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	05/06/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 one of three sampled residents (Resident 1) was provided with the care and services free from accidents and/or injuries. * The facility failed to maintain Resident 1's skin integrity when provided with care. CNA 1 had long nails and scratched Resident 1 during shower . This failure resulted in Resident 1 sustaining multiple scratches on the head and face and posed a risk for the resident's skin to get infected.Findings: Review of the facility's P&P titled Dress Code dated 1/2026 showed nursing staff must keep nails trimmed to 1/8 of an inch to avoid injury to residents. Medical record review for Resident 1 was initiated on 5/7/26. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 5/20/25, showed Resident 1 had no capacity to understand and make his own decisions. Review of Resident 1's Licensed Nurses Progress Note dated 4/29/26 at 1710 hours, showed a CNA reported during shower care, Resident 1 sustained superficial scratch marks to the facial area, forehead, right and left side of the face. Noted linear superficial scratches, no active bleeding, and minimal redness present. On 5/6/26 at 1150 hours, an interview was conducted with RN 1. RN 1 stated on 4/29/26, an incident was reported to her involving Resident 1. RN 1 stated LVN 1 reported that CNA 1 was showering Resident 1 and during the shower, Resident 1 obtained multiple linear scratches on his forehead, cheeks, and chin. RN 1 stated CNA 1 informed her while giving a shower to Resident 1, his tracheostomy [NAME] got disconnected. While CNA 1 was securing the [NAME] with one hand, CNA 1 was trying to rinse Resident 1's head and face with the other hand and her nails caused scratches on Resident 1's face, cheeks and chin. RN 1 stated Resident 1's scratches was assessed and found them to be superficial with no new orders from the physician. RN 1 cleaned the scratches and left them open to air. RN 1 stated CNA 1 was removed from direct resident care pending the police report and ultimately was sent home. RN 1 further stated the facility had a policy for nail hygiene and they should be kept short. RN 1 also stated the facility did not conduct a staff inspections to ensure they were following the facility code. On 5/6/26 at 1239 hours, an interview was conducted with the DON. The DON stated the RN supervisors were the ones who should be conducting uniform inspections to ensure compliance with the facility dress code. On 5/6/26 at 1430 hours, an interview was conducted with RN 2. RN 2 stated it was the responsibility of the DSD to inspect the CNAs for compliance with the dress code; however, the facility did not currently have a full-time DSD. On 5/6/26 at 1458 hours, an interview was conducted with CNA 1. CNA 1 stated while she was showering Resident 1 the resident's [NAME] came loose twice. CNA 1 stated she was focused on keeping the [NAME] connected and was not paying attention to her other hand rinsing Resident 1's head and her long nails were causing scratches to Resident 1's forehead, cheeks and chin. CNA 1 stated she knew she should not have long nails. CNA 1 stated the facility had done multiple in-services about nail grooming and following the dress code, but the policy was never enforced. On 5/6/26 at 1539 hours, an observation and concurrent interview was conducted with LVN 2. LVN 2 was observed at the nursing station with long nails appearing to be artificial nails. When asked about her nails, LVN 2 stated her nails were not compliant (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the facility's policy but has not taken them off since their last in-service. Review of facility's documents titled Inservice Education Record dated 3/20/26, showed the course title/subject for Nail Hygiene and the subject summary showed proper nail hygiene for nursing staff and prevention of resident injury and infection. The document further showed CNA 1 and LVN 2 attended an inservice education. On 5/7/26 at 0905 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings.