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	11/21/2024

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 0558 Level of Harm - Potential for minimal harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, clinical record review, and facility P&P review, the facility failed to ensure the call light was within reach for one of 26 final sampled residents (Residents 110). This failure had the potential for Resident 110 not being able to summon help if needed and not receiving care timely. Findings: Review of the facility's P&P titled Call lights dated 1/2017 showed when the resident is in bed or in the wheelchair or chair in the room, staff should make sure that the call light is within easy reach of the resident. Medical record review of Resident 110 was initiated on 11/18/24. Resident 110 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 110's care plan dated 11/6/24, showed a care plan problem addressing the resident's impaired self-care and functional mobility related personal history of acute renal failure, transients ischemic attack (blockage blood flow to the brain), and cerebrovascular accident (stroke). The intervention included toileting/hygiene was total dependent on the assistance of the staff. On 11/18/24 at 0900 hours, Resident 110 was awake and his call light was hanging on the wall. On 11/18/24 at 1030 hours, LVN 11 was summoned to the room. LVN 11 acknowledged the call light was out of the resident's reach. LVN 11 stated the resident used the call light to call for assistance sometimes. LVN 11 verified the 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

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 11/21/2024
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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on interview and medical record review, the facility failed to ensure the POLST was signed and dated by the physician and failed to provide an advance directive Acknowledgement form for one of seven final sampled residents (Resident 104) reviewed for advanced directives. This failure had the potential of not following the resident's health wishes and not providing the resident and resident representative the information about the advance directive. Findings: Medical record review for Resident 104 was initiated on 11/18/24. Resident 104 was admitted to the facility on [DATE]. Review of Resident 104's H&P examination dated 7/24/24, showed Resident 104 did not have the capacity to understand and make decisions. Review of Resident 104's POLST dated 7/24/24, showed under Section D, the Information and Signatures portion was incomplete. The POLST failed to show documented evidence of the physician, NP, or PA's name and date signed. Further review of Resident 104's medical record failed to show documented evidence of an Advanced Directive Acknowledgment form provided to the resident or resident representative. On 11/21/24 at 0922 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 104's POLST was incomplete and not signed and dated by the resident's physician. RN 1 further verified there was no advance directive acknowledgement form in Resident 104's medical record. RN 1 stated there should be an Advance Directive Acknowledgement form and the POLST should be signed by the physician to be valid. On 11/21/24 at 0926 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD verified Resident 104's POLST was not signed and dated by the physician. The SSD also verified Resident 104 did not have an Advance Directive Acknowledgement form. The SSD stated the Advance Directive Acknowledgement form was used to offer information to the resident and the resident's representatives about the advance directive. On 11/21/24 at 1437 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified the above findings.

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	11/21/2024

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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37726 Based on observation and interview, the facility failed to maintain a clean and homelike environment for one of 26 final sampled residents (Resident 43) and five nonsampled residents (Residents 22, 98, 99, 106, and 117). * Residents 43 and 106 resided in Room E. Room E was observed with the door frame casings in disrepair. * Resident 22 resided in Room A, Resident 98 resided in Room B, Resident 99 resided in Room C, and Resident 117 resided in Room D. Rooms A, B, C, and D were observed with yellowish stains on the residents' curtains. These failures posed the risk for unsanitary and unsightly conditions and had the potential to negatively impact the residents' quality of life. Findings: 1. On 11/18/24 at 1109 hours, an observation of Room E was conducted. Residents 43 and 106 resided in Room E. Room E was observed with the door frame casings in disrepair, as evidenced by cracks, scratches, and missing paint. On 11/21/24 at 1541 hours, an interview was conducted with the DON. The DON was shown a photograph taken of the Room E door frame casings and acknowledged the findings. The DON stated the damage may have resulted from the resident beds possibly hitting the door frame. The DON stated the resident rooms were in the process of being refurbished. 32179 2. On 11/18/24 at 0830 hours, the curtains were observed with yellowish stained and dirty in Rooms A, B, C, and D. - Resident 22 resided in Room A, - Resident 98 resided in Room B, - Resident 99 resided in Room C, and - Resident 117 resided in Room D. On 11/18/24 at 1000 hours, LVN 7 was summoned to the rooms. LVN 7 acknowledged the curtains needed to be changed. LVN 7 verified the findings.

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 11/21/2024
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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the PASRR screening was completed as per the facility's P&P for two of two final sampled residents (Residents 61 and 76) reviewed for PASRR. * The facility failed to ensure Resident 76 had a Level 1 PASRR screening upon readmission back to the facility. * The facility failed to perform a PASRR Level 1 Screening Resident Review Status Change after Resident 61 was diagnosed with depression and prescribed a psychotropic medication. These failures had the potential of not providing the residents screened for mental illness or intellectual disabilities with additional resources if needed. Findings: Review of the facility's P&P titled PASRR (Preadmission Screening Resident Review) revised 3/2019 showed each resident is screened regardless of payment source, when applying for admission to, or residing in the facility, which is a Medicaid-certified facility, for mental illness and intellectual disability. Level 1 screenings are to be submitted online. All admissions to the facility will receive a Preadmission Screening (PAS) prior to the admission of the resident. The P&P further showed if the result of the Level 1 screening is positive due to a diagnosed or suspected mental illness identified, the Level 1 Screening will automatically be sent to the DHCS (Department of Health Care Services) Contractor for a Level II prescreening call. 1. Medical record review for Resident 76 was initiated on 11/18/24. Resident 76 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 76's H&P examination dated 6/19/24, showed Resident 76 did not have the capacity to understand and make decisions. Further review of Resident 76's medical record showed the resident had a hospital stay from 6/9/24 to 6/13/24, and had a diagnosis of depression (mental health disorder that causes persistent feeling of sadness and loss of interest) with an onset date of 6/13/24. However, Resident 76's medical record failed to show a PASRR was completed when the resident was readmitted to the facility on [DATE]. On 11/20/24 at 1005 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 verified Resident 76's medical record showed no documented evidence a PASRR was completed after the resident was readmitted back to the facility on [DATE]. LVN 2 stated the PASRR available in Resident 76's medical record was last dated 1/19/24. LVN 2 stated the PASRR should be updated so the physician could accurately assess the resident and the facility could provide the appropriate care. (continued on next page)

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 11/21/2024
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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 1457 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON verified Resident 76 was readmitted back to the facility on [DATE]. The ADON stated the residents returning from the hospital after 72 hours were considered a new admission and should have a PASRR completed. The ADON verified Resident 76 returned after 72 hours; however, the resident did not have a PASRR completed upon the resident's return to the facility on [DATE]. The ADON stated a PASRR should have been done. The ADON further stated PASRR Level I was completed to assess if the resident qualified for Level II screening, which provided the facility more resources to care for residents who have a positive Level II screening. The ADON stated this ensured the facility provided the proper care for residents with mental illness or intellectual disabilities. On 11/21/24 at 1437 hours, an interview was conducted with the Administrator and the DON . The Administrator and the DON verified the above findings. 37726 2. Medical record review for Resident 61 was initiated on 11/18/24. Resident 61 was admitted to the facility on [DATE]. Review of Resident 61's PASRR Level 1 Screening dated 9/20/24, showed Resident 61 had no diagnosis of a serious mental illness and had no prescribed psychotropic medications, consequently, a Level 2 mental health evaluation was not required. Review of Resident 61's H&P examination dated 9/25/24, showed Resident 61 had a diagnosis of mild depression. Review of Resident 61's physician's order dated 9/26/24, showed an order for mirtazapine (antidepressant medication) 15 mg orally at bedtime for depression manifested by poor oral intake. On 11/19/24 at 1600 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated after Resident 61 was diagnosed with depression and prescribed a psychotropic medication (mirtazapine) on 9/26/24, a PASRR Level 1 Screening Resident Review Status Change should have been performed reflecting Resident 61's diagnosed mental illness and prescribed psychotropic medications.

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 11/21/2024

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** 37726 Based on interview and medical record review, the facility failed to develop the comprehensive care plan to reflect the individual care needs for two of 26 final sampled residents (Residents 73 and 88). * The facility failed to develop a care plan to address the use of elevated side rails for Resident 73. * The facility failed to develop a care plan for a high bed for Resident 88. These failures posed the risk for not providing appropriate and individualized care to the residents. Findings: 1. Medical record review for Resident 73 was initiated 11/18/24. Resident 73 was admitted to the facility on [DATE]. Review of Resident 73's physician's order dated 8/7/24, showed an order for bilateral grab bars for bed mobility and repositioning. On 11/18/24 at 0835 hours, an observation and concurrent interview was conducted with Resident 73. Resident 73 was observed lying in bed with bilateral grab bars elevated. Resident 73 stated he utilized the grab bars to get up in bed. On 11/21/24 at 1357 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated when the side rails were implemented for a resident who resided in the facility, a care plan specific to the use of side rails would then be developed. RN 1 reviewed Resident 73's medical record and verified the facility failed to develop a care plan specific to the use of side rails for Resident 73. 32179 2. Medical record review of Resident 88 was initiated on 11/18//24. Resident 88 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 88's care plan dated 9/11/24, showed a care plan problem addressing the resident's risk for fall or injury related medication and cognitive impairment. The intervention included to maintain the bed in the lowest or locked postiion. However, the care plan failed to identify the resident was noncompliant and the education was given to Resident 88 and other alternative was offered to prevent the fall or injury. On 11/18/24 at 0815 and 1000 hours, Resident 88 was sitting upright in a high bed, awake, and without bilateral floor mats. (continued on next page)

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 11/21/2024
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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at 1100 hours, an interview and concurrent medical record review was conducted with RN 3, LVN 7, and CNA 3. RN 3 stated the resident requested a high bed and did not want the bed to be lowered. LVN 7 stated CNA 3 mentioned the resident preferred a high bed and acknowledged the absence of floor mats. CNA 3 confirmed the resident always preferred a high bed and would raise it if CNA lowered it. RN 3 was asked if any care plan had been developed to address the resident's noncompliance with care and risk of falls from the high bed. RN 3 acknowledged no interventions or alternatives had been offered to implement for the resident with a high bed. RN 3 verified the above findings.

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 11/21/2024
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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the pressure ulcer for three final sampled residents (Residents 3, 102, and 103) and one nonsampled resident (Resident 334) reviewed for pressure injury and skin management. * Resident 334 was developing a new blister to the right underneath first and second toes. The facility failed to assess Resident 334's skin, inform the physician of new change of skin condition, and provide the treatment. * The facility failed to ensure the LAL mattress setting was consistently monitored to ensure the appropriate settings of the low air loss mattress for Resident 3. * The facility failed to ensure the LAL mattress setting was consistently monitored to ensure the appropriate settings of the low air loss mattress for Resident 102. * The facility failed to ensure Resident 103's LAL mattress setting was appropriate to the resident's weight. These failures had the potential of Resident 334 not receiving the appropriate care and services to prevent wound from getting worse. Findings: Review of the facility's P&P titled Pressure Ulcer/Injury management dated 7/2019 showed Stage 2 pressure sore. Medical record review was initiated for Resident 334 on 12/13/17. Resident 334 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 334's Initial Nursing History and Assessment - Initial dated 11/6/24, under the skin condition section showed the resident had sacrococcyx redness, lower abdomen with multiple skin scratch, lower abdomen multiple with skin yellowish, left forearm IV site, and GT site. On 11/18/24 at 1100 hour, an observation and concurrent interview were conducted with Resident 334's family member. The family member stated last week, they notified the nurse about a small new blister on the right great toe, between the first and second toes, though they did not remember the specific day and shift. The family member also mentioned the nurse had treated it so far. The family member wondered why the dressing was on the other side and not on the blister area. A sterile dressing was observed on the opposite side of the great toe. (continued on next page)

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 11/21/2024

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 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 11/19/24 at 1415 hours, LVN 3 was summoned to the room. LVN 3 was observed removing the sterile dressing and noticed there were no skin abnormalities. LVN 3 acknowledged there was a fluid-filled blister on the right great toe, between the first and second toes, and stated she was not aware of it. LVN 3 mentioned there had been no assessment, and the physician had not been informed about this new blister. LVN 3 acknowledged there was no treatment for the new blister and verified the findings. LVN 3 measured the fluid-filled blister, which was 1 cm (length) X 0.6 cm (width), and depth was unable to determine with intact surrounding skin. When asked if the blister was considered a pressure injury, LVN 3 stated it was a blister and not considered a pressure injury. When asked why the blister was not considered a pressure injury, LVN 3 stated she was not sure and would ask another treatment nurse.

On 11/19/24 at 1430 hours, LVN 3 acknowledged the fluid-filled blister was considered a Stage 2 pressure injury and verified the findings.

On 11/19/24 at 1500 hours, an interview was conducted with RN 5. RN 5 stated that if the fluid-filled blister's skin was closed, it would be considered a Stage 1 pressure injury, and if ruptured or open, it would be categorized as a Stage 2 pressure injury.

On 11/19/24 at 1530 hours, an interview was conducted with LVN 6. LVN 6 stated a fluid-filled blister was considered a Stage 2 pressure sore, whether it was closed or open/ruptured. LVN 6 stated they should inform the physician of any skin condition changes and apply xeroform gauze and a dry dressing.

Further review of the Resident Weekly Pressure Injury Record dated 11/19/24, showed the right first toes fluid filled blister was a Staged 2 pressure injury with mild erythema.

On 11/21/24 at 1530 hours, the DON was informed and acknowledged the above findings.

47476

2. Medical record review for Resident 3 was initiated on 11/18/24. Resident 3 was readmitted to the facility on [DATE].

Review of Resident 3's Order Summary Report dated 11/19/24, showed a physician's order dated 9/6/24, to use a LAL mattress for skin maintenance and monitor for placement every shift.

Review of Resident 3's Weekly Pressure Injury Record dated 11/4/24, showed Resident 3 had a left buttock Stage 4 pressure injury which was closed and resolved.

Review of Resident 3's Weights and Vitals Summary dated 11/21/24, showed Resident 3's last weight taken was 119 lbs on 11/4/24.

Review of the DynaRest Airfloat 100 Air Mattress with Pump instruction manual showed the DynaRest Airfloat 100 Air Mattress is designed for bed sore and wound care therapy treatment and prevention. Under the controls section, showed the Pressure Adjust Knob was adjustable by patient's weight and to turn the Pressure Adjust to set a comfortable pressure level by using the weight scale as a guide.

(continued on next page)

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 11/21/2024
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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at 1058 hours, 11/20/24 at 1120 hours, and 11/21/24 at 0820 hours, Resident 3 was observed lying on a LAL mattress. The LAL mattress was on and set to less than 80 pounds. On 11/21/24 at 0859 hours, a concurrent observation, interview, and medical record review was conducted with LVN 9. LVN 9 stated Resident 3 had a left buttock Stage 4 pressure injury which was resolved within the past month. LVN 9 stated they were doing daily dressing changes for the skin maintenance. LVN 9 verified Resident 3 was on a LAL mattress for preventative skin maintenance and stated all the nurses were responsible for checking the LAL mattress. LVN 9 stated the setting was according to the weight of the patient and comfort. LVN 9 was then brought to Resident 3's room for observation of the LAL mattress. LVN 9 verified Resident 3's current weight of 119 lbs and verified the above findings. LVN 9 stated the LAL mattress should be set between 100 - 120 lbs and verified the setting was not correct. On 11/21/24 at 1438 hours, the Administrator and DON were informed and acknowledged the above findings. 45064 3. Review of the facility document titled Oasis Alternating Pressure with Low Air Loss manual, undated, showed users determine the patient's weight and set the control knob to that weight setting on the control unit. Medical record review for Resident 103 was initiated on 11/19/24. Resident 103 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 103's H&P examination dated 11/4/24, showed the resident had no capacity to understand and make decisions. Review of Resident 103's Order Summary Report dated 11/1/24, showed the following physician's order: - dated 11/1/24, for LAL mattress for skin and wound management, and to check for proper setting and function every shift. Review of Resident 103's Weights and Vital Summary showed Resident 103's weigh of 88 pounds on 11/17/24. On 11/18/24 at 0928 hours, during an observation, Resident 103 was in bed lying on a LAL mattress with the mattress pressure setting set between 120 to 155 pounds. On 11/18/24 at 0938 hours, a concurrent observation and interview with LVN 3 was conducted in Resident 103's room. LVN 3 verified the mattress pressure setting was between 120 to 155 pounds. LVN 3 further verified Resident 103 did not weigh between 120 to 155 pounds; however, she verified the resident's current weight was 88 pounds. LVN 3 stated the mattress pressure setting should be based on the resident's weight to prevent skin breakdown or cause worsen of wound. 46787 (continued on next page)

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 11/21/2024
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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Medical record review for Resident 102 was initiated on 11/18/24. Resident 102 was admitted to the facility on [DATE]. Review of Resident 102's Order Summary Report dated active as of 11/21/24, showed a physician's order dated 8/14/24, to use a LAL mattress for skin and wound management and to check for proper setting and function every shift. Review of Resident 102's Plan of Care addressing Pressure Ulcers showed to provide LAL mattress as a pressure-relieving device in bed. Review of the Med-Aire 8 Alternating Pressure Mattress Replacement System with Low Air Loss instruction manual showed the low air loss mattress is designed for prevention of bedsores. Under the Pressure Set Up section, showed users can easily adjust the air mattress to a desired firmness according to the patient's weight and comfort. On 11/19/24 at 1054 hours, Resident 102 was observed lying on a LAL mattress. The LAL mattress was on and set to more than 150 pounds. On 11/20/24 at 1509 hours, a concurrent observation, interview, and medical record review was conducted with LVN 4. LVN 4 verified Resident 102 was on a LAL mattress for preventative skin maintenance and stated all the nurses were responsible for checking the LAL mattress. LVN 4 stated the setting was according to the weight of the patient and the comfort. LVN 4 verified Resident 102's current weight of 100 lbs and verified the above findings. LVN 4 stated the LAL mattress should be set according to the resident's weight and verified the setting was not correct.

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 11/21/2024
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)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, and medical record review, the facility failed to provide the necessary GT care and services for one of three residents (Resident 74) reviewed for tube feeding. * The facility failed to ensure Resident 74 was connected to the continuous infusing enteral feeding as ordered by the physician. This failure posed the potential risk for not meeting Resident 74's nutritional needs. Findings: Medical record review for Resident 74 was initiated on 11/18/24. Resident 74 was readmitted to the facility on [DATE]. Review of Resident 74's Order Summary Report dated 11/19/24, showed a physician's order dated 10/9/24, to administer Nepro 1.8 (type of enteral feeding) via enteral pump and infuse at 50 ml per hour over 16 hours or until volume limit was completed (800 ml), off at 0500 hours and on at 1300 hours. On 11/18/24 at 1400 hours, Resident 74 was observed laying in bed. Resident 74's GT feeding was connected via a feeding pump, which was turned on and infusing at 50 ml/hr. The GT feeding tubing was observed hanging from the pole where the feeding pump was connected, but the feeding tubing was not connected to Resident 74. The GT feeding was observed dripping onto the floor. On 11/18/24 at 1432 hours, an observation and concurrent interview was conducted with RN 4. RN 4 verified the above findings and stated she would need to inform the charge nurse. RN 4 proceeded to leave the room and stated she would get Resident 74's charge nurse. On 11/18/24 at 1434 hours, an observation and concurrent interview was conducted with LVN 10. LVN 10 verified Resident 74's GT feeding was not connected or infusing to Resident 74. LVN 10 stated she needed to change the whole GT feeding. LVN 10 stated Resident 74 just had dialysis and maybe the dialysis nurse disconnected it. LVN 10 also stated when the facility staff gave showers, they would disconnect the GT feeding. When asked who she was referring to, LVN 10 stated the CNAs. On 11/21/24 at 1438 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the findings.

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 11/21/2024
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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure four of seven final sampled residents (Residents 8, 44, 58, and 75) and one nonsampled resident (Resident 29) reviewed for respiratory care were provided the appropriate respiratory care. * The facility failed to ensure Resident 75's oxygen was administered as ordered and a No Smoking/Oyxgen in Use sign was outside the resident's door per the facility's P&P. In addition, the facility failed to ensure Resident 75 had a physician's order and care plan developed to address the use of the suction machine. The suction storage bag was also observed undated and unlabeled. * The facility failed to ensure Resident 8 who was on oxygen had a No Smoking/Oxygen in Use sign outside the resident's door as per the facility's P&P. In addition, the facility failed to ensure Resident 8's oxygen nasal cannula was stored in a sanitary manner. * The facility failed to ensure Resident 58's physician orders for the use of CPAP had the settings. Additionally, Resident 58's CPAP was not stored in a sanitary manner. * The facility failed to ensure Resident 44's oxygen was administered as ordered. * The facility failed to ensure a no smoking and oxygen in use sign was posted per the facility's P&P for Resident 29 who was receiving oxygen. These failures had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: Review of the facility's P&P titled Oxygen Administration revised on 3/2017 showed to verify that there is a physician's order for oxygen administration and to review the resident's care plan for any special needs of the resident. Oxygen therapy is administered by way of an oxygen mask, nasal cannula or non-rebreather mask. The P&P further showed a No Smoking/Oxygen in use signs were necessary. 1. On 11/18/24 at 0823 hours, Resident 75 was observed with oxygen at three liters per minute via nasal cannula. There was no No Smoking/Oxygen in use sign observed inside or outside Resident 75's room. In addition, a suction machine was observed at Resident 75's bedside with the suction storage bag not dated or labeled. On 11/18/24 at 0906 hours, Resident 75 was observed with oxygen at three liters per minute via nasal cannula. Medical record review for Resident 75 was initiated on 11/18/24. Resident 75 was admitted to the facility on [DATE]. Review of Resident 75's H&P examination dated 3/22/24, showed Resident 75 did not have the capacity to understand and make decisions. (continued on next page)

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 11/21/2024
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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 75's Order Summary Report showed a physician's order dated 3/16/24, to administer oxygen at two liters per minute via nasal cannula to keep oxygen saturation level above 92% every shift. Further review of Resident 75's Oder Summary Report for November 2024 showed no documented evidence the resident had a physician's order for suction. On 11/18/24 at 0911 hours, an observation, interview, and concurrent medical record review was conducted with LVN 15. LVN 15 verified Resident 75 had oxygen orders for two liters per minute; however, the resident was observed receiving three liters per minute of oxygen. LVN 15 verified there was No Smoking/Oxygen in Use signage outside of Resident 75's room. LVN 15 further verified a suction machine was at bedside with the suction storage bag not dated or labeled. On 11/20/24 at 1418 hours, an observation, interview, and concurrent medical record review was conducted with LVN 4. LVN 4 verified Resident 75 had a suction machine at bedside. LVN 4 verified the suction storage bag was not dated or labeled. LVN 4 stated the storage bags for the respiratory equipment were changed out weekly on Sundays, to ensure infection control was maintained. LVN 4 reviewed Resident 75's medical record and verified the resident did not have documented evidence to show a physician's order or care plan problem was initiated for the suction machine use. LVN 4 stated there should have been a physician's order and care plan for the use of the suction machine. LVN 4 further stated a physician's order was needed in order to suction a resident. On 11/21/24 at 1437 hours, an interview was conducted with the Administrator and DON . The DON stated the residents needed a physician's order to use the suction machine and to receive the oxygen as ordered. The DON further stated the respiratory storage bags were changed weekly and should be dated and labeled. The Administrator and DON verified the above findings. 2.a. On 11/18/24 at 0857 hours, Resident 8 was observed with oxygen at three liters per minute via nasal cannula. There was no No Smoking/Oxygen in use sign observed inside or outside of Resident 8's room. Medical record review for Resident 8 was initiated on 11/18/24. Resident 8 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 11/1/24, showed Resident 8 had the capacity to understand and make decisions. Review of Resident 8's Order Summary Report showed a physician's order dated 10/17/24, to administer oyxgen at two liters per minute via nasal cannula to keep oxygen saturation level above 92% as needed. On 11/18/24 at 0949 hours, an observation and concurrent interview was conducted with RN 5. RN 5 verified Resident 8 was on oxygen; however, there was no signage for No Smoking/Oxygen in Use posted inside or outside of the resident's room. RN 5 stated the No Smoking/Oxygen in Use signage ensured everyone being informed about the potential fire hazard. RN 5 further stated the No Smoking/Oxygen in Use signage should be posted as a safety precaution. 37726 (continued on next page)

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 11/21/2024

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 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

b. On 11/18/24 at 1625 hours, an observation and concurrent interview was conducted with LVN 6. Resident 8 was observed lying in bed receiving continuous oxygen at a rate of two liters per minute via nasal cannula. Resident 8's wheelchair was observed adjacent to her bed. Resident 8's wheelchair was observed with an oxygen tank attached to the wheelchair. A nasal cannula was observed attached to the oxygen tank. The nasal cannula was observed hanging on the wheelchair. The nasal cannula was not stored in a clean bag. LVN 6 verified the findings and stated Resident 8's nasal cannula needed to be stored in a clean bag for infection control. LVN 6 stated she would change Resident 8's nasal cannula.

47476

3. Review of the facility's P&P titled CPAP/BiPAP Support revised 6/2018 showed under the section for Preparation, the resident's physician's orders should be reviewed to determine the oxygen concentration and flow, and the PEEP pressure.

On 11/18/24 at 0855 hours, Resident 58's CPAP mask was observed on the floor behind his bed. Resident 58 stated the staff helped him to clean and store his CPAP mask. There was no respiratory bag observed at the bedside.

On 11/18/24 at 0935 hours, the IP was summoned to Resident 58's room. The IP verified the above findings and proceeded to pick up Resident 58's CPAP mask from the floor. The IP verified the CPAP mask should be cleaned and stored in a plastic bag when not in use.

Medical record review for Resident 58 was initiated on 11/18/24. Resident 58 was readmitted to the facility on [DATE].

Review of Resident 58's Order Summary Report dated 11/18/24, showed a physician's order dated 4/30/24, for CPAP off in the morning and on at bedtime.

Further review of Resident 58's Order Summary Report failed to show a physician's order for the settings of the CPAP.

Review of Resident 58's plan of care showed a care plan problem dated 4/30/24, addressing Resident 58's risk for altered breathing pattern and risk for respiratory distress. The approach plan included to provide CPAP as ordered.

On 11/20/24 at 1331 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the facility was required to have a physician's order for the settings of the CPAP. The DON verified Resident 58 did not have a physician's order for the settings of the CPAP. The DON was informed of the above findings. The DON stated the facility had to store the CPAP mask in a bag labeled with the resident's name on it for infection control.

On 11/20/24 at 1438 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed of the above findings.

32179

(continued on next page)

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 11/21/2024
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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Medical record review for Resident 44 was initiated on 11/18/24. Resident 44 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 44's Order Summary Report dated 10/31/24, showed a physician's order dated 9/25/23, to administer oxygen two liters per minute via nasal cannula as needed for shortness of breath and oxygen saturation level less than 90%. On 11/19/24 at 0830 hours, Resident 44 was observed with oxygen connected to an oxygen concentrator at three liters per minute via a nasal cannula . On 11/19/24 at 1030 hours, an observation and concurrent interview was conducted with LVN 3. LVN 3 verified the above finding. On 11/21/24 at 1530 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 39453 5. On 11/18/24 at 0854 hours, Resident 29 was observed in bed receiving two liters per minute of oxygen via nasal cannula. A no smoking and oxygen in use sign was not posted at the door. Medical record review for Resident 29 was initiated on 11/18/24. Resident 29 was admitted to the facility on [DATE]. Review of Resident 29's Order Summary Report dated 11/21/24, showed a physician's order dated 6/20/24, to administer oxygen at two liters per minute via nasal cannula to keep oxygen saturation level above 92% every shift. Review of Resident 29's MAR for November 2024 showed Resident 29 was administered oxygen from 11/1 to 11/18/24, every shift. On 11/18/24 at 0909 hours, an observation for Resident 29 and concurrent interview was conducted with LVN 15. LVN 15 verified the above finding.

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 11/21/2024

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 0698

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe, appropriate dialysis care/services for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46787

Based on interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate dialysis care was provided for one of two final sampled residents (Resident 82) reviewed for dialysis services.

* The facility failed to ensure the dialysis communication forms were completed for Resident 82. This failure had the potential for the resident to experience medical complications.

Findings:

Review of the facility's P&P titled Dialysis Care Inhouse revised 1/2019, showed it is the policy of the facility that a resident admitted for dialysis care will receive quality care and quality of life from the dialysis nurse, dialysis staff, and facility nursing staff. There will be continuity of care and communication between nursing staff and the dialysis nursing staff. A pre-dialysis checklist will be completed by the facility each time the resident is scheduled for dialysis. This checklist includes information regarding the type of access site and the condition of the access site and the dressing. The post dialysis checklist part of the form is to be completed by the facility upon completion of dialysis. Information to be documented include information regarding the type of access site and condition of the dressing and access site.

Medical record review for Resident 82 was initiated on 11/18/24. Resident 82 was admitted to the facility on [DATE].

Review of Resident 82's H&P examination dated 10/2/24, showed Resident 82 had no capacity to understand and make decisions.

Review of Resident 82's Admission Record showed Resident 82 had a diagnosis of ESRD and was dependent on renal dialysis.

Review of Resident 82's Order Summary Report for November 2024 showed a physician's order dated 9/30/24, for hemodialysis every Monday, Wednesday, and Friday with the dialysis facility.

Review of Resident 82's dialysis communication assessment forms showed multiple blank entries as follows:

- on 10/30/24, the pre-dialysis access site assessment

- on 11/1/24, the pre-dialysis access site assessment

- on 11/13/24, the pre-dialysis access site assessment

- on 11/20/24, the pre and post-dialysis access site assessments

(continued on next page)

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	11/21/2024

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 1431 hours, an interview and concurrent medical record review was conducted with LVN 12. LVN 12 verified the above findings. LVN 12 stated the dialysis forms should not have been left blank and should have been filled out accordingly.

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 11/21/2024
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)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, and medical record review, the facility failed to ensure two of 26 final sampled residents (Residents 46 and 73) remained free from accident hazards. * The facility failed to attempt the alternatives and failed to obtain the informed consent prior to the use of side rails for Resident 73. * For Resident 46, the facility failed to asses for the risk of entrapment and failed to attempt alternatives prior to the use of side rails. Additionally, the facility failed to inform the responsible party of side rail use. These failures had the potential for placing the residents at risk for entrapment for the use of side rails. Findings: The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. , that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. 1. Medical record review for Resident 73 was initiated 11/18/24. Resident 73 was admitted to the facility on [DATE]. Review of the physician's order dated 8/7/24, showed an order for a bilateral grab bars for bed mobility and repositioning. Review of Resident 73's care plan titled Altered Cognitive Status revised 11/11/24, showed Resident 73 had moderately impaired cognition. The care plan showed to provide Resident 73 with a safe and comfortable environment and provide frequent visual checks. On 11/18/24 at 0835 hours, an observation and concurrent interview was conducted with Resident 73. Resident 73 was observed lying in bed with the bilateral grab bars elevated. Resident 73 stated he utilized the grab bars to get up in bed. On 11/21/24 at 1350 hours, an observation was conducted of Resident 73. Resident 73 was observed sitting in his bed with the bilateral grab bars elevated. (continued on next page)

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 11/21/2024
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)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 73's medical record failed to show an informed consent prior to the use of the side rails was obtained. Further review of the medical record failed to show alternatives were attempted prior to the use of side rails. On 11/21/24 at 1357 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 reviewed Resident 73's medical record and verified the facility failed to obtain an informed consent and failed to attempt alternatives prior to the use of the side rails. 32179 2. Medical Record review for Resident 46 was initiated on 11/18/24. Resident 46 was admitted to the facility on [DATE]. Review of the Order Summary Report dated 10/31/24, showed a physician order dated 9/16/22, to have bilateral padded side rails up due to medical necessity for seizure. Review of the Bedrail/Grab bar use and Entrapment Risk Evaluation dated 10/24/24, showed under the section asking if the bedrails/grab bars place the resident at high risk for strangulation, entanglement, or asphyxiation. The answer was documented as no with explanation, the acute care hospital bed dimension was in within the recommended limit. However, there was no documented evidence to show the assessment of the bed zone entrapment. In addition, under the section for the least restrictive measures attempted or in place, and current measures effective or not was left blank. On 11/18/24 at 0930 and 1130 hours, Resident 46 was observed sleeping in bed with the bilateral padded side rails (from elbow to upper thigh). On 11/19/24 at 1450 hours, an interview and concurrent medical record review was conducted with RN 5. RN 5 was asked the purpose of the bilateral padded side rails. RN 5 stated the purpose of the bilateral padded side rails was for medical necessity and epilepsy. RN 5 was unable to locate the documentation for the assessment of the zone entrapment of the side rail installation, bed rail, and bed mattress. RN 5 stated she could not locate the documentation. RN 5 was asked if the resident or responsible party had informed for the use of side rails. RN 5 stated she was unable to provide the documentation. RN 5 acknowledged the side rail assessment was not completed. RN 5 verified the finding. On 11/21/24 at 1430 hours, an interview was conducted with the Medical Record Assistant. The Medical Record Assistant was asked regarding the informed consent of the side rails use. The Medical Record Assistant could not find the informed consent for the use of the side rails and acknowledged they did not have it. The Medical Record Assistant verified the findings.

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 11/21/2024
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)

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 47476

Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the pharmaceutical services were provided to meet the needs of one of 26 final sampled residents (Resident 74).

* The facility failed to ensure Resident 74's GT medication was administered via gravity.

* The facility failed to ensure Resident 74's bowel pattern was checked for loose stool/diarrhea prior to administering docusate sodium (stool softener).

These failures had the potential to result in poor health outcomes to the resident.

Findings:

Review of the facility's P&P titled Medication Administration via Enteral Tube revised 4/2017 showed the purpose of the policy was to safely and accurately administer oral medications through an enteral tube. The policy showed under the section Administering Medications, to allow each medication to flow down the tube by gravity.

Medical record review for Resident 74 was initiated on 11/18/24. Resident 74 was readmitted to the facility on [DATE].

Review of Resident 74's Order Summary Report dated 11/19/24, showed a physician's order dated 9/17/24, to administer docusate sodium tablet 100 mg one tablet by mouth one time a day for bowel management.

Review of Resident 74's Task - B&B - Bowel Elimination POC Response History dated 11/19/24, showed the consistency of Resident 74's bowel movements over the past 30 days. The document showed Resident 74 had loose stools/diarrhea from 10/28/24 through 11/19/24.

On 11/19/24 at 0835 hours, a medication administration observation was conducted with LVN 8. LVN 8 prepared Resident 74's medications and placed them into individual medication cups. Upon preparation of the docusate sodium medication, LVN 8 was observed not checking Resident 74's bowel pattern for loose stool/diarrhea. LVN 8 verified she would be giving Resident 74 seven medications via GT, two supplements via GT, and one insulin injection. During the medication administration, LVN 8 was observed mixing water into each of the medication cups and administered eight of the nine medications/supplements via GT by gravity. During the observation of the last medication administration, LVN 8 was observed aspirating the contents of the crushed docusate sodium tablet with a syringe and pushing the medication through Resident 74's GT.

(continued on next page)

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 11/21/2024
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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 1123 hours, a follow-up interview was conducted with LVN 8. LVN 8 was informed of the observation of medication administration for the docusate sodium medication. LVN 8 acknowledged she did not administer the medication by gravity. LVN 8 was asked about Resident 74's bowel pattern prior to administering the docusate sodium medication. LVN 8 stated she got endorsement from the last nurse and the nurse stated Resident 74 did not have loose stools. LVN 8 verified she did not review Resident 74's documented bowel pattern and verified Resident 74 had been having loose stools/diarrhea since 10/28/24. LVN 8 stated she should have not given the docusate sodium medication since Resident 74 was reported to have loose stools. On 11/21/24 at 1438 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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 11/21/2024
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)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview and medical record review, the facility failed to provide adequate monitoring of the blood pressure and heart rate to ensure one of 26 final sampled residents (Resident 73) was free from unnecessary drugs. * Resident 73 was administered amlodipine (blood pressure medication) and lozartan (blood pressure medication) when the resident's blood pressure and heart rate were not checked prior to administering the medications, as prescribed by the physician. This failure had the potential to negatively affect Resident 73's health condition and well-being. Findings: Medical record review for Resident 73 was initiated on 11/18/24. Resident 73 was admitted to the facility on [DATE]. Review of Resident 73's Order Summary Report showed the following physician's orders dated 8/7/24: - to administer amlodipine 5 mg one tablet by mouth two times a day for hypertension (high blood pressure), and to hold if the systolic blood pressure less than 110 mmHg, and if the heart rate less than 60 beats per minute; and - to administer losartan 50 mg one tablet by mouth two times a day for hypertension, and to hold if the systolic blood pressure less than 110 mmHg, and if the heart rate less than 60 beats per minute. Review of Resident 73's MAR for November 2024 showed Resident 73 was administered the amlodipine and losartan medications from 11/1/24 to 11/19/24, at 0900 and 1700 hours. However, there was no documented evidence to show the licensed staff monitored Resident 73's blood pressure and heart rate prior to the administration of the amlodipine and losartan medications. On 11/20/24 at 1356 hours, an interview and concurrent medical record review for Resident 73 was conducted with RN 5. RN 5 verified the above findings.

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 11/21/2024
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)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of 26 sampled residents (Residents 86 and 124) were free from unnecessary medications. * Resident 124 was prescribed zolpidem (hypnotic) as needed, but this medication was not only limited to 14 days. * The facility failed to ensure Resident 86 was not prescribed quetiapine fumarate (antipsychotic medication) unless the medication was necessary to treat a specific condition or diagnosis. These failures posed the risk of providing residents with unnecessary medications and the potential for development of significant side effects. Findings: Review of the facility's P&P titled Psychotherapeutic Drug Treatment revised 1/2017 showed the facility is to provide psychotherapeutic drug treatment for a resident with a specific condition as diagnosed and documented in the clinical record. The resident has the right to be free from unnecessary drugs/medications and protection from medication errors. Residents should not receive psychotropic drugs with a PRN (as needed) order unless the medication is necessary to treat a diagnosed , specific condition that is documented in the resident's medical record and PRN orders for psychotropic medications are limited to 14 days. 1. Medical record review for Resident 124 was initiated on 11/18/24. Resident 124 was admitted to the facility on [DATE]. Review of Resident 124's H&P examination dated 8/4/24, showed Resident 124 did not have the capacity to understand and make decisions. Review of Resident 124's Order Summary Report dated active as of 11/20/24, showed a physician's order dated 8/22/24, for zolpidem 5 mg oral tablet as needed for insomnia manifested by inability to fall asleep at bedtime. On 11/21/24 at 1033 hours, a concurrent interview and medical record review was conducted with RN 2. RN 2 verified the zolpidem was ordered for Resident 124 on an as needed basis. RN 2 acknowledged the medication did not have a stop date of 14 days. On 11/21/24 at 1107 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified the above findings. 47476 (continued on next page)

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 11/21/2024
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)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 86 was initiated on 11/18/24. Resident 86 was readmitted to the facility on [DATE], with diagnoses including dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of Resident 86's Order Summary Report for November 2024 showed a physician's order dated 8/28/24, to administer quetiapine fumarate oral tablet 25 mg one-half tablet by mouth every morning and at bedtime for intermittent explosive disorder manifested by recurrent outburst of anger without apparent reason. Review of Resident 86's Acute Care Hospital ED Provider note dated 8/23/24 showed Resident 86 was previously taking quetiapine (Seroquel) 25 mg one-half tablet (12.5 mg total) by mouth two times a day every morning and at bedtime for psychosis. However, the hospital record did not show Resident 86 had a diagnosis of psychosis or intermittent explosive disorder. Review of Resident 86's H&P examination dated 8/29/24 showed the resident had a diagnosis of dementia and did not have the capacity to understand and make decisions. However, there was no documentation of the clinical rationale for continuing Resident 86's dose of quetiapine fumarate medication. Further review of Resident 86's medical record failed to show when or by whom Resident 86 was diagnosed with intermittent explosive disorder prior to continuing Resident 86's dose of quetiapine fumarate medication on 8/28/24. Review of Resident 86's Social Work Progress Notes dated 9/4/24, showed Resident 86 was seen by a psychiatrist. Review of Resident 86's Psychiatric Follow-Up dated 9/4/24 showed Resident 86 was diagnosed with intermittent explosive disorder. On 11/20/24 at 1529 hours, a concurrent interview and observation was conducted with RN 1. RN 1 verified Resident 86 did not have a documented diagnosis of intermittent explosive disorder prior to Resident 86 continuing the quetiapine fumarate medication on 8/28/24. On 11/21/24 at 1328 hours, a concurrent interview and observation was conducted with the ADON. The ADON verified there was no documented clinical rationale or diagnosis for Resident 86 to continue the quetiapine fumarate medication on 8/28/24. The ADON verified Resident 86 was first seen by the psychiatrist on 9/4/24.

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 11/21/2024
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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47476 Based on observation, interview, and facility P&P review, the facility failed to ensure for the safe storage of the medications and supplies for one of three medication rooms (Medication Room A) and five of 10 medication carts (Medication Carts B, C, D, E, and F) inspected. In addition, the facility failed to ensure the medications were not stored at the resident's bedside. * Medication Room A contained multiple expired medications. This failure had the potential to result in the unsafe administration of medications. * The facility failed to ensure the antifungal cream was not kept at Resident 87's bedside. This failure had the potential for unauthorized persons having access to the medication. * Medication Cart D had external and internal medications, and bleach germicidal wipes stored together. This failure had the potential to result in the unsafe administration of medications. * Medication Cart E contained multiple expired vials of normal saline. This failure had the potential to result in the unsafe administration of medications. * The facility failed to ensure a medication cup with zinc oxide cream (medicated cream, ointment or paste that treats or prevents skin irritation) was not left at Resident 20's bedside table. This failure had the potential for unauthorized persons having access to the medication. * The facility failed to ensure germicidal wipes, adult washcloths and Povidone-Iodine swabsticks (antiseptic) were stored separately from a thickener and Boost supplement and failed to ensure the inhalation solutions were kept inside the foil pouch as per the manufacturer's recommendations, in Medication Cart F. This failure posed the risk for cross-contamination of the medications. * The facility failed to ensure . This posed the risk of affecting the potency of the medications. * The facility failed to ensure the DON signed the narcotic disposition log when the pharmacist and DON disposed the controlled medications. This failure had the potential for drug diversion (illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber). * Medication Cart B contained multiple expired alcohol free liquid skin prep and opened wound dressing treatment supplies. * Medication Cart C contained several expired povidone iodine prep pad (topical antiseptic wipe), intravenous (IV - infusion of substances such as an antibiotic directly into a vein) supplies, and opened sterile gloves. Findings: (continued on next page)

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 11/21/2024
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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Storage of Medications dated 4/2008 showed the medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions. Potentially harmful substances such as urine test reagent tablets, household poisons, cleaning supplies; disinfectants are clearly identified and stored in a locked area separately from medications. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. Review of the facility's P&P titled Bedside Medication Storage dated 4/2008 showed a written order for the bedside storage of medication is present in the resident's medical record. 1. On 11/19/24 at 1616 hours, an observation of Medication Room A was conducted with RN 3. The following items were observed in Medication Room A: - one bottle of acetaminophen (analgesic) 160 mg/5 ml had expired 1/2024. - one bottle of vitamin B6 100 mg had a best by date of 10/2024. - 28 vials of normal saline had expired 9/2024. RN 3 verified the above findings. 2. On 11/18/24 at 1031 hours, during an initial tour of the facility, an observation was made at Resident 87's bedside. One tube of clotrimazole (antifungal) cream 1% was observed on top of Resident 87's bedside table. LVN 7 was summoned to the room. LVN 7 verified the findings and stated Resident 87's wife applied the medication. LVN 7 verified the medication should be stored in the treatment cart and not at Resident 87's bedside. Medical record review for Resident 87 was initiated on 11/18/24. Resident 87 was admitted to the facility on [DATE]. Review of Resident 87's MDS Section C dated 9/5/24, showed Resident 87 had moderate cognitive impairment. Review of Resident 87's Self-Administration of Medication assessment dated [DATE] showed Resident 87 was not a candidate for self-administration of medications. Further review of Resident 87's medical record failed to show a physician's order for the use of clotrimazole cream 1%. On 11/20/24 at 1338 hours, a concurrent interview and medical record review was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated there should not be any medications stored at the resident's bedside. The DON verified Resident 87 did not have physician's orders for the clotrimazole cream 1% and did not know why the resident had the medication. (continued on next page)

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 11/21/2024
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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 11/19/24 at 1511 hours, an observation of Medication Cart D was conducted with LVN 7. The following items were observed in Medication Cart D: - three boxes of artificial tears lubricant eye drops were stored together with two saline laxative enemas, one opened box of bisacodyl (laxative) suppositories and one opened box of acetaminophen suppositories 650 mg. - bleach germicidal wipes were stored together with four bottles of liquid medications. LVN 3 verified the above findings. 4. On 11/19/24 at 1525 hours, an observation of Medication Cart E was conducted with RT 1. 24 vials of normal saline had expired 9/2024 were observed in Medication Cart E. RT 1 verified the findings. 39453 5. On 11/18/24 at 0830 and 0906 hours, during the initial tour of the facility, a medication cup containing a white cream was observed on the bedside table in Resident 20's room. On 11/18/24 at 0914 hours, an observation for Resident 20 and concurrent interview was conducted with LVN 4. A medication cup containing a white cream was observed on the bedside table in Resident 20's room. LVN 4 verified the above findings. LVN 4 stated the white cream could be a zinc oxide, and he was not sure why the zinc oxide cream was on Resident 20's bedside table. Medical record review for Resident 20 was initiated on 11/18/24. Resident 20 was admitted to the facility on [DATE], and readmitted on [DATE]. 6. On 11/19/24 at 1552 hours, an inspection of Medication Cart F, concurrent interview, and medical record review was conducted with LVN 14. The following was observed: a. A container of germicidal wipes was stored with a container of thickener. b. A container of adult washcloths, and two boxes of Povidone-Iodine swabsticks were stored with five containers of Boost supplement. c. Opened foil packets containing units of albuterol inhalation solution (used to prevent and treat wheezing, difficulty breathing, chest tightness, and coughing caused by lung diseases such as asthma and chronic obstructive pulmonary disease or COPD) with no open dates, and inhalation units were also observed outside the foil packets. Review of the medication insert for albuterol sulfate inhalation solution dated 10/2012 showed to store in pouch until time of use. LVN 14 verified the above findings. (continued on next page)

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 11/21/2024
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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Review of the facility's P&P titled Disposal of Medications and Medication-Related Supplies, under Controlled Medication Disposal section, dated 4/2008 showed Schedule II to V controlled substances (these are established five schedules of drugs, substances, and certain chemicals used to make drugs based on the potential for abuse and potential to create severe psychological and/ or physical dependence) remaining in the facility after a resident has been discharged , or the other discontinued, are disposed of in the facility by the DON or designated facility RN in conjunction with the pharmacist. On 11/21/24 at 1309 hours, a concurrent interview and facility document review was conducted with the DON. When asked about the disposal of controlled medications, the DON stated two licensed nurses would bring the controlled medication to the DON, and she would then verify the quantity of the controlled medications given. The DON stated she would then store the controlled medications inside a lock container, until the consultant pharmacist would come to the facility to destroy the controlled medications with the DON. The DON stated this was documented in the Antibiotic or Controlled Drug Record. Review of the Antibiotic or Controlled Drug Record did not show any documented evidence the DON verified the quantity of the controlled medications brought to her by the two licensed nurses. In addition, the record only showed the consultant pharmacist's signature but did not show the DON's signature to show the controlled medications were disposed by the DON (or designated facility RN) with the pharmacist as per the facility's P&P. For example: - The Antibiotic or Controlled Drug Record for hydrocodone/APAP (narcotic medication used for severe pain) 5-325 mg showed 30 doses were signed off by an RN and LVN. The record also showed the pharmacist's signature but did not show the DON's signature; - The Antibiotic or Controlled Drug Record for morphine sulfate (narcotic medication used for moderate to severe pain) 20 mg/ml solution showed 28 ml was signed off by the RN and LVN. The record also showed the pharmacist's signature but did not show the DON's signature; - The Antibiotic or Controlled Drug Record for another morphine sulfate 20 mg/ml solution showed 15 ml was signed off by the RN and LVN. The record also showed the pharmacist's signature but did not show the DON's signature; and - The Antibiotic or Controlled Drug Record for hydrocodone/APAP 5-325 mg showed 53 doses were signed off by the RN and LVN. The record also showed the pharmacist's signature but did not show the DON's signature. The DON verified the above findings. The DON stated the RN and LVN's signatures were when they brought the controlled medications to her for disposal. The DON stated the pharmacist also signed the record when the controlled medications were disposed. The DON acknowledged she did not sign the record to show she verified the quantity of the controlled medications brought to her by the RN and LVN. The DON also acknowledged she did not sign the record to show the controlled medications were disposed of by the pharmacist and herself. 47474 (continued on next page)

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	11/21/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. On 11/19/24 at 1408 hours, a concurrent observation and interview with LVN 3 was conducted at Medication Cart B. The following was observed: - 38 packets of DermaRite StingFree Alcohol Free Liquid Skin Prep and Shield had expired on 5/2024. - Five pieces of calcium alginate wound dressing were opened. LVN 3 verified the above findings. LVN 3 stated the expired items should not be used and should have been discarded. LVN 3 further stated the treatment supplies like calcium alginate wound dressings should be discarded after use for infection control. 9. On 11/19/24 at 1548 hours, a concurrent observation an interview with RN 1 was conducted at Medication Cart C. The following was observed: - One povidone iodine prep pad had expired on 5/2024. - Two povidone-iodine prep pad had expired on 4/2024. - Three povidone-iodine prep pad had expired on 2/2024. - Three sterile gloved were opened. - Two IV tubing had expired on 5/2024. - One IV tubing had expired on 3/2024. RN 1 verified the above findings. RN 1 stated the expired items should be discarded. RN 1 further stated the opened sterile gloves would no longer be considered sterile. On 11/21/24 at 1437 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified the above findings.

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	11/21/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32179 Based on observation, interview, facility document review, and facility P&P review, the facility failed to follow the food safety and sanitation guidelines in several areas as evidenced by: * The blender used for preparing the pureed food was not air-dried properly. * Two kitchen frying pans showed signs of corrosion. * Staff members (Cooks 1 and 2) lacked the knowledge on proper food cooling procedures. * The storage area for water pitchers and cups was not maintained in a sanitary condition. These failures had the potential to negatively impact the residents' well-being. Findings: Review of the facility's diet count dated 11/18/24, showed 53 of 129 residents received regular and mechanical soft meals prepared in the kitchen. 1. Review of the facility's P&P titled Electrical Food Machines dated 2023 showed to keep and maintain all food machines in good operating, sanitary condition. This includes mixers, grinders, slicers and toasters. Mixing machine: after washing and rinsing, allow beater and bowl to air dry. Then store in the proper place. On 11/19/24 at 0950 hours, [NAME] 1 was observed making pureed chicken for 20 residents. [NAME] 1 then asked [NAME] 2 to wash the blender. After washing and rinsing, [NAME] 1 immediately took the blender without allowing it to air dry. [NAME] 1 used the wet blender to make pureed spinach. When [NAME] 1 removed the blender from the machine, the top of the blender was still wet. On 11/19/24 at 1030 hours, [NAME] 1 was informed the blender was not air-dried. [NAME] 1 verified the findings. 2. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, for materials that are used in the construction of utensils and food-contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be safe, durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. According to the USDA Food Code 2022, 4-601.11 Equipment, Food- Contact Surfaces, Nonfood Contact Surface, and Utensils, the food- contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. On 11/19/24 at 0950 hours, two corroded frying pans were hanging on the shelf rack. (continued on next page)

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 11/21/2024
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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 1030 hours, an observation and concurrent interview was conducted with [NAME] 1. [NAME] 1 acknowledged the inside and outside of the pans were black and corroded and the black substance had the potential to come into contact with the food. [NAME] 1 verified these findings. 3. Review of the facility's P&P titled Cooling and Reheating of Potentially Hazardous or Time/Temperature Control for Safety Food.dated 2023 showed the two stage method: cool cooked food from 140 degree Fahrenheit to 70 degree Fahrenheit within two hours. Then cool from 70 to 41 degree Fahrenheit or less in additional four hours for a total cooling time of six hours. Corrective action is to be taken when the cool down process is not done correctly. Take corrective action as follows: Discard cooked, hot food immediately when the food is: - Above 70 degree Fahrenheit and more than 2 hours into the cooling process or Above 41 degree Fahrenheit and more than 6 hours into the cooling process. On 11/18/24 at 1620 hours, an interview and concurrent facility document review of the cool down log was conducted with [NAME] 3. [NAME] 3 stated they rarely performed cooling down because they usually finished the food right away. When asked if they had ever needed to cool down food in the past, [NAME] 3 mentioned occasions with roasted beef or roasted turkey. [NAME] 3 described their cooling down method as placing the roasted beef with an internal temperature of 190 F on top of ice, waiting for 2 hours to cool down to 160 F, then another 2 hours to cool down to 140 F, and a further 2 hours to reach 40 F. When asked what they would do if the food had not cooled to 41 F within 6 hours (e.g., if the temperature remained at 45 F), [NAME] 3 stated they would either place it on top of ice for an additional 2 hours or put it in the refrigerator. On 11/18/24 at 1640 hours, [NAME] 1 was asked about how to cool down food. [NAME] 1 stated he always cooked Korean food and had never performed cooling down. [NAME] 1 stated he did not know how to do it and verified the finding. On 11/20/24 at 1600 hours, an interview was conducted with the DSS. The DSS stated after 6 hours of cooling down, if the temperature did not reach 41 degrees or less, the food should be discarded. The DSS verified the finding. 4. On 11/20/24 at 1100 hours, the cart inside the clean room that stored the water pitcher and cups was observed to be covered with a dirty curtain stained with brown residue. LVN 2 stated the curtain should have been cleaned. LVN 2 verified the finding. On 11/21/24 at 1600 hours, the DON and administrator was informed of the above findings.

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 11/21/2024
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)
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 32179 Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure the facility's P&P was updated and followed as evidenced by: * The facility failed to ensure the food items in the residents' refrigerator were labeled and dated for one of two resident refrigerators. This failure had the potential to cause foodborne illnesses to the medically vulnerable resident population who consumed food brought from outside sources. Findings: Review of the facility's P&P titled Bringing in Food for a Resident dated 2023 showed food or beverages should be labeled and dated to monitor for food safety. Food or beverages in the original containers marked with manufacturer expiration dates and unopened, need to be marked with resident's name. Food in unmarked or unlabeled containers will be marked with the current date and the resident's name. On 11/20/24 at 1015 hours, a concurrent observation and interview was conducted with RN 2 and LVN 13. The following items were observed in the resident refrigerator in Nursing Station 1: - One strawberry yogurt was unlabeled with expiration date of 9/29/24. - One vanilla yogurt was unlabeled with expiration date of 11/4/24. - Three lemon cookies were unlabeled with expiration date of 9/12/24. - One packet of beef kimbap was unlabeled and undated. - One plate of vegetarian kimbap was unlabeled and undated. - One 180 ml pouch of black bean and black sesame soy milk was unlabeled and undated. - One dirty Tupperware was unlabeled and undated. - A jar of chia seeds was unlabeled and undated. RN 2 stated food brought from outside should be labeled with the resident's name and dated. LVN 13 was informed the bottom inner part of the refrigerator was observed to be dirty and sticky. RN 2 stated the jar belonged to the staff and the staff should not keep their food in the resident's refrigerator. RN 2 and LVN 13 verified the above findings. On 11/21/24 at 1600 hours, the DON and administrator was informed of the above findings.

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 11/21/2024
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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47474 Based on observation, interview, and medical record review, the facility failed to ensure three of 26 final sampled residents (Residents 73, 100, and 124) had accurate and complete medical records. * The facility failed to ensure the information on Resident 73's POLST was accurate and updated. * Resident 100 had conflicting information documented in the medical record as to whether Resident 100 had formulated an advance directive. * Resident 124 did not have a complete smoking assessment and accurate care plan problem for smoking. These failures had the potential of not following the residents' health wishes. Findings: 1. Medical record review for Resident 73 was initiated on 11/18/24. Resident 73 was admitted to the facility on [DATE]. Review of Resident 73's H&P examination dated 8/7/24, showed Resident 73 did have the capacity to understand and make decisions. Review of Resident 73's POLST dated 8/7/24, showed Section D, no advance directive. Further review of Resident 73's medical record showed an advanced directive dated 8/28/24, and signed by the resident, two witnesses, and the ombudsman. On 11/20/24 at 0941 hours, a concurrent interview and medical record review was conducted with LVN 2. LVN 2 verified Resident 73's POLST was not updated and showed the resident did not have an advance directive; however, LVN 2 stated Resident 73 did have a copy of an advance directive dated 8/28/24. LVN 2 stated the POLST should have been updated. On 11/21/24 at 0938 hours, a concurrent interview and medical record review was conducted with the SSD. The SSD verified the above findings. The SSD stated the POLST should have been updated to reflect Resident 73's current health care directive and status. On 11/21/24 at 1437 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified the above findings. 37726 2. Medical record review for Resident 100 was initiated on 11/18/24. Resident 100 was admitted to the facility on [DATE]. (continued on next page)

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 11/21/2024
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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 100's POLST dated 11/18/24, showed Resident 100 had not formulated an advance directive. Further review of the same document showed Resident 100 had formulated an advance directive, however, the advance directive was not available. On 11/20/24 at 1417 hours, a concurrent interview and medical record review was conducted with RN 1. RN 1 verified the findings and stated she would clarify whether Resident 100 had formulated an advance directive. 46787 3. On 11/19/24 at 1300 hours, an observation of Resident 124 in the smoking patio was conducted. Resident 124 was observed in the smoking patio with the supervision of the Activity Assistant. The Activity Assistant was observed lighting Resident 124's cigarette and providing Resident 124 with a smoking apron. Medical record review for Resident 124 was initiated on 11/18/24. Resident 124 was admitted to the facility on [DATE]. Review of Resident 124's H&P examination dated 8/4/24, showed Resident 124 did not have the capacity to understand and make decisions. Review of Resident 124's plan of care showed a care plan problem dated 9/27/24, addressing Resident 124's choice to smoke. The care plan showed Resident 124 was an independent smoker. Review of Resident 124's Safe Smoking Assessments dated 9/27/24 and 11/11/24 showed no entries for the following sections: - cognitive function; - visual function; - communication function; - resident observation; and - resident interview. On 11/21/24 at 0824 hours, an interview and concurrent medical record review was conducted with the Activities Director. The Activities Director acknowledged and verified the above findings.

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 11/21/2024
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the safe and sanitary environment to help prevent the development and transmission of infection when: * The facility failed to ensure LVN 1 changed gloves in between administering medications through a different route. * The facility failed to ensure LVN 1 changed the PPE in between administering medications to two nonsampled residents (Residents 26 and 40) on EBP precautions. These failures posed the risk for transmission of disease-causing microorganisms. Findings: Review of the facility's P&P titled Infection Control revised 5/2018 showed the facility has an established infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Review of the facility's P&P titled Medication Administration revised 5/2019, showed staff shall follow infection control procedures i.e., hand-washing, antiseptic techniques, gloves, isolation precautions, etc., as applicable. Review of the facility's P&P titled Enhanced Standard Precautions revised 5/2024, showed the purpose of enhanced standard precautions is a resident-centered and activity-based approach for preventing MDRO transmission in skilled nursing facilities. Enhanced barrier precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of MDROs. 1. On 11/19/24 at 0848 hours, a medication observation for Resident 26 was conducted with LVN 1. LVN 1 was observed administering the following medications: - acetaminophen (pain medication) 325 mg 2 tablets by mouth, - amlodipine (medication used to treat high blood pressure) 2.5 mg one tablet by mouth, - vitamin C (supplement) 500 mg 1 tablet by mouth, - cranberry (supplement) 450 mg one tablet by mouth, - docusate sodium (laxative) 100 mg two tablets by mouth, - multivitamin with minerals (supplement) one tablet by mouth, (continued on next page)

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 11/21/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- metoprolol succinate ER (medication used to treat high blood pressure) 25 mg one tablet by mouth, - Lidoderm (pain medication) patch 5% topically to both knees. Medical record review for Resident 26 was initiated on 11/21/24. Resident 26 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 26's H&P examination dated 6/19/24, showed Resident 26 had the capacity to understand and make decisions. Review of Resident 26's Admission Record showed Resident 26 had a diagnosis of a colostomy. Review of Resident 26's Order Summary Report for November 2024 showed a physician's order dated 6/14/24, for enhanced barrier precautions every shift. 2. On 11/19/24 at 0902 hours, a medication observation for Resident 40 was made with LVN 1. LVN 1 was observed to use the same gown previously used to administer the medications to Resident 26. Medical record review for Resident 40 was initiated on 11/21/24. Resident 40 was admitted to the facility on [DATE]. Review of Resident 40's H&P examination dated 3/13/24, showed Resident 40 had the capacity to understand and make decisions. Review of Resident 40's Admission Record showed Resident 40 had a diagnosis of a GT. Review of Resident 40's Order Summary Report dated active as of 11/1/24, showed a physician's order dated 6/5/24, for enhanced barrier precautions every shift. On 11/19/24 at 0926 hours, an interview was conducted with LVN 1. LVN 1 acknowledged and verified the above findings. LVN 1 stated she should have changed gloves in between different routes of medication administration and changed the PPE in between medication administration of residents on enhanced barrier precautions.

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 11/21/2024
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)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 46787 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to inform the physician of the residents who had not met McGeer's Criteria and were prescribed antibiotics for two of 26 final sampled residents (Residents 82 and 87) and five nonsampled residents (Resident 12, 25, 57, 83, and 99). This failure had the potential for the continued use of unnecessary antibiotics, potentially resulting in adverse reactions associated with antibiotics, and the development of antibiotic resistant bacteria. Findings: According to the CDC, an estimated 70% of nursing home residents receive one or more courses of antibiotics during a year. Studies have shown that 40% to 75% of the antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Frail and older adults are at significant risk of harm from antibiotic overuse including increased adverse drug events, increased drug interactions and infection with antibiotic-resistant organisms. The WHO cites antibiotic resistance as one of the biggest threats to human health. Review of the facility's P&P titled Infection Control - Antibiotic Stewardship revised 01/2018, showed it is the policy of the facility to establish an antibiotic stewardship program that promotes the appropriate use of antibiotics and a system of monitoring to improve resident outcomes and reduce antibiotic resistance. On 11/19/24 at 1040 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated the facility's antibiotic stewardship program consisted of reviewing the residents' prescribed antibiotics and determining whether they had met the McGeer's criteria. The IP stated when a resident had failed to meet McGeer's criteria, the physician would then be notified that the resident had not met the facility's criteria for a true infection. The IP stated the purpose of notifying the physician of the residents with prescribed antibiotics and did not meet the McGeer's Criteria was to prevent the unnecessary use of antibiotics. The IP stated the unnecessary use of antibiotics could lead to the development of multidrug resistant organisms and result in the residents experiencing adverse reactions associated with the antibiotic use. Review of the facility's monthly Infection Prevention and Control Surveillance Logs for August, September, and October 2024 conducted with the IP showed the following documentation: * August 2024: - 15 residents who were prescribed antibiotics and did not meet MCGeer's criteria for infection. * September 2024: - 13 residents who were prescribed antibiotics and did not meet MCGeer's criteria for infection. * October 2024: (continued on next page)

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 11/21/2024
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)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 14 residents who were prescribed antibiotics and did not meet MCGeer's criteria for infection. Review of the residents' McGeer's Criteria forms for the months of August, September, and October 2024 was conducted with the IP. After reviewing the residents' McGeer's Criteria forms, the IP verified Residents 25, 83, and 99 (August 2024); Residents 12, 57, and 87 (September 2024); and Residents 82 and 87 (October 2024) had not met the MCGeer's criteria. The IP verified the residents' physicians had not been notified of the residents not meeting the McGeer's criteria.

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 11/21/2024
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)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 47474 Based on observation, interview, facility document review, and the facility P&P review, the facility failed to ensure the glucometers (a device which measures the amount of sugar in the blood) were calibrated and the quality control was performed for these glucometers as evidenced by: * The facility failed to ensure the glucometer in Medication Cart A was calibrated and quality control was performed for several dates in November 2024. * The facility failed to ensure the two glucometers stored in Medication Cart F were calibrated and maintained in safe operating condition. * The facility failed to ensure the glucometer stored in Medication Cart D was maintained in safe operating condition. These failures had the potential for residents requiring blood glucose checks to have inaccurate readings. Findings: Review of the facility's P&P titled Quality Control Testing on Assure Glucometer revised 11/2024, showed quality control testing using the Assure Dose Control Solution will be performed to examine the performance of the Assure Blood Glucose Monitoring System. The Assure Dose Control Solution checks if the meter and test strips are working correctly as a system and if you are testing correctly. A control solution test should be performed every night. The P&P further showed to compare the result to the range printed on the test strip bottle. Make sure the results is within the acceptable range. If the result falls within this range, the meter and test strip are working correctly. Do not use system if control solution result is out of range. 1. Review of the facility document titled Quality Control Record dated 11/2024 for Medication Cart A, showed no documented evidence the glucometer was calibrated and had quality control check on 11/18/24. Further review of the Quality Control Record showed the following: - on 11/19/24, the normal control result was 93 mg/dL and the high control result was 221 mg/dL. - on 11/10/24, the normal control result was 96 mg/dL and the high control result was 231 mg/dL. - on 11/13/24, the normal control result was 96 mg/dL and the high control result was 240 mg/dL. - on 11/17/24, the normal control result was 97 mg/dL and the high conrol result was 238 mg/dL. However, the above normal control and high control results were not observed on the glucometer with the serial number of 1040-4378125. (continued on next page)

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 11/21/2024

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 1408 hours, a concurrent inspection of Medication Cart A and interview with LVN 1 was conducted. LVN 1 verified the above findings. LVN 1 stated the licensed nurses on the 11-7 shift (2300 to 0700 hours) calibrated the glucometer and performed the quality control. LVN 1 further stated the glucometers and quality controls were checked nightly to ensure the facility had accurate blood sugar level check for the residents. On 11/21/24 at 1437 hours, an interview was conducted with the Administrator and DON . The Administrator and DON verified the above findings. 39453 2. On 11/19/24 at 1552 hours, a concurrent inspection of Medication Cart F and interview was conducted with LVN 14. There were two glucometers with serial numbers 1040-4306940 and 1040-4381046 inside Medication Cart F. Review of the Quality Control Record for October 2024 showed a calibration log for glucometer with serial number 1040-4381046. However, the calibration log showed missing entries and no calibration was documented from 10/1 to 10/10, 10/12, 10/14, and from 10/20 to 10/28/24. In addition, there was no documented evidence the glucometer with serial numbers 1040-4306940 was calibrated in October. Review of the Quality Control Record for November 2024 showed a calibration log for glucometer with serial number 1040-4261376, which did not match the two glucometers stored in Medication Cart F. In addition, there was no documented evidence the two glucometers with serial numbers 1040-4306940 and 1040-4381046 inside Medication Cart F were calibrated in November. LVN 14 verified the above findings. 47476 3. On 11/20/24 at 1135 hours, a concurrent inspection of Medication Cart D and interview was conducted with LVN 7. There was one glucometer with serial number 1040-4429790 inside Medication Cart D. LVN 7 stated the quality control for the glucometer was done during the night shift. Review of the Daily Quality Control Record for November 2024 showed a calibration log for glucometer 1040-4378229 on page one (which did not match the glucometer in Medication Cart D) with the results for the normal and high controls from 11/1 through 11/18/24, and a calibration log for glucometer 1040-4429790, on page two with the results for the normal and high controls for 11/19 and 11/20/24. Further review of the calibration log showed the following results were documented: - on 11/17/24, the control level 1 result was 98 mg/dL and control level 2 result was 215 mg/dL. - on 11/19/24, the control level 1 result was 96 mg/dL and control level 2 result was 248 mg/dL. Review of the quality control history on glucometer 1040-4429790 showed the results taken from 11/16 through 11/19/24. Upon review of the history, there was no history of a quality check performed on 11/17 and 11/19/24. (continued on next page)

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 11/21/2024
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)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 7 verified the results on the Daily Quality Control Record did not match the quality control history on glucometer 1040-4429790 for 11/17 and 11/19/24. LVN 7 also verified the first page of the Daily Quality Control Record for November 2024 did not match the glucometer serial number in Medication Cart D. On 11/20/24 at 1349 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the glucometer control numbers should be the same according to what was on the Daily Quality Control Record.