of aspirin (nonsteroidal anti-inflammatory medication) 81 mg; - one tablet of cyclobenzaprine (medication to treat muscle spasm) 10 mg; - one tablet of Eliquis (blood thinner medication) 5 mg; - one tablet of famotidine (medication that's treat and prevents heartburn from acid indigestion and upset stomach) 20 mg; - one tablet of folic acid (supplement) 1 mg; - one tablet of jardiance (medication to treat diabetes-high blood sugar) 10 mg; - one tablet of levetiracem (medication to treat and manage seizure) 500 mg; - one tablet of losartan (medication to treat high blood pressure) 25 mg; - one tablet of zinc sulfate (supplement) 50 mg; - one tablet of multi-vitamins with minerals (supplement); and - Prostat (supplement) 30 ml. Medical record review for Resident 520 was initiated on 6/22/25. Resident 520 was admitted to the facility on [DATE]. (continued on next page)

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	555445	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 520's H&P examination dated 6/5/25, showed Resident 520 had a capacity to understand and make decisions. Review of Resident 520's Order Summary Report dated 6/23/25, showed a physician's order dated 6/5/25, to administer zinc sulfate 220 mg to give one tablet by mouth one time a day for supplement. On 6/23/25 at 1222 hours, an interview and concurrent medical record review for Resident 520 was conducted with LVN 8. LVN 8 verified she administered 50 mg tablet instead of 220 mg tablet of zinc sulfate to Resident 520. On 6/24/25 at 1558 hours, an interview and concurrent medical record review for Resident 520 was conducted with the DON. The DON acknowledged the above findings. The DON stated the licensed nurse should have checked the physician's order and checked the medication before giving to Resident 520.

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	555445	A. Building B. Wing	06/25/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and facility P&P review, the facility failed to ensure the medications were handled securely, accurately labeled, and stored appropriately. * The facility failed to dispose of the expired medication supplies and store the treatment cream separate from the food thickener. This failure had the potential to result in cross-contamination of the medications and posed the risk of non-licensed staff members having access to the medications. Findings: Review of the facility's P&P titled Medication Labeling and Storage dated 2/2023 showed the compartments (including but not limited to the drawers, cabinets, rooms, refrigerators, carts, and boxes) containing the medications and biologicals are locked when not in use and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. The nursing staff are responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. On 6/22/25 at 0950 hours, a concurrent observation and interview was conducted with the MDS Coordinator. One crash cart had two packages of biohazard spill kit expired on 1/31/20. The content list included a pair of disposable gloves, an absorbent towel, disinfectant wipes, hand sanitizer wipe, plastic scoop with detachable scraper, a packet of absorbent powder, twist tie for biohazard bag closure and one red biohazard trash bag. The MDS Coordinator stated these medical supplies should be disposed of. On 6/23/25 at 1030 hours, a concurrent observation and interview was conducted with the MDS Coordinator. Medication Cart 3 had a transparent box compartment attached to the side of cart unlocked. There were two packets of hydrocortisone acetate cream 1% (anti-itch cream) was stored mixed with multiple packages of simply thick easy mixed food thickener 6 grams (0.2 fluid ounces), the tape measurement, medication label directions, and batteries. The MDS Coordinator stated they should have locked the cream in the treatment cart and not to store together with food and other items. The MDS Coordinator verified the findings.

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	555445	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menus were followed and the resident nutritional needs were met when the correct portion sizes were not followed for the Mandarin Oranges. This failure had the potential for 10 out of 69 residents receiving pureed food prepared in the kitchen to not meet their nutritional needs, which may lead to nutritional related health complications. Findings: Review of the facility's P&P titled Portion Control (undated) showed the residents will receive the appropriate portions of food as planned on the menu. Control at the point of service is necessary to assure that only the standard portion is served. Serving too small of portions results in the residents not receiving the nutrients needed. Serving too large of portions increases the costs as well as gives the residents more food than they need or are allowed to have (in the case of special diets). Review of the Mandarin Oranges puree recipe showed a number 10 scoop (three ounces) was used per serving. On 6/24/25 at 1105 hours, during the puree preparation, an observation was conducted with the Dietary Staff. The Mandarin Oranges were served in a clear individual cup using a number 8 scoop (four ounces). On 6/25/25 at 1503 hours, an interview and concurrent facility document review was conducted with the DSS. The DSS was informed and acknowledged the findings. The DSS stated the Dietary Staff gave extra serving of the Mandarin Oranges when she used the number 8 scoop which was equivalent to four ounces. The DSS further stated the Dietary Staff should have used the number 10 scoop which was equivalent to three ounces, and she should have followed the spreadsheet.

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	555445	A. Building B. Wing	06/25/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and were in good condition. * The facility failed to ensure the heavy-duty blenders used for puree preparation, the clear plastic pitchers, and a measuring pitcher used for beverages were air dried prior to storing and stacking. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. These failures had the potential for cross contamination and foodborne illnesses for the residents consuming the food prepared in the facility's kitchen. Findings: Review of the facility's Report dated 6/22/25, showed 69 of 72 residents consumed the foods prepared in the kitchen. 1. Review of the facility's P&P titled Sanitization revised 11/2022 showed all the equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 6/22/25 at 0810 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed: - Two scoops with the cream handles for food portioning were observed dirty with dry crusted residue and had fuzzy films. - One scoop with a white handle for food portioning was observed dirty with dry crusted residue and had fuzzy films. (continued on next page)

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	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Crest Nursing Center	3067 W Orange Avenue Anaheim, CA 92804

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One scoop with a gray handle for food portioning was observed dirty with dry crusted residue and had fuzzy films. - One stainless steel scoop for food portioning was observed dirty and had fuzzy films. - Two stainless steel spatulas with the black handles were observed dirty and had dry watermarks and fuzzy films. - One stainless steel spatula with a wooden handle had dry watermarks and fuzzy films. - Two stainless steel spatulas with the white handles had dry watermarks and fuzzy films. - Three stainless steel serving spoons had dry watermarks and fuzzy films. - Two stainless steel serving scoops with the black handles had dry watermarks and fuzzy films. - One stainless steel serving scoop with a gray handle had dry crusted residue, watermarks, and fuzzy films. - Two stainless steel slotted serving scoops with the cream handles had dry watermarks and fuzzy films. - One stainless steel serving scoop with a cream handle had dry watermarks and a fuzzy films. - One stainless steel serving scoop with a red handle had dry watermarks and a fuzzy films. - One stainless steel serving scoop was observed with dry residue, had watermarks, and a fuzzy films. - One set of measuring spoons was observed with dry residue, had watermarks, and fuzzy films. The DSS acknowledged the above findings and stated the dirty utensils had to be washed again for infection control purposes and to prevent cross contamination. The DSS further stated the kitchen utensils needed to be cleaned to prevent illnesses and bacteria growth, needed to rewashed and air dried prior to storage and use. 2. Review of the facility's P&P titled Sanitization revised 11/2022 showed all the utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair. The plastic ware, China and glassware that cannot be sanitized or are hazardous because of chips, cracks or loss of glaze are discarded. Damaged or broken equipment that cannot be repaired is discarded. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. (continued on next page)

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	555445	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 6/22/25 at 0810 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed: - One scoop with a cream handle was observed discolored and peeling. - One scoop with a white handle was observed discolored. - One scoop with a gray handle was observed peeling. - One stainless steel dough cutter with wooden handle was worn out and had deformities on the corners. - Two stainless steel spatulas with the black handles were observed partially burnt. - Two stainless steel spatulas with the white handles were observed discolored. - One stainless steel serving spoon had a deformed handle. - Two stainless steel slotted serving scoops with the cream handles were observed discolored. - Three stainless steel whisks were observed deformed in shape. The DSS verified the above findings and stated the worn-out and old utensils should have been replaced. 3. Review of the facility's P&P titled Sanitization revised 11/2022 showed food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Drying food preparation equipment and utensils with a towel or cloth may increase risks for cross contamination. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 6/22/25 at 0810 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed: (continued on next page)

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	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- One heavy-duty blender and one clear glass blender stored on the countertop shelf were observed still wet with visible water inside and on the lids. - Two clear plastic pitchers and one measuring pitcher used for beverages were observed wet with visible water inside and stacked on top of each other. The DSS verified the above findings and stated all kitchen utensils and equipment should have been air dried to prevent bacteria growth. 4. Review of the facility's P&P titled Cleaning Instructions, Cleaning Hoods and Filters dated 2005 showed stove hoods and filters will be cleaned according to cleaning schedule, or at least monthly. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 6/22/25 at 0810 hours, during the initial kitchen tour, an observation, and concurrent interview was conducted with the DSS. The kitchen hood over the stove was observed with black dirt and greasy residue. The DSS acknowledged the findings and stated the dietary aide deep cleaned the hood weekly, and the greasy residue should not be found on the hood because of fire hazard. In addition, the DSS stated an outside company service for the kitchen hood was conducted on 5/2/25.

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	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Crest Nursing Center	3067 W Orange Avenue Anaheim, CA 92804

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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 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the garbage was properly stored in two of two garbage dumpsters. This failure had the potential to attract pest/rodents that carried diseases. Findings: Review of the facility's P&P titled Waste Disposal revised date 1/2012 showed all infectious and regulated waste shall be handled and disposed of in a safe and appropriate manner. In addition, further review of the facility's P&P titled Pest Control revised date 5/2008 showed garbage and trash are not permitted to accumulate and are removed from the facility daily. Further review of the facility's P&P titled Sanitization revised date 11/2022, showed kitchen wastes that are not disposed of by mechanical means are kept in clean, leakproof, nonabsorbent, tightly closed containers and disposed of daily. Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/ compactors with lids or otherwise covered. According to the 2022 FDA (Food and Drug Administration) Food Code, the outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 6/22/25 at 1005 hours, an observation and concurrent interview was conducted with the Maintenance Director. One of the facility's two outside garbage dumpsters was observed with the lid partially propped open by the bulky boxes, preventing the lid from closing. The Maintenance Director verified the findings and stated the garbage dumpster lids should be completely closed for infection control purposes. On 6/23/25 at 0942 hours, an observation was conducted of the facility's two of two outside garbage dumpsters. One of the garbage dumpsters was observed with the lids partially propped open by the trash bags, preventing the lids from fully closing. On 6/24/25 at 1135 hours, the Maintenance Director was informed of the above observation with a photograph of the garbage dumpster taken on 6/23/25 at 0942 hours and stated the lids of the garbage dumpster should be closed for infection control purposes.

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	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Crest Nursing Center	3067 W Orange Avenue Anaheim, CA 92804

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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 interview, medical record review, and facility P&P review, the facility failed to ensure the medical record for one of 19 final sampled residents (Resident 44) was accurate. * The facility failed to ensure Resident 44's information on the POLST was accurate. This failure had the potential for the resident's care needs not being met as their medical information was inaccurate. Findings: Review of facility's P&P titled Charting and Documentation revised 7/2017 showed documentation in the medical record will be objective, completed, and accurate. Medical record review for Resident 44 was initiated on 6/22/25 . Resident 44 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 44's POLST under Section D - Information and Signatures dated 5/29/25, showed the box for the Advance Directive not available was checked. On 6/22/25 at 1621 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD stated Resident 44 did have a Durable Power of Attorney which was uploaded in the resident's electronic medical record on 6/2/25. The SSD stated Resident 44's POLST Section D was inaccurate, and the box for the Advance Directive if available and reviewed should have been checked and dated to reflect the accuracy of Resident 44's current medical record. On 6/24/25 at 0824 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Crest Nursing Center	3067 W Orange Avenue Anaheim, CA 92804

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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** 3. Review of the facility's P&P titled Cleaning and Disinfection of Resident-Care Items and Equipment revised 9/2022 showed the resident-care equipment, including reusable items and durable medical equipment will be clean and disinfected according to current CDC (Center of Disease Control and Prevention - service organization that protects the public's health) recommendations for disinfection. On 6/22/25 at 0852 hours, during a general observation of the facility, LVN 1 was in Resident 40's room to verify the call light was on the floor. LVN 1 did not clean the call light when the LVN picked up the call light from the floor, put it on Resident's 40's bed then proceeded to wash her hands. LVN 1 was informed the call light was not cleaned when it was picked up from the floor. LVN 1 stated she should have cleaned the call light before putting it back on the bed for the resident to prevent the spread of infection. On 6/23/25 at 1550 hours, an interview with the DON was conducted in the DON's office. The DON was informed and verified the above findings. Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection prevention control program and practices designed to provide a safe and sanitary environment to help prevent the transmission of infections. * The facility failed to ensure the analysis of the infection surveillance data for the antibiotic stewardship program was communicated to the physician. Resident 14 had signs and symptoms of infection and was prescribed with the antibiotics when the resident did not meet the McGeer's Criteria for true infection. This failure posed the risk of antibiotics not being used appropriately which could prevent better patient care and reduced antibiotic resistance. * The facility failed to ensure the pneumonia cases were screened for possible Legionnaire's disease. This failure posed the risk of not identifying the resident infections and thereby preventing the implementation of interventions to control the potential transmission of communicable diseases to other residents in the facility. * The facility failed to ensure LVN 1 cleaned the call light when she picked it up from the floor and placed it on Resident 40's bed. This failure posed the risk of transmission of infections. Findings: 1. According to the CDC, unnecessary antibiotic use promotes the development of antibiotic-resistant bacteria. Every time a person takes antibiotics, sensitive bacteria are killed, but resistant germs may be left to grow and multiply. Repeated and improper use of antibiotics is the primary cause of the increase in drug-resistant bacteria. (continued on next page)

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	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Surveillance for Infections dated 9/2017 showed the criteria in identifying infections are based on the current standard definitions of infections. The Charge Nurse will notify the attending physician and the Infection Preventionist of suspected infection. The Infection Preventionist and the Attending Physician will determine if laboratory tests are indicated, and whether special precautions are warranted. Review of Resident 14's medical records was initiated on 6/24/25. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's H&P examination dated 1/7/25, showed Resident 14 had the capacity to understand and make decisions. Review of Resident 14's MAR for 3/2025 showed Amoxicillin-Potassium Clavulanate (medication to treat infection) oral tablet 250- 125 mg, to give one tablet by mouth one time a day for recurrent UTI prophylaxis for 80 days. Review of Resident 14's Infection Screening Evaluation dated 3/5/25, showed the following signs and symptoms: - afebrile - respiratory rate is not more than 25 breaths per minute - pulse is not more than 100 beats per minute - did not complain of pain - with suprapubic tenderness - with urinary frequency - with urinary urgency - infection analysis showed McGeer's Criteria: Suspected UTI without an indwelling catheter. On 6/24/25 at 833 hours, an interview and concurrent medical record review for Resident 14 was conducted with the IP. The IP stated Resident 14 was on antibiotic therapy for suspected UTI. The IP stated Resident 14 did not meet the McGeer's criteria, it was a suspected UTI only, and was considered chronic since Resident 14 was treated with antibiotics on 10/27/24. On 6/24/25 at 1156 hours, further review of Resident 14's Infection Screening was determined to be not a true infection. Resident 14's medical record failed to show documentation the resident's physician was informed about the signs and symptoms of the suspected UTI and did not meet the McGeer's criteria for true infection. On 6/25/25 at 0954 hours, an interview and concurrent medical record review for Resident 14 was conducted with the DON. The DON verified there was no documentation the resident's physician was notified of the suspected UTI and did not meet the criteria of a true infection. (continued on next page)

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	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anaheim Crest Nursing Center	3067 W Orange Avenue Anaheim, CA 92804

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 1525 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified the above findings. 2. Review of the facility's P&P titled Legionella Surveillance and Detection dated 9/2022 showed the facility is committed to the prevention, detection, and control of water-borne contaminants, including Legionella (bacteria causing a serious type of pneumonia). As part of the infection prevention and control program, all cases of pneumonia that are diagnosed with residents more than 48 hours after admission are investigated for possible Legionnaire's disease (a type of severe pneumonia). Review of the facility's Infection Control Surveillance Report from 1/2025 to 5/2025 showed Health Care Associated Infection (HAI) surveillance for pneumonia as follows: - January 2025 showed five cases - February 2025 showed one case - March 2025 showed three cases - April 2025 showed one case - May 2025 showed three cases Review of the facility's Infection Control Surveillance Report from 1/2025 to 5/2025 showed documentation of the residents having HAI - pneumonia and prescribed with the antibiotic medications. On 6/24/25 at 735 hours, an interview and concurrent medical record and facility record review was conducted with the IP. The IP stated the monthly meetings were held for Infection Control and Antibiotic Stewardship Program every second Thursday of the month. The IP further stated she did not coordinate with the Maintenance Director when the facility had an increase in the number of pneumonia cases in the facility. On 6/24/25 at 1125 hours, an interview and concurrent facility document review was conducted with the Maintenance Director regarding water management. The Maintenance Director stated he ensured measures to prevent the growth of Legionella or other opportunistic waterborne pathogens (bacteria, virus, or microorganisms which can cause disease). The Maintenance Director stated Legionella testing was conducted when the Administrator gave him instructions to test. The Maintenance Director verified the last time the water system was tested for Legionella was in 2023. When the Maintenance Director was asked if he worked hand in hand with the IP on pneumonia cases and possible Legionella testing, the Maintenance Director responded by saying, not really. The Maintenance Director further stated the facility's pneumonia cases and a possible Legionella testing on the facility's water system was not discussed during their Infection Control meetings. On 6/25/25 at 1525 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified the above findings.