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	06/04/2026

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, and facility P&P review, the facility failed to provide the necessary care and services to prevent fall for one of four sampled residents (Resident 1). * The facility failed to ensure Resident 1 was adequately assisted when turned and positioned during a diaper change in bed to prevent the resident from sliding off the bed and landed on the floor. This failure had the potential to place the resident at risk for more serious injury and compromised resident safety. Findings: Review of the facility's P&P titled Comprehensive Care Planning dated 3/2019 showed it is the policy of the facility a comprehensive resident - centered care plan be developed for each resident that includes measurable objectives and time frames to meet each residents' medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must include services that are to be provided to attain or maintain the residents' highest level of well-being. Review of the facility's P&P on Fall Risk & Prevention of Injury to Include Pathological Fractures dated 3/2019 showed it is the policy of the facility to identify residents that are at risk for falls and to implement a plan of care in an attempt to prevent falls. If the fall risk assessment is ten or above, the resident is at risk for falls and a plan of care will be developed and with approaches in an attempt to prevent falls, including falls of serious injury. Medical record review for Resident 1 was initiated on 6/3/26. Resident 1 was initially admitted to the facility on [DATE]. Review of Resident 1's CNA Task, Documentation Survey Report showed Resident 1's ability to roll from lying to the left and right side and return to lying back on the bed as follows:* on 3/3/26 and 3/4/26 - day, evening, and night shifts: dependent, CNA does all of the effort, the resident does none of the effort to complete the activity or the assistance of two or more CNA's is required to complete the activity.* on 3/5/26 - for the day shift, the resident needed substantial maximum assistance, CNA performs more than half of the effort. For evening shift, dependent, CNA does all of the effort, the resident does none of the effort to complete the activity or the assistance of two or more CNA's is required to complete the activity and for the night shift, Resident 1 was dependent, CNA does all of the effort, the resident does none of the effort to complete the activity or the assistance of two or more CNA's is required to complete the activity. Review of Resident 1's Care Plan Report on Falls/Injury initiated on 12/8/25, and revised on 3/17/26, showed the goal was to minimize/eliminate risk of fall/injury daily. Review of Resident 1's MDS section GG Functional Abilities dated 3/17/26, showed the code 01 (Helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required for the resident to complete the activity) for the following:a. Self-Care- toileting hygiene -the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement; and- lower body dressing - the ability to dress and undress below the waist.b. Mobility- roll left and right (the ability to roll from lying on back to left and right side, and return to lying back on bed) Review of Resident 1's Daily Skilled Nurses Notes dated 3/23/36, showed the ADL toileting hygiene was coded as one (1) dependent with two staff assistance. Review of Resident 1's Fall Risk Evaluation dated 4/23/26, showed a score of 19 (high risk for potential falls). Review of Resident 1's Weekly Summary dated 4/2426, for (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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(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	ADL/Self-performance Support showed as dependent in toileting hygiene, shower/ bathing, lower body dressing and personal hygiene and the resident was able to roll left to right with substantial and maximal assist. Review of Resident 1's Progress Notes dated 5/6/26 showed the following:- at 0400 hours, Resident 1 was noted to be sliding from the bed during a diaper change. Resident 1's body was noted sliding off the bed and CNA 1 assisted Resident 1 to slowly slide down the floor in a sitting position on the right side of the bed. Resident 1 was asked and Resident 1 stated fall. The progress note further showed Resident 1 complained of pain, pointing to the left upper quadrant of the abdominal area and was provided with pain medication; and- at 0815 hours, the CNA reported Resident 1 complained of pain to the left side flank (side of the upper body between the lower ribs and hip bone). When the RN supervisor assessed, Resident 1 complained of 10/10 pain level and Resident 1 was provided with pain medication; and- at 0900 hours, the physician was made aware of and ordered for a stat left side x-ray. Reviewed Resident 1's Patient Report for left rib x-ray dated 5/6/26, showed an acute 7th to 8th rib fractures. Review of Resident 1's H&P examination dated 5/11/26, showed Resident 1 had no capacity to understand and make decisions. On 6/4/26 at 0926 hours, an interview and concurrent medical record and facility record review was conducted with the ADON. The ADON stated Resident 1 was assessed as totally dependent, two staff assistance needed in bed mobility and transfers prior to the recent fall. On 6/4/26 at 1302 hours, a telephone interview was conducted with CNA 1. CNA 1 stated, I was turning her to her right side. The bed was at an appropriate height. I had to turn her; she's heavy. After I pulled the dirty diaper out and was sliding the clean diaper under the resident, I had to turn Resident 1 away from me. I saw her leg dangling, and I immediately helped her, assisting her to slide to the floor. I grabbed her, I was solely grabbing the resident to maintain control, and the resident landed on the floor. CNA 1 further stated there were no care plan instructions available for review, and he was not informed how many staff members were required to assist Resident 1 before he provided care. On 6/4/26 at 1323 hours, an interview and concurrent medical record review were conducted with the DOR. The DOR stated Resident 1 was discharged from the rehab with previous status in bed mobility as totally dependent and upon discharge on [DATE], was maximum assistance. The DOR was asked which plan of care for the need of assistance in toileting and bed mobility should the CNAs follow and how this information was imparted to the CNAs. The DOR stated we teach the CNA's depending on how the resident is feeling that day, if the resident is tired, probably we always recommend two staff assist for safety, considering the CNA's different skill levels, it is hard to tell, the nurses also tells them. On 6/4/26 at 1515 hours, an interview was conducted with CNA 6. CNA 6 was asked how many staff are needed in Resident 1's bed mobility, CNA 6 stated, Resident 1 needed 2 staff assistance in pulling up and turning resident side to side, I changed her before, she's heavy. On 6/4/26 at 1645 hours an interview was conducted with the Administrator and DON. The Administrator and DON was made aware and acknowledged the above findings.