

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055742	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/05/2024
NAME OF PROVIDER OR SUPPLIER  Harbor Villa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  861 S. Harbor Blvd Anaheim, CA 92805	

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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882</b></p> <p>Based on interview, medical record review, and facility P&amp;P review, the facility failed to ensure one of three closed record sampled residents reviewed for discharges (Resident 1) was properly discharged from the facility after his elopement.</p> <p>* Resident 1 was found after his elopement from the facility and transported to an acute hospital for evaluation. Resident 1 was cleared to transfer back to the facility; however, the facility denied Resident 1's readmission. This failure had the potential to place Resident 1 at risk for decline in his health condition if placed inappropriately.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Transfer or Discharge Documentation revised 12/2026 showed when a resident is transferred or discharged from the facility, the following information will be documented in the medical record: a. the basis for the transfer or discharge; if the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: the specific resident needs that cannot be met, the facility's attempt to meet those needs, and the receiving facility's services that are available to meet those needs. Should the resident be transferred or discharged for any of the following reasons, the basis for the transfer or discharge will be documented in the resident's clinical record by the resident's attending physician: the transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the facility.</p> <p>On 5/21/24 at 0810 hours, an interview was conducted with Resident 1's responsible party. Resident 1's responsible party stated the facility refused to readmit Resident 1 since Resident 1 had eloped from the facility twice. Resident 1's responsible party further stated the facility told him that Resident 1 needed to be in a lock-down unit facility.</p> <p>Closed medical record review for Resident 1 was initiated on 5/21/24. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>Review of Resident 1's MDS dated [DATE], showed Resident 1 had moderately impaired cognitive skills for daily decision making.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's MDS dated [DATE], showed Resident 1 had an unplanned discharge. The MDS Entry/discharge reporting section showed discharged assessment - return anticipated.</p> <p>Review of Resident 1's Physician's Progress Note dated 5/15/24, showed the plan of care was reviewed with the resident, had no revision at this time, and to continue with the current plan of care.</p> <p>Review of Resident 1's Social Service Review dated 5/15/24, showed Resident 1's discharge plan was to be discharged home with home health services, and the social services would continue to provide the 1:1 (one on one) visit and ensure the safe discharge.</p> <p>Review of Resident 1's Progress Notes showed the following nursing documentation:</p> <ul style="list-style-type: none"> <li>- on 5/18/24 at 1224 hours, the RN notified the Administrator, DON, and Resident 1's physician of Resident 1's elopement event.</li> <li>- on 5/20/24 at 1808 hours, the RN received call from the police officer notifying the facility that Resident 1 was found in an apartment complex. The RN documentation further showed the police officer requested Resident 1 to be picked up; however, the police officer was made aware Resident 1 needed to be transferred to the nearest ED for further evaluation.</li> <li>- on 5/21/24 at 0130 hours, the RN received a call from the staff of Acute Hospital B, and per the Acute Hospital B staff, Resident 1 was seen and evaluated by the ED physician and gave an okay for Resident 1 to go back to the facility and if agreeable to accept the resident back. The DON was made aware of the call. The RN documentation further showed the DON instructed the RN to inform the hospital staff of Resident 1 needing a locked facility as Resident 1 had already eloped twice from the facility and it was not safe for the resident to go back to the facility.</li> </ul> <p>Further review of Resident 1's closed medical record failed to show an IDT meeting was conducted to discuss the facility's inability to meet Resident 1's needs and failed to show a physician's note documenting the basis and/or need for Resident 1's discharge.</p> <p>On 5/21/24 at 1422 hours, an interview was conducted with the DON. When asked about the protocol when a resident was found after elopement, the DON stated the resident would be taken to the ED to get evaluated for any injuries. Once the resident was medically cleared, the facility would coordinate the resident's transfer back to the facility. The DON stated the resident was not accepted back to the facility if the facility was not capable of providing care to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/5/24 at 0923 hours, a follow-up interview and concurrent closed medical record review was conducted with the DON. The DON was asked about the protocol for the facility-initiated discharges. The DON stated for the facility-initiated discharges, the IDT would discuss with the physician for the determination of the resident's discharge. The DON verified on 5/21/24, he was informed Resident 1 was cleared for the transfer from Acute Hospital B back to the facility. The DON verified he informed the nurse Resident 1 needed to be at a locked facility. The DON stated the facility was unable to meet Resident 1's care needs in the facility. When asked what services the facility was unable to provide to meet the care needs of Resident 1, the DON stated the facility was unable to keep Resident 1 within the building and prevent Resident 1 from leaving unsupervised. When asked for the documentation if an IDT meeting was conducted to discuss the facility's inability to meet Resident 1's care needs or the physician's documentation of the facility not able to meet Resident 1's need, the DON stated there was no documentation.</p> <p>On 6/5/24 at 1519 hours, the Administrator and DON were informed and acknowledged the above findings.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882</b></p> <p>Based on interview, medical record review, and facility P&amp;P review, the facility failed to ensure one of three sampled residents reviewed for elopement (Resident 1) was provided adequate supervision and necessary services to prevent elopement.</p> <p>* The facility failed to monitor Resident 1's whereabouts, resulting in Resident 1 leaving the facility undetected twice.</p> <p>* The facility failed to reassess Resident 1 for elopement risk as per the IDT's recommendations after an elopement episode.</p> <p>* The facility failed to monitor Resident 1 for his exiting behaviors.</p> <p>These failures placed Resident 1 at risk to not receive the appropriate care and services and placed the resident at risk for harm or injury.</p> <p>Findings:</p> <p>Review of the facility's P&amp;P titled Wandering and Elopements (undated) showed the facility will identify the residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for the residents.</p> <p>Review of the facility P&amp;P titled Tab Alarms, Bed Alarms, Wanderguard System (undated) showed the Wanderguard would be used for residents at risk for elopement. Nursing assessment of each resident must be done on admission and change in status to evaluate if he/she is at risk for falls or elopement. A plan of care must be formulated with the Interdisciplinary Team to determine the need for tab or bed alarms or Wanderguard bracelet and document in the Care Plan. The Wanderguard bracelet will be applied to the resident's wrist or ankle and not removed until replacement is needed. The Wanderguard bracelets are checked daily by the Licensed Nurse and documented in resident record.</p> <p>Review of the TL-4005SYS Depart Alert Anti-Wandering Door System Installation and Use Instructions dated 7/12/22, showed the Smart Caregiver Corporation devices designed to be installed by the end user. As such, it is the entire responsibility of the buyer to ensure that the system is properly installed and tested. Further, the system is not designed to replace good caregiving practices including, but not limited to direct patient supervision, adequate training for staff personnel for fall prevention and elopement and testing of the system before each use. The Warning statement showed the device is not a substitute for visual monitoring by a caregiver.</p> <p>Closed medical record review for Resident 1 was initiated on 5/21/24. Resident 1 was admitted to the facility on [DATE] and discharged on [DATE].</p> <p>Review of Resident 1's MDS dated [DATE], showed Resident 1 had moderately impaired cognitive skills for daily decision making.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Residents 1's Progress Notes showed the following nursing documentation:</p> <ul style="list-style-type: none"> <li>- on 5/12/24 at 2055 hours, 911 was called to report Resident 1 was missing. Resident 1's responsible party, physician, Administrator, and DON were made aware of the resident's elopement;</li> <li>- on 5/13/24 at 1118 hours, the facility received a call from the staff of Acute Care Hospital A stating Resident 1 was at Acute Care Hospital A;</li> <li>- on 5/13/24 at 1815 hours, Resident 1 returned from the acute care hospital;</li> <li>- on 5/18/23 at 1216 hours, the facility noticed Resident 1 was missing at 1130 hours. Resident 1 was last seen at 1100 hours by the charge nurse and CNA;</li> <li>- on 5/20/24 at 1808 hours, the facility received a call from the police officer to notify the facility that Resident 1 was found in an apartment complex. The documentation further showed the police officer requested Resident 1 to be picked up; however, the police officer was made aware Resident 1 needed to be transferred to the nearest ED for further evaluation; and</li> <li>- on 5/21/24 at 0130 hours, the facility received a call from the staff of Acute Care Hospital B, and per the Acute Care Hospital B staff, Resident 1 was seen and evaluated by the ED physician.</li> </ul> <p>a. Review of Resident 1's Order Summary Report showed the following physician's order dated 5/13/24:</p> <ul style="list-style-type: none"> <li>- to apply the Wanderguard on the left wrist to alert the staff should the resident exit the facility without supervision;</li> <li>- to check the Wanderguard on the left wrist functioning one time a day; and</li> <li>- to check the Wanderguard placement on the left wrist every shift.</li> </ul> <p>Review of Resident 1's IDT Review dated 5/14/24, showed the IDT recommended to place a Wanderguard on Resident 1 to alert the staff should the resident attempt to leave the facility unsupervised.</p> <p>Review of Resident 1's Progress Note dated 5/17/24, showed Resident 1 was observed walking, looking for his daughter and was reeducated.</p> <p>Review of Resident 1's Plan of Care revised on 5/18/24, showed a care plan problem to address Resident 1's risk of elopement/wandering related to an episode of wandering outside the facility premise unsupervised on 5/12/24. The interventions included the application of a Wanderguard, encourage to be involved with the activities of choice, and conduct the frequent visual checks of the resident's whereabouts.</p> <p>On 5/21/24 at 0825 hours, a telephone interview was conducted with Resident 1's responsible party who stated on 5/20/24, he was informed by the police department that Resident 1 was found. Resident 1's responsible party further stated Resident 1 was taken to his home by the police officer and he observed Resident 1 was wearing his Wanderguard.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/24 at 1134 hours, an interview was conducted with RN 1. RN 1 stated she worked on 5/18/24, and was informed by LVN 1 of Resident 1 missing from the facility. RN 1 stated she interviewed the facility staff working on 5/18/24, and the facility staff denied hearing any door alarm sounds.</p> <p>On 5/21/24 at 1154 hours, a telephone interview was conducted with CNA 1. CNA 1 stated he worked on 5/18/24, and provided the morning care to Resident 1 at 0900 hours. CNA 1 stated he last saw Resident 1 in his room around 1100 hours before leaving for his lunch break. CNA 1 stated when he came back from lunch, he noticed Resident 1 was not in his room and asked CNA 4 who was covering for him if he had seen Resident 1. CNA 4 stated he did not see Resident 1. CNA 1 stated he informed LVN 1, and the facility was involved in searching for Resident 1. CNA 1 further stated he did not hear any alarms beeping or sounding that day.</p> <p>On 5/23/24 at 0825 hours, a telephone interview was conducted with LVN 1. LVN 1 stated he was assigned to care for Resident 1 on 5/18/24. LVN 1 stated he checked his assigned residents at the beginning of his shift and noticed Resident 1 was wearing his Wanderguard. LVN 1 further stated he checked Resident 1's Wanderguard for the functionality and placement and the sensor beep which indicated the Wanderguard was active. When LVN 1 was asked if he heard any door alarms that day, LVN 1 stated he did not.</p> <p>On 5/21/24 at 1446 hours, an interview was conducted with the DON. The DON stated on 5/18/24, the CNAs were aware and the RN at the nurses' station was keeping an eye on Resident1 due to a report the day before of Resident 1 had attempted to leave the facility to see his daughter. However, the RN went on break and the CNA was with other residents and there was no staff reliever to watch Resident 1. The DON further stated the facility staff looked for the Resident 1 when the charge nurse noticed Resident 1 was not in his room. The DON verified and acknowledged Resident 1 went out of the facility on 5/12 and 5/18/24, undetected.</p> <p>b. Review of Resident 1's Elopement Risk assessment dated [DATE], showed Resident 1 did not pace, wander, try to get out of the door, find family or friend, did not have a history of elopement/wandering/getting lost, and was not at risk for elopement based on the criteria.</p> <p>Review of Resident 1's Post Event IDT dated 5/14/24, showed the facility conducted an IDT review when Resident 1 was not seen in the facility, was ultimately found, and brought to the acute hospital on 5/12/24. The IDT review further showed the recommendations to update Resident 1's elopement risk assessment, reeducate resident to advise the resident to stay within the facility premises unless supervised or accompanied by the staff or family.</p> <p>Review of Resident 1's Progress Note date 5/17/24, showed Resident 1 was observed walking and looking for his daughter.</p> <p>Further review of Resident 1's Elopement Risk Assessment failed to show the elopement risk assessment update as recommended in the IDT on 5/17/24, and following Resident 1's re-admission to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/24 at 1446 hours, an interview and concurrent closed record review for Resident 1 was conducted with the DON. The DON verified Resident 1 eloped from the facility on 5/12/24, resulting in Resident 1's hospitalization in the acute hospital. The DON stated Resident 1 was at risk for elopement. The DON verified the elopement risk assessment was not done after Resident 1 was readmitted to the facility 5/13/24. The DON further stated Resident 1 should have been reassessed for the risk of elopement.</p> <p>c. Review of Resident 1's Post Event IDT dated 5/14/24, showed an unexpected event when Resident 1 did not have any signs of exiting behaviors and left the facility unsupervised.</p> <p>Review of Resident 1's Progress Note dated 5/17/24, showed Resident 1 was observed walking, looking for his daughter and was reeducated.</p> <p>Review of Resident 1's MAR for May 2024 failed to show Resident 1 was monitored for exiting behaviors.</p> <p>On 6/5/24 at 0923 hours, an interview and concurrent closed record review for Resident 1 was conducted with the DON. The DON stated the exiting behaviors were defined as the resident attempting to leave or verbalizing the intent to leave. When asked how the DON ensured the residents were monitored for elopement, the DON stated residents were supervised by the CNAs and LVNs. The DON further stated the licensed nurses were expected to check on the MARs to see if the residents had exiting behaviors which should be documented every shift. The DON stated the indication for the use of the Wanderguard was Resident 1's exiting behaviors/elopement. The DON verified there was no nursing documentation to show Resident 1 was monitored for the exiting behaviors.</p> <p>On 6/5/24 at 1519 hours, the Administrator and DON were informed and acknowledged the above findings.</p>		