

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 08/01/2025
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 provide the necessary care and services to prevent accidents for three of six sampled residents (Residents 1, 2, and 3). * The facility failed to ensure the risks of leaving the facility unsupervised without informing the staff were explained to Resident 1. * The facility failed to ensure Resident 1's smoking assessment was accurate and complete. * Resident 2 and 3's post fall neuro checks were not completed per their care plans. These failures had the potential to negatively affect Resident 1, 2, and 3's health condition and well-being. Findings: 1. a. Review of the facility's P&P titled Care Plans - Comprehensive (undated) showed each resident's care plan is designed to:- incorporate identified problem areas- incorporate risk factors associated with identified problems- build on resident's strengths- reflect the resident's expressed wishes regarding acre and treatment goals- reflect treatment goals, timetables and objectives in measurable outcomes- identify the professional services that are responsible for each element of care- aid in preventing or reducing declines in the resident's functional status and/or functional levels- enhance optimal functioning of the resident by focusing on a rehabilitative program- reflect currently recognized standards of practice for problem areas and conditions. Medical record review for Resident 1 was initiated on 7/30/25. Resident 1 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 1's Change in Condition dated 7/10/25, showed the resident headed out of the facility after dinner without informing the staff. Resident 1 was being pulled by another resident on an electric chair. When passing over the gate frame, Resident 1's chair tilted over, and Resident 1 landed on her right shoulder. Resident 1 did not have any head or skin injury. The vitals signs were within normal limits. Resident 1 was transferred out to the acute care hospital. Review of Resident 1's care plan date initiated 7/11/25, showed a care plan problem for the fall incident on 7/10/25. Interventions included educating the resident of the importance of informing the staff every time she was going out of the facility, the resident was to comply with facility house rules and policies, and the risks of not informing the staff when leaving the facility were explained. Review of Resident 1's medical record failed to show documented evidence the facility informed the resident of the risks of leaving the facility without notifying the staff. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had a BIMS score of 14, meaning the resident was cognitively intact. On 8/1/25 at 0925 hours, a concurrent interview and medical record review for Resident 1 was conducted with RN 1. RN 1 verified there was no documentation on educating the resident on the risks of leaving the facility without notifying the staff. b. Review of the facility's P&P titled admission Assessment and Follow Up: Role of Nurse revised on 9/2012 showed the following information should be recorded in the resident's medical record: - the date and time the assessment was performed- the name and title of the individual(s) who performed the procedure- all relevant assessment data obtained during the procedure- how the resident tolerated the assessment- orders obtained from the physician- the signature and title of the person recording the data. Review of Resident 1's Admission/ readmission Data dated 7/21/25, showed Resident 1's Smoking Assessment was still in progress or not completed. On 7/31/25 at 1024 hours, a concurrent interview and medical (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055742	Facility ID: 055742 If continuation sheet Page 1 of 2

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record review for Resident 1 was conducted with LVN 1. LVN 1 verified Resident 1's readmission Smoking Assessment was not completed and should have been. 2. a. Medical record review for Resident 2 was initiated on 7/30/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident's H&P examination dated 5/15/25, showed Resident 2 had capacity to make decisions. The H&P further showed Resident 2 had unsteadiness and was on fall precautions. Review of Resident 2's Change in Condition Evaluation dated 5/19/25, showed Resident 2 was found sitting on the floor at 2110 hours. The resident did not sustain any injuries. The Change in Condition Evaluation further showed to monitor the resident. Review of Resident 2's care plan dated 5/22/25, showed Resident 2 had an actual fall. The interventions included neuro-checks for 72 hours. Review of Resident 2's medical record failed to show documented evidence a post fall neuro check assessment was completed after Resident 2's fall on 5/19/25. 3. Medical record review for Resident 3 was initiated on 7/30/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Change in Condition Evaluation dated 7/16/25, showed Resident 3 was lying on the floor facing up on left side of the bed. Resident 3 had stated he sat on the edge and was trying to reach for his diaper which was falling off but slid on the floor. Resident 3 denied hitting his head, and there were no injuries Review of Resident 3's care plan dated 7/16/25, showed Resident 3 had an actual fall with no apparent injury. The interventions included neuro checks for 72 hours. Review of Resident 3's medical record failed to show documented evidence a post fall neuro check assessment was completed after Resident 3's fall on 7/16/25. On 7/31/25 at 0822 hours, a concurrent interview and medical record review for Residents 2 and 3 was conducted with LVN 1. LVN 1 stated the residents with fall incidents should have a head-to-toe assessment and neuro- checks to make sure the residents were fine after the fall incidents. LVN 1 was asked to provide any documentation if the neuro checks were performed for Residents 2 and 3 after their fall incidents. LVN 1 further verified she could not find any neuro checks for Residents 2 and 3 and stated they should have been completed post falls. On 8/1/25 at 1406 hours, a concurrent interview and medical record review for Residents 1, 2, and 3 was conducted with the DON. The DON verified the above findings.		