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	03/27/2025

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 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** 49348 Based on observation, interview, medial record review, and facility P&P review, the facility failed to provide an environment free from the physical restraint (physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body) for one of three sampled residents (Resident 2). * The facility failed to obtain the orders to place a soft mitten on Resident 2's left hand. * The facility failed to ensure the appropriate assessment was completed prior to placing a soft mitten restraint on Resident 2. * The facility failed obtain the consent for the application of the soft mitten restraint for Resident 2. * The facility failed to monitor Resident 2 for the use of restraints. * The facility failed to ensure the comprehensive plan of care for Resident 2 was revised to reflect the current resident assessment for restraints. These failures had the potential to negatively affect Resident 2's physical mobility and psychosocial well-being. Findings: Review of the facility's P&P titled Physical Restraint Application revised 10/2010 showed the following: 1. Verify physicians' order for the use of restraints. 2. Review the resident's care plan to assess for any special needs of the resident. 4. Check on the resident every 30 min (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Remove the restraint every two hours for at least 10 minutes and change the resident's position. Exercise the resident. 6. The following information should be recorded in the resident's medical records: a. The date and time the restraint was applied b. The name and title of the individual(s) who applied the restraint. c. The type of physical restraint applied. d. The specific reason the restraint was applied e. The length of time the restraint will be used. f. Each time the device is released for resident exercise, toileting, and position change. g. Each time the resident is monitored, per facility policy. h. All assessment data (e.g., bruises, rashes, sores, etc.) observed during the procedure. i. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure. j. Any problems or complaints made by the resident related to the restraint application k. If the resident refused the treatment and the reason(s) why. l. The signature and title of the person recording the data. Review of the facility's P&P titled Use of Restraints revised 4/2017 showed the following: 1. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/ or representative (sponsor). The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptoms); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint. Should a resident not be capable of making a decision, the surrogate or sponsor may exercise the right of the use or non-use of a restraint. (Note: The surrogate/ sponsor may not give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms). 2. Care plans for residents in restraints will reflect interventions that address not only the immediate medical underlying problems that may be causing the symptom(s). (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Care plans shall also include the measures take to systematically reduce or eliminate the need for restraint use. Medical record review for Resident 2 was initiated on 3/20/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 2 had diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (condition where blood flow to the brain is interrupted, causing brain tissue damage) affecting right dominant side, and aphasia (language disorder that affects a person's ability to understand, produce, or use language). Review of Resident 2's MDS assessment dated [DATE], showed under Section C, Resident 2's cognitive skills for daily decision making were severely impaired and the resident did not use physical restraints in bed, chair and/or out of bed. Section GG showed Resident 2's functional abilities for the upper and lower extremities were impaired on both sides. Review of Resident 2's H&P examination dated 3/13/25, showed the resident was not competent and not able to enter a contract, including admission agreement. On 3/19/25 at 1346 hours, during an observation, Resident 2 was lying in his bed with a soft mitten on his left hand with the ties wrapped around his left wrist. On 3/20/25 at 1040 hours, during an observation, Resident 2 was lying in bed wearing a soft mitten restraint on his left hand with the ties wrapped around his left wrist. Review of Resident 2's medical record failed to show the following: - There was no physician's order for the use of restraint. - There were no physical assessments conducted for the resident's restraint. - There was no informed consent for the restraint. - There was no monitoring of the resident for the use of the restraint. - There was no care plan to address and implement restraints. On 3/20/25 at 1705 hours, an interview was conducted with the DSD. When asked what was considered a restraint, the DSD stated any device used when the residents were unable to move by themselves such as side rails and mittens. On 3/20/25 at 1707 hours, a concurrent observation, interview, and medical record review was conducted with the DSD. The DSD verified Resident 2 was wearing a soft mitten restraint on his left hand. Review of Resident 2's medical record was conducted with the DSD. The DSD verified there was no physician's order, no assessments, no informed consent, no monitoring, and no care plan for the use of the restraint. The DSD stated the care plan should reflect mittens to make sure it was not too tight and check for the skin integrity by removing the restraints. When asked if the mitten was considered a restraint, the DSD stated yes, if not, there should be an order for that. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 1710 hours, the Administrator and RN 3 acknowledged the above findings.

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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 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** 49348 Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the highest practicable well-being for two of three sampled residents (Residents 1 and 2). * The facility failed to assess the resident for the use of supplemental oxygen and failed to obtain a physician's order for Resident 1's use of the oxygen as per the facility's P&P. * The facility failed to follow up with the pharmacy services for Resident 1's delivery of the breathing treatment medications. * The facility failed to ensure Resident 2's humidifier was labeled, dated, and changed when it was empty. These failures had the potential to negatively affect the resident's well-being as the necessary care and services were not provided. Findings: 1. Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed the following: 1. Verify that there is a physician's order for this procedure. 2. Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: signs of symptoms of cyanosis (blue tone to the skin and mucous membranes), hypoxia (rapid breathing, rapid pulse rate, restlessness, confusion), oxygen toxicity (tracheal irritation, difficulty breathing, or slow, shallow rate of breathing), and vital signs. 3. After completing the oxygen set up or adjustment, the following information should be recorded in the resident's medical record: a. the date and time procedure was performed; b. name and title of the individual who performed the procedure; c. the rate of oxygen flow, route, and rationale; d. the frequency and duration of the treatment; e. the reason for the PRN administration; Review of the facility's P&P titled Changes in a Resident's Condition or Status revised 2/2021 showed the nurse will record in the resident's medical record information relative to the changes in the resident's medical/mental condition or status. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Closed medical record review for Resident 1 was initiated on 3/19/25. Resident 1 was admitted to the facility on [DATE], and transferred to the acute care facility on 12/4/24. Resident 1's diagnoses including acute and chronic respiratory failure with hypoxia (condition where the lungs are failing to provide enough oxygen to the blood), COPD with acute exacerbation and pneumonia (infection of the lungs caused by bacteria, viruses or fungi). Review of Resident 1's Order Summary Report showed a physician's order dated 12/4/24, for oxygen at 3 liters per min via nasal cannula continuously for COPD every shift. Review of Resident 1's eINTERACT Change in Condition V5 Form dated 12/4/25, showed Resident 1 had a change in condition starting on 12/4/24, in the afternoon. The form showed the following vital signs: - On 12/3/24 at 2351 hours, the respiration rate was 19 respirations per minute. - On 12/3/24 at 2351 hours, the temperature was 97.8 Fahrenheit degrees. - On 12/3/24 at 2351 hours, the oxygen saturation level was 96%. - On 12/4/24 at 1023 hours, the blood pressure was 138/68 mmHg. Further review of Resident 1's eINTERACT Change of Condition V5 Form dated 12/4/24, showed the resident had abnormal lung sounds with shortness of breath and dropped in the oxygen saturation when the oxygen was lowered to below 15 liters per minute via non re-breather mask. The form further showed the resident with cracklesin bilateral lung fields. Further Review of Resident 1's Order Summary Report did not show a physician's order to administer the 10-15 liters per minute of oxygen via non re-breather mask prior to the change of condition. Review of Resident 1's closed medical record failed to show the resident was monitored for the use of receiving supplemental oxygen per the facility's P&P prior to the resident's change in condition. On 3/21/25 at 1230 hours, an interview and concurrent closed medical record review was conducted with LVN 1. LVN 1 stated Resident 1 began to have breathing issues after breakfast on 12/4/24. When asked if a physician's order was needed when administering the oxygen at 10-15 liters per minute, LVN 1 stated normally yes, along with a change of condition. LVN 1 stated the physician was notified of the resident's change in condition on 12/4/24 at 1400 hours, and not prior. LVN 1 stated when Resident 1's oxygen saturation levels fell below 88%, LVN 1 was not sure why Resident 1 needed 10-15 liters per minute of oxygen. LVN 1 verified Resident 1 did not have the physician's orders for the oxygen to be administered at 10-15 liters per minute. LVN 1 verified there was no documented evidence the resident's oxygen saturation levels were monitored before the change in condition. 2. Review of the facility's P&P titled Pharmacy Services Overview revised 4/2019 showed the nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration. Closed medical record review for Resident 1 was initiated on 3/19/25. Resident 1 was admitted to the facility on [DATE], and transferred to the acute care facility on 12/4/24. (continued on next page)

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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 12/3/24, for acetylcysteine inhalation solution 20% 4 ml (breathing treatment) orally via nebulizer every four hours for pneumonia. Review of Resident 1's MAR for December 2024 dated 12/3/24 at 2000 hours, showed a documentation of 10 (Other, specify) for the acetylcysteine inhalation solution. Further review of Resident 1's MAR for December 2024 dated 12/4/24 at 0000 hours, and 12/4/24 at 0400 hours, showed a documentation of 4 (hold med, see progress notes) for acetylcysteine inhalation solution. Review of Resident 1's eMAR Medication Administration Note for December 2024 showed the following documentation for the acetylcysteine inhalation solution: - On 12/3/24 at 2145 hours, new admission, waiting for delivery from the pharmacy. - On 12/4/24 at 2351 hours, acetylcysteine inhalation solution, pending from the pharmacy delivery. - On 12/4/24 at 0320 hours, acetylcysteine inhalation solution, pending from the pharmacy delivery. On 3/20/25 at 1140 hours, an interview was conducted with RN 2. When asked what the process was if a medication was due and not delivered, RN 2 stated to call the pharmacy to deliver as soon as possible. On 3/20/25 at 1422 hours, an interview was conducted with LVN 1. LVN 1 stated for new admissions, the medication orders that were critical, then, the process would be to call the pharmacy right away. If the medication did not arrive, call the physician for a possible alternative, and depending on the medication, it might be a medication that is in the Cubex (automized medication dispensing system). On 3/21/25 at 1638 hours, an interview and concurrent closed medical record review was conducted with the DON. When asked if the physician was notified the acetylcysteine medication was not administered, the DON stated there was nothing indicating the physician was notified, or a pharmacy follow up. The DON stated medical records only showed the medication was on hold, and pending for delivery. When asked if RN 2 should have followed up, the DON stated yes. When asked if RN 2 should have notified the physician, the DON stated yes. 3. Review of the facility's P&P titled Departmental Respiratory Therapy Prevention of Infection revised 11/2011 showed to check the water levels of refillable humidified units daily. If the water level falls below the fill line: refill with distilled water to fill line. Medical record review for Resident 2 was initiated on 3/20/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. On 3/20/25 at 1040 hours, during the observation, Resident 2's humidified water on the oxygen concentrator was not labeled, undated, and empty. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 1204 hours, a concurrent observation and interview was conducted with LVN 3. When asked if there was a date labeled on Resident 2's humidifier, LVN 3 stated no. When asked if there was any water in the bottle, the LVN stated no, there was not. On 3/27/25 at 1624 hours, an interview was conducted with RN 3. RN 3 stated the humidifiers were changed every Wednesday night but if low, then it should be replaced. When asked what happens when the oxygen concentrator is running without a humidifier, RN 3 stated oxygen was dry air so it could dry out the nostrils. On 3/27/25 at 1710 hours, during an interview, the Administrator and RN 3 acknowledged the above findings.