

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055571	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/03/2025
NAME OF PROVIDER OR SUPPLIER Buena Park Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8520 Western Avenue Buena Park, CA 90620	

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)
<p>F 0552</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**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 informed consents for the use of psychotropic medications for one of five sampled residents (Resident 1) was obtained. * The facility failed to ensure Resident 1's informed consent for the Ativan (anti-anxiety medication) was obtained. This failure posed the risk for the residents to not be informed of their care and treatment. Findings:</p> <p>Review of the facility's P&P titled Psychotherapeutic Drug Treatment revised 1/2017 showed the resident has the right to be free from unnecessary drugs and/or medications and protection from medication errors. Chemical restraint is defined as a psychotherapeutic drug that is used to treat medical symptoms. Psychotherapeutic drugs include antianxiety agents, antidepressants, sedatives, hypnotics, antipsychotics and other drugs that affect behavior. Moreover, the P&P further showed chemical restraints shall be used only after alternative methods have been tried unsuccessfully and only upon the written order of a physician and after informed consent has been obtained by the physician from the resident and/or his/her representative. The resident or his/her representative will be given information regarding the need for, the desired effects and the potential side effect of the medication. This enables the resident or his/her representative to make an informed decision regarding the use of any psychoactive medication.</p> <p>Closed medical record review for Resident 1 was initiated on 10/23/25. Resident 1 was admitted to the facility on [DATE], and was discharged to the acute care hospital on 3/2/25.</p> <p>Review of Resident 1's H&P examination dated 10/14/24, showed Resident 1 had no capacity to understand and make decisions.</p> <p>Review of Resident 1's Telephone Order Report dated 12/19/24, showed a physician's order to administer Ativan 0.5 mg, one tablet via GT every six hours as needed for 14 days for anxiety manifested by inability to relax.</p> <p>Review of Resident 1's medical record failed to show documented evidence an Informed Consent was obtained for use of the Ativan medication as ordered.</p> <p>On 10/30/25 at 0950 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with RN 2. RN 2 reviewed Resident 1's medical record and stated Resident 1 was previously prescribed the Ativan medication for inability to relax for 14 days. RN 2 stated on 12/8/24, the Ativan medication was not renewed after 14 days. RN 2 further stated a new informed consent was not obtained when the Ativan medication was ordered by the physician on 12/19/24.</p> <p>(continued on next page)</p>

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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<p>F 0552</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>On 10/30/25 at 1553 hours, an interview was conducted with the DON. The DON acknowledged and verified the above findings.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, medical record review, and facility document review, the facility failed to develop an individualized care plan for one of five sampled resident (Resident 1). *The facility failed to ensure a care plan was developed for Resident 1's Actual Fall Incident on 11/22/24. This failure posed the risk of not providing the appropriate and individualized care to Resident 1 to prevent another episode of fall. Findings: Review of the facility's P&P titled Comprehensive Care Planning revised 3/2019 showed the plan of care must include measurable objectives and timeframes and describe the services that are to be furnished to attain and maintain the resident's highest practicable level of well-being. Closed medical record review for Resident 1 was initiated on 10/23/25. Resident 1 was admitted to the facility on [DATE], and was discharged to the acute care hospital on 3/2/25. Review of Resident 1's H&P examination dated 10/14/24, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's Licensed Nurses Progress Note dated 11/22/24, showed Resident 1 was found on the right side of bed on floor and on side lying position. Review of Resident 1's Plan of Care failed to show a care plan problem was developed to address Resident 1's actual fall. On 10/30/25 at 1022 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 1. RN 1 reviewed Resident 1's Resident Care Plan and verified there was no care plan problem to address Resident 1's actual fall on 11/22/24. On 10/30/25 at 1553 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. When the DON was asked about the process when a resident had a fall incident, the DON stated it was the responsibility of the licensed nurse to do the change of condition and care plan should be completed with each change of condition for the resident. The DON acknowledged and verified the above findings.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**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 provide the necessary care and services to maintain the highest practicable well-being for two of five sampled residents (Residents 1 and 2). * The facility failed to ensure the physician's recommendation was carried out as ordered for Resident 1. * The facility failed to ensure Residents 1 and 2's neurological checks (Neuro check -series of tests performed by healthcare providers to evaluate the function of the brain) were completed. * The facility failed to ensure the orthostatic hypotension monitoring was implemented for Resident 1 for the use of the Seroquel (antipsychotic medication). These failures had the potential to negatively affect the residents' well-being as the necessary care and services were not provided. Findings:</p> <p>Review of the facility's P&P titled Physician Services and Orders revised 1/2017 showed it is the policy of the facility that each resident remain under the care of a physician. Drugs, biologicals, laboratory services, radiology and other diagnostic services shall be administered or performed only upon the written order of a person duly licensed and authorized to prescribe such drugs and services.</p> <p>Review of the facility's P&P titled Accidents and Incidents-Resident Investigating and Reporting revised 1/2017 showed initiation of investigation, data included on Report of Incident/Accident Form Documentation Protocols: the following data, as applicable, such as corrective action, follow-up information, other pertinent data as necessary or required shall be included.</p> <p>1. Closed medical record review for Resident 1 was initiated on 10/23/25. Resident 1 was admitted to the facility on [DATE].</p> <p>a. Review of Resident 1's H&P examination dated 10/14/24, showed Resident 1 had no capacity to understand and make decisions.</p> <p>Review of Resident 1's Psychiatric Evaluation and assessment dated [DATE], showed a recommendation to consider starting the resident on Depakote (medication used to stabilize mood) 125 mg every 12 hours for poor impulse control.</p> <p>Review of the [DATE]/2024 for failed to show the recommendation for the Depakote 125 mg every 12 hours for poor impulse control was communicated and obtained from the physician.</p> <p>On 10/30/25 at 1022 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 1. RN 1 reviewed Resident 1's medical record and verified there was a documentation for Psychiatric Evaluation and assessment dated [DATE], and there was a recommendation to consider starting Depakote 125 mg every 12 hours for poor impulse control. RN 1 further stated there was no documentation the recommendation for Depakote was carried out.</p> <p>b. Review of Resident 1's Licensed Nurses Progress Note dated 11/22/24, showed Resident 1 was found on the right side of bed on floor and on side lying position. The progress note further showed neurological checks for 72 hours was implemented.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's medical record failed to show documented evidence a neurological check was initiated status post fall on 11/22/24.</p> <p>On 10/30/25 at 1022 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 1. RN 1 verified a neurological check was documented on the Licensed Nurses Progress note, however, it was not initiated after Resident 1's fall on 11/22/24. RN 1 stated the neurological checks were done for 72 hours status post fall to monitor if there were changes in mental status, reflexes and functioning of the nerves. RN 1 verified there was no documented Neuro-check initiated for Resident 1's actual fall on 11/22/24.</p> <p>On 10/30/25 at 1553 hours, an interview was conducted with the DON. The DON acknowledged and verified the above findings.</p> <p>c. Resident 1 was readmitted back to the facility on 1/3/25, and was discharged to the acute care hospital on 3/2/25.</p> <p>Review of Resident 1's H&P examination dated 1/6/25, showed the resident had no capacity to understand and make decisions.</p> <p>Review of Resident 1's Order Summary Report for March 2025 showed a physician's order dated 1/28/25, for Seroquel 100 mg give one tablet via GT at bedtime for mood disturbance manifested by pulling on medical devices, informed consent obtained by the physician from the responsible party. Risks and benefits were explained. Further review of the Order Summary Report showed a physician's order dated 1/28/25, for Seroquel 50 mg give one tablet via GT one time a day for mood disturbance manifested by pulling on the medical devices, informed consent was obtained by the physician from the responsible party. Risks and benefits were explained.</p> <p>On 10/30/25 at 1623 hours, a concurrent interview and medical record review for Resident 1 was conducted with the DON. The DON verified Resident 1 was on Seroquel 100 mg at bedtime and 50 mg one time a day. The DON also verified Resident 1 did not have documented evidence orthostatic hypotension were monitored for Resident 1 for the use of the Seroquel medication. The DON stated the orthostatic hypotension should be monitored for laying, sitting, and standing with parameters as it was one of the side effects of the Seroquel medication.</p> <p>On 10/31/25 at 1615 hours, an interview with the DON was conducted. The DON acknowledged and verified the above findings.</p> <p>2. Medical record review for Resident 2 was initiated on 10/23/25. Resident 2 was admitted to the facility on [DATE].</p> <p>Review of Resident 2's H&P examination dated 9/30/25, showed Resident 2 had no capacity to understand and make decisions.</p> <p>Review of Resident 2's Licensed Nurses Progress Note dated 10/1/25, showed Resident 2 was found on the floor and sitting on left side of bed. The progress note further showed neurological checks for 72 hours was implemented.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 2's IDT Progress Note dated 10/2/25, showed the IDT recommendation included a 72 hours neurological check.</p> <p>Further review of Resident 2's medical record failed to show documented evidence a neurological check was initiated status post fall on 10/1/25.</p> <p>On 10/30/25 at 1300 hours, an interview and concurrent medical record review for Resident 2 was conducted with RN 1. RN 1 verified the above findings. RN 1 verified a neurological check was not initiated after Resident 2's fall on 10/1/25. RN 1 stated neurological checks were done for 72 hours status post fall and were done to monitor for changes in the resident's level of consciousness and for neurological changes.</p> <p>On 10/30/25 at 1623 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON verified Resident 2 had an unwitnessed fall on 10/1/25. The DON stated Resident 2 should have had a neurological check for 72 hours status post unwitnessed fall. The DON further stated that neurological check allowed the nurses to assess for significant changes to the resident, which may indicate a head injury where the physician will need to be notified immediately.</p> <p>On 10/31/25 at 1615 hours, an interview was conducted with the DON. The DON acknowledged and verified the above findings.</p>