STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055571	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	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)
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 and facility P&P review, the facility failed to ensure the care plan was followed for the use of restraints for one of six sampled residents (Resident 6). * The facility failed to ensure Resident 6's left hand mitten was released every two hours as per the care plan. This failure had the potential to cause delays in identifying possible health risks associated with the use of hand mitten restraint including poor circulation and impaired skin integrity. Findings: Review of the facility's P&P titled Physical Restraints revised 1/2017 showed if the restraints are utilized, the opportunity for motion and exercise should be provided for a period of not less than 10 minutes during two hour period in which restraints are utilized. Medical record review for Resident 6 was initiated on 1/28/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's Order Summary Report showed a physician's order dated 3/10/25, to apply left hand mitten necessity due to persistent pulling out of GT. Review of Resident 6's care plan for usage of the left hand mittens or persistent pulling out of GT initiated 3/10/25 and revised 11/9/25, showed interventions including the application of the left hand mitten to prevent pulling out the tube and release every two hours for circulation and comfort for 15 minutes. Review of Resident 6's MAR for March 2025 showed the left hand mitten placement was monitored every shift on 3/10 - 3/31/25. Review of Resident 6's medical record failed to show documented evidence Resident 6's left hand mitten restraint was released every two hours for skin integrity and circulation. On 1/30/26 at 1100 hours, an interview and concurrent medical record review for Resident 6 was conducted with RN 1. RN 1 stated the facility protocol for the use of hand mitten restraint was to remove the hand mitten every two hours and check for circulation and skin condition. RN 1 verified Resident 6 did not have an order to monitor circulation and skin condition every 2 hours. RN 1 further verified there was no documentation to show whether Resident 6's hand mittens were released every two hours to monitor for circulation and comfort. On 1/30/26 at 1315 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, facility document review, and facility P&P review, the facility failed to provide the pharmaceutical services to one of six sampled residents (Resident 1) as ordered by the physician. * The facility failed to ensure Resident 1's Refresh Plus (eye lubricant), Timoptic ophthalmic solution (a prescription eye drop used to lower high fluid pressure within the eye) and Lumify (an eye drop used to reduce eye redness) were available for administration as ordered by the physician. In addition, the facility failed to ensure Resident 1's physician was made aware when the medications were not available for administration. These failures had the potential to affect resident's health status and wellbeing.Findings: Review of the facility's P&P titled Medication Administration revised 5/2019 showed it is the policy of the facility that medications for residents be administrated in a safe and timely manner and as prescribed. Medications must be administered in accordance with the physician orders, including any required time frame.Medical record review for Resident 1 was initiated on 1/15/26. Resident 1 was admitted to the facility on [DATE] and readmitted to facility on 3/13/25 with medical history including glaucoma. Review of Resident 1's H&P examination dated 3/15/25, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's Order Summary Report showed the following physician's orders:- dated 3/29/25, to administer Refresh Plus ophthalmic solution one drop in both eyes every two hours for dry eyes, ocular surface irritation;- dated 6/27/25, to administer Timoptic Ophthalmic solution (timolol) one drop in both eyes two times a day for uncontrolled primary open angle glaucoma; and- dated 7/30/25, to administer Lumify ophthalmic solution (brimonidine tartrate) one drop in both eyes two times a day for ocular hyperemia (red eye). Review of Resident 1's MAR showed the following medications were not administered on the following dates:- dated 3/29/25, Refresh Plus administration was coded 5 (indicating hold/see progress notes) at 1600 hours and coded 4 (indicating the vitals were outside of the parameters for administration) at 2000 hours. However, the administration progress note failed to show the reason why the medication was not administered and what parameters of administration.- dated 6/1/25, Refresh Plus was not administered 12 times from 0000 to 2200 hours. Further review of the MAR progress note showed awaiting medication from pharmacy. In addition, review of the nursing progress note dated 6/1/25, showed that pharmacy was contacted and requested for refill; however, there was no documentation if the physician was informed regarding multiple missed doses.- dated 6/2/25, Refresh Plus was not administered nine times from 0000 to 1600 hours. Further review of the MAR progress note showed awaiting medication from pharmacy.- dated 8/11/25, Timoptic ophthalmic solution administration for 1700 hours was coded 9 (indicating to see the progress note). However, reviewed of the administration progress note failed to show a reason why the medication was not administered - dated 9/3/25, Timoptic ophthalmic solution administration for 1700 hours was coded 9 (indicating to see the progress note). Review of the administration progress note showed awaiting for delivery.- dated 10/15/25, Lumify ophthalmic solution administration for 0900 hours was coded 9 (indicating to see progress note). Review of the nursing progress note showed three nursing documentation indicating that follow up phone calls were made with the pharmacy; however, pharmacy does not have stock of Lumify medication. On 1/27/26 at 1500 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 acknowledged the above findings and stated it was the responsibility of the charge nurse to submit a request for refill five days before the medication runs out. RN 1 further stated the physician should have also been notified when the medication was not administered as ordered. On 1/30/26 at 1315 hours, an interview was conducted with the DON and Administrator. The DON (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Administrator were informed and acknowledged the findings.