STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055742	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Villa Care Center	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)
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** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to ensure one of three sampled residents (Resident 1) attained and maintained the highest practicable physical well-being. * The facility failed to ensure the physician was timely notified when Resident 1 had a change in condition to theright leg. This failure posed the risk for Resident 1 to not receive the necessary care and services timely to maintain the resident's highest physical well-being. Findings: Review of the facility's P&P titled Change in Resident's Condition or Status revised February 2021 showed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/ mental condition and/ or status. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the eINTERACT SBAR Communication Form. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Closed medical record review for Resident 1 was initiated on 2/27/25. Resident 1 was admitted to the facility on [DATE], readmitted on [DATE], and discharged on [DATE]. Review of Resident 1's H&P examination dated 12/28/24, showed the resident was competent and able make decision. Review of Resident 1's MDS Significant Change in Status assessment dated [DATE], showed the BIMS score of 14 which indicated intact cognitive function. Review of Resident 1's Plan of Care showed a care plan focus problem dated 1/17/25, addressing Resident 1's nonhealing bilateral lower extremity cellulitis. Theinterventions included to monitor for pain, increase in size, and skin integrity. Further review of resident's plan of care showed a care plan focus problem revised on 12/30/24, addressing Resident 1'srisk for the development of skin breakdown and pressure ulcers. The intervention included to do the skin checks daily and as needed. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Order Summary Report showed a physician's order dated 1/20/25, to provide the following treatment to the lower extremities: apply mupirocin ointment (used to treat secondarily infected traumatic skin lesions due to specific bacteria) topically daily. On 2/26/25 at 1604 hours, a telephone interview was conducted with Family Member 1. Family Member 1 stated when she visited Resident 1 on 2/8/25, she noticed Resident 1's right leg looked purple. Family Member 1 stated she informed the nurse, and the nurse replied she would change the dressing soon. On 2/27/25 at 1557 hours, an interview and concurrent closed medical record review was conducted with LVN 4. LVN 4 stated on 2/8/25, Resident 1's bilateral leg dressings were soiled and wet from the exudate. LVN 4 statedshe cleansed the resident's bilateral lower extremities with normal saline, applied mupirocin ointment, covered with the ABD pads and wrapped with the Kerlix (roll of gauze) dressing. LVN 4 stated Resident 1's right leg was observed purplish in color and cold to touch, with blisters and serous exudate. LVN 4 further stated she informed RN 2; however, she was not able to follow up if the physician was notified of the changes in Resident 1's right leg because she had been busy with the other residents' wound care. LVN 4 stated she only worked part time and did not know how to do a change of condition documentation. LVN 4 stated on 2/9/25, Resident 1's right leg was observed to remain cold and purplish in color. LVN 4 stated Resident 1's right leg being cold and purplish in color were signs of no circulation and acknowledged the physician and family should have been notified. Review of Resident 1's closed medical record failed to show documentation of the health condition change and physician notification when Resident 1's right leg was observed purplish in color and cold to touch as identified by LVN 4 on 2/8/25. On 2/28/25 at 0948 hours, an interview and concurrent closed medical record review was conducted with RN 2. RN 2 verified there was no documentation to show the physician and Resident 1's family member were notified of the change of condition on Resident 1's right leg as identified by LVN 4 on 2/85/25. RN 2 stated she did not remember being notified by LVN 4 of Resident 1's change in condition of the right leg on 2/8/25. RN 2 stated she observed Resident 1's right leg was swollen, inflamed, reddish purple in color surrounding the slough area, and blisters on 2/9/25 at approximately 1400 hours after Family Member 1 had informed LVN 1 of the concern regarding Resident 1's right leg wound was not getting better. On 3/4/25 at 1045 hours, an interview and concurrent closed medical record review was conducted with the interim DON. The interim DON stated he expected the nurses to call the physician and resident's family member for any changes in condition and document in the narrative nursing progress notes when the nurse did not know how to do an eINTERACT Change in Condition Form. The DON verified there was no documentation to show the physician and Resident 1's family member were notified of resident's change in condition as identified on 2/8/25. On 3/4/25 at 1245 hours, an interview was conductedwith the Administrator. The Administrator was informed and acknowledged the findings as above.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 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 treat and prevent the development of pressure injuries for one of three sampled residents (Resident 2). * The facility failed to provide the skin treatment to Resident 2 as ordered by the physician and developed a care plan to address Resident 2's Stage 3 pressure injury to the lumbosacral spine. These failures had the potential for Resident 2 to not receive the appropriate care and services to promote healing of the pressure ulcer. Findings: Review of facility's P&P titled Pressure Ulcers/ Skin Breakdown - Clinical Protocol revised February 2024 showed the nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s). The physician will assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer. The physician will help identify and define any complications related to pressure ulcers. The physician will order pertinent wound treatments. As needed, the physician will help identify medical and ethical issues influencing wound healing. The facility will implement interventions to address identified risk factors. The physician will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. Review of facility's P&P titled Wound Care revised February 2024 showed to verify that there is a physician's order for the wound care. Review the resident's care plan to assess for any special needs of the resident. Medical record review for Resident 2 was initiated on 2/28/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 1/26/25, showed the resident was not competent and not able to enter into a contract. Review of Resident 2's MDS Admission assessment dated [DATE], showed the resident had impairment to both sides of the upper extremity and both sides of the lower extremities. The MDS assessment further showed Resident 1 was dependent on the staff member assistance with the bed mobility and toileting, and Resident 1 was always incontinent of both bowel and urinary functions. Review of Resident 2's Order Summary Report showed the following physician's orders: - dated 2/25/25, to provide the following wound treatment to Resident 2's pressure injuries on the right and left elbows: cleanse with the normal saline, pat dry, apply Santyl (an enzymatic debriding ointment) ointment 250 unit/gm topically, and cover with a foam dressing daily for 21 days. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 2/28/25, to provide the following wound treatment to Resident 2's pressure injury on the lumbosacral spine: cleanse with the normal saline, pat dry, apply Medihoney (used to treat wounds and burns), and followed by the absorbent dressing every day shift for 30 days. a. On 2/28/25 at 1154 hours, a wound care treatment observation was conducted with LVN 5 for Resident 2. LVN 5 was observed to apply Medihoney on Resident 2's right and left elbow wounds instead of the Santyl ointment as ordered by the physician. Review of Resident 2's TAR for February 2025 showed documentation of the wound treatment provided to Resident 2's pressure injuries on the right and left elbows on 2/28/25, as follows: cleansed with normal saline, patted dry, applied Santyl ointment 250 unit/gm topically, and covered with the foam dressing, which was initialed on 2/28/25, as provided. On 2/28/25 at 1205 hours, an interview was conducted with LVN 5. LVN 5 acknowledged the treatments for Resident 2's right and left elbow pressure injuries were to use Santyl ointment; however, according to the wound consultant's recommendation, Medihoney may be used if the Santyl ointment was not available. On 2/28/25 at 1430 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified the treatment order for Resident 2's right and left elbow pressure injuries was to apply Santyl ointment. RN 2 stated she was to contact the resident's physician to get an order to use Medihoney. b. Review of Resident 2's Surgical Consult dated 2/25/25, showed Resident 3 had Stage 3 pressure injuries to the right lower back, sacrum, and lumbosacral spine. Review of Resident 2's Plan of Care showed a care plan problem was initiated on 1/27/25, to address Resident 2's risk for the development of the skin breakdown and pressure injuries related to bowel and bladder incontinence and fragile skin. The interventions included to perform the following: - assess for risk for alteration in skin integrity; - monitor for skin redness and report promptly; - provide good incontinence care; - assist resident with ADL functions; - treatment as ordered; and - notify the physician of any changes in the resident's skin condition. Further review of Resident 2's plan of care failed to show a care plan problem and interventions were developed for Resident 2's stage 3 pressure injuries to the right lower back, sacrum, and lumbosacral spine. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 0855 hours, an interview and concurrent medical record review was conducted with LVN 5. LVN 5 verified there was no care plan initiated to address Resident 2's right lower back, sacrum, and lumbosacral spine pressure injuries. On 3/4/25 at 1045 hours, an interview was conducted with the interim DON. The interim DON stated he expected the nurses to follow the physician's orders and clarify the orders as needed. The interim DON further stated each pressure injury should have a treatment order and a written plan of care. The DON was informed and acknowledged the above findings. On 3/4/25 at 1245 hours, an interview was conducted with the Administrator. The administrator was informed and acknowledged the above findings.