

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555790	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER Cedar Crest Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 797 E Fremont Avenue Sunnyvale, CA 94087	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure drinks were served at a safe and appetizing temperature when cold drinks were served with a temperature higher than 41F (Fahrenheit, unit of measurement). This failure had the potential to discourage residents from increasing the amount they eat and drink. Resident census was 80. Findings: During the kitchen tray line observation on 8/7/25 at 12:03 p.m. with the Dietary Supervisor (DS), temperature of cold drinks being served were checked. Milk was 56.7 F and yogurt was 55.8 F. These drinks were kept in a black bin on a movable shelf and kitchen staff took one from the bin during tray line. DS stated cold drinks must be at temperature below 41 F. DS also stated it was due to the facility not having ice. A review of facility's policy and procedure (P&P) entitled Meal Serving Temperatures dated 2023, the P&P indicated, .2. Cold food items shall be held at 41 degrees or below and served at not greater than temperatures of 45-50 degrees F at bedside or dining room to ensure serving temperatures are palatable. 5. Milk will not remain out of refrigeration during meal service if proper temperature of 41 degrees F or below cannot be maintained. Milk will be placed in an ice bath in order to maintain the proper temperature and/or only the amount that is needed will be removed from refrigeration .		

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 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 and record review, the facility failed to ensure proper sanitation and maintenance of the ice bin (where ice is stored) when it was found to have black substances in the ice chute (ice dispenser), green substances on the corner edges, fine grayish particles on the exterior front, and was not cleaned according to the manufacturer's manual. Due to these systemic failures (as stated above) with potential to affect all residents and staff who uses and consumes ice from the ice bin, the facility needed to take immediate action to correct the noncompliance. On 8/6/25 at 7:30 p.m., an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified and declared, in the presence of the facility's Administrator (ADM) and their Regulatory and Operations Advisor (ROA). On 8/8/2025 at 3:18p.m., the IJ was removed after the ADM submitted an acceptable IJ Removal Plan (IJRP, a plan with interventions to immediately correct the deficient practices), and after the survey team verified and confirmed the corrective actions while onsite. These failures put residents and staff who uses and consumes ice from the ice bin at risk for food-borne illnesses. Findings: 1. During a concurrent observation and interview on 8/6/25 at 1:31 p.m. with Dietary Supervisor (DS) and Environmental Services Director/Maintenance Director (ESD), the facility ice machine was located in the back patio. DS and ESD verified there were black substances around the opening where the ice gets dispensed, there were also fine grayish particles on the exterior of the machine and green substance on the upper left corner of the ice bin, and there was reddish-brown discoloration on the metal rack which catches the ice. The ESD stated the Maintenance Department cleans the exterior of the ice machine once a week. The ESD stated that they cannot open the ice bin. The ESD also stated an outside vendor cleans the ice machine every six months. During a concurrent interview and record review on 8/6/25 at 2:30 p.m. with ESD and Maintenance Aide (MA), the ESD stated MA cleans the exterior of the ice machine once a week every Wednesday but had not cleaned it that day (8/6/25) yet. ESD stated that the ice machine had always been located outside and he would be glad if the machine was put inside the facility because when the gardener used the blower, the ice machine gets dirty. ESD stated the ice machine is cleaned by an outside vendor every six months and verified the vendor last performed ice machine cleaning and sanitizing on 1/7/25 and 5/29/25. ESD stated ice machine was not clean enough. ESD further stated the ice should not be used. During an interview on 8/6/25 at 2:45 p.m., the Director of Nursing (DON) stated staff interviewed residents and identified the residents (41 residents) who preferred cold water or ice in their pitchers. During an interview on 8/6/25 at 3:13 p.m., Certified Nursing Assistant (CNA D) stated she handles ice for the pitchers stored on all medication carts. CNA D stated she replenishes ice for the water and juice pitchers used during medication pass (administration of medication). During an interview on 8/6/25 at 3:15 p.m., Certified Nursing Assistant (CNA B) stated he fills his assigned residents' pitchers with ice from the ice machine. CNA B stated the ice machine is located outside the facility. During an interview on 8/6/25 at 3:20 p.m., Certified Nursing Assistant (CNA C) stated she fills residents' pitchers with ice as needed from the ice machine located in the patio outside behind the building. During an interview on 8/6/25 at 4:04 p.m., Resident 94 stated she uses ice in her water, iced tea, and soda. She stated facility staff are providing ice when requested. During an interview and record review on 8/6/25 at 4:09 p.m. with DS, DS stated that the kitchen department was responsible for checking the ice machine. DS stated that anyone ambulatory (able to walk) can access the ice machine such as staff, visitors and residents. DS also stated the condition of the ice machine could put anyone who could access ice from it at risk for food-borne illness. DS verified there was only one ice machine for the facility. DS verified the kitchen had no log for checking the cleanliness of the ice machine. During an interview on 8/6/25 at 4:12 p.m., Resident 95 stated she uses ice in her water. During an interview on 8/6/25 at 4:31 p.m., Licensed Vocational (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse E (LVN E) stated about 30 percent of the time he got ice from the ice machine in the patio. LVN E stated the ice was for the residents' drinks or their ice boxes brought from home. He stated the CNAs get ice for the residents more often. During a phone interview on 8/6/25 at 5:05 p.m. with the Registered Dietician (RD), RD stated the kitchen department must be responsible for the ice machine because ice is served to residents. RD stated she does not check the ice machine. RD stated a contaminated ice machine can cause sickness for anyone who uses the ice. During a concurrent observation and interview on 8/6/25 5:23 p.m. with DS and ESD, ESD stated staff cleans the exterior of the ice machine and they do not clean the inside. ESD also stated his staff are not cleaning the area where the ice is coming out of the machine. During a concurrent interview and record review on 8/7/25 at 11:15 a.m. with the Administrator (ADM) and ESD, the ADM and ESD verified the top of the ice machine is separate and had a different model (KY0500A-161) from the ice bin below it (Model SPA310). The ADM and ESD verified the manufacturer instruction manual the facility follows was for the Model KY0500A-161, the top part of the ice machine and it indicated the ice machine must be cleaned every six months. The ADM and ESD verified, the lower part of the ice machine (ice bin), Model SPA310 had a separate instruction manual and indicated it must be cleaned every month. The ADM and ESD verified, the black substances found were on Model SPA310 (ice bin). The ADM and ESD verified they do not have the manual for Model SPA310. During a concurrent observation of the ice machine and interview on 8/7/25 at 2:36 p.m. with Outside Vendor (OV), OV verified and stated the upper part is the ice machine where the ice is made is Model KY0500A-161 which is cleaned every six months as per manufacturer's manual and the lower part of the ice machine called the ice bin, where the ice is stored and dispensed, is Model SPA310 with a different manufacturer's manual. The OV also verified, the model numbers were indicated at the back of the ice machine and the ice bin. OV also verified the ice bin was cleaned every six months. During a concurrent observation of the ice bin and interview on 8/11/25 at 1:57 p.m. with the DS, the DS verified ice was touching the door of the ice dispenser that had black substance on 8/6/25. Review of the facility's January 2025 to July 2025 Calendars Exterior Cleaning Ice Machine provided by ESD on 8/6/25 at 2:30pm, calendars indicated maintenance staff performs weekly cleaning only of the exterior part of the ice machine on Wednesdays since January 2025. Review of US Food Code 2022, .4- 601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.(A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (C) Non FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. A review of undated facility policy and procedure (P&P) entitled Ice Machines and Ice Storage Chests, the P&P indicated, Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice.3.Our facility has established procedures for cleaning and disinfecting ice machines and ice storage chests which adhere to the manufacturer's instructions. The infection preventionist (or designee) maintains a copy of these procedures. A review of facility policy and procedure (P&P) entitled, Sanitization revised November 2022, the P&P indicated, .10. Ice machines and ice storage containers are drained, cleaned and sanitized per manufacturer's instructions.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when:1. The filter of Resident 6's oxygen concentrator was dusty;2. Licensed vocational nurse M (LVN M) did not cleanse her hands before administering Pataday eye drops (allergy itch relief eye drops) to Resident 12;3. Licensed vocational nurse N (LVN N) did not cleanse her hands and change gloves before administering Fluticasone nasal spray (used to relieve allergy symptoms in the nose) to Resident 95; and4. Unlabeled personal care items in a shared bathroom by multiple residents.Findings: 1. Review of Resident 6's admission Record indicated she was admitted to the facility on [DATE] with chronic obstructive pulmonary disease (COPD, a condition caused by damage to the airways or other parts of the lung). Review of Resident 6's physician order, dated 7/17/25, indicated she has an order for oxygen at 2-4 liters (L, a metric unit of volume) per minute as needed for shortness of breath. During an observation with LVN M on 8/5/25, at 10:20 a.m., the filter of Resident 6's oxygen concentrator was dusty. LVN M confirmed the filter was not clean and stated it should be kept clean. During an interview with the director of staff development/infection preventionist consultant (DSD/IPC) on 8/8/25, at 10:45 a.m., she stated the filter of the oxygen concentrator should be kept clean and cleansed every week. Review of the facility's user manual, "Oxygen Concentrator," dated 2016, indicated, "Remove the filter and clean as needed. Environmental conditions may require more frequent inspection and cleaning of the filter." 2. During a medication pass observation on 8/5/25, at 10:25 a.m., Resident 12 held the medication cup in her hand and administered the oral medications herself. Resident 12 put the medication cup on her overbed table. LVN M repositioned Resident 12's medication cup on the overbed table; then without cleansing her hands, LVN M put on gloves and administered Pataday eye drops to Resident 12. During a concurrent interview with LVN M, she stated she should cleanse her hands before putting on gloves to administer Pataday eye drops to Resident 12. Review of the facility's policy, "Medication Administration - Eye Drops," dated 1/2023, indicated, "Procedures: 3. Perform hand hygiene." 3. During a medication pass observation on 8/7/25, at 4:18 p.m., LVN N sanitized her hands, put on gloves, and repositioned Resident 95 in his bed; then without cleansing her hands and changing gloves, LVN N administered Fluticasone nasal sprays to Resident 95's nostrils. During a concurrent interview with LVN N, she acknowledged that she should clean her hands and change gloves before administering Fluticasone nasal sprays to Resident 95. During an interview with the DSD/IPC on 8/8/25, at 10:45 a.m., she stated the licensed nurses should (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sanitize their hands and change gloves before administering eye drops or nasal sprays to the residents. Review of the facility's policy, "Medication Administration – Nose Drops," dated 1/2023, indicated, "Procedures: 3. Perform hand hygiene." 4. During an initial room rounds on 8/5/2025 at 9:54 a.m., observed in bathroom between resident's room A and B with unlabeled one plastic pink wash basin (a light weight container used for personal care for residents), one pink plastic bed pan (a shallow, toilet shaped container used for collecting urine and feces from a resident who unable to get out of the of the bed), two urinals (a portable container designed to collect urine when access to toilet is limited or with mobility issues with residents), and one kidney shape plastic pink basin (a small kidney shape light weight container used for mouth care for residents) with tooth brush and half used tooth paste tube inside. During a concurrent observation and interview with certified nursing assistant K (CNA K) on 8/5/2025 at 9:56 a.m., CNA K confirmed above resident's care items unlabeled with resident's name or room number and currently all are in use, not new. CNA K also confirmed this bathroom is currently being shared by four residents from room A and B. CNA K stated without label, there is risk of using these care items for unassigned resident. During an interview with director of staff development/infection preventionist consultant (DSD/IP C) on 8/8/2025 at 8:10 a.m., DSD/IP C stated above care items should be labeled. DSD/IP C also stated nursing staff should have labeled these care items before using them for residents for infection control. Review of facility's undated policy and procedure titled, "Cleaning of bed pans and urinals," the P&P indicated, "All bed pans and urinals will be marked with resident's name for individual use."		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to maintain equipment in safe operating and sanitary conditions when: A bedside commode (a portable toilet, chair like structure to accommodate different user heights)'s metal pipe was found with dark brown patches and paint peeling off; Sink overflow drain hole area was found with black, white and dark brown spots in room C's bathroom; Lint filter and lint compartment with lint for dryer 1 and 2. The above failures had the potential to adversely affect the health and safety of residents in the facility. Findings: 1) During an observation on 8/5/2025 at 10:06 a.m., noted bed side commode placed on a toilet commode in a resident (room D)'s bathroom with dark brown patches and paint peeling off on metal pipe below and behind the seat cover. During an observation and interview with facility's maintenance aide (MA) on 10:14 a.m., MA confirmed a bedside commode metal pipe was rusted and painting was feeling off. MA stated this commode was left outside the facility for long time and caused the rust and paint to come off the metal pipe. MA also stated it is not safe for residents to use bedside commode with rust. MA removed rusted bedside commode from bathroom and replaced with a new one. During an interview with facility's director of nursing (DON) on 8/8/2025 at 9:25 a.m., DON stated it is not ok to use the rusted bedside commode for residents. She stated it should be replaced with a new commode. 2) During an observation on 8/5/2025 at 10:30 a.m., noted in a resident (room C)'s bathroom sink overflow drain hole area was found with black, white and dark brown spots with sharp edges. During an observation and interview with facility's maintenance director/environmental services director (MD/ESD) on 8/11/2025 at 8:48 a.m., MD/ESD confirmed above spots and stated rotten porcelain causing sharp edges. MD/ESD stated this area needs cleaning. MD/ESD also stated housekeeping staff will clean to see if these spots will come off. MD/ESD further stated not sure he can fix the rotten porcelain, if not he will replace with a new sink. 3) During an observation of laundry room and interview with laundry staff J (LS J) on 8/11/2025 at 10:50 a.m., observed lint filter was with thick layer of white lint and patches of lint floating in lint compartment for dryers 1 and 2. LS J confirmed above findings and stated lint should be cleaned every two hours. During an observation and interview with MD/ESD on 8/11/2025 at 11:10 a.m., MD/ESD confirmed presence of lint for both dryers. MD/ESD stated dryers should be lint free. MD/ESD also stated potential for fire if lint not removed of dryers. During review of facility's undated policy and procedures (P&P) titled, Equipment, the P&P indicated, The Maintenance Director will evaluate for repair needs and/or replacement. During review of facility's undated P&P titled, Laundry Room Cleaning Policies and Procedures, the P&P indicated, Clean Lint Trays: Lint trays under dryers should be cleaned at least daily.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure a call light was accessible and within reach for one of 20 sample residents (Resident 100). This failure had the potential to result in the resident's needs not being met. Findings: During observation and concurrent interview on 8/5/25 at 3:25 p.m. in Resident 100's room, Resident 100 was in bed and was requesting for help. Resident 100's call light was wrapped around the bed side rail and was hanging off the bed. Resident 100's call light was not within the resident's reach. When asked what she needed help with, Resident 100 stated her incontinent brief needed to be changed. When asked whether she was able to reach her call light to ask for help, Resident 100 responded, No. During observation and concurrent interview on 8/5/25 at 3:27 p.m., Certified Nursing Assistant O (CNA O) was instructed to assist Resident 100. When asked how Resident 100's call light should be positioned, CNA O did not respond. CNA O unwrapped Resident 100's call light from around the bed side rail and gave it to Resident 100. Review of the facility's undated policy, Call Light, Answering indicated, When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review, the facility failed to ensure to protect resident's confidential personal care and medical information for five out of thirteen sampled residents (Resident 92, 96, 26, 45, and 10) when: Personal care instructions were posted visible to public for Residents 92, 96, 26, and 45; The computer screen was opened and unattended with Resident 10's protected medical information in a hallway. This deficient practice had the potential to compromise the privacy and confidentiality of above sampled residents. Findings: 1. During an initial room rounds on 8/5/2025 at 9:36 a.m., noted open, handwritten care instruction, No straw please, on red color cover page, posted below the light fixture on the wall at the head of the bed (HOB) of Resident 92. This handwritten instruction was not covered and was visible to public in the resident's room. Review of Resident 92's face sheet (FS: a document that gives resident's information at a quick glance) indicated Resident 92 was admitted to facility on 7/23/2025. During room rounds on 8/5/2025 at 10:04 a.m., noted open and visible, handwritten care instructions, Spoon sips please, no straw please on a red color cover page, posted on wooden bulletin board near HOB of Resident 45. Review of Resident 45's FS indicated Resident 45 was admitted to facility on 10/3/2023. During room rounds on 8/5/2025 at 10:34 a.m., observed open and visible, handwritten care instructions indicated, Position of bed in lowest position and extensive assistance with ambulation with a picture of a bed posting on wooden bulletin board near the HOB of Resident 96. Review of Resident 96's FS indicated Resident 96 was admitted to facility on 7/22/2025. During room rounds on 8/5/2025 at 10:39 a.m., observed open and visible, handwritten care instructions, TSP (teaspoon) only. No Straw Please, on a red color cover page, posted on a wooden bulletin board near HOB for Resident 26. Review of Resident 26's FS indicated Resident 26 was admitted to facility on 7/5/2025. During a concurrent observation and interview with facility's Administrator (ADM) on 8/7/2025 at 1:22 p.m., ADM confirmed above open and visible postings for Resident 92, 45, 96 and 26. ADM stated these posted care instructions for communication for staff, and they were posted inside resident's rooms. During a concurrent observation and interview with licensed vocational nurse I (LVN I) on 8/11/2025 at 10:11 a.m., LVN I confirmed above postings for Resident 92, 45, 96 and 26 in their rooms and confirmed not covered. LVN I stated above residents were receiving visitors often if not on daily basis and sit with residents during their visits inside resident's room. LVN I also stated above postings are visible and open to the public. Review of facility's policy and procedures (P&P) titled, Signage and Posting, undated, the P&P (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, Signage will be posted so that it is inside of the room where it is not visible to the public. Examples of signage includes bed height, assistance required, no water pitcher, no use of straws, etc. 2. During an observation on 8/8/25, at 10:20 a.m., after administering medications to Resident 10, licensed vocational nurse L (LVN L) pushed his medication cart to the nurse station. LVN L parked his medication cart with his laptop open. Resident 10's Medication Administration Record (MAR) was on the screen. LVN L walked into Resident 98's room to check his pain level. During an observation and interview with LVN L on 8/8/25, at 10:22 a.m., he confirmed that he left Resident 10's MAR open on his laptop's screen. LVN L stated he should close Resident 10's MAR and his laptop before walking away. Review of the facility's undated policy, Confidentiality of Information and Personal Privacy, indicated, . 1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to accurately code the minimum data set (MDS: an assessment tool) for 1 of 3 sample resident (Resident 34) when Resident 34's MDS assessment did not reflect status of the resident. This failure had the potential to affect care and interventions for Resident 34. Findings: Review of Resident 34's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 34 was admitted to facility on 4/14/2021. Review of Resident 34's diagnoses included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), diabetes type 2 (a chronic condition that happens with persistent high blood sugar levels) and congestive heart failure (a chronic condition where the heart muscle is weakened or damaged, making it difficult for the heart to pump blood effectively). Review of Resident 34's physician orders indicated an order dated 7/13/2025 for enoxaparin (medication used to treat to prevent the formation of blood clots) 40 MG (MG: milligram, a unit of mass equal to one thousandth of a gram)/0.4ML (ML: milliliter, a unit of volume, equal to one-thousandth of a liter) inject subcutaneously (SQ: a method of administering medication by injecting into the layer just below the skin) one time a day for DVT (deep vein [vein: a blood vessel that carries blood from body back to heart] thrombosis, a condition where a blood clot forms in a deep vein) prophylaxis until ambulating well >100 feet. Review of Resident 34's electronic medication administration record (EMAR: digital system for documenting medication administration) for July and August/2025 indicated Resident 34 received enoxaparin SQ injection at 1340 on 7/13/2025 and every day at 0900 on 7/14/2025 to 8/5/2025. Review of Resident 34's MDS assessment dated [DATE], section N, N0300 for injections indicated 0 received during the last 7 days or since admission/entry or reentry. During concurrent record review of Resident 34's EMAR for July and August/2025, MDS assessment dated [DATE], section N, and interview with facility's MDS coordinator (MDSC) on 8/11/2025 at 9:47 a.m., MDSC confirmed Resident 34 received SQ injections every day starting 7/13/2025. MDSC also confirmed MDS assessment, section N for injections coded as 0. MDSC stated MDS assessment for injections was not coded accurately for this resident. MDSC also stated number of injections received during this assessment period should be coded as 4 not 0. MDSC also stated MDSC will modify this MDS assessment to correct number of injections received for Resident 34. Review of facility's policy and procedures (P&P) titled, Comprehensive Assessments undated, the P&P indicated, Comprehensive assessment are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual (official guidance for using the RAI process, ensuring consistent and accurate assessments and care planning).		

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NAME OF PROVIDER OR SUPPLIER Cedar Crest Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 797 E Fremont Avenue Sunnyvale, CA 94087	
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide services that meet professional standards for two of 20 residents (8 and 102) when their physician orders for clonazepam (used to treat anxiety - feelings of fear, worry, nervousness, and unease) and trazodone (used to treat depression - a mental disorder that negatively affects how the persons feel, think, act, and perceive the world) did not have indication for the frequency of administration. This failure had the potential to result in Resident 8 and Resident 102 being overmedicated with medications capable of causing adverse effects. Findings: 1. Review of Resident 8's admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 8's physician order, dated 7/30/25, indicated she had an order for clonazepam 0.5 milligrams (mg, a metric unit of mass) as needed for anxiety. However, the order had no frequency of administration indicated. During an interview with the director of nursing (DON) on 8/11/25, at 2:43 p.m., she reviewed Resident 8's clonazepam physician order and confirmed that the order did not have an indication for the frequency of administration. 2. Review of Resident 102's admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 102's physician order, dated 7/29/25, indicated she had an order for trazodone 50 mg as needed for depression. However, the order had no frequency of administration indicated. During an interview with the DON on 8/11/25, at 2:40 p.m., she reviewed Resident 102's trazodone physician order and confirmed that the order did not have an indication for the frequency of administration. Review of the facility's undated policy, Medication and Treatment Orders, indicated, . 9. Orders for medications must include: . c. Dosage and frequency of administration .		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate care and services for one of seven sampled resident (Resident 26) when Resident 26's foley catheter (F/C: a catheter which inserted into a bladder [a body organ that stores the urine] and remains in place to drain urine) drain tube was noted with bloody urine and there was no order to continue use of the F/C. These failures had the potential to result in urinary tract infection (UTI, an infection cause by a bacteria [germ] that get into the bladder) and ill effects on the health and well-being of Resident 26. Findings: During an observation on 8/5/2025 at 3:20 p.m., observed Resident 26's F/C drain tube draining red color urine. Review of Resident 26's face sheet (FS: a document that provides resident's information at a quick glance) indicated Resident 26 was admitted to facility on 7/5/2025. Review of Resident 26's diagnoses included myocardial infarction (a blockage of blood flow to the heart muscle), heart failure (a chronic condition in which the heart does not pump blood as well as it should), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and benign prostatic hyperplasia (a condition where the prostate gland [sits below the bladder [body organ that collects and stores urine] part of male reproductive system, enlarges over time). Review of order summary report for Resident 26 indicated there was no evidence of documented order to continue use of F/C for Resident 26. Review of Nursing admission assessment dated [DATE] indicated Resident 26 was admitted to facility with F/C. Review of Resident 26's care plan for F/C indicated indication of obstructive uropathy for use of F/C. During an observation and interview with license vocational nurse A (LVN A) on 8/5/2025 at 3:30 p.m., LVN A confirmed bloody urine in F/C drain tube for Resident 26. LVN A stated urine should be clear and amber color, will follow up with MD (medical doctor) today. During an interview with facility's director of staff development/infection preventionist consultant (DSD/IP C) on 8/8/2025 at 2:35 p.m., DSD/IP C stated urine should be clear and amber color, will find out why Resident 26's urine was red. During a concurrent record review of physician orders for Resident 26 and interview with director of nursing (DON) on 8/11/2025 at 9:12 a.m., DON confirmed Resident 26 admitted to facility on 7/5/2025 with F/C and there was no physician orders to continue the F/C while in facility. DON stated nursing staff should have received orders to continue F/C upon admission to facility for Resident 26. During an interview with DON on 8/11/2025 at 10:30 a.m., DON provided admission nursing assessment which indicated Resident 26 was admitted to facility with F/C. When asked whether this nursing assessment replaced the physician orders to continue F/C, DON stated No. During an interview with primary care physician (PCP) assigned for Resident 26 on 8/11/2025 at 11:10 a.m., PCP stated F/C was placed while Resident 26 was in hospital and admitted to facility with F/C. PCP also stated facility should have an order to continue F/C after resident was admitted to facility. Review of facility's undated policy and procedure (P&P) titled, Catheter Care, Urinary, the P&P indicated, Check the urine for unusual appearance (i.e., color, blood, etc.). Notify the physician or supervisor in the event of bleeding.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview and record review, the facility failed to ensure intravenous (IV, refers to giving medicines or fluids through a needle or tube inserted into a vein) therapy was consistent with professional standards of practice and in accordance with physician orders when one (Resident 97) out of two sampled residents had an unlabeled IV site and had no longer Physician Orders for medications to be administered through IV. This failure had the potential to put Resident 97 at risk for complications related to intravenous therapy such as phlebitis (inflammation of the vein). Findings: During a concurrent observation and interview on 8/5/25 at 10:32 a.m. with Licensed Vocational Nurse (LVN) A in Resident 97's room, LVN A verified Resident 97's IV site on his right hand had no label. During an interview on 8/8/25 at 12:56 p.m. with the Director of Nursing (DON), the DON stated IV site must be labeled with the date when it was changed. During an observation on 8/11/25 at 10:55 a.m. in Resident 97's room, Resident 97 still had his IV on his right hand. During a concurrent interview and record review on 8/11/25 at 2:04 p.m. with the DON, the DON verified Resident 97 had no physician order for any medications to be administered through IV. The DON also verified Resident 97's physician order for antibiotic to be administered through IV ended on 8/8/25. The DON verified there was no physician order to remove the IV and there was no documentation that the nurse informed the physician if IV was still needed. A review of the facility's Policy and Procedure (P&P) entitled Peripheral and Midline IV Dressing Changes revised June 2025, the P&P indicated, .Steps in the Procedure:.8.Label dressing with initials and the date and time of dressing change.Reporting.1. Notify provider, supervisor, and/or oncoming shift of any complications/interventions that were done.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and record review, the facility failed to ensure the proper care and treatment services for oxygen (O2, a colorless, odorless gas) use was provided for two of five sampled residents (Residents 29 and 34) when:1. Facility staff did not post an Oxygen in use/No smoking sign on Resident 29's room entrance door;2. Resident 34's nasal cannula (NC, flexible tubing inserted into the nostrils and connected to an oxygen source) was not dated.These failures had the potential to compromise the residents' health and safety. Findings: 1. Review of Resident 29's clinical record titled, admission Record, dated 8/8/2025, indicated Resident 29 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of skin (an abnormal growth of cells that divide uncontrollably), hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone) and anxiety disorder (a condition or excessive worry, feelings of fear, dread, and uneasiness). Review of Resident 29's physician's order, dated 7/26/25, indicated an order for oxygen (O2) at 2 to 3 liters per minute (LPM, rate of oxygen administration) via nasal cannula for hypoxia, shortness of breath and comfort as needed. During an observation on 8/5/25 at 9:25 a.m., Resident 29 was awake and sitting up in bed with an oxygen concentrator and nasal cannula not in use at the bedside. There was no oxygen signage displayed at the entrance of Resident 29's room. During an interview on 8/9/25 at 12:59 p.m. with the Director of Nursing (DON), the DON confirmed the signage for, Oxygen in Use, should be posted outside the rooms of all residents receiving oxygen. 2. During an observation on 8/5/2025 at 9:28 a.m., noted Resident 34 was receiving oxygen (O2: colorless, odorless and tasteless gas, essential for living organisms) via nasal cannula (NC: a plastic medical device tube that provides supplemental O2 through nose). This NC was undated/unlabeled. Review of Resident 34's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 34 was admitted to facility on 4/14/2021. Review of Resident 34's diagnoses included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), acute respiratory failure with hypoxia (a severe condition where the lungs [a pair of body organs in the chest helps to breathe] cannot adequately oxygenate [combine or supply with oxygen] the blood, leading to dangerously low oxygen levels in the body), and congestive heart failure (a chronic condition where the heart muscle is weakened or damaged, making it difficult for the heart to pump blood effectively). Review of Resident 34's physician order dated 7/12/2025 indicated Oxygen (O2): Change O2 Tubing to include NC and/or Mask and Storage Bag every week & PRN (as needed). Date Tubing and Bag. During an observation and interview with license vocational nurse/case manager (LVN/CC) on 8/5/2025 at 9:30 a.m., LVN/CC verified NC for Resident 34 and confirmed NC was not labeled with date. LVN/CC stated not sure NC should be labeled, wanted to verify with facility's director of nursing (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DON). LVN/CC left the Resident 34's room, came back after few minutes, stated NC should be changed on weekly basis and should be labeled with date when changed. During an interview with DON on 8/8/2025 at 12:59 p.m., DON stated NC should be labeled with date when changed on weekly basis for residents. Review of facility's policy and procedure (P&P) tilted, Oxygen Administration, undated, the P&P indicated, Oxygen tubing and humidifier (a medical device used to add moisture to O2 delivered to residents) will be changed every 7 days and as needed.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 6 residents (6) was free from unnecessary medications when Resident 6 received morphine sulfate (used to treat pain) but was not monitored for the side effects and not care-planned on the use of the medication. This failure had the potential for the residents to experience unrecognized adverse effects. Findings: Review of Resident 6's admission Record indicated she was admitted to the facility on [DATE]. Review of Resident 6's physician orders, dated 7/17/25, indicated she had orders for morphine sulfate 20 milligrams (mg, a metric unit of mass)/milliliter (ml, a metric unit of volume) give 0.125 ml every 4 hours as needed for moderate pain and give 0.25 ml every 2 or 4 hours as needed for severe pain. However, the review of Resident 6's clinical record did not indicate that Resident 6 was monitored for the side effects and care-planned on the use of the medication. During an interview with the director of nursing (DON) on 8/11/25, at 2:36 p.m., she reviewed Resident 6's clinical record and confirmed that Resident 6 was not monitored for the side effects and was not care-planned on the use of morphine sulfate. Review of the facility's 2001 policy, Administering Pain Medications, indicated . 7. When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility had a medication error rate of 8% when two medication errors occurred out of 25 opportunities during medication administrations for two out of seven residents (60 and 98). This failure resulted in medications not given in accordance with the prescriber's orders which resulted in residents not receiving the therapeutic effects of the medications and the residents' medications not accounted for. Findings: 1. During a medication pass observation on 8/7/25, at 4:53 p.m. with licensed vocational nurse G (LVN G), LVN G stated he did not have Artificial Tears Solution (eye drops used to lubricate dry eyes) on hand to give to Resident 60. Review of Resident 60's physician order, dated 8/8/21, indicated Resident 60 was to receive Artificial Tears Solution one drop in both eyes four times a day at 9 a.m., 1 p.m., 5 p.m., and 9 p.m. 2. During a medication pass observation on 8/8/25, at 9:06 a.m. with LVN L, LVN L was to administer tramadol (used to relieve moderate to severe pain) 50 milligrams (mg, a metric unit of mass) one tablet to Resident 98 for his complaint of severe pain, but LVN L dispensed the one tablet of tramadol 50 mg from Resident 7's bubble pack of tramadol 50 mg to give to Resident 98. During a concurrent observation and interview with LVN L, he observed and reviewed Resident 7's tramadol 50 mg bubble pack and counting sheet and confirmed that he dispensed the one tablet of tramadol 50 mg from Resident 7's bubble pack of tramadol 50 mg to give to Resident 98. Review of the facility's 2003 job description, Charge Nurse, indicated Duties and Responsibilities - Drug Administration Functions: . Ensure that prescribed medication for one resident is not administered to another. Ensure that an adequate supply of floor stock medications, supplies, and equipment is on hand to meet the nursing needs of the residents. Report needs to the Nurse Supervisor.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure supplies were stored appropriately when expired incontinent wash bottle was found in the central supply room. This failure had the potential for the expired incontinent wash being used on the residents. Findings: On [DATE], at 3:54 p.m., during an observation in central supply room with central supply coordinator (CSC), one Ca-Rezz incontinent wash bottle was expired on 3/2025. During a concurrent observation and interview with the CSC, he observed the Ca-Rezz incontinent wash bottle and confirmed that it was expired, and he would put it away. Review of the facility's 2001 policy, Medication Labeling and Storage, indicated . 3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.		

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure to accommodate liquid consistency for one of five sampled residents (Resident 45). This failure had the potential for decreased meal intake, negative effect on health and well-being of Resident 45. Findings: During an observation of lunch meal in dining room on 8/5/2025 at 12:15 p.m., noted Resident 45 lunch meal tray was served with thick consistency white liquid in a plastic cup, not able to come out of the cup when tilted to the sides. Also noted flowing consistency apple juice in a plastic cup was in lunch tray. Resident 45 refused to drink thick white consistency liquid from lunch tray. Resident 45 consumed 3/4th cup of flowing consistency apple juice when fed by staff. Review of Resident 45's face sheet (FS: a document that gives resident's information at a quick glance) indicated Resident 45 was admitted to facility on 10/3/2023. Review of Resident 45 diagnoses included cerebral infarction (occurs when blood vessel supplying the brain is blocked) and dysphagia (difficulty swallowing food and liquids). Review of Resident 45's order summary report indicated a diet order, dated 10/3/2023, No Added Salt (NAS) diet pureed texture (soft and blended to smooth texture), moderately Thick consistency, Honey -Thick Liquids (slightly thicker, similar to honey or milkshake, pours slowly than nectar-thick). Review of Resident 45's lunch tray card dated, Tue-[DATE]/25 Lunch, indicated under Special Diets: Moderately Thick Liquids. During an observation and interview with certified nursing assistant H (CNA H) on 8/5/2025 at 12:20 p.m., CNA H confirmed thick white liquid in a plastic cup served for Resident 45 was pudding thick consistency (thickest liquid consistency, resembling the texture of pudding or mousse) mighty shake (type of nutritional shake designed to provide extra calories and protein [essential for various bodily functions, must get from foods]) and honey thickened apple juice in Resident 45's lunch tray. CNA H reviewed lunch tray card and stated Resident 45 should have honey thickened liquids not pudding thickened liquids. CNA H also stated Resident 45 refused pudding thickened mighty shake because it's too thick to drink. During an interview with dietary supervisor (DS) on 8/5/2025 at 12:31 p.m., DS confirmed Resident 45 was received pudding consistency mighty shake, and honey thick consistency apple juice for lunch meal. DS stated dietary staff might have mixed too much thickener for mighty shake than required for consistency. DS also stated dietary staff should have provided honey thick liquids to Resident 45 as indicated in lunch tray card. During an observation and interview with facility's speech pathologist (SP: a healthcare professional who evaluates, diagnoses, and treats swallowing disorders) on 8/5/2025 at 12:35 p.m., SP confirmed mighty shake was pudding consistency. SP stated Resident 45 had an order for honey thickened liquids. SP also stated Resident 45 should have served honey thickened liquids, not pudding thickened liquids. During review of facility's undated policy and procedure (P&P) titled, Therapeutic Diets, the P&P indicated, Thickened liquids will be made with consistency as ordered by the attending physician. If thickener is used, the manufacturer's instructions will be followed.		