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	01/23/2026

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 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 observation, interview, and medical record review, the facility failed to ensure an environment free of accident hazards was provided for two of three sampled residents (Residents 1 and 2). * Resident 1 used a razor to self-inflict harm. * Resident 2 had two razors and two scissors in an unlocked bag inside Resident 2's closet, easily accessible to other residents. * The razors used to shave the male residents were unlocked and unsecured at Nurse Station A and inside a supply closet. These failures posed the risk of the residents accessing the sharp devices and resulting in injuries to the residents.Findings: 1. On 1/23/26, CDPH received a complaint about Resident 1 verbalizing thoughts of committing suicide. Closed medical record review for Resident 1 was initiated on 1/23/26. Resident 1 was admitted to the facility on [DATE], and was sent out to an acute hospital on 1/22/26, due to self-inflicted wounds. Review of Resident 1's Psychiatric Progress Note dated 12/4/25, showed the resident had a diagnosis of depressive disorder. Review of Resident 1's Progress Note dated 1/22/26, showed at 1508 hours, a report was received from the nursing staff, while making rounds regarding Resident 1 being seen with bleeding on the left wrist. The RN and charge nurse assessed the resident. Resident 1 was noted with multiple self-inflicted lacerations on the left wrist and was observed with one razor at hand. Resident 1 stated he wanted to harm himself. Resident 1 was transferred to an acute hospital via paramedics for further evaluation due to self-inflicted injuries to the left wrist with multiple lacerations. 2. On 1/23/26 at 1508 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 2 and LVN 1 inside the resident's room. Resident 2 was observed with a beard. Resident 2 stated he was independent for his shaving needs. When asked how he addressed his shaving needs, Resident 2 was observed going to his closet, retrieving his personal bag, and retrieving shaving supplies including two pairs of scissors and two razors from his bag. Resident 2 stated the razors were supplied to him by the facility staff. LVN 1 verified the findings. LVN 1 stated the sharp items were not supposed to be stored inside the resident's room. Medical record review for Resident 2 was initiated on 1/23/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 12/19/25, showed Resident 2's diagnoses included schizoaffective disorder and anxiety. Resident 2 had the capacity to understand and make decisions. 3. On 1/23/26 at 1515 hours, an observation and concurrent interview was conducted with RN 1. RN 1 was observed at Nurse Station A which faced the facility's rehabilitation room. RN 1 stated residents could obtain shaving supplies from the nurse station, and there was a supply of razors inside the supply closet for the residents' use. When asked to show where the razors at the nurse station were stored, RN 1 showed an unlocked, five tier storage cart with transparent drawers located near an open path from a hallway into the nurse's station. RN 1 verified she was facing the rehabilitation room, with her back facing the unlocked storage cart. RN 1 showed one of the drawers contained a blue razor and another drawer contained two razors. RN 1 was asked to show the supplies (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	closet containing the supply of razors for residents. RN 1 was observed going to a supplies closet located across from the facility's dining/activities room. The supply closet was unlocked. Inside the supply closet, an unlocked drawer was observed with multiple blue razors. RN 1 verified the findings and acknowledged the razors were not secured and easily accessible to the residents. On 1/23/26, an interview was conducted with the Administrator. The Administrator stated the facility did not know how Resident 1 got a hold of a razor. The Administrator also stated the staff in-services had been conducted on 1/22 and 1/23/26, including the staff going into residents' rooms to ensure razors were not being stored inside residents' rooms. The Administrator was informed of the above findings.