STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055459	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vista Care Center	1440 S Euclid Avenue Anaheim, CA 92802

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **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 protect Resident 1's right to be free from physical abuse by another Resident (Resident 2), for one of three sampled residents reviewed for abuse. * During resident activities, a facility staff member witnessed Resident 2 hit Resident 1 on the chin, with a clenched fist. This failure to prevent physical abuse had the potential to result in serious injury and/or psychosocial harm to Resident 1. Findings: Review of the facility's P&P titled Identifying Types of Abuse revised 9/2022 showed abuse of any kind against residents is strictly prohibited. Abuse toward a resident can occur as resident-to-resident abuse. Physical abuse includes but is not limited to hitting or punching. Some situations of abuse do not result in an observable physical injury. The psychosocial effects of abuse may not be immediately apparent. 1. Medical record review for Resident 1 was initiated on 5/11/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 was cognitively intact. Review of Resident 1's Change in Condition note dated 4/30/26, showed on 4/30/26 around 1440 hours, an incident occurred between two residents (Resident 1 and Resident 2) in the dining room. Per staff member, Resident 1 was backing his wheelchair out from the table and at the same time Resident 2 (also in his wheelchair) was attempting to leave the dining room. The residents bumped into each other. Resident 2 was angry and was seen hitting Resident 1 in the chin area. Both residents were immediately separated by staff. On 5/11/26 at 1331 hours, an interview was conducted with Resident 1. Resident 1 stated on 4/30/26 in the afternoon, he was seated in his wheelchair at a table in the dining room, during activities. Resident 1 stated Resident 2 was seated in a wheelchair and self-propelled himself into the dining room. Resident 1 stated Resident 2 wheeled himself to a table which contained prizes residents could purchase as a result of winning Bingo games. Resident 1 stated he told Resident 2 the prizes were for residents who participated in Bingo and Resident 2 had not participated. Resident 1 stated Resident 2 then self-propelled himself into Resident 1's wheelchair. Resident 1 stated he yelled, what are you doing! Resident 1 stated Resident 2 then hit him on the right side of his mouth with a clenched right fist. Resident 1 stated the force of the punch was a four out of 10. Resident 1 stated he felt pain in his mouth and rated his pain a three out of 10. Resident 1 stated he sustained an abrasion on the inside of his mouth, on the right side between his lips. Resident 1 stated after he was punched by Resident 2 he felt angry and wanted to retaliate. Resident 1 stated staff separated the residents and he did not retaliate. On 5/11/26 at 1402 hours, an interview was conducted with the IP. The IP stated on 4/30/26 in the afternoon, residents had gathered in the dining room for activities. The IP stated Resident 2 was seated in his wheelchair and self-propelled himself up to the activities table to view available resident prizes. The IP stated Resident 2 then self-propelled himself away from the table. The IP stated Resident 1 was seated in his wheelchair and was backing away from a table, at which time Resident 1 and Resident 2's wheelchairs bumped into each other. The IP stated Resident 2 became upset and started yelling at Resident 1. The IP stated she then saw Resident 2 hit Resident 1 on the area of his chin, with a right clenched fist. The IP stated staff then separated the residents. The IP stated Resident 1 was upset (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and stated he attempted to avoid Resident 2. 2. Medical record review for Resident 2 was initiated on 5/11/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's care plan for alteration in mood and pattern related to psychosis manifested by sudden angry outbursts initiated 2/25/25, showed goals including Resident 2's episodes of sudden angry outbursts will be reduced to zero from one episode per week. Review of Resident 1's MDS assessment dated [DATE], showed Resident 2 had moderately impaired cognition. On 5/11/26 at 1520 hours, Resident 2 was observed in the hallway seated in his wheelchair. Resident 2 was asked if he was involved in an incident with Resident 1 during activities on 4/30/26 in the afternoon. Resident 2 stated, no comment. On 5/11/26 at 1700 hours, an interview was conducted with the Administrator. The Administrator stated she was the facility's Abuse Coordinator. The Administrator stated the facility investigated the incident involving Resident 1 and Resident 2, with occurred on 4/30/26 in the dining room. The Administrator stated during the investigation that staff who witnessed the incident were interviewed. The Administrator stated the IP witnessed Resident 1 and Resident 2 bump into each other while seated in their wheelchairs. The Administrator stated the IP witnessed Resident 2 become upset and hit Resident 1 on the chin area. The Administrator was asked if Resident 1 and Resident 2 had been involved in any other altercations in the past. The Administrator stated in March of 2026, the facility investigated an alleged incident involving the residents. The facility investigated an allegation that Resident 2 had pushed Resident 1 from the back, at which time Resident 1 grabbed Resident 2 by the arm and Resident 1 then punched Resident 2's arm a couple of times. Cross reference F610.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to thoroughly investigate an allegation of resident-to-resident physical abuse, for two of three residents (Residents 1 and 2) reviewed for abuse. * The facility failed to interview other residents present at the time of a physical altercation between Residents 1 and 2. The failure to interview all potential witnesses to an allegation of resident-to-resident physical abuse potentially inhibited the facility's ability to determine if resident abuse occurred and posed the risk for further abuse.Findings: Review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revised 9/2022 showed all reports of resident abuse are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. All allegations are thoroughly investigated. The Administrator initiates investigations. The individual conducting the investigation at a minimum interviews the residents and interviews any witnesses to the incident. Witness statements are obtained in writing, signed and dated. The witness may write their statement, or the investigator may obtain a statement. Medical record review for Resident 1 was initiated on 5/11/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 was cognitively intact. On 5/11/26 at 1331 hours, an interview was conducted with Resident 1. Resident 1 stated on 4/30/26 in the afternoon, he was sitting in his wheelchair at a table in the dining room, during activities. Resident 1 stated Resident 2 was sitting in a wheelchair and self-propelled himself into the dining room. Resident 1 stated Resident 2 wheeled himself to a table which contained prizes residents could purchase as a result of winning Bingo games. Resident 1 stated he told Resident 2 the prizes were for residents who participated in Bingo and Resident 2 had not participated. Resident 1 stated Resident 2 then self-propelled himself into Resident 1's wheelchair. Resident 1 stated he yelled, what are you doing! Resident 1 stated Resident 2 then hit him on the right side of his mouth with a clenched right fist. Resident 1 stated the force of the punch was a four out of 10. Resident 1 stated he felt pain in his mouth and rated his pain a three out of 10. Resident 1 stated he sustained an abrasion on the inside of his mouth, on the right side between his lips. Resident 1 stated after he was punched by Resident 2, he felt angry and wanted to retaliate. Resident 1 stated staff separated the residents and he did not retaliate. Resident 1 was asked if anyone else had witnessed the incident. Resident 1 stated facility staff were present and Residents 3 and 4 were seated at the table with him. On 5/11/26 at 1402 hours, an interview was conducted with the IP. The IP stated on 4/30/26 in the afternoon, residents had gathered in the dining room for activities. The IP stated Resident 2 was seated in his wheelchair and self-propelled himself up to the activities table to view available resident prizes. The IP stated Resident 2 then self-propelled himself away from the table. The IP stated Resident 1 was seated in his wheelchair and was backing away from a table, at which time Resident 1 and Resident 2's wheelchairs bumped into each other. The IP stated Resident 2 became upset and started yelling at Resident 1. The IP stated she then saw Resident 2 hit Resident 1 on the area of his chin, with a right clenched fist. The IP stated staff then separated the residents. The IP stated Resident 1 was upset and stated he attempted to avoid Resident 2. The IP was asked if any other residents were seated at Resident 1's table. The IP stated Residents 3 and 4 were seated at Resident 1's table. On 5/11/26 at 1434 hours, an interview was conducted with Resident 3. Resident 3 was asked if she had witnessed an incident between Residents 1 and 2, which occurred on 4/30/26, during activities in the dining room. Resident 3 stated she had witnessed a physical altercation between Residents 1 and 2. Resident 3 stated she was seated at a table with Resident 1. Resident 3 stated Resident 1 was seated in his wheelchair at the table. Resident 3 stated she saw Resident 2 seated in his wheelchair at the Bingo prize table. Resident 3 stated she then saw Resident 2 for no reason, self-propel himself away from the prize table toward Resident 1 and hit Resident 1's (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair. Resident 3 stated she then saw Resident 2 punch Resident 1 in the mouth. On 5/11/26 at 1442 hours, an interview was conducted with Resident 4. Resident 4 reported having not witnessed the incident. On 5/11/26 at 1700 hours, an interview and concurrent facility document review, was conducted with the Administrator. The Administrator stated she was the facility's Abuse Coordinator. The Administrator stated the facility investigated the incident involving Resident 1 and Resident 2, with occurred on 4/30/26 in the dining room. Review of the facility's Investigative Summary dated 5/1/26, showed the Administrator conducted interviews with Residents 1 and 2. The Investigative Summary showed Resident 1 claimed Resident 2 hit him on the chin. Further review of the Investigative Summary also showed Resident 2 claimed Resident 1 hit him on the cheek. The Administrator verified during her interview with Resident 2, he claimed Resident 1 had hit him on the cheek. The Administrator was asked if any witnesses had corroborated Resident 2's claim he was hit by Resident 1. The Administrator stated no one had witnessed Resident 1 hit Resident 2. Review of the investigative interviews the facility conducted specific to the incident, failed to show documentation interviews were conducted with other residents, who were present at the time of the incident, who may have witnessed the incident. The Administrator was asked for the names of the residents who were present during the incident, and if these residents may have witnessed the incident. The Administrator stated she was uncertain and no interviews were conducted with other residents who were present during the incident, because staff had witnessed the incident. Cross reference F600.