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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure three of five final sampled residents (Residents 3, 14, and 16) reviewed for the unnecessary medications were free from the unnecessary psychotropic medication. * The facility failed to implement and document the nonpharmacological interventions for Resident 14 when the resident experienced behavioral episodes associated with the use of Rexulti (antipsychotic medication) and venlafaxine (antidepressant medication). * The facility failed to ensure the orthostatic blood pressure was accurately monitored for Resident 3 related to the use of the psychotropic medication. These failures had the potential for the residents to have adverse complications from the medications and the potential of not providing the correct data to the prescriber in order to adjust the dose of the psychotropic medications for the residents.Findings: Review of the facility's P&P titled Psychotropic Drug Treatment dated 9/2017 showed the facility to provide psychotropic 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. When their use is indicated, the facilities would use the least restrictive alternative for the least amount of time and document ongoing evaluation of the need for psychotropic drug treatment. Further review of the P&P showed medication use is not the sole approach for behavior intervention. Other non-pharmacological intervention will be identified and implemented on the plan of care. 1. Medical record review Resident 14 was initiated on 3/11/26. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's H&P examination dated 8/14/25, showed Resident 14 had no capacity to understand and make medical decisions. Review of Resident 14's Order Summary Report showed the following physician's orders: - dated 8/12/25, to monitor episodes of depression as manifested by verbalization of sadness every shift and to record number of episodes every shift; - dated 1/14/26, for Rexulti 1 mg to give one tablet via G- Tube on time a day for dementia with agitation as manifested by responding to internal stimuli leading to resisting care and to monitor episode of responding to internal stimuli leading to resisting care and to record the number of episodes every shift; and - dated 1/30/26, for venlafaxine 25 mg, to give 0.5 tablet via G-Tube three times a day for depression (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as manifested by verbalization of sadness. Review of Resident 14's MAR for March 2026 showed the Rexulti and venlafaxine medications were being administered as ordered by the physician and the behaviors were monitored as ordered for the medications. The MAR further showed Resident 14 had 17 behavior episodes of responding to the internal stimuli leading to resisting care in the day shift. In addition, Resident 14 had one episode of depression as manifested by verbalization of sadness. Further review of medical record for Resident 14 did not show if a nonpharmacological intervention was provided when the resident had the above behavior episode(s) related to the use of Rexulti and venlafaxine medications. On 3/13/26 at 1447 hours, an interview and concurrent medical record review for Resident 14 was conducted with LVN 6. LVN 6 was unable to show the documentation of the nonpharmacological interventions provided when Resident 14 had the above behavior episode(s) related to the use of Rexulti and venlafaxine medications. On 3/17/26 at 1406 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 3 was initiated on 3/12/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Order Summary Report dated 3/2/26, showed the following physician's order dated: - dated 10/20/25, to administer buspirone (antianxiety medication) 5 mg one tablet by G-Tube every eight hours for anxiety; - dated 11/20/25, to check for orthostatic hypotension by checking the blood pressure in two positions (lying down and sitting) once a day every Sunday related to the use of the buspirone and lorazepam (antianxiety medication); and - dated 1/23/26, to administer lorazepam 1 mg via G-Tube every six hours as needed for anxiety. Review of Resident 3's MAR for March 2026 showed the orthostatic blood pressures (sitting and lying positions) were scheduled to be monitored every Sunday. However, the blood pressure readings for both positions (lying and sitting positions) were the same as follows: - dated 3/1/26, the blood pressure readings were 122/78 mmHg for the sitting position and 122/78 mmHg for the lying position; and - dated 3/8/26, the blood pressure readings were 151/68 mmHg for the sitting position and 151/68 mmHg for the lying position. On 3/17/26 at 0842 hours, an interview and concurrent medical record review was conducted for Resident 3 with RN 6. RN 6 verified Resident 3's physician orders for orthostatic hypotension monitoring for the use of antipsychotic medications once a week every Sunday. RN 6 was informed of the above findings. RN 6 verified and acknowledged the orthostatic hypotension monitoring were (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inaccurate because of the same blood pressure readings on sitting and lying positions. On 3/18/26 at 0839 hours, an interview and concurrent medical record review for Resident 3 was conducted with the DON. The DON was informed and 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of pressure injuries for two of three final sampled residents (Residents 8 and 110) reviewed for pressure injuries. * The facility failed to ensure the LAL mattress setting was appropriate to the residents' weight for Residents 8 and110. These failures had the potential for the residents to develop pressure injuries or worsening of the existing pressure injuries.Findings: Review of facility's P&P titled Low Air Loss Mattress revised dated 3/2017 showed the manufacturer's guidelines should be reviewed for each individual mattress to ensure this policy is what recommended; if this policy is not in agreement with manufacturer's guidelines, the manufacturer's guidelines will be followed. Review of the DynaRest Airfloat 100 Air Mattress with Pump manual (undated) showed to turn the pressure adjust knot to set a comfortable pressure level by using the weight scale as a guide. 1. Medical record review for Resident 110 was initiated on 3/11/26. Resident 110 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 110's H&P examination dated 3/6/26, showed the resident had no capacity to understand and make decisions. Review of Resident 110's Order Summary Report dated 3/17/26, showed a physician order dated 3/3/26, for LAL mattress for skin and wound management and check for proper setting and function every shift. Review of Resident 110's Weights and Vital Summary showed Resident 110 weighed 128 pounds on 3/8/26. On 3/11/26 at 0906 hours, an observation was conducted for Resident 110. Resident 110 was observed in bed lying on a LAL mattress with the mattress pressure setting passed the 150 pounds mark. On 3/11/26 at 0929 hours, a follow-up observation and concurrent interview was conducted with LVN 1 in Resident 110's room. LVN 1 verified the LAL mattress pressure setting was passed the 150 pounds mark. LVN 1 verified Resident 110 did not weigh more than 150 pounds and verified the resident's current weight was only 128 pounds. LVN 1 stated the mattress pressure setting should be based on the resident's weight to prevent skin breakdown or wound to get worse. On 3/18/26 at 0923 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 8 was initiated on 3/11/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 8/14/25, showed Resident 8 had no capacity to understand and make decisions. (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 8's Order Summary Report dated 3/12/24, showed a physician's order dated 8/16/24, for LAL mattress for skin and wound management and check for proper setting and function every shift. Review of Resident 8's Care Plan dated 1/13/26, showed a care plan problem addressing Resident 8's high risk for further skin break down and history of pressure ulcer. The interventions included LAL pressure reduction mattress. Review of Resident 8's Weights and Vital Summary showed Resident 8 weighed 120 pounds on 3/1/26. On 3/11/26 at 1135 hours and 3/12/26 at 1007 hours, an observation was conducted for Resident 8. Resident 8 was observed in bed, lying on a LAL mattress with the mattress pressure setting at the 150 pounds mark. On 3/12/26 at 1134 hours, an follow-up observation and concurrent interview and medical record review for Resident 8 was conducted with LVN 13 in Resident 8's room. LVN 13 verified the LAL mattress pressure setting was at the 150 pound mark. LVN 13 verified that Resident 8 did not weigh 150 pounds, noted the resident's current weight was only 120 pounds. LVN 13 stated the mattress pressure setting should be adjusted according to the resident's weight to prevent skin breakdown. On 3/17/26 at 1406 hours, an interview was conducted with the DON. The DON was informed and acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, medical record reviews, and facility P&P review, the facility failed to provide the necessary respiratory care services for six of 25 final sampled residents (Residents 3, 4, 7, 21, 69, and 136) and one nonsampled resident (Resident 94) reviewed for respiratory care. * The facility failed to ensure the manufacturer's recommendation for cleaning and disinfecting of the ventilator machines was followed for Resident 3, 4, and 7. * The facility failed to ensure Resident 69 received the oxygen therapy as ordered by the physician. Additionally, the facility failed to ensure the staff followed the proper infection control practices when a staff member attempted to place a nasal cannula on the resident after it had been on the floor. * The facility failed to ensure the Oxygen In Use signage was posted outside of Resident 94's room while the resident was on oxygen therapy. * The facility failed to ensure Resident 136's oxygen concentrator did not have a motor like sound. * The facility failed to ensure Resident 21's nebulizer tubing was not touching the floor. These failures had the potential to affect the respiratory health and well-being of the residents in the facility.Findings: 1. Review of the Covidien [NAME] HT70 Ventilator with Accessories Plus Model Operator's Manual (undated), under the Cleaning and Maintenance section, showed the ventilator machine should be clean with the use of a medical detergent or alcohol based cleaning solutions to remove blood, tissue and other residue. Rinse thoroughly with sterile, distilled water and allow to dry. Wipe clean between patients and as needed while in use. The exterior of the ventilator should be wiped clean with a cloth dampened with a medical detergent, disinfectant or alcohol based cleaning solution. a. Medical record review for Resident 7 was initiated on 3/11/26. Resident 7 was admitted to the facility on [DATE]. On 3/11/26 at 1009 hours, an observation was conducted for Resident 7. Resident 7 was observed asleep in bed. Resident 7 was observed with tracheostomy, connected to the ventilator machine and with oxygen supply from concentrator machine. Review of Resident 7's Order Summary Report dated 3/2/26, showed a physician's order dated 12/13/26, for the ventilator setting as follows: AC (Assist Control), VT - 500, rate - 20, 3 liters oxygen, PEEP + 5 four times a day. b. Medical record review for Resident 4 was initiated on 3/11/26. Resident 4 was admitted to the facility on [DATE]. On 3/11/2026 at 1119 hours, an observation was conducted for Resident 4. Resident 4 was observed asleep in bed. Resident 4 was observed with tracheostomy, connected to the ventilator machine and with oxygen supply from concentrator machine. Review of Resident 4's Order Summary Report dated 3/2/26, showed a physician's order dated 1/24/26, for the ventilator machine setting as follows: AC, VT 450, Rate 16, PEEP +5, and 2 liters per minute oxygen four times a day. c. Medical record review for Resident 3 was initiated on 3/12/26. Resident 3 was admitted to the facility on [DATE]. On 3/11/2026 at 1132 hours, an observation was conducted for Resident 3. Resident 3 was observed (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	asleep in bed. Resident 3 was observed with tracheostomy, connected to the ventilator machine and with oxygen supply from concentrator machine. Review of Resident 3's Order Summary Report dated 3/2/26, showed the physician's order dated 3/10/26, for the ventilator setting as follows: daytime: 5 LPM via T-Piece/T-Collar ; Night: SIMV Rate 12, VT 500, PEEP +5, PS 12, 5 LPM four times a day. Further review of the Order Summary Report for Residents 3, 4, and 7 failed to show the physician's order to clean and disinfect the ventilator machine per manufacturer's recommendation were obtained. In addition, further review of the medical record for Residents 3, 4, and 7 failed to show documented evidence of the cleaning and disinfecting of the ventilator machine. On 3/16/2026 at 1054 hours, an interview and concurrent medical record review for Resident 3, 4, and 7 was conducted with RT 1. RT 1 was asked for cleaning and disinfecting of the ventilator machines. RT 1 stated they would use bleach wipes to clean the ventilator machine every day. RT 1 was asked about the physician's order for the cleaning and disinfecting of the ventilator machine per manufacturer's manual and asked if they had documented the cleaning of the ventilator machine everyday. RT 1 verified and acknowledged there were no physician's order and documentation for the cleaning of the ventilator machines. RT 1 was uncertain if they followed the manual from the manufacturer of the ventilator machine. On 3/16/2026 at 1354 hours, an interview and concurrent medical record review for Residents 3, 4, and 7 was conducted with RT 2. RT 2 stated she would inform the facility's contracted company for the ventilator machine yearly maintenance. RT 2 stated she kept a log for the ventilator machine when it was serviced and when would be the next maintenance. RT 2 was asked about the everyday cleaning of the ventilator machine when the resident was using the machine. RT 2 stated the RTs were responsible for the cleaning by wiping the ventilator machines, suction machines, nebulizer machines and concentrator machine using the bleach wipes for everyday cleaning. When asked if there was a log or record when they cleaned the machines, RT 2 verified there was no record of the cleaning of the machines done by RTs. RT 2 was asked if there was a manufacturer's manual of the ventilator machines available, RT 2 verified there was none. RT 2 was asked if they followed the manufacturer's manual of the ventilator machine for cleaning and disinfecting the ventilator machines, RT 2 was uncertain. RT 2 verified and acknowledged the cleaning and disinfecting of the ventilator machines was not followed per manufacturer's recommendation. On 3/17/2026 at 0842 hours, an interview and concurrent medical record review for Residents 3, 4, and 7 was conducted with RN 6. RN 6 verified the RT's were responsible for providing of the respiratory care to the residents who needed respiratory care. RN 6 added the RTs were responsible for the cleaning and maintenance of the ventilator machines. When asked if the cleaning of the ventilator machines were documented, RN 6 verified there was no documentation or recorded evidence if the cleaning of the ventilator machine was performed. RN 6 reviewed the RT flowsheet and verified there was no documentation of cleaning of the vent machine. On 3/18/26 at 0839 hours, an interview and concurrent medical record review for Residents 3, 4, and 7 was conducted with the DON. The DON was informed and verified the above findings Cross reference to F0657, example # 2 a, b, and c. 2. Review of the facility P&P titled Oxygen Administration dated 2/2017 showed to verify that there is (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a physician order for the oxygen administration. On 3/11/26 at 0826 hours, an observation was conducted for Resident 69. Resident 69 was observed lying in his bed with an oxygen machine positioned on the left side of the bed. The oxygen tubing connected to the machine was observed touching the floor, and the nasal cannula, which was a part of the oxygen tubing, was also touching the floor. The oxygen machine was observed to be off. Medical record review for Resident 69 was initiated on 3/11/26. Resident 69 was admitted to the facility on [DATE]. Review Resident 69's H&P examination dated 2/17/26, showed Resident 69 had no capacity to understand and make decisions. Review of Resident 69's Order Summary Report showed an order dated 2/16/26, for oxygen at a rate of 4 LPM via mask/nasal cannula continuously to keep the oxygen saturation level above 92% for COPD exacerbation. On 3/11/26 at 0836 hours, an observation with a concurrent interview and medical record review for Resident 69 was conducted with LVN 6. LVN 6 was called to Resident 69's room and LVN 6 verified the oxygen tubing and nasal canula was touching the floor. LVN 6 stated the resident should be receiving oxygen at a rate of 4 LPM as per the physician's order. LVN 6 was observed turning on the oxygen machine and was preparing to connect the resident using the same nasal cannula that had been observed on the floor. LVN 6 was stopped and asked whether the oxygen tubing had been on the floor. LVN 6 acknowledged the oxygen tubing for Resident 69 had been on the floor. LVN 6 stated she should have discarded it and used new oxygen tubing before administering oxygen. LVN 6 also stated the oxygen machine needed to be replaced and was observed bringing a new nasal cannula and a new oxygen machine. LVN 6 was observed checking Resident 69's oxygen saturation, which measured 88% without oxygen. After applying oxygen at a rate of 4 LPM, the resident's oxygen saturation increased to 94%. When asked how long the resident had been without oxygen, LVN 6 stated she could not determine the exact time; however, LVN 6 stated she last checked on the resident on 3/11/26 at 0700 hours, and he was receiving oxygen at that time. On 3/17/26 at 1406 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. On 3/11/26 at 0858 hours, during the initial tour of the facility, Resident 94 was observed awake and lying on the bed. Resident 94 was observed wearing a nasal canula and the oxygen concentrator setting was at a rate of 2 LPM. However, there was no signage warning of No Smoking/Oxygen in Use posted inside or outside of Resident 94's room. Medical record review for Resident 94 was initiated on 3/11/26. Resident 94 was admitted to the facility on [DATE]. Review of Resident 94's H&P examination dated 1/19/26, showed Resident 94 had the capacity to understand and make decisions. Review of Resident 94's Order Summary Report showed a physician's order dated 1/16/26, may apply oxygen via nasal cannula at a rate of 2 LPM to keep the oxygen saturation level greater than 92% as needed. (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/11/26 at 0930 hours, a follow-up observation of Resident 94 and concurrent interview was conducted with the IP. The resident's room was observed with no signage of No Smoking/Oxygen in Use. The IP stated while the resident was on oxygen there should be a No Smoking/Oxygen in Use sign posted by the door outside of the resident's room. The IP verified and acknowledged that there was no sign of No Smoking/Oxygen in Use posted for this resident. On 3/18/26 at 0923 hours, an interview conducted with the DON. The DON was informed and acknowledged the above findings. 4. On 03/11/2026 at 0907 hours, an observation was conducted for Resident 136. A motor like sound was heard out into the hallway, outside Resident 136's room. Resident 136 was observed in bed with a motor like sound coming from Resident 136's oxygen concentrator. Medical record review for Resident 136 was initiated on 3/11/26. Resident 136 was admitted to the facility on [DATE]. Review of Resident 136 H&P examination dated 3/11/26, showed Resident 136 had no capacity to make decision. Review of Resident 136's Order Summary Report showed a physician's order dated 3/10/26, for oxygen at a rate of 2 LPM via nasal cannula to keep the oxygen saturation above 92%. On 3/11/26 at 936 hours, a follow-up observation and concurrent interview was conducted with Resident 136 and LVN 2. LVN 2 verified the motor like sound was coming from Resident 136's oxygen concentrator. LVN 2 stated she noticed the sound but thought it might be related to the oxygen concentrator's position and did not report the sound. When asked if the noise bothered Resident 136, Resident 136 replied yes the sound bothered her. 5. On 3/11/26 1645 hours, an observation was conducted for Resident 21 and concurrent interview was conducted with RN 5. Resident 21's nebulizer tubing was observed touching the floor. RN 5 verified Resident 21's nebulizer tubing was touching the floor. Medical record review for Resident 21 was initiated on 3/12/26. Resident 21 was readmitted to the facility on [DATE]. Review of Resident 21's Order Summary Report showed a physician's order dated 3/7/26, for albuterol solution to be administered via nebulizer every six hours as needed for shortness of breath/wheezing. Review of Resident 21's H&P examination dated 3/9/26, showed Resident 21 was nonverbal and had no capacity to make decisions.

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility document review, the facility failed to ensure the menu was followed for 10 residents who received pureed food. * The facility failed to ensure the Korean menu was followed during pureed preparation observation when the cook did not puree one food item (roasted [NAME]) posted on menu, and the cook liquified seaweed soup. This failure posed the risk for the residents who received food prepared in the kitchen to not have their nutritional needs met.Findings: Review of the facility's document titled Order Listing Report dated 3/12/26, showed a total of 48 of 124 residents (including 10 on puree diets) received meals prepared in the facility's kitchen. Review of the facility's posted menu for the lunch meal dated 3/12/26, showed the following Korean menu food items were to be served on 3/12/26: Bulgogi (meat), seaweed soup, mixed simple salad, steamed rice, kimchi, and roasted [NAME] (dried seaweed sheets). On 3/12/26 at 0941 hours, a puree food preparation observation and concurrent interview was conducted with [NAME] 1. [NAME] 1 stated he would be doing puree for the Bulgogi and seaweed soup. When asked about the other food items on the menu, [NAME] 1 stated those were pureed in the morning and were currently refrigerated. On 3/12/26 at 1046 hours, [NAME] 1 was observed pouring seaweed soup into a blender. [NAME] 1 showed a liquified version of the seaweed soup. When asked if he (Cook 1) was finished pureeing the seaweed soup to the correct consistency, [NAME] 1 verbalized yes because Koreans liked to drink soup. The Dietary Services Director was called to verify the consistency of the seaweed soup for residents on puree diet. The Dietary Services Director instructed [NAME] 1 to follow the IDDSI Level #4 soup recipe. The directions for pureeing the soup included to add saltine crackers. [NAME] 1 was observed gathering packets of saltine crackers. [NAME] 1 then hesitated and asked the Dietary Services Director. The Dietary Services Director then instructed [NAME] 1 to use thickener and omit the saltine crackers. Per the Dietary Services Director, the RD had instructed her to omit the saltine crackers via telephone. When asked about pureeing the roasted [NAME], [NAME] 1 stated he would not be pureeing this food item, posted on the Korean menu. When asked about how the kimchi was pureed, [NAME] 1 verbalized the kimchi was bought in tubs and was then pureed. The Dietary Services Director was asked for a copy of the puree recipe for kimchi. Per the Dietary Services Director, there was not one specific recipe for kimchi. On 3/13/26 at 1316 hours, an interview and concurrent review of dietary manuals was conducted with the RD. The RD was informed of the above findings. When asked about recipes for the seaweed soup and the kimchi, the RD verbalized the puree recipes provided to the facility were challenging because they were not geared to the specific population Korean and the cultural foods they eat. When asked if she (RD) had done a follow up to the recipes not being geared towards Korean foods, the RD stated she did not do a follow up as the recipes had been approved a long time ago by company's registered dieticians.

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed. * The hairnet for one kitchen staff (Tray Line Staff 1) did not completely cover the hair. * There were ten ladles stored above the three compartment sink, above the wash and rinse sinks. * The facility staff (CNA 6) distributed a food tray to Resident 105 without having the licensed nurse check the food tray. * The kitchen staff (Cook 1) failed to wash her hands after touching a trash can during puree preparation observation. These failures had the potential to cause foodborne illnesses to the medically vulnerable residents population who consumed food prepared in the kitchen.Findings: Review of the facility's document titled Order Listing Report dated 3/12/26, showed a total of 48 of 124 residents (including 10 on puree diets) received meals prepared in the facility's kitchen. 1. According to the FDA Food Code Section 2-402.11, Effectiveness, food employees to wear hair restraints (nets, hats, beard nets) to effectively keep hair from contacting exposed food, clean equipment, utensils, linens, and unwrapped single-service items. On 3/11/26 at 0800 hours, an observation in the kitchen was conducted with the Dietary Services Director. Tray line Staff 1 was inside the dishwashing area. Tray line Staff 1 was observed with strands of hair coming out of the side of her hairnet. The Dietary Services Director verified the findings. 2. On 3/11/26 at 0810 hours, an observation in the kitchen was conducted with the Dietary Services Director. There were a total of ten ladles observed stored about two to three feet above the dishwashing and rinse compartments of the three compartment manual dishwash sinks. The findings was verified with the Dietary Services Director. 3. On 3/11/26 at 1155 hours, a dining observation in Station 1 and concurrent interview was conducted with CNA 6. The meal cart was observed delivered to the hallway outside Room A. CNA 6 was observed removing Resident 105's food tray and delivering it to the resident. The food tray was delivered to the resident without being checked by a licensed nurse. CNA 6 verified the findings. 4. Review of the facility's P&P titled Hand Washing Procedure dated 2023 showed hand washing was to be completed after touching a trash can or lid. On 3/12/26 at 0941 hours, a puree food preparation observation was conducted with [NAME] 1. During the food preparation observation, [NAME] 1 was observed removing the gloves and then touched the barrel trash can to dispose of the used gloves. [NAME] 1 put on new gloves without performing hand hygiene and touched the blender used to puree foods. [NAME] 1 touched the barrel of the trash can to dispose of the used gloves, retrieved kimchi from the refrigerator and retrieved a fork without performing hand hygiene in between. When asked about no handwashing after touching the trash can on two separate observations, [NAME] 1 did not acknowledge the 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on interview and facility P&P review, the facility failed to ensure the personal food policy addressed personal food brought in from the outside for the residents who wanted to store and reheat the foods for later consumption. * The facility failed to ensure the residents were able to store food and reheat brought from outside sources in the facility. This failure posed the risk of the residents not being able to choose to store and/or reheat foods brought from the outside and being able to enjoy foods brought from the outside, at their leisure. Findings: Review of the facility's P&P titled Food and Liquids food From Outside Sources or Other Than the Dietary Department revised 3/2025 showed foods brought from outside could not be reheated or stored in the facility. Review of the facility's document titled Order Listing Report dated 3/12/26, showed a total of 48 of 124 residents (including 10 on puree diets) received meals prepared in the facility's kitchen. On 3/11/26 at 0818 hours, an interview was conducted with the ADON. The ADON stated there was no residents' refrigerator. On 3/13/26 at 1316 hours, an interview was conducted with the RD. The RD stated she was aware of the facility's P&P to not allow the residents to store or reheat foods brought from the outside. The RD stated she was not included in the development of this P&P. On 3/18/26 at 1029 hours, the above findings were shared with the DON and Administrator. The DON stated personal food brought from the outside was not to stored or reheated per the facility's P&P.

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the infection control program in accordance with the facility's P&P. * The facility failed to maintain an accurate infection control surveillance program for September 2025 through February 2026. The facility failed to ensure the Surveillance Data was accurate to determine whether the resident's infection met the McGeer's (a standardized surveillance definitions used to detect infections in long-term care facilities, ensuring consistent reporting and monitoring) criteria for true infection. * The facility failed to ensure the facility's water system flowchart identified the risk areas in the facility's water flow system where Legionella may grow as per the facility's P&P; additionally, the facility failed to conduct accurate monitoring of the control area as part of the preventative maintenance plan for Legionnaire's (a severe form of pneumonia, when inhaled as tiny water droplets) disease when the facility failed to conduct monitoring of the temperature for the main water pipe which supplied water to the facility's three water heater tanks. * The facility failed to ensure CNA 1 disinfected Resident 67's call light after picking it up from the ground, and before placing the call light on Resident 67's bed. * The facility failed to ensure CNA 2 performed hand hygiene after changing Resident 137's brief (in Room A) and before entering Resident 141's room (Room B) to turn off the call light. * LVN 2 was observed with long artificial fingernails. These failures posed the risk of not identifying the residents' infections and controlling the potential transmission of communicable diseases to other residents, staff, and visitors throughout the facility.Findings: 1. Review of the facility's P&P titled Infection Control Program System reviewed 1/2023 showed the facility's infection control program includes a system for preventing, identifying, reporting, investigating and controlling infections and communicable diseases for all the residents, staff, volunteers, visitors, and other individuals providing services under a contractual agreement based upon the facility assessment. The facility maintains written standards, policies and procedures for the infection control program which includes: - The IP collects data and analyzes the information, utilizing the facility's surveillance tools, to develop strategies to prevent further infection transmission. - The IP utilizes the revised McGeer's Criteria for definitions of infection control practices. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from September 2025 through February 2026 showed the following infection surveillance data for HAIs (Healthcare Acquired Infections), CAIs (Community Acquired Infections), and residents who did not meet McGeer's Criteria (DNMC): - September 2025: a total of 37 infections, including 16 HAIs, three CAIs, and 12 DNMCs. - October 2025: a total of 35 infections, including 11 HAIs, 11 CAIs, and nine DNMCs. - November 2025: a total of 42 infections, including 14 HAIs, 10 CAI, and 15 DNMCs. - December 2025: a total of 38 infections, including 14 HAIs, six CAI, and 15 DNMCs. - January 2026: a total of 39 infections, including 15 HAIs, five CAI, and 12 DNMCs. (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- February 2026: a total of 51 infections, including 17 HAIs, six CAI, and 19 DNMCs. On 3/16/26 at 1400 hours, an interview and concurrent facility document and medical record review for Residents 16, 34, 45, 76, 78, 99, 117, and 143 was conducted with the IP. The IP stated she was responsible for the surveillance and tracking of infections in the facility. The IP stated she tracked the number of infections in the facility to determine the facility's infection rate, and the rate of antimicrobial usage when the infection did not meet the criteria for true infection. The IP stated the facility utilized the McGeer's criteria for all the infections to determine if an infection was a true infection. The IP further stated, if the infection did not meet the criteria for a true infection, it would prompt the facility to reevaluate the antimicrobial therapy to prevent the unnecessary use of antimicrobials and thus contributing to antimicrobial resistance to therapy. Review of the facility's Surveillance Data Collection Form for Residents 16, 34, 45, 76, 78, 99, 117, and 143 was conducted with the IP. The residents' Surveillance Data Collection Form showed the following documentation: * For Resident 45, the report showed the following: - the antibiotic treatment prescribed for Resident 45 was vancomycin (an antibiotic used to treat severe infection) 1 gm every 12 hours for 10 days, started on 9/17/25, for urinary tract infection (UTI). - The criteria for UTI (Urinary Tract Infection) without an indwelling catheter showed both criteria 1 and 2 must be present. For criteria 1b, fever or leukocytosis (high white blood cell count signaling the immune system is responding to an infection) and at least one of the following localizing urinary tract infections: acute costovertebral (connects the ribs and the spine) angle pain or tenderness, suprapubic pain, gross hematuria (blood in the urine), new or marked increase in incontinence, urgency, or frequency; however, only fever was circled and none of the localizing urinary tract sub-criteria were documented. - HAI and CAI were both not selected (however, on the Infection Prevention and Control Surveillance Log for September 2025, showed the infection was selected as HAI). * For Resident 78, the report showed the following: - the antibiotic treatment prescribed for Resident 78 was Zosyn 3.375 gm every six hours for seven days, started on 11/3/25, for leukocytosis. - HAI was selected in the section on the form to indicate whether the infection met the criteria for a true infection, and under addition notes showed the documentation the WBC was 18.32 cells/microliter . - further review of the form showed a blood culture was obtained, however the section for results was blank - Review of the Infection Prevention and Control Surveillance Log for November 2025 showed Resident 78's infection was categorized as a blood infection and the blood culture results were negative. (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* For Resident 16, the report showed the following: - the antimicrobial treatment prescribed for Resident 16 was fluconazole (antifungal) 100 mg daily for five days, started on 11/11/25. - HAI was selected in the section on the form to indicate whether the infection met the criteria for a true infection. - The criteria for lower respiratory tract infections showed all three criteria must be present. For criteria 2- at least two respiratory sub criteria must be present; however, only one was documented (new or changed lung examination abnormalities). * For Resident 143, the report showed the following: - the antibiotic treatment prescribed for Resident 143 was ceftriaxone (an antibiotic to treat severe infections) 1 gm every 24 hours for 10 days, started on 11/25/25, for leukocytosis. - CAI was selected in the section on the form to indicate whether the infection met the criteria for a true infection, and under addition notes showed the documentation the WBC (White Blood Count) was 17.94 cells/microliter. - further review of the form showed a urine (not blood) culture was obtained and the section for results was blank - review of the Infection Prevention and Control Surveillance Log for November 2025,showed Resident 148's infection was categorized as a blood infection and the urine and blood cultures were negative. * For Resident 76, the report showed the following: - the antibiotic treatment prescribed for Resident 76 was Rocephin (an antibiotic to treat severe infections) 1 gm every 24 hours for seven days, started on 12/4/25. The diagnosis was blank. - HAI was selected in the section on the form to indicate whether the infection met the criteria for a true infection, and under addition notes showed the documentation the WBC was 14.17; and the CXR (chest x-ray) was negative. - further review of the form showed a sputum and urine culture (not blood) were obtained and the section for results was blank - review of the Infection Prevention and Control Surveillance Log for December 2025, showed Resident 76's infection was categorized as a blood infection and the blood culture results were negative. * For Resident 117, the report showed the following: - the antimicrobial treatment prescribed for Resident 117 was Tamiflu 75 mg every 12 hours for five days, started on 1/29/26. - HAI was selected in the section on the form to indicate whether the infection met the criteria for a (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	true infection. - the criteria for respiratory tract infections- influenza like illness showed both criteria 1 and 2 must be present. For criteria 2- at least three of the following influenza-like illness sub criteria: chills, new headache/pain, myalgia/body aches, malaise/loss of appetite, sore throat, or new or increased dry cough; however, only one was documented (chills). * For Resident 34, the report showed the following: - the antibiotic treatment prescribed for Resident 34 was meropenem (an antibiotic used to treat severe infection) 1 gm every 12 hours for seven days, and vancomycin 1 gm daily for seven days, started on 2/2/26, for leukocytosis. - HAI was selected in the section on the form to indicate whether the infection met the criteria for a true infection, and under addition notes showed the documentation the WBC was 45.09 cells/microliter and the heart rate was 110 beats per minute. - further review of the form showed a urine, blood, and sputum culture were obtained, however the section for results was blank - review of the Infection Prevention and Control Surveillance Log for February 2026 showed Resident 34's infection was categorized as a blood infection and the sputum culture was negative, the urine culture and mixed organism, and no documentation of the blood cultures results. * For Resident 99, the report showed the following: - the antibiotic treatment prescribed for Resident 99 was vancomycin 1.25 gm every 48 hours for 10 days, and meropenem 500 mg every 24 hours for 10 days, stated on 2/4/26, for leukocytosis. - HAI was selected in the section on the form to indicate whether the infection met the criteria for a true infection, and under addition notes showed the documentation the temperature was 100.4 degrees F and the heart rate was 145 beats per minute. - further review of the form showed a blood and sputum culture were obtained, however the section for results was blank. - review of the Infection Prevention and Control Surveillance Log for February 2026, failed to showed Resident 99's blood infection on the surveillance log. Additionally, Resident 99 was included on the log for a respiratory infection, however, a surveillance form was not completed to determine whether the respiratory infection met the McGeer's criteria for a true infection. The IP was asked what criteria she used to determine if a blood infection was a true infection. The IP stated she completed the Surveillance Data Collection Form for other infection and if the resident presented with any of the constitutional criteria: fever, leukocytosis, acute mental status change, or acute functional decline, she would select the infection as a true infection. The IP was asked to show the reference literature for the determination of a true infection for the blood infection; however, the IP was unable to provide the reference. The IP reviewed the medical record and Surveillance Data Collection Forms for Residents 16, 34, 45, (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	76, 78, 99,117, and 143 and verified the Surveillance Data Collection Forms were inaccurate. The IP stated the Surveillance Data Collection Form and the determination of a true infection should be accurate to effectively conduct surveillance and track the prevalence of infections in the facility. On 3/18/26 1008 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Legionnaire's Disease (Legionella Pneumophila) reviewed 10/2017 showed it is the policy of the facility to have a plan for the prevention of Legionnaire's disease, recognize signs and symptoms of the disease test as appropriate with a physician's order and report confirmed cases to the local and state health department. The facility will complete a Legionella Risk Assessment to determine their risk for Legionella outbreaks. This assessment will be completed annually. The facility will develop a Water Management Program which will be reviewed annually. The facility will complete the Water Flow Diagram specific to the facility to identify risk areas in which Legionella can grow. The facility will determine risk areas by completing the Building Water System Process Flowchart and implement controls and indicate where these controls are located by completing the Control Area Monitoring Flowchart. During routine inspection of control areas, the facility will attempt to reduce areas if concern with specific pans that have been developed. Preventative maintenance plans have been developed for each control area. Review of the facility's Building Water System Flowchart (undated) showed the flow of water from the main water source through the facility. The facility's water flowchart showed the flow of water into the facility and to the three water heaters tanks that supplied water to the kitchen, laundry, and sinks/showers/nursing stations. Further review of the flowchart showed the legend labeled Potential Hazards with the legend item markers included; however, further review of the facility's flowchart failed to show the identification of areas in the facility's water system (utilizing the legend) where the potential hazards may exist. Review of the facility's Water Management Program updated 10/2025 showed water conditions that tend to promote the growth of legionella included: Stagnation, low water flow, Temperatures between 68 to 122 degrees F (Optimal range 95 to 115 degrees F) Further review of the facility's Water Management Program showed the facility identified a potential hazardous event in the hot water storage would be when the storage temperature would be too low (below 140 degrees F). The Operational Monitoring chart showed the following: - the incoming water would be tested for chlorine residual weekly at the point of entry into the facility, with the critical limit if less than 0.5 mg/L, and recorded in the Chlorine Residual Record sheet, and - the hot water temperature would be tested weekly at the hot water outlet in the kitchen, with the critical limit when the temperature is less than 140 degrees F and recorded in the Weekly Temperature kitchen record sheet. On 3/18/26 at 0915 hours, an observation was conducted in the soiled utility room. Three water (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	heater tanks were observed. The temperature gauge on the left water heater tank showed less than 120 degrees F. The temperature gauges for the other two water heater tanks showed 145 degrees and 155 degrees F. On 3/18/25 at 0918 hours, a concurrent observation, facility document review, and interview was conducted with the Maintenance Director. The Maintenance Director stated he was part of the facility's Water Management Team. When asked about the facility's Water Management Program, the Maintenance Director stated Legionella (a type of bacteria found in water that causes Legionnaires' disease, a severe form of pneumonia, when inhaled as tiny water droplets) could grow when the water temperature was below 140 degrees F and the facility monitored the hot water system by checking the water temperatures daily to ensure the water temperatures were above 140 degrees F. The Maintenance Director stated the main water line supplied the three water heater tanks, and each tank supplied a different part of the facility: the kitchen, laundry room, and showers/sinks/ nursing stations. A concurrent review of the facility's temperature log for March 2026 showed the water temperatures were measured daily in the laundry, kitchen, shower rooms (three), and one resident room per nursing station. Further review of the temperature log showed the documented water temperatures for the shower rooms and resident rooms ranged from 102 to 118 degrees F. When asked how the facility ensured the water supplying the water heater tank for the showers/sinks/resident rooms were within the control limits, the Maintenance Director stated he set the water heater tank which supplied the water to the showers, nursing stations, and resident rooms below 120 degrees for the resident's safety. A concurrent observation of the water pipes which supplied the three water heater tanks (from outside the facility) was conducted with the Maintenance Director. A temperature gauge was observed with the temperature at 120 degrees F. The Maintenance Director verified the above findings. When asked if the water temperature was being monitored and documented in the log, the Maintenance Director stated he was not documenting the water temperature for the pipes leading to the water heater tanks and the temperature had always been 120 degrees F. When asked about the measuring of the chlorine residual level at the point of water entry to the facility, the Maintenance Director stated the chlorine was only tested in the kitchen. A concurrent review of the facility's Building Water System Process Flowsheet and interview was conducted with the Maintenance Director. The Maintenance Director reviewed the flowchart and verified the flowchart only listed the locations of the flow of water through the facility and the potential hazards were not identified and labeled on the flowchart. On 3/18/26 1008 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. 3. Review of the facility's P&P titled Enhanced Standard Precautions reviewed 5/2024 showed for all the residents regardless of transmission risk or MDRO status: always follow standard precautions, including hand hygiene; use of gowns, gloves, masks, eye shields when contact with moist fluids is likely. Hand hygiene before and touching any resident is critical under all circumstances. On 3/11/26 at 0810 hours, during the initial tour of the facility, Resident 67's call light was observed on the ground. On 3/11/26 at 0813 hours, an observation and concurrent interview was conducted with CNA 1. CNA 1 (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	verified the above findings and was observed picking up the call light and placing the call light on Resident 67's bed. CNA 1 was not observed disinfecting the call light. CNA 1 was interviewed and verified she did not disinfect Resident 67's call light prior to placing it back on the resident's bed. On 3/16/26 at 1430 hours, an interview was conducted with the IP. The IP stated when the resident's call light fell on the ground, the staff were expected to disinfect the call light prior to placing the call light within the resident's reach. On 3/17/26 at 1530 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. On 3/16/26 at 0839 hours, CNA 2 was observed in Room A wearing gloves and placing the dirty linen in the hamper located outside of the Room A. CNA 2 was then observed exiting Room A after discarding her gloves and entering Room B to answer and turn off the call light. CNA 2 was not observed performing hand-hygiene after removing her gloves, exiting Room A, and before entering Room B to turn off the call light. On 3/16/26 at 0841 hours, an interview was conducted with CNA 2. CNA 2 stated she was in Room A changing Resident 137's brief. CNA 2 stated after she was done changing Resident 137, she exited the room to answer Resident 141's call light in Room B. CNA 2 verified she did not perform hand-hygiene after removing the gloves and before entering Resident 141's room to answer the call light. CNA 2 further stated she should have performed hand hygiene after the removal of the gloves and before entering another resident's room to prevent contamination and transmission of microorganisms. On 3/16/26 at 1430 hours, an interview was conducted with the IP. The IP stated after changing the resident, the staff should remove the gloves and perform hand hygiene before assisting another resident for infection control purposes. On 3/17/26 at 1530 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross Reference to F881. 5. Review of the facility's P&P titled Dress Code dated 2023 showed employee fingernails were to be kept short. On 3/11/26 at 0936 hours, LVN 2 was observed helping to reposition Resident 136. LVN 2 was observed removing her gloves. LVN 2 was observed with artificial long fingernails, extending approximately one half inch in length beyond LVN 2's fingertips. The edge of the nails were observed with a narrow tip, resembling an arrow. When asked about wearing artificial and long fingernails, LVN 2 acknowledged she would need to remove the artificial fingernails.

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility's P&P review, the facility failed to ensure the residents or their representatives were informed in advance of the proposed treatment regarding the use of psychotropic medications (medications affecting brain activity) for one of five residents (Resident 14) reviewed for unnecessary medication. * The facility failed to ensure the informed consent for the venlafaxine (antidepressant medication) indicated the nonpharmacologic measures for Resident 14. This failure had the potential to compromise the resident's and/or their designated representative's right to be fully informed regarding the psychotropic medication and its possible nonpharmacological interventions in order to make an informed decision.Findings: Review of the facility's P&P titled Informed Consent Policy dated 4/2024 showed that the attending physician, PA or NP must obtain the informed consent of the resident or their responsible party for purpose of prescribing, ordering, or increasing an order for a psychotherapeutic medication. The information material to a decision concerning the administration of a psychotherapeutic drug shall include the reasonable alternative treatments and risks, and why this particular treatment is recommended. Review of the AFL 25-38.1 titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 2/3/26, showed the facilities may use the CDPH (California Department of Public Health) Psychotherapeutic Drug Informed Consent Form or use their own in-house form as long as the in-house form contains all the data elements on the CDPH form. The form must be in use by January 1, 2026, for new residents, residents being prescribed a new psychotherapeutic drug, and residents having a psychotherapeutic drug dosage change. Review of the CDPH 9168 document titled Psychotherapeutic Drug Informed Consent Form dated 12/2025 showed to include the following psychotherapeutic drug information: drug category, drug name, dosage prescribed, frequency, duration, administration method, caution and earning summary, reason for use of the psychotherapeutic drug and benefits, the probable side effects and significant risks associated with the use of the psychotherapeutic drug, and the reasonable alternative mode(s) of treatment or possible non-pharmacological approaches that could address the resident's needs. Medical record review for Resident 14 was initiated on 3/11/26. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's H&P examination dated 8/14/25, showed Resident 14 had no capacity to understand and make decisions. Review of Resident 14's Order Summary Report showed a physician's order dated 1/30/26, to administer venlafaxine 25 mg tablet, 0.5 tablet via G-Tube three times a day for depression as manifested by verbalization of sadness. Further review of the physician's order showed the informed consent was obtained by the physician with the resident's representative. Review of Resident 14's Informed Consent dated 10/12/25, showed for venlafaxine 25 mg to give 0.5 mg medication, Resident 14's responsible party was informed on 10/12/25. However, further review of the form failed to show the list of possible nonpharmacological approaches that could address the resident's behavior related to the use of the venlafaxine medication. On 3/13/26 at 1444 hours, an interview and concurrent medical record review for Resident 14 was conducted with RN 1. RN 1 verified the Informed Consent for the venlafaxine medication for Resident 14 did not show the list of the possible nonpharmacological approaches that could address the resident's behavior related to the use of the medication. On 3/17/26 at 1406 hours, an interview was conducted with the DON. The DON was informed and acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility document review, the facility failed to provide the written Notice of Medicare Non-coverage (NOMNC) form CMS-10123 for one of three residents (Resident 139) reviewed for beneficiary notification. * The facility failed to make sure Resident 139 was provided with NOMNC form prior to discharge from the facility. This failure had the potential for Resident 139 and/or the representative to not be aware of the resident's rights and make informed decision regarding Resident 139's care and services.Findings: Medical record review for Resident 139 was initiated on 3/17/26. Resident 139 was admitted to the facility on [DATE]. Review of Resident 139's H&P examination dated 7/7/25, showed the resident had no capacity to make medical decisions. Review of the facility's Beneficiary Notice - Residents discharged Within Last Six Months showed Resident 139 was to be discharged from the Medicare Covered Part A stay on 9/25/25, and would be discharged home, or to a facility for lesser care. Further review of Resident 139's medical record failed to show if Resident 139 and/or the resident's representative were provided with a copy of the NOMNC form when Resident 139 was to be discharged from Medicare Part A services. On 3/17/26 at 1449 hours, an interview was conducted with the Business Office Manager (BOM). The BOM stated they were unable to locate Resident 139's NOMNC form in her chart. On 3/17/26 at 1546 hours, an interview was conducted with the DON. The DON was made aware and acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to address the resident's grievance in accordance with the facility's P&P for one of 25 final sampled residents (Resident 81). * The facility failed to address the concern when Resident 81 verbalized the staff was rude and giving attitude when answering his call light. This failure posed the risk for the resident's grievance not being thoroughly addressed, investigated, documented, and resolved.Findings: Review of the facility's P&P titled Grievance Procedure revised 1/2017 showed the resident has the right to and the facility must take prompt efforts to resolve grievances that the resident, responsible party, other family members, or advocates may have and any resident, their responsible party, family member or advocate may file a grievance or complaint concerning resident's treatment, medical care, behavior of other residents or staff members. Medical record review for Resident 81 was initiated on 3/13/26. Resident 81 was admitted to the facility on [DATE]. Review of Resident 81's H&P examination 6/11/15, showed the resident had the capacity to understand and make medical decisions. On 3/17/26 at 1017 hours, an interview was conducted with Resident 81. Resident 81 stated LVN 10 had an attitude and was told he was pressing the call light button too much during the evening shift. Resident 81 stated he told RN 3 about the interaction that transpired. On 3/17/26 at 1113 hours, an interview was conducted with RN 3. RN 3 stated she was made aware of a situation about two weeks ago between Resident 81 and LVN 10. RN 3 stated Resident 81 had said LVN 10 was rude to him and was giving him attitude when answering his call light. RN 3 stated she did not document the interaction between Resident 81 and LVN 10 had occurred and only learned of the incident the following morning. RN 3 further stated if she was working the evening shift when the interaction between Resident 81 and LVN 10 had occurred, she would have handled it differently. On 3/17/26 at 1302 hours, a follow up interview was conducted with RN 3. When RN 3 was asked what the process was when complaints about staff being rude were brought to her attention, RN 3 stated they first would verify with both parties involved to get both sides of the event, and if another incident occurred, they would then file a grievance or give the nurse a write up. On 3/17/26 at 1327 hours, an interview was conducted with the DON. The DON was asked about the process for when the residents would report to staff members about another resident being rude. The DON stated the incidents should be reported to the Social Services, and Social Services would reach out to her and a grievance report would be initiated so they can conduct their own investigation on what happened between the residents and staff members involved. On 3/17/26 at 1546 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged the 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 25 final sampled residents (Resident 98) was free from the physical restraints. * The facility failed to implement the least restrictive measures prior to applying a hand mitten to Resident 98's left hand. In addition, the facility failed to follow and document the release of the left hand mittens as per the physician's order. These failures posed the risk of compromising the residents' independence and psychosocial well-being.Findings: Review of the facility's P&P titled Physical Restraints dated 9/2017 showed the restraints will only be used after other alternatives have been tried unsuccessfully and only after a thorough assessment, informed consent from the resident or their responsible party, a physician's order and a care plan to address the use of the restraint. Least restrictive measures shall be assessed prior to the use of an actual restraint. Restraints must be used only as a last resort, and the medical record must indicate the events leading up to their necessity. If restraints are utilized, the opportunity for motion and exercise should be provided for a period of not less than ten minutes during each two hour period in which the restraints are utilized. On 3/11/2026 at 0951 hours and 2/12/26 at 0858 hours, Resident 98 was observed lying in bed with a left hand mitted in placed. Resident 98 was able to move his left arm and was observed touching his body. Medical record review for Resident 98 was initiated on 3/12/26. Resident 98 was admitted to the facility on [DATE]. Review of Resident 98's MDS assessment dated [DATE], showed Resident 98's cognitive skills for daily decision making was severely impaired. Review of Resident 98's Physician Order Summary dated 3/2/26, showed the following physician's orders dated:- to apply left soft hand mitten due high risk for injury related to attempting to pull on medical devices;- to monitor episodes of pulling on medical devices every shift and record number of episodes every shift;- to release left soft hand mitten every two hours for at least 10-15 minutes for ROM, circulation and skin integrity every two hours; and- to check left soft hand mitten for proper fit and placement every shift. a. Review of Resident 98's Restraint Assessment and Reduction Management Program dated 10/27/25, showed for the use of the left hand mitten due to high risk for injury related to attempting to pull on medical devices. However, the assessment did not show the least restrictive interventions were attempted prior to using the left hand mitten devices. b. Review of Resident 98's MAR for March 2026, showed the day and night shift checking of the left soft hand mitten, monitor for signs and symptoms of circulatory impairment related to the left hand mitten use every two hours, and release of the left soft hand mitten every two hours for at least 10 -15 minutes for ROM, circulation and skin integrity every two hours. Further review of the MAR showed the licensed nurses initials when the left hand mitten was released every two hours; however, there was no indication when the left hand mitten was released and what intervention the staff provided to the resident. There were no documented evidence when the left hand mitten was reapplied after the release for at least 10 to 15 minutes. On 3/12/2026 at 1017 hours, an interview was conducted with CNA 5. CNA 5 verified Resident 98 was wearing a hand mitten on the left hand. CNA 5 stated Resident 98 was wearing the mitten because the resident was pulling out his catheter. On 3/12/2026 at 1348 hours, an interview and concurrent medical record review for Resident 98 was conducted with LVN 12. LVN 12 verified the physician's order for the left hand mittens due to behavior of grabbing tubing. When asked about the documentation on what other alternatives they attempted when the left hand mittens was released, LVN 12 stated they just watch the resident making sure he will not grab his tubing. LVN 12 was asked about the documentation on the MAR for the application and releasing of the hand mittens. LVN 12 verified the left hand mittens was released every two hours. LVN 12 was asked about the times when the hand mittens were applied, LVN 12 verified there was no documentation. LVN 12 verified the documentations were not accurate because there was no specific time on when the left (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hand mittens was reapplied. On 3/12/2026 1403 hours, an interview and concurrent medical record review for Resident 98 was conducted with RN 4. RN 4 verified the physician's order for the left hand mitten restraint of Resident 98 for high risk of injury due to pulling out of medical devices. RN 4 was asked about the restraint assessment and attempts for the least restrictive interventions prior to the application of the left hand mitten, RN 4 verified there were no least restrictive interventions attempted prior to the application of the left hand mitten. On 3/18/2026 at 0839 hours, an interview and concurrent medical record review for Resident 98 was conducted with the DON. The DON was informed and verified the above findings. Cross Reference to F657, example # 1.

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the MDS was accurate for one of 25 final sampled residents (Resident 11). * The facility failed to accurately code the functional limitation of the range of motion for Resident 11. This failure posed the risk for the resident to not receive an individualized plan of care based on their specific needs.Findings: On 3/11/26 at 1241 hours, an observation and concurrent interview was conducted with Resident 11. Resident 11 was observed sitting in a wheelchair and using an iPad with his left arm. Resident 11 was observed not moving his right arm. Resident 11 stated he had a stroke that affected the right side of his body, resulting in his inability to move his right arm and right leg. When asked if he had been receiving exercises in the facility to maintain range of motion for the affected areas, he stated he had been this way for a long time and did not want to receive any exercises. Resident 11 added that he did not want to discuss the matter further. Medical record review for Resident 11 was initiated on 3/11/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 7/18/25, showed Resident 11 had the capacity to understand and make decisions. Review of Resident 11's OT Evaluation and Plan of Treatment dated 7/22/25 to 8/16/25, showed Resident 11 had impaired range of motion on his right upper extremity. Review of Resident 11' PT Evaluation and Plan of Treatment dated 7/20/25 to 8/15/25, showed Resident 11 had impaired right lower extremity, and no impairment in the left lower extremity. Review of Resident 11's admission MDS assessment dated [DATE], showed Resident 11 had impairment in the range of motion on one side of the upper and lower extremity. Review of Resident 11's MDS assessment dated [DATE], showed Resident 11 had no impairment on bilateral upper extremity and had impairment on both sides of lower extremity. On 3/13/26 at 1323 hours, an interview and concurrent medical record review for Resident 11 was conducted with the Director of Rehabilitation. The Director of Rehabilitation stated Resident 11 had a rangeˆofˆmotion impairment on his right upper extremity and right lower extremity upon admission to the facility. The Director of Rehabilitation stated Resident 11 had shown improvement in his activities of daily living functioning; however, she was unable to find documentation indicating whether there had been any improvement or decline in the right upper extremity and right lower extremity range of motion. On 3/13/26 at 1340 hours, an observation in Resident 11's room and a concurrent interview was conducted with the Director of Rehabilitation. The Director of Rehabilitation was observed assessing Resident 11's right upper extremity range of motion. The Director of Rehabilitation verified Resident 11 had impaired ROM on the right upper extremity. On 3/13/26 at 0940 hours, an interview and medical record review for Resident 11 was conducted with the MDS Coordinator. The MDS Coordinator stated Resident 11 had ROM impairment on the right upper and lower extremity. The MDS Coordinator verified the MDS assessment on 1/30/26 for Resident 11 was inaccurate. The MDS Coordinator stated MDS assessment should have been coded as impairment on one side of upper and lower extremity. On 3/17/26 at 1406 hours, an interview was conducted with the DON. The DON was informed and acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure coordination of PASARR and assessments for one of two final sampled residents (Resident 16). * The facility failed to ensure a follow-up was made regarding Resident 16's PASARR level II recommendation for a psychiatric consult and psychotherapy/counseling services for Resident 16 was completed. This failure posed the risk for Resident 16 to not receive the appropriate care.Findings: On 3/11/26 at 1011 hours, Resident 16 was observed in bed, sleeping. Medical record review for Resident 16 was initiated on 03/11/2026. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's H&P examination dated 9/14/24, showed Resident 16's diagnoses included a history of bipolar affective disorder. Review of Resident 16's PASRR Notice of Individual Determination Letter dated 4/12/25, showed the recommended specialized services included psychology consultation and psychotherapy/counseling services. On 3/13/26 at 928 hours, an interview was conducted with CNA 3. When asked about Resident 16, CNA 3 stated Resident 3 had family visits every so often and would get out of bed from time to time to attend the social gatherings. CNA 3 stated Resident 16 would sometimes sleep and sometimes would stay in bed. On 3/13/26 at 1017 hours, a concurrent interview and medical record review was conducted with MDS Coordinator 1. When asked about Resident 16 receiving the PASRR recommended psychology consultation and psychotherapy/counseling service, the MDS Coordinator stated the psychology and psychotherapy recommended services were not completed. Per MDS Coordinator 1 Resident 16 was diagnosed at the acute care hospital prior to being admitted to the facility with bipolar disorder, did not take medications and did not have any behaviors related to bipolar disorder. When asked if MDS Coordinator 1 did a follow up with PASRR staff, MDS Coordinator 1 stated she did not do a follow up to inform the PASRR unit about Resident 16 being diagnosed at the acute care hospital with bipolar disorder and the PASRR unit recommendations.

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the level 1 PASRR contained accurate information for one of two final sampled residents (Resident 15) reviewed for PASRR. * Resident 15 had a diagnosis of psychosis; however, the level 1 PASRR showed Resident 15 had no diagnosis of serious mental illness. Additionally, the facility failed to complete a Resident Review when Resident 15's level 2 PASRR evaluation was inaccurate. These failures posed the potential risk for Resident 15 to not receive the necessary care and services as the assessments were inaccurate.Findings: Review of the facility's P&P titled PASRR (Preadmission Screening Resident Review) reviewed 3/2019 showed all admissions to the facility will receive a Preadmission Screening prior to the admission of the resident. If the resident had already been admitted to the facility and the PASRR is being updated because the resident had exceeded the 30-day exempted hospital discharge or there is a significant change according to the MDS, this is considered a resident review (RR) status change. Medical record review for Resident 15 was initiated on 3/11/26. Resident 15 was admitted to the facility on [DATE], and readmitted on [DATE]. a. Review of Resident 15's level 1 PASRR dated 6/9/25, showed Resident 15 had no diagnosis of mental illness and no prescribed psychotropic medications. The form further showed the level 1 screening was negative and a level 2 evaluation was not required for reasons which included Resident 15 did not have a serious mental illness. Review of Resident 15's Order Summary Report showed a physician's order dated 10/8/25, to administer trazadone (antidepressant) 50 mg tablet by mouth at bedtime for as manifested by verbalization of depression leading to inability to sleep. Review of Resident 15's admission MDS assessment dated [DATE], showed Resident 15 had an active diagnosis of psychotic disorder. Review of Resident 15's medical record failed to show a level 1 PASRR Resident Review was conducted (during her initial stay at the facility) for the inaccuracy for the selection of no serious mental illness diagnosis, or when Resident 15 had the new diagnosis of depression and was prescribed the trazodone medication. On 3/12/26 at 1354 hours, an interview and concurrent medical record review for Resident 15 was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings and stated the level 1 screening was inaccurate and a resident review should have been conducted, as well as when Resident 15 had a new diagnosis of depression and was prescribed the antidepressant medication. b. Review of Resident 15's MDS assessment dated [DATE], showed Resident 15 had no functional limitation in ROM in the bilateral upper and lower extremities. Resident 15 was independent for eating and required supervision or touching assistance for rolling left and right, sit to lying, and lying to sitting on the edge of the bed. Review of Resident 15's MDS assessment dated [DATE], showed Resident 15 had functional limitations in ROM in bilateral lower extremities and required partial to moderate assistance (when the helper does less than half the effort) for eating and oral hygiene, and was dependent on staff assistance for toileting, shower/bathe, dressing, rolling left and right and sitting to lying in bed. Review of Resident 15's level 2 PASRR letter titled Notice of Attempted Evaluation dated 12/20/25, showed after reviewing the positive level 1 screening and speaking with staff, a level 2 mental health evaluation was not scheduled for the following reason: the individual had no serious mental illness (SMI) - no functional limitation in the last six months. The case is now closed. To reopen, the facility must resubmit a new level 1 screening. SNFs must submit another screening as a Resident Review (RR). On 3/12/26 at 1550 hours, an interview and concurrent medical record review for Resident 15 was conducted with the MDS Nurse. The MDS Nurse reviewed Resident 15's medical records and verified the above findings. The MDS Nurse stated the level 2 evaluation was inaccurate, and a Resident Review should have been conducted. On 3/17/26 at 1530 hours, an interview was conducted with the DON. The DON was informed and acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and the facility P&P review, the facility failed to develop the comprehensive plans of care to reflect the individual care needs for two of 25 final sampled residents (Residents 6 and 21). * The facility failed to develop a care plan for Resident 6's use of the blood glucose monitoring device (Dexcom G7). * The facility failed to develop a care plan problem to address Resident 21's IV site. These failures posed the risk of not providing appropriate, consistent, and individualized care to these residents.Findings: Review of facility's P&P titled Comprehensive Care Planning dated 3/2019 showed a comprehensive resident-centered care plan be developed for each resident that includes measurable objectives and timeframes to meet each resident's medical nursing and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will provide specific information to include resident strengths, goals, life history and preferences, discharge planning and will be completed within seven days of the assessment completion. 1. Medical record review for Resident 6 was initiated on 3/12/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's Physician Order Summary showed a physician's order dated 2/9/26, to use Dexcom G7 Receiver Device (Continuous Glucose System Receiver). Inject 1 application subcutaneously every day shift every 10 days for DM. Review of Resident 6's comprehensive care plans failed to show documented evidence an individualized care plan problem was developed to address Resident 6's use of blood glucose monitoring device (Dexcom G7). On 3/12/26 at 1428 hours, an interview and concurrent medical record review for Resident 6 was conducted with RN 4. RN 4 verified there was no care plan formulated for the use of the blood glucose monitoring device for Resident 6. On 3/18/2026 at 0839 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DON. The DON was informed and verified the above findings. Cross reference F0684, example number 1. 2. On 3/11/26 at 1039 hours, an observation was conducted of Resident 21 in the resident's room. Resident 21 was in bed with an empty container of vancomycin (antibiotic) hanging from Resident 21's IV pump. Resident 21 had a blanket covering the upper arms. On 3/11/26 1645 hours, an observation of Resident 21 and concurrent interview was conducted with RN 5. RN 5 uncovered Resident 21's blanket to show the right arm. Resident 21 was observed to have a peripheral IV to the right arm. RN 5 verified the resident had an IV to the right arm. Medical record review for Resident 21 was initiated on 3/12/26. Resident 21 was readmitted to the facility on [DATE]. (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 21's Physician Order Summary showed an order dated 3/7/26, for vancomycin 500 mg via the IV route every 12 hours for nine days. Review of Resident 21's H&P examination dated 3/9/26, showed Resident 21 muscle weakness and hemiplegia. Resident 21 was nonverbal and did not have the capacity to make decisions. Review of Resident 21's comprehensive care plans failed to show documented evidence an individualized care plan problem was developed to address Resident 21's IV site. On 3/13/26 at 0909 hours, an interview and concurrent medical record review for Resident 21 was conducted with RN 3. RN 3 verified a care plan for Resident 21's IV site was not developed.

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care was revised to reflect the resident's current care needs and interventions for five of 25 final sampled residents (Residents 3, 4, 7, 73, and 98) reviewed for care plans. * The facility failed to ensure the care plan was revised to include the manufacturer's recommendations for cleaning and disinfecting the ventilator machines for Residents 3, 4, and 7. * The facility failed to ensure Resident 73's care plan interventions for weight loss were revised to reflect Resident 73's NPO status; and failed to ensure the care plan for hydration needs related to NPO status was revised to include the current IV hydration therapy. * The facility failed to ensure Resident 98's care plan for the use of the hand mittens was revised to include the use of least restrictive interventions when the left hand mittens was released every two hours for 15 minutes. These failures posed the risk of not providing the residents with individualized and person-centered care.Findings: Review of the facility's P&P titled Comprehensive Care Planning reviewed 3/2019 showed the care plan must be reviewed and revised periodically, a least quarterly and on an ongoing basis to reflect changes in the resident and the services provided or arranged must be consistent with each resident's written plan. 1. Medical record review for Resident 98 was initiated on 3/12/26. Resident 98 was admitted to the facility on [DATE]. Review of Resident 98's Physician Order Summary showed the following physician's orders: - dated 10/27/25, to apply left soft hand mitten due high risk for injury related to attempting to pull on medical devices; - dated 10/27/25, to monitor episodes of pulling on medical devices every shift and record number of episodes every shift; - dated 10/27/25, to release left soft hand mitten every two hours for at least 10-15 minutes for ROM, circulation and skin integrity every two hours; and - dated 10/27/25, to check left soft hand mitten for proper fit and placement every shift. Review of Resident 98's MDS assessment dated [DATE], showed Resident 98's cognitive skills for daily decision making was severely impaired. Review of Resident 98's plan of care showed a care plan problem dated 10/27/25, addressing Resident 98's use of the left hand mittens to prevent attempting to pull out medical devices. The care plan showed the interventions to check and release mittens every two hours for 15 minutes for skin integrity and circulation. However, the care plan interventions failed to include the use of least restrictive interventions when the left hand mittens was released every two hours for 15 minutes. On 3/12/26 at 1403 hours, an interview and concurrent medical record review for Resident 98 was conducted with RN 4. RN 4 verified the above findings and stated the care plan should have been revised to reflect Resident 98's most current plan of care. (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.a. Medical record review for Resident 7 was initiated on 3/11/26. Resident 7 was admitted to the facility on [DATE]. On 3/11/26 at 1009 hours, Resident 7 was observed in bed asleep. Resident 7 had a tracheostomy connected to a ventilator machine and with oxygen supply from concentrator machine. Review of Resident 7's plan of care showed a care plan problem dated 12/13/25, addressing Resident 7's impaired gas exchange related to ineffective airway. The care plan showed the interventions ventilator management. However, the care plan interventions failed to include the cleaning and disinfecting of ventilator machine per manufacturer's manual were included. b. Medical record review for Resident 4 was initiated on 3/11/26. Resident 4 was admitted to the facility on [DATE]. On 3/11/2026 at 1119 hours, Resident 4 was observed in bed asleep. Resident 4 had a tracheostomy connected to a ventilator machine and with oxygen supply from concentrator machine. Review of Resident 4's plan of care showed a care plan problem dated 1/24/26, addressing Resident 4's impaired gas exchange related to ineffective airway. The care plan showed the interventions ventilator management. However, the care plan interventions failed to include the cleaning and disinfecting of ventilator machine per manufacturer's manual were included. c. Medical record review for Resident 3 was initiated on 3/12/26. Resident 3 was admitted to the facility on [DATE]. On 3/11/2026 at 1132 hours, Resident 3 was observed in bed asleep. Resident 3 had a tracheostomy connected to a ventilator machine and with oxygen supply from concentrator machine. Review of Resident 3's plan of care showed a care plan problem dated 10/20/25, addressing Resident 3's impaired gas exchange related to ineffective airway. The care plan showed the interventions for ventilator management. However, the care plan interventions failed to include the cleaning and disinfecting of the ventilator machine per manufacturer's manual were included. Review of Residents 3, 4, and 7's Order Summary Reports failed to show documented evidence a physician's order was obtained to clean and disinfect the ventilator machine per manufacturer's recommendation were obtained. In addition, further review of Residents 3, 4, and 7's medical records failed to show documented evidence for the cleaning and disinfecting the ventilator machine was recorded. On 3/17/2026 at 0842 hours, an interview and concurrent medical record review for Residents 3, 4, and 7 was conducted with RN 6. RN 6 verified the care plan was formulated for the use of the ventilator machine. RN 6 verified the interventions did not include the cleaning and disinfecting the ventilator machine per manufacturer's manual. On 3/18/2026 at 0839 hours, an interview and concurrent medical record review for Residents 3, 4, and 7 was conducted with the DON. The DON was informed and verified the above findings. Cross Reference F0695, examples # 1a, b and c. (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the facility's P&P titled Weight Change Protocol dated 2023 showed a care plan is to be developed stating the problems, the goals, and the approached, interventions to accomplish the goals. The care plan must be revised as the goals and interventions change. The goals and interventions in the care plan should match the latest assessment. Medical record review for Resident 73 was initiated on 3/11/26. Resident 73 was admitted to the facility on [DATE]. Review of Resident 73's H&P examination dated 2/2/26, showed Resident 73 had no capacity to understand and make decisions a. Review of Resident 73's Order Summary Report showed the following physician's orders: - dated 2/6/26, to administer Boost VHC (high-calorie nutrition drink) 237 ml four times a day with med pass; and - dated 2/10/26, for Resident 73 to be on an NPO diet, NPO texture, NPO consistency, except for medications and boost if tolerated. Review of Resident 73's plan of care showed care plan problem dated 3/1/26, addressing Resident 73's weight loss of seven pounds in one month. The interventions included to monitor Resident 73's meal intake. b. Review of Resident 73's Order Summary Report showed a physician's order dated 3/10/26, to administer 5% dextrose- 0.9% NaCl IV solution with 20 mEQ potassium chloride at 50 ml/hr intravenously every shift for hydration until 4/2/26. Review of Resident 73's plan of care showed care plan problem dated 2/16/26, addressing Resident 73's hydration needs related to Resident 73's NPO status. The interventions revised on 3/3/26, showed 5% dextrose with 20 mEQ potassium chloride at 50 ml/hr. On 3/17/26 at 1047 hours, an interview and concurrent medical record review or Resident 73 was conducted with RN 2. RN 2 stated the care plans should be developed and individualized to the residents and updated or revised whenever there was a change in the resident's care. RN 2 reviewed Resident 73's medical record and verified the above findings. RN 2 stated Resident 73 was NPO except for medications and boost supplements and was receiving continuous IV hydration therapy of 5% dextrose-0.9% sodium chloride with 20 mEQ of potassium chloride. RN 2 further stated Resident 73 was not eating or receiving meals, therefore the intervention should have been revised. On 3/17/26 at 1530 hours, an interview was conducted with the DON. The DON was informed and acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the quality care and services were provided for three of 25 final sampled residents (Residents 3, 6, and 8). * The facility failed to ensure a physician's order was obtained, the assessment was completed, and appropriate instructions were obtained to maintain the appropriate care of a blood glucose monitoring device (Dexcom G7 - a discreet, all-in-one continuous glucose monitor (CGM) for diabetes management) for Resident 6. This failure posed a risk for the resident to not receive the necessary care and services to maintain their highest physical well-being. * The facility failed to ensure the injection sites for the insulin administration were rotated for Resident 3. This failure had the risk for lipodystrophy (buildup of fatty lumps) and decreased with insulin absorption. * The facility failed to ensure medication was held as per the physician's ordered parameters for Resident 8's metoprolol (blood pressure medication) use. This failure posed a risk for the resident to receive unnecessary blood pressure medication. Findings: 1. Medical record review for Resident 6 was initiated on 3/12/26. Resident 6 was admitted to the facility on [DATE], with a diagnosis of diabetes mellitus (DM). Review of Resident 6's MDS assessment dated [DATE], showed Resident 6 was cognitively intact. On 3/12/2026 at 1120 hours, an observation and concurrent interview was conducted with Resident 6. A box of Dexcom G7 was observed at Resident 6's bedside drawer. Resident 6 was asked about her blood sugar monitoring device. Resident 6 stated the nurse checked her blood sugar four times a day before meals. When asked if she had the blood glucose monitoring device (Dexcom G7) in place to monitor her blood sugar. Resident 6 stated she did not have it because the facility did not have a new one. Resident 6 was able to show the box of Dexcom G7 and the equipment to monitor the blood sugar at the bedside and acknowledged she did not have the probe that should be attached to the resident. Review of Resident 6's Physician Order Summary dated 2/12/26, showed a physician's order dated 2/9/26, to use Dexcom G7 Receiver Device (Continuous Glucose System Receiver). Inject one application subcutaneously every day shift every 10 days for DM. However, further review of the Physician's Order Summary failed to show a physician order for the care of the monitor probe placed on the resident's skin. Review of Resident 6's MAR for February 2026 showed the application of Dexcom G7 receiver device subcutaneously every 10 days. On 3/12/2026 at 1422 hours, an interview and concurrent medical record review for Resident 6 was conducted with LVN 4. LVN 4 verified Resident 6 was on blood sugar monitoring four times a day before meals. LVN 4 was asked about the machine for blood sugar monitoring. LVN 4 verified the resident had an order; however, LVN 4 stated the resident refused to use the machine because the machine was not accurate and preferred to have a finger stick instead. When asked if the Dexcom G7 applicator was with the resident, LVN 4 verified there was no device applicator applied to the resident. LVN 4 verified there was a documentation in the MAR the applicator device was provided with the resident. On 3/12/2026 at 1428 hours, an interview and concurrent medical record review for Resident 6 was conducted with RN 4. RN 4 verified Resident 6 had a physician's order for the finger stick blood sugar (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring four times a day and the Dexcom G7 device application every 10 days. RN 4 was asked if there was a physician's order for the monitoring of Dexcom G7 device, skin assessment of the application site and care plan. RN 4 verified and acknowledged there was no physician's order for the skin assessment of the application site, no monitoring of the device if it was functioning correctly and no care plan. Cross Reference F0656, example # 1. 2. Review of the facility's P&P titled Insulin Administration dated 10/2013 showed when administering insulin, select the injection sites into subcutaneous tissue of the upper arm, anterior or lateral areas of the thighs and abdomen. Injection sites should be rotated, preferably within the same general area. Medical record review for Resident 3 was initiated on 3/12/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Order Summary Report dated 3/2/26, showed the physician's order dated 10/21/25, to administer 12 units of insulin NPH (immediate-acting insulin, medication to treat diabetes) subcutaneously every 12 hours for diabetes mellitus and insulin Lispro Injection Solution (medication to treat diabetes) as per sliding scale subcutaneously every six hours for DM. Review of Resident 3's MARs for January, February and March 2026 showed the injection site to administer the insulin medications injection were not rotated. For example, Resident 3 received the insulin medication at the left upper quadrant of the abdomen on the following dates and times: - on 1/9/26 at 0507 hours and 1/10/26 at 1226 hours; - on 1/12/26 at 1126 and 0548 hours; - on 1/27/26 at 0221 and 0529 hours; - on 1/28/26 at 0446 and 0522 hours; - on 2/1/26 at 1717 and 2/2/26 at 0234 and 0544 hours; - on 2/4/26 at 0011 and 0528 hours; - on 2/11/26 at 0002 and 0533 hours; - on 3/2/26 at 0000 and 0546 hours; - on 3/9/26 at 2323 and 0541 hours; and - on 3/16/26 at 0349 and 0515 hours. On 3/17/26 at 0842 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 6. RN 6 was asked about the insulin administration of the resident. RN 6 stated the one thing to remember when administering an insulin injection to the resident was to have the injection sites rotated to prevent complications related to the injection of medications. RN 6 was informed of the above findings. RN 6 verified and acknowledged the insulin injection sites were not (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rotated. On 3/18/26 at 0839 hours, an interview and concurrent medical record review for Residents 3 and 6 was conducted with the DON. The DON was informed and verified the above findings. 3. Review of the facility's P&P titled Medication Administration dated 4/2025 showed it is the policy of the facility that medication for the residents be administered in a safe and timely manner, and as prescribed. Medical record review for Resident 8 was initiated on 3/11/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 8/14/25, showed Resident 8 had no capacity to understand and make decisions. Review of Resident 8's Order Summary Report showed the following physician's order: - dated 9/8/24, for digoxin (medication that helps the heart beat stronger and more regularly, and it is used to treat heart failure and certain irregular heart rhythms) 125 mcg oral tablet, to give 2 tablets (250 mcg) via G-Tube one time a day for arterial fibrillation (irregular heart beat), and to hold if the pulse rate was below 60 beats per minute; and - dated 11/20/25, for metoprolol (a medication that slows the heart rate and lowers blood pressure to help the heart work more safely and efficiently) oral tablet 25 mg, to give one tablet via G-Tube every 12 hours for hypertension and to hold if the systolic blood pressure less than 110 mmHg or the heart rate was less than 60 beats per minute. Review of Resident 8's MAR for March 2026 showed the following: - dated 3/10/26 at 0900 hours, Resident 8 was administered with the metoprolol medication. However, Resident 8's blood pressure reading was 104/46 mmHg and the pulse was 56 beats per minute; and - dated 3/12/26 at 0900 hours, Resident 8 was administered with the digoxin medication. However, Resident 8's pulse rate reading was 58 beats per minute. On 3/12/26 at 1432 hours, an interview and concurrent medical record review for Resident 8 was conducted with LVN 10. LVN 10 verified the above findings and stated she documented digoxin and metoprolol medications as administered when the blood pressure was less than 110 mmHg and pulse was less than 60 beats per minute. LVN 10 was not able to verify if the metoprolol medication was held when Resident 8's blood pressure was 104/46 mmHg, and pulse was 56 beats per minute on 3/10/26 at 0900 hours, and if the digoxin medication was held when Resident 8's pulse was 58 beats per minute on 3/12/26 at 0900 hours. On 3/17/26 at 1406 hours, an interview was conducted with the DON. The DON was informed and acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of two sampled residents (Resident 11) reviewed for limited range of motion (ROM) received the appropriate treatment and services. * The facility failed to ensure the instruction for the RNA services for Resident 11 was accurate. In addition, the facility failed to ensure the risk of possible ADL decline was explained to the resident when Resident 11 requested to reduce the frequency of the RNA treatment. These failures had the potential to result in the decline in Resident 11's ROM which could lead to further deterioration in the resident's physical well- being.Findings:Review of the facility P&P titled Restorative Nursing Assistant Referrals dated 9/2016 showed facility to ensure ongoing communication and care giver training take place between Restorative Nursing Assistant (RNA) and therapy department. If the resident is screened and it is determined that the resident could benefit from referral for services by RNA, the Resident's attending physician to be contacted for a physician's order. If the resident receives rehabilitation services and it is determined that the resident is to be deferred for RNA services at the completion of the therapy, the appropriate referral form will be completed by the therapist and the therapy department will provide caregiver training to the RNA. If there is any change in status, RNA will notify the appropriate therapist. On 3/11/26 at 1241 hours, an observation and concurrent interview was conducted with Resident 11. Resident 11 was observed sitting in a wheelchair and using an iPad with his left arm. Resident 11 was observed not moving his right arm. Resident 11 stated he had a stroke that affected the right side of his body, resulting in his inability to move his right arm and right leg. When asked if he had been receiving exercises in the facility to maintain ROM for the affected areas, he stated he had been this way for a long time and did not want to receive any exercises. Resident 11 added that he did not want to discuss the matter further. Medical record review for Resident 11 was initiated on 3/11/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 7/18/25, showed Resident 11 had the capacity to understand and make decisions. Review of admission MDS assessment dated [DATE], showed Resident 11 had impairment in the ROM on one side of the upper and lower extremity. a. Review of Resident 11's Physician Order dated 12/31/25, showed the following:- RNA to provide bilateral lower extremity AAROM as tolerated everyday three times a week, every day shift, on Mondays, Wednesdays, and Fridays; and- RNA to provide bilateral upper extremity AROM every day as tolerated three times a week, every day shift, on Mondays, Wednesdays, and Fridays. Review of Resident 11 Restorative Nursing Program Referral/Care Plan dated 12/19/25, showed RNA to provide bilateral lower extremity AAROM everyday five times a week, and bilateral upper extremity AROM everyday five times a week. Review of Resident 11's OT Evaluation and Plan of Treatment dated 7/22/25 - 8/16/25, showed Resident 11 had impaired ROM on his right upper extremity. Review of Resident 11's OT Discharge summary dated [DATE], under the section discharge status and recommendation showed for RNA to provide bilateral upper extremities AROM as tolerated five times a week. On 3/13/26 at 1100 hours, an interview was conducted with RNA 1. RNA 1 stated Resident 11 had weakness on the right upper and right lower extremities and he had been providing PROM exercises to the resident's right upper extremity since he began providing RNA services. RNA 1 explained that he had consistently provided PROM exercises on Resident 11's right upper extremity and documented them but did not realize the order showed active range of motion. When asked if RNA 1 had followed up with the therapist regarding their recommendations for active ROM when he was providing PROM exercises on right upper extremity for Resident 11, RNA 1 stated he had not done so. On 3/13/26 at 1323 hours, an interview and concurrent medical record review for Resident 11 was conducted with the Director of Rehabilitation. The Director of Rehabilitation stated Resident 11 had a ROM impairment on his right upper extremity upon admission to the facility. The Director of (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Rehabilitation stated Resident 11 had shown improvement in his activities of daily living functioning; however, the Director of Rehabilitation was unable to find documentation indicating whether there had been any improvement on the right upper extremity ROM. On 3/13/26 at 1340 hours, an observation in Resident 11's room and a concurrent interview was conducted with the Director of Rehabilitation. The Director of Rehabilitation was observed assessing Resident 11's right upper extremity ROM. The Director of Rehabilitation verified that Resident 11 had impaired ROM on the right upper extremity and required PROM exercises to maintain his current ROM. The Director of Rehabilitation stated the RNA treatment recommendation should have been PROM rather than AROM for Resident 11's right upper extremity. The Director of Rehabilitation further stated the RNA should have communicated with the rehabilitation department when he was providing PROM exercises despite the OT recommendation and physician order indicating AROM. b. Review of Resident 11's Licensed Nurse Progress Notes dated 12/31/25, showed an order was obtained from the NP for RNA services to be provided three times a week per the resident's request. The documentation further showed the order was noted and carried out. Further review of the medical records for Resident 11 did not show if Resident 11 was explained the risk of possible ADL decline when Resident 11 requested to decrease the RNA services to three times a week instead of five times a week as recommended by the PT and OT. On 3/13/26 at 1405 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified the above Licensed Nurse Progress Notes and stated RNA services for Resident 11 were reduced from five days a week to three days a week at as per the resident's request. RN 3 stated if Resident 11 did not receive RNA services as recommended, five days per week, he could experience a decline in his ADL functioning. RN 3 further stated she was unable to locate documentation to show Resident 11 had been informed of the potential risk of ADL decline when he requested to reduce the RNA services from five days a week to three days a week, as recommended by the PT and OT. On 3/13/26 at 1415 hours, an interview was conducted with RNA 2. RNA 2 stated Resident 11 had been receiving RNA services five days a week as recommended by the PT and OT. However, Resident 11 requested to reduce the RNA services to three days a week. RNA 2 reported that she informed the RN on duty of the resident's request. When asked whether she asked Resident 11 why he wanted to reduce the frequency of the RNA services, RNA 2 stated she had not asked him. On 3/13/26 at 1420 hours, a follow^up interview was conducted with the Director of Rehabilitation. The Director of Rehabilitation stated when a resident requests for the RNA services to be three times a week instead of the five times per week as recommended by the PT and OT, the resident should be educated on the potential risk of ADL decline so the resident can make an informed decision. On 3/17/26 at 1406 hours, an interview was conducted with the DON. The DON was informed and acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary GT care and services for two final sampled residents (Residents 5 and 98) reviewed for tube feeding. * The facility failed to ensure Resident 98 was positioned safely at 30 to 45 degrees during the enteral feeding via G-Tube. * The facility failed to ensure Resident 5's water flush connected via feeding pump was labeled. These failures posed the risk for developing complications related to the residents' GT.Findings: Review of facility P&P titled Gastrotomy Tube Feeding Via Continuous Pump dated 1/2017 showed to always keep the resident's bed elevated more than 30 degrees or as directed by physician order. 1. Medical record review for Resident 98 was initiated on 3/11/26. Resident 98 was admitted to the facility on [DATE]. Review of Resident 98's H&P examination dated 8/18/25, showed Resident 98 was GT feeding dependent. Review of Resident 98's Order Summary Report dated 3/2/26, showed the following physician's orders: - dated 8/31/25, to administer Glucerna (enteral feeding formula) 1.5 at 65 ml per hour via the enteral pump to provide 1300 ml/1950 calories in 20 hours; and - dated 8/16/25, to check the residuals every shift and hold the tube feeding if residual was above 100 ml, and to resume. On 3/11/2026 at 0954 hours and 3/16/26 at 0826 hours, an observation was conducted with Resident 98. Resident 98 was observed lying in bed, asleep with Glucerna 1.5 infusing at 65 ml per hour via GT. The head of bed was observed slightly elevated but not high enough to at least 30 degrees. On 3/17/26 at 1314 hours, an observation of Resident 98 and concurrent interview was conducted with LVN 14 at Resident 98's bedside. LVN 14 stated when the enteral feeding was infusing, the head of the bed should be elevated at 30 degrees or more to prevent aspiration. LVN 14 verified Resident 98's GT feeing was infusing and the head of the bed was not at least 30 degrees. LVN 14 stated he would determine the elevation of the head of the bed by looking at the bed to see if it was high enough. LVN 14 further stated he was uncertain on how high the head of the bed specific measurement was because there was no leveler device. On 3/17/2026 at 1349 hours, an interview and concurrent medical record review for Resident 98 was conducted with RN 6. RN 6 stated the head of the bed elevation was important to prevent aspiration. RN 6 was asked on how the nurses would know if the head of the bed was elevated to at least 30 degrees for the resident who was on GT feeding. RN 6 stated they will observe the bed and use their own judgement to determine if the head of the bed was high enough. When asked if there was any measuring device to know the elevation of the head of the bed, RN 6 verified and acknowledged the facility's bed had no equipment to measuring the elevation of the head of the bed. (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/26 at 0839 hours, an interview and concurrent medical record review for Resident 98 was conducted with the DON. The DON was informed and verified the above findings. 2. Medical record review for Resident 5 was initiated on 3/11/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's Order Summary Report showed the following physician orders: - dated 12/17/25, for enteral feeding of Nepro 1.8 (enteral feeding formula) to be administered via enteral pump at 60 ml per hour over 16 hours, or until the prescribed volume limit was reached, with the feeding to be turned off at 0500 hours and resumed at 1300 hours; and - dated 1/12/26, to flush the GT with a minimum of 5 ml of water every hour for 16 hours. On 3/11/26 at 0910 hours, an observation was conducted for Resident 5. Resident 5 was observed lying in bed. The feeding tube and water bag were connected to the resident via the feeding pump. The feeding pump was observed to be off. The water bag connected to the feeding pump was not labeled with the date and time when it was connected to the resident. On 3/11/26 at 0930 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 verified the water bag connected to Resident 5 via feeding pump was not labeled. LVN 5 stated the staff should have labeled the tubing when they started the water flush via feeding pump to the resident. On 3/17/26 at 1406 hours, an interview was conducted with the DON. The DON was informed and acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility's P&P review, the facility failed to ensure professional standards of practice were followed for two of two final sampled residents (Residents 21 and 73) reviewed for the IV therapy. * The facility failed to ensure Resident 21's IV dressing was labeled with the date on when it was placed. * The facility failed to ensure Resident 73's IV tubing was discarded after 72 hours as per the physician's order. These failures posed the risk for the residents to experience complications related to the IV therapy.Findings: 1. According to Intravenous Infusion Therapy for Nurses, Principles and Practice, when the residents are on IV therapy, it is best practice to label the IV site dressing with information including the date, time, and staff initials. On 3/11/26 at 1039 hours, an observation was conducted with Resident 21. Resident 21 was observed in bed with an empty container of vancomycin (an antibiotic) medication hanging from Resident 21's IV pump. Resident 21 was observed with a blanket covering both is bilateral upper extremities. Medical record review for Resident 21 was initiated on 3/11/26. Resident 21 was readmitted to the facility on [DATE]. Review of Resident 21's H&P examination dated 3/9/26, showed Resident 21 was nonverbal and had no capacity to make decisions. Review of Resident 21's IV MAR for March 2026 showed Resident 21 was being administered vancomycin medication IV solution 500 mg IV every 12 hours for right chest wall cellulitis with a start date of 3/8/26. Further review of the MAR showed Resident 21's IV site was to be monitored for signs and symptoms of complications every shift. On 3/11/26 1645 hours, concurrent observation and interview was conducted with RN 5. When asked to observe Resident 21's IV site, RN 5 uncovered Resident 21's right arm. Resident 21's IV site was observed to have white tape with a clear tape on top of the white tape, surrounding Resident 21's right arm. When asked about the date for Resident 21's IV, RN 5 was observed peeling the back part of the tapes on Resident 21. RN 5 verified there was no label or date on Resident 21's IV site. On 3/12/26 at 1340 hours, an interview was conducted with RN 3. When asked about what information was to be included on Resident 21's IV site dressing, RN 3 stated the IV site dressing should be labeled with the date. When asked about dating the IV site dressing, RN 3 stated she did not remember if she had dated Resident 21's IV site dressing with the date. 2. On 3/11/26 at 0905 hours, during the initial tour of the facility, Resident 73 was observed lying in bed. A one-liter bag labeled Dextrose 5%-0.9% Normal Saline (IV fluid hydration) with 20 mEq KCL (potassium chloride) was observed hanging on the IV pole and infusing at a rate of 50 ml per hour into Resident 73's left arm. The label on the IV tubing showed 72 hours only, the start date indicated 3/6/26 at 0400 hours, and discard date indicated 3/9/26. Medical record review for Resident 73 was initiated on 3/11/26. Resident 73 was admitted to the facility on [DATE]. (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 73's Order Summary Report dated 3/11/26, showed a physician's order dated 3/10/26, to administer 5% dextrose- 0.9% NaCl IV solution with 20 mEq potassium chloride at 50 ml/hr intravenously every shift for hydration until 4/2/26. Review of Resident 73's IV Medication Administration Record for 3/2026 showed the following: - dated 2/1/26, to change the IV tubing every 72 hours (if on IV fluids only) and - dated 3/3/26, to change the IV tubing every 24 hours or change every 72 hours (if on IV fluids only). On 3/11/26 at 0914 hours, an interview was conducted with RN 1. RN 1 stated if the IV tubing was used to administer antibiotic therapy, then the IV tubing should be used and discarded after 24 hours. RN 1 stated if the IV tubing was used for continuous IV hydration therapy, the IV tubing should be discarded and changed every 72 hours. RN 1 further stated the IV tubing should have a sticker labeled with the start and discard date and the RN should check the label on the IV tubing. On 3/11/26 at 0925 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified the above findings and stated the IV tubing should have been discarded on 3/9/26. On 3/17/26 at 1439 hours, an interview was conducted with the DON. The DON stated the RN should check the label on the IV tubing and discard the IV tubing if it was past the discard date for infection control purposes. On 3/17/26 at 1530 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate pain management was provided for one of 25 final sampled residents (Resident 31) reviewed for pain management. * The facility failed to ensure the hydrocodone-acetaminophen (a narcotic pain medication) medication was administered per the physician's orders for Resident 31. In addition, the facility failed to ensure the nonpharmacological interventions were provided and documented prior to the administration of Resident 31's PRN hydrocodone-acetaminophen medications. These failures had the potential to put Resident 31 at risk for ineffective pain management and adverse effects related to the use of unnecessary pain medication.Findings: Review of the facility's P&P titled Pain Management Protocol reviewed 1/2017 showed documentation on the flow sheet should reflect every PRN administered, response to the medication and the nonpharmacological interventions. Review of the facility's P&P titled Medication Administration reviewed 4/2025 showed the medications must be administered in accordance with the physician's orders, including any required time frame. Medical record review for Resident 31 was initiated on 3/11/26. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's H&P examination dated 8/4/25, showed Resident 31 had no capacity to understand and make decisions. Review of Resident 31's Order Summary Report dated 3/12/26, showed the following physician's orders dated 12/26/25:- to administer hydrocodone-acetaminophen 5-325 mg, one tablet by mouth every four hours as needed for moderate pain (a pain level from 4 to 6, on a 0 to 10 pain scale with 0 = no pain and 10 = worst pain); and - to administer hydrocodone-acetaminophen 5-325 mg, two tablets by mouth every four hours as needed for severe pain (a pain level from 7 to 10). a. Review of Resident 31's MAR for February and March 2026 showed the documentation when Resident 31 was administered the hydrocodone-acetaminophen medications outside the pain level parameters as ordered by the physician.* The hydrocodone-acetaminophen 5-325 mg, one tablet by mouth every four hours as needed for moderate pain (pain levels of 4 to 6) was administered to Resident 31 on the following dates and times:- dated 2/19/26 at 1627 hours, for a pain level of 7;- dated 3/6/26 at 1817 hours, for a pain level of 3; and- dated 3/7/26 at 1729 hours, for a pain level of 3.* The hydrocodone-acetaminophen 5-325 mg, two tablets by mouth every four hours as needed for severe pain (pain levels of 7 to 10) was administered to Resident 31 on the following dates and times:- dated 2/14/26 at 1700 hours, for a pain level of 6;- dated 3/5/26 at 1900 hours, for a pain level of 6; and- dated 3/10/26 at 1742 hours, for a pain level of 0. b. Review of Resident 31's MAR for March 2026 showed Resident 31 was administered the following medications: * for the hydrocodone-acetaminophen 5-325 mg, one tablet by mouth every four hours as needed for moderate pain, on the following dates and times:- dated 3/1/26 at 0910 and 1305 hours;- dated 3/2/26 at 0800 and 1305 hour;- dated 3/3/26 at 0802 and 1203 hours;- dated 3/4/26 at 1355 hours;- dated 3/5/26 at 1003 hours;- dated 3/6/26 at 1817 hours;- dated 3/7/26 at 0800, 1233, and 1729 hours; and- dated 3/8/26 at 1649 hours. * for the hydrocodone-acetaminophen 5-325 mg, two tablets by mouth every four hours as needed for severe pain, on the following dates and times:- dated 3/2/26 at 1707 hours;- dated 3/3/26 at 1812 hours;- dated 3/4/26 at 0947 and 1822 hours;- dated 3/5/26 at 1447 and 1900 hours;- dated 3/8/26 at 1245 hours;- dated 3/9/26 at 1707 hours;- dated 3/10/26 at 1742 hours;- dated 3/11/26 at 1042 and 1711 hours; and- dated 3/12/26 at 0849 hours. However, further review of Resident 31's medical record failed to show the documented evidence of the nonpharmacological pain interventions attempted prior to the administration of the hydrocodone-acetaminophen 5-325 mg pain medications for the above dates and times. On 3/12/26 at 1145 hours, an interview and concurrent medication record review for Resident 31 was conducted with LVN 5. LVN 5 verified the above findings. LVN 5 stated the nonpharmacological interventions should be implemented and documented in the resident's MAR or nurse's progress notes. LVN 5 verified the resident's medical record failed to contain the documented evidence of the (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nonpharmacological pain interventions provided and its effectiveness for the above dates and times when Resident 31 was administered the PRN hydrocodone-acetaminophen 5-325 mg medications. On 3/17/26 at 1439 hours, an interview was conducted with the DON. The DON stated when the resident complained of pain, the licensed nurse should assess the pain, provide nonpharmacological interventions and document the nonpharmacological interventions and its effectiveness in the resident's medical record. The DON further stated the nonpharmacological pain interventions should be implemented prior to the administration of the PRN pain medications because if the non-pharmacological pain interventions were effective, the PRN pain medication would not be needed and there would be less potential adverse reactions to the resident. The DON stated if the nonpharmacological pain interventions were ineffective, then the PRN pain medication should be administered as per the physician's orders. On 3/17/26 at 1530 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the nurse staffing information was posted in a prominent place accessible to residents and visitors. This failure has the potential of not having the staffing information be available to the residents and the public to determine if sufficient staff were available to care for the residents.Findings: Review of facility's P&P titled Staffing Nurse Information revised on 1/2017 showed it is the policy of the facility to post the nurse staffing information daily; and posted information will be in a prominent place readily accessible to residents and visitors. On 3/17/26 at 1330 hours, a concurrent observation and interview was conducted with the DSD. The Daily Nurse Staffing Information was observed posted and positioned sideways between a vase and other paperwork, making it not visible to the residents and visitor in station 2, SNF side. In addition, the staffing data was dated 3/16/26, and not the current date. The DSD stated the RN supervisor was supposed to post it but forgot to post the current staffing data. The DSD further stated the nurse staffing information should be posted every day. The DSD verified the posted staffing information on the SNF side of the facility was not for current date of 3/17/26, and was not in a visible place accessible to residents and visitors.

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services. * The facility failed to ensure the administration of the controlled medication for one nonsampled Resident 99 was documented on the MAR. This failure had the potential for the medications to be administered in error and opportunities for drug diversion or drug misuse.Findings: Review of the facility P&P titled Controlled Medication (undated) showed when a controlled medication is administered, the licensed nursed administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): - Date and time of administration. - Amount administered. - Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. - Initials of the nurse administering the dose on the MAR after the medication is administered. Medical record review for Resident 99 was initiated on 3/13/26. Resident 99 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 99's H&P examination dated 1/21/26, showed Resident 99 had no capacity to understand and make decision. Review of Resident 99's Order Summary Report dated 3/13/26, showed a physician's order dated 1/21/26, to give hydrocodone-acetaminophen (Norco – a controlled pain medication) 10-325 mg one tablet by mouth every four hours as needed for severe pain level of 7-10 (using the 0-10 pain scale; 0 = no pain and 10 = worst pain), not to exceed 3 gm per 24 hours from all sources. Review Resident 99's Antibiotic or Controlled Drug Record showed Norco 10-325 mg one tablet was dispensed and signed out on 3/13/26 at 0630 hours. Review of Resident 99's MAR for March 2026 failed to show the documentation of the administration for Norco medication 10-325 mg one tablet on 3/13/26. On 3/13/26 at 1108 hours, an interview and concurrent medical record review for Resident 99 was conducted with LVN 4 at the nurses' station during the medication inspection. LVN 4 verified one tablet of Norco 10-325 mg medication was pulled out on 3/13/26 at 0635 hours; however, there was no documented evidence on the MAR the medication was administered on 3/13/26. On 3/13/26 at 1312 hours, an interview and concurrent MAR review for Resident 99 was conducted with the DON in the DON's office. The DON verified one tablet of Norco 10-325 mg was pulled out on 3/13/26 at 0635 hours; however, there was no documented evidence on the MAR the medication was administered on 3/13/26. The DON further stated the process was, when the resident required a pain (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication, the licensed nurse would assess the resident, check the order, pull the medication, sign on the Individual Narcotic Record, administered to the resident, then document the administration on the MAR. The DON acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the drugs and biologicals were stored, labeled, and/or disposed properly. * The facility failed to ensure the orally administered medications were stored separately from the externally used medications. This failure posed a risk for the medications to be used or improperly administered to the residents. * The facility failed to ensure the opened box of ipratropium-albuterol (breathing treatment medication) was labeled with the opened date for Residents 83 and 122. These failures posed a risk for the administration potentially contaminated or deteriorated medications. * The facility failed to ensure the vancomycin (an antibiotic) IV medication and supplies were properly disposed. This failure posed a risk for the residents and/or visitors to have access to a potential toxic substance. Findings: 1. Review of the facility's P&P title Storage of Medications dated 4/2008 showed orally administered medications are kept separate from external use medications, such as suppositories, liquids, and lotions. On 3/12/26 at 1525 hours, a medication cart inspection for Medication Cart F was conducted with LVN 3. The following was observed: - one bottle of aspirin (a medication used for pain or reduce the risk for heart attack) tablet was stored with five boxes of artificial tears (eye drops) in a cube in the first drawer of Medication Cart F; - one bottle of ibuprofen (pain medication), vitamin C (supplement), acetaminophen tablet (pain medication), docusate sodium (stool softener) were stored with 18 patches of rivastigmine transdermal system (medication for dementia) and a box of cyclosporine ophthalmic emulsion 0.5% (eye drops) in a cube of the first drawer of the Medication Cart F; - one opened box of ipratropium-albuterol 0.5-3 mg/3 ml inhalation solution for Resident 83. The box was not labeled with the opened date.-one opened box of ipratropium-albuterol 0.5-3 mg/3 ml inhalation solution for Resident 122. The box was not labeled with the opened date. LVN 3 verified the above findings. LVN 3 stated the internal and external medications should not be stored in the same cube because the medications were administered via different routes and could cause medication errors and contamination. LVN 3 further stated the opened medications in the medication cart should be labeled with the opened date when it was first opened. On 3/13/26 at 1312 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON further stated the external and internal medications should be stored separately to prevent medication errors and opened medication should be labeled with a date on when it was opened 2. On 3/12/26 at1340 hours, a concurrent observation and interview was conducted with RN 3. An IV tubing, normal saline bag, and empty container of Resident 21's vancomycin medication was observed disposed into Resident 21's personal trash can. RN 3 verified the above findings. On 3/12/26 at 1350 hours, an interview was conducted with RN 7. RN 7 verified she disposed of Resident 21's IV tubing, normal saline bag, and empty vancomycin bottle into Resident 21's personal trash can. When asked what the facility's P&P for disposing of the medications was after use, RN 7 stated she did not know. On 3/12/26 at 1430 hours, an interview was conducted with the ADON. The ADON was informed of the above findings. When asked what the P&P was for disposing of the residents' medications after use, the ADON verified the medication supplies and containers should not be thrown into residents' trash cans.

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the American and Korean pureed preparation were prepared properly. * The facility failed to ensure the American and Korean pureed food preparation was not conducted too far in advance of the serving time. Also, the staff were not knowledgeable about the serving temperature for kimchi. These failures posed the risk of the foods served losing nutritive value and of the residents not being able to enjoy foods at a palatable temperature.Findings: Review of the facility's document titled Order Listing Report dated 3/12/26, showed a total of 48 of 124 residents (including 10 on puree diets) received meals prepared in the facility's kitchen. On 3/11/26 at 0840 hours, an interview was conducted with the Dietary Services Director. The Dietary Services Director stated lunch was served starting at 1130 hours. On 3/12/26 at 0757 hours, an interview was conducted with the Dietary Services Director. The Dietary Services Director stated the Korean food puree preparation started at 0930 hours and the American food puree preparation started at 1000 hours. Review of the facility's posted menu for the lunch meal dated 3/12/26, showed the following:- Korean menu food items: Bulgogi (meat), seaweed soup, mixed simple salad, steamed rice, kimchi, and roasted [NAME] (dried seaweed sheets); and- American menu food items: Hawaiian pork, Polenta, Ginger carrots and a Wheat roll. On 3/12/26 at 0941 hours, a puree food preparation observation and concurrent interview was conducted with [NAME] 1. [NAME] 1 stated he would be doing puree for the Bulgogi and seaweed soup. When asked about the other food items on the menu, [NAME] 1 stated those were pureed in the morning and were currently refrigerated. On 3/12/26 at 1002 hours, a puree food preparation observation and concurrent interview was conducted with [NAME] 2. [NAME] 2 was observed starting the puree preparation for the American menu. [NAME] 2 stated was pureeing food for a total of two residents. When asked what [NAME] 2 would be pureeing, [NAME] 2 stated Hawaiian Pork. When asked about the other food items on the menu, [NAME] 2 stated those food items had been pureed earlier in the morning. On 3/12/26 at 1122 hours, a tray line observation was conducted with Dietary Aide 1. When asked for the temperature for the kimchi being served to the residents, Dietary Aide 1 said it was 56 degrees Fahrenheit. When asked if that was the correct temperature to serve the kimchi, Dietary Aide 1 said no, because kimchi was like a salad food item it should be served at less than 40 degrees Fahrenheit. Dietary Aide 1 verbalized she would place the kimchi in ice to reduce the temperature of the kimchi. A second temperature reading was obtained at 1135 hours and the kimchi was documented at 48 degrees Fahrenheit. At this time, the Dietary Services Director verbalized Koreans liked eating kimchi at room temperature so 48 degrees Fahrenheit was okay to serve kimchi. On 3/13/26 at 1333 hours, an interview was conducted with the RD. The RD was informed of the above findings. The RD stated she was aware the kitchen staff were doing the puree preparations too in advance of serving times. The RD further stated she had already discussed this with staff but staff stated they started at around 5 am and that is why they started their puree preparations earlier in the morning.

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary adaptive equipment was provided for one nonsampled resident (Resident 33). * The facility failed to ensure Resident 33 was provided with the sippy cup as per the meal ticket and the physician's order. This failure had the potential for Resident 33 not having an appropriate assistive device to properly consume her drinks.Findings: Review of the facility's P&P titled Assistive Devices-Frequency of Meals, Assistive Devices & Food Safety reviewed 1/2017 showed the facility will provide eating equipment and utensils for residents who are assessed to require them. Residents who are assessed to require special eating equipment and utensils will be provided appropriate assistance to ensure that they can use the assistive devices when consuming meals and snacks. On 3/11/26 at 1134 hours, a lunch observation was conducted in the dining room. Resident 33 was observed sitting in a chair and was assisted with her lunch by RNA 1. Resident 33 was observed served with a four-ounce carton of mighty shake, a cup of milk, and a cup of pink-colored beverage. RNA 1 was observed placing a straw inside of the mighty shake and the pink-colored beverage and serving Resident 33 the beverages to drink. Review of Resident 33's lunch meal ticket (undated) showed devices: sippy cup, one to one feeding assist. However, a sippy cup was not observed for Resident 33 to drink her beverages. On 3/11/26 at 1152 hours, an interview and concurrent observation was conducted with LVN 1. LVN 1 verified the above findings and was observed providing RNA 1 with the sippy cup and instructing RNA 1 to serve Resident 33's beverages in the sippy cup. Medical record review for Resident 33 was initiated on 3/11/26. Resident 33 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 33's Order Summary Report showed a physician's order dated 2/26/26, Resident 33 may have a sippy cup with meals per family's request. On 3/17/26 at 1439 hours, an interview and concurrent medical record review for Resident 33 was conducted with the DON. The DON stated if there was a physician's order and the meal ticket showed to provide a sippy cup the resident should been served the beverages in the sippy cup. The DON reviewed Resident 33's medical record and verified the above findings. On 3/17/26 at 1530 hours, an interview was conducted with the DON. The DON was informed and acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on interview, facility document review, facility P&P review, and Title 22 review, the facility failed to ensure documented evidence of compliance with the State law. * The sign in sheet for the review of the facility's P&P related to pharmaceutical services failed to include the facility's pharmacist. This failure posed the risk of the P&Ps not being maintained and reviewed. Findings: Per Title 22 S 72525 - Required Committees showed under (a) Each facility shall have at least the following committees: patient care policy, infection control and pharmaceutical service (a) Each facility shall have at least the following committees: patient care policy, infection control and pharmaceutical service. (b) Minutes of every committee meeting shall be maintained in the facility and indicate names of members present, date, length of meeting, subject matter discussed and action taken. Review of the facility's provided document titled Policy and Procedure Review dated 10/9/25, failed to show the facility's pharmacist had attended this review as per Title 22, Chapter 3, Section 72525. On 3/17/26, at 1553 hours, a sign in sheet for review of the facility's policies and procedures was requested from the DON. On 3/17/26 at 1029 hours, during an interview with the DON and the Administrator, the DON was asked about documented evidence of the pharmacist's participation for reviewing of policies and procedures. The DON stated the pharmacist attended quarterly. The DON further stated the pharmacist's signature should be on the P&P review dated 10/9/25. The DON and Administrator were informed the pharmacist's signature was not on the document. The DON stated she would do a follow up. On 3/20/26, there was no sign in sheet received from the DON to show documented evidence the pharmacist had participated in reviewing the facility's P&P.

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical records were accurate for four of 25 final sampled residents (Residents 8, 11, 21, and 73). * The facility failed to ensure Resident 73's Nutrition Risk Assessment was completed accurately. The licensed nurse selected 0 for albumin level of 3.5 to 5.0 g/dL, instead of 3 for albumin level of less than 2.8 g/dL, when Resident 73's albumin level was 2.5 g/dL. * The facility failed to ensure Resident 11's POLST was accurate. The POLST showed Resident 11 had no advance directive, however Resident 11 had an advance directive. * The facility failed to ensure Resident 8's MAR for March 2026 was accurate. Resident 8's furosemide (diuretic) medication was held due to low blood pressure as per the physician' parameters, however, Resident 8's MAR showed the medication was administered. * RN failed to document Resident 21's IV site condition; IV site was no longer patent and had to be removed These failures had the potential for the resident's care needs to not be met as their medical information was inaccurate.Findings: Review of facility's P&P titled Documentation Principles dated 2/2018 showed the residents' clinical records shall be current and kept in detail consistent with good medical and professional practice based on care provided to each resident. Entries must be accurate, timely, objective, specific, concise, legible, clear and descriptive. 1. Medical record review for Resident 73 was initiated on 3/11/26. Resident 73 was admitted to the facility on [DATE]. Review of Resident 73's acute hospital records showed Resident 73's albumin level was 2.5 g/dL on 2/1/26. Review of Resident 73's Nutrition Risk assessment dated [DATE], showed the RN selected 0 for albumin level of 3.5 to 5.0 g/dL, instead of 3 for albumin level of less than 2.8 g/dL. On 3/17/26 at 1047 hours, an interview and concurrent medical record review for Resident 73 was conducted with RN 2. RN 2 stated when a resident was admitted to the facility, a nutrition risk assessment was competed to assess the residents nutritional risk. RN 2 stated when completing the nutrition risk assessment, the licensed nurse should check the discharge acute care hospital records to find the resident's latest albumin levels. RN 2 reviewed Resident 73's medical records and verified the above findings. On 317/26 at 1439 hours, an interview was conducted with the DON. The DON stated the nutrition risk assessment was done initially on admission by the admitting nurse. The DON stated the nurse should review the medical records and ensure the assessment areas were accurate. The DON further stated the nutrition risk score determined the resident's nutritional management and interventions for continued care at the facility. On 3/17/26 at 1530 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 11 was initiated on 3/11/26. Resident 11 was admitted to the facility on [DATE]. (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 11's H&P examination dated 7/18/25, showed Resident 11 had the capacity to understand and make decisions. Review of Resident 11's POLST dated 7/28/25, showed Resident 22 did not have an advance directive under section D. Review of Resident 11's Advance Health Care Directive Form dated 8/1/25, showed the advance directive was formulated on 8/1/25. Further review of Resident 11's medical records did not show if the POLST was updated to reflect Resident 11's advance directive status. On 3/11/26 at 1536 hours, an interview and concurrent medical record review for Resident 11 was conducted with LVN 9. LVN 9 confirmed the above findings and stated the advance directive was completed on 8/1/25, however, the POLST should have been updated to reflect the accurate information. LVN 9 stated staff refer to the POLST to determine whether to provide lifeˆsustaining treatment during an emergency, and an inaccurate POLST could mislead the staff and affect the care provided. 3. Medical record review for Resident 8 was initiated on 3/11/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's Order Summary Report showed a physician's order dated 8/15/24, for furosemide oral tablet 20 mg to give one tablet via GT one time a day for hypertension and to hold the medication if systolic blood pressure less than 110 mmHg. Review of Resident 8's H&P examination dated 8/14/25, showed Resident 8 had no capacity to understand and make decisions. Review of Resident 8's MAR dated for March 2026 showed on 3/10/26 at 0900 hours, Resident 8's blood pressure was 104/46 mmHg. Further review revealed that the furosemide medication was administered at 0900 hours on 3/10/26, despite the systolic blood pressure being below 110 mmHg. On 3/12/26 at 1432 hours, an observation, interview, and concurrent medical record review for Resident 8 was conducted with LVN 10. LVN 10 verified the findings above and stated she had held the furosemide medication on 3/10/26 at 0900 hours, because the resident's systolic blood pressure was below 110 mmHg; however, she mistakenly documented it as administered. LVN 10 presented the bubble pack, which showed that the furosemide medication for 3/10/26 had been held. On 3/17/26 at 1406 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. On 3/11/26 at 1039 hours, an observation was conducted of Resident 21 in the resident's room. Resident 21 was in bed with an empty container of vancomycin (antibiotic) hanging from Resident 21's IV pump. Resident 21 had a blanket covering the upper arms. On 3/11/26 at 1645 hours, an observation of Resident 21 and concurrent interview was conducted with RN 5. RN 5 uncovered Resident 21's blanket to show the right arm. Resident 21's IV site had white tape with clear tape on top of the white tape, surrounding Resident 21's right arm. When asked about the date for Resident 21's IV, RN 5 was observed peeling back part of the tapes on Resident 21. There was no label or date (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident 21's IV site when the tapes were peeled back. RN 5 verified the findings. RN 5 checked Resident 21's IV tubing for patency. RN 5 was observed trying to flush Resident 21's IV site with a 10 ml normal saline syringe/flush. One ml was observed going down Resident 21's IV site. Then the normal saline flush was observed stopped, no more normal saline was entering Resident 21's IV. Also, swelling was observed near Resident 21's IV site. RN 5 was observed asking Resident 21 if Resident 21 felt pain and Resident 21 nodded his head up and down to indicate, yes he felt pain at the IV site. The findings were verified with RN 5, who stated she would remove Resident 21's IV tubing. Medical record review for Resident 21 was initiated on 3/12/26. Resident 21 was readmitted to the facility on [DATE]. Review of Resident 21's Physician Order Summary showed an order dated 3/7/26, for vancomycin 500 mg medication via the IV route every 12 hours for nine days. Review of Resident 21's H&P examination dated 3/9/26, showed Resident 21 muscle weakness and hemiplegia. Resident 21 was nonverbal and had no capacity to make decisions. Further review of Resident 21's medical record failed to show documentation related to the condition of Resident 21's IV on 3/11/26. On 3/12/26, at 1607 hours, a follow up interview was conducted with RN 5. RN 5 verified she did not document Resident 21's IV site condition observed on 3/11/26.

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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the coordination of hospice services for one of two final sampled residents (Resident 31) reviewed for hospice. * The facility failed to ensure Resident 31's hospice visitation calendar showed the scheduled hospice staff visits; failed to ensure the hospice nurse, hospice aide, and hospice social worker progress notes were available in Resident 31's hospice binder; and failed to ensure the hospice plan of care was consistent with the actual hospice aide visits for Resident 31. These failures had the potential to put Resident 31 at risk for uncoordinated medical care between the facility and hospice agency.Findings: Review of the facility's P&P titled Hospice Care reviewed 9/2018 showed the facility is responsible for ensuring that hospice services meet professional standards and principles and the timeliness of the services. A care plan should be developed in coordination with the hospice, and the facility will continue to offer the same services to its residents who have elected the hospice benefit as it furnishes to residents who have not elected the hospice benefit. The facility is responsible for developing and updating the resident's plan of care. Review of Hospice A agreement with the facility dated 8/1/25, showed Hospice A shall retain responsibility for ensuring that applicable requirements related to hospice medical records are met. The facility shall allow Hospice A access to appropriate medical records and permit the inclusion of Hospice A care plans and other appropriate documentation in the Hospice Patient's facility medical records. Hospice A shall coordinate with the facility to ensure documentation of services is completed as applicable for hospice residents. Communications- the parties will communicate pertinent information with each other either verbally or in the residential hospice resident's record at least weekly, and/or at each hospice resident visit to ensure that the needs of each residential hospice resident are addressed and et 24 hours per day. Documentation of such communication shall be included in the Residential Hospice Patient's (Resident's) medical record. Medical record review for Resident 31 was initiated on 3/11/26. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's H&P examination dated 8/4/25, showed Resident 31 had no capacity to understand and make decisions. Review of Resident 31's Order Summary Report showed a physician's order dated 11/5/25, to admit Resident 31 to Hospice A for routine level of care. The Order Summary Report failed to show the frequency of hospice staff visits. a. Review of Resident 31's hospice calendar for March 2026 showed the hospice RN was scheduled to visit Resident 31 on 3/24/26. No other hospice staff names were noted on Resident 31's March 2026 hospice calendar for the week of 3/22/26. b. Review of Resident 31's Hospice A Plan of Care dated 1/27/26, showed the following care plan problems:- Personal care ADL Laundry: change linens. The intervention included the hospice aide to provide linen changes three times per week for Resident 31;- Personal care service bathing: sponge bath. The interventions included the hospice aide to provide the sponge bath three times per week for Resident 31; and- Personal care services: dressing. The intervention included the hospice aide to provide dressing three times per week for Resident 31. However, review of Resident 31's Hospice A Visit Description Log, showed the documentation Resident 31 was visited by the hospice aide twice a week on 2/3, 2/5, 2/10, 2/12, 2/17, 2/19, 2/24, 2/26, 3/3, 3/5, 3/10, and 3/12/26. c. Review of Resident 31's Hospice A Visit Description Log showed Resident 31 was visited by the hospice staff on the following dates:- The hospice registered nurse visits: on 2/9, 2/23, and 3/3/26.- The hospice aide visits: on 2/10, 2/12, 2/24, 2/26, 3/3, and 3/5/26.- The hospice social worker visit: on 2/27/26.- The hospice licensed nurse visit: on 3/5/26. Review of Resident 31's hospice record failed to show any nursing progress notes for the above listed dates and failed to show any documentations of the visitation notes by the hospice aide and social worker for the above listed dates. On 3/12/26 at 1050 hours, an interview and concurrent medical record review for Resident 31 was conducted with the DON. The (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated the purpose of the hospice binder was to provide coordination of care between the facility and the hospice agency so both parties would be aware of what care was being provided and when the care would be provided to the resident. The DON stated the hospice calendar should show when the resident would be visited by the hospice staff and should be updated at the end of each month for the following month. The DON stated following each hospice staff visit by the hospice staff (licensed nurse, hospice aide, or social worker), the hospice staff was responsible for placing the progress notes for that visit in the resident's hospice binder. The DON further stated the RN Supervisors were responsible for checking the hospice binders, following each visit, to ensure the hospice binder was up to date. The DON reviewed Resident 51's hospice binder and verified the above findings. On 3/16/26 at 1527 hours, a follow-up interview was conducted with the DON. The DON stated the hospice plan of care for the frequency of visits by the hospice aide was incorrect. The DON stated the hospice aide was scheduled to visit Resident 31 twice a week. The DON further stated the hospice POC should have been reviewed for accuracy and the frequency of visits clarified. On 3/17/26 at 1530 hours, an interview was conducted with the DON. The DON was informed and acknowledged 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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview, facility document review, and facility P&P review, the facility failed to accurately determine whether one final sampled resident (Resident 16) who was prescribed antimicrobial therapy and seven nonsampled residents (Residents 34, 45, 76, 78, 99, 117, and 143) met the criteria for true infection. * Residents 16, 34, 45, 76, 78, 99, 117, and 143 who did not meet the McGeer's (a standardized surveillance definitions used to detect infections in long-term care facilities, ensuring consistent reporting and monitoring) criteria were prescribed antimicrobial therapy. These failures resulted in continued use of unnecessary antibiotic therapy, potentially resulting in adverse reactions associated with antibiotics and the development of antibiotic-resistant bacteria. Findings: According to the Centers for Disease Control and Prevention (CDC), antibiotics are among the most frequently prescribed medications in nursing homes, with up to 70% of residents in a nursing home receiving one or more courses of systemic antibiotics over a year. Studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Harms from antibiotic overuse are significant for the frail and older adults receiving care in nursing homes. These harms include risk of serious diarrheal infections from Clostridium difficile (a type of bacteria that can cause diarrhea and inflammation of the colon), increased adverse drug events and drug interactions, and colonization and/or infection with antibiotic-resistant organisms. Review of the facility's P&P titled Infection Control Program System reviewed 1/2023 showed the facility's infection control program includes a system for preventing, identifying, reporting, investigating and controlling infections and communicable diseases for all the residents, staff, volunteers, visitors, and other individuals providing services under a contractual agreement based upon the facility assessment. The facility maintains written standards, policies and procedures for the infection control program which includes:- The IP collects data and analyzes the information, utilizing the facility's surveillance tools, to develop strategies to prevent further infection transmission.- The IP utilizes the revised McGeer's Criteria for definitions of infection control practices. Review of the facility's P&P titled infection Control-Antibiotic Stewardship revised 1/2018 showed it is the facility's policy to establish an antibiotic stewardship program that promotes appropriate use of antibiotics and a system of monitoring to improve resident outcomes and reduce antibiotic resistance. The goal is to ensure antibiotic is prescribed for the correct indication, dose and duration to treat a resident while attempting to reduce the development of antibiotic-resistant organisms. The facility's IP, DON, and pharmacy consultant will :Maintain a separate report for the number of residents on antibiotics that did not meet McGeer's criteria for active infection;Collect and review: the type of antibiotic ordered and route of administration, whether a culture was obtained before ordering antibiotic, whether antibiotic was changed during the course of treatment. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from September 2025 through February 2026 showed the following infection surveillance data for HAIs (Healthcare Acquired Infections), CAIs (Community Acquired Infections), and residents who did not meet McGeer's Criteria (DNMC):- September 2025: a total of 37 infections, including 16 HAIs, three CAIs, and 12 DNMCs.- October 2025: a total of 35 infections, including 11 HAIs, 11 CAIs, and nine DNMCs.- November 2025: a total of 42 infections, including 14 HAIs, 10 CAI, and 15 DNMCs.- December 2025: a total of 38 infections, including 14 HAIs, six CAI, and 15 DNMCs.- January 2026: a total of 39 infections, including 15 HAIs, five CAI, and 12 DNMCs.- February 2026: a total of 51 infections, including 17 HAIs, six CAI, and 19 DNMCs. On 3/16/26 at 1400 hours, a concurrent interview and facility document review was conducted with the IP. The IP stated she was responsible for conducting the surveillance of the residents with infections in the facility. The IP stated a Surveillance Data Collection Form was completed for each resident with signs and symptoms of an infection and also completed for the residents admitted to the facility on antimicrobial therapy. The IP stated she was responsible for reviewing the data and using the McGeer's criteria to determine whether each infection was a HAI, CAI, or DNMC. The IP further stated, (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	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Park Nursing Center	8520 Western Avenue Buena Park, CA 90620

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if the infection did not meet the criteria for a true infection, it would prompt the facility to reevaluate the appropriateness of the antimicrobial therapy to prevent the unnecessary use of antimicrobials and thus contributing to antimicrobial resistance to therapy. Review of the facility's Surveillance Data Collection Form for Residents 16, 34, 45, 76, 78, 99, 117, and 143 was conducted with the IP. After reviewing Residents 16, 45, and 117's Surveillance Data Collection Form, the IP verified the residents' infections did not meet McGeer's criteria for a true infection were prescribed antibiotics, and was not indicated as DNMC. * After reviewing the Surveillance Data Collection Forms for Residents 34, 76, 78, 99, and 143, the IP verified the residents received antimicrobial therapy; however, the residents did not have positive blood culture results for the blood infections. The IP was asked what criteria she used to determine if a blood infection was a true infection. The IP stated she completed the Surveillance Data Collection Form for other infection and if the resident presented with any of the constitutional criteria: fever, leukocytosis (high white blood cell count signaling the immune system is responding to an infection), acute mental status change, or acute functional decline, she would select the infection as a true infection. The IP was asked to show the reference literature for the determination of a true infection for the blood infection, however, the IP was unable to provide the reference. Furthermore, the IP verified Resident 99 had two infections in February 2026 was prescribed antimicrobial therapies, however, the Surveillance Data Collection Form was not completed to determine if Resident 99's respiratory infection met the McGeer's criteria for a true infection. On 3/17/26 at 0801 hours, a follow-up interview was conducted with the IP. The IP stated she did not use the proper criteria in determining a true infection for the resident's with blood infection. On 3/18/26 1008 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.