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

Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 056192 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
| --- | --- |
| Harbor Post Acute Care Center | 21521 S. Vermont Avenue<br>Torrance, CA 90502 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
| --- | --- |
| F 0626<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537<br><br>Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 1) who was transferred to a General Acute Care Hospital (GACH) on 1/21/2025 due to shortness of breath (SOB) was readmitted to the facility when the GACH cleared him to return to the facility on [DATE].<br><br>This deficient practice resulted in Resident 1 remaining at a GACH for 22 days beyond the date the GACH attempted to transfer him back to the facility. This deficient practice had the potential for Resident 1's continuity of care to be interrupted.<br><br>Findings:<br><br>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] with diagnoses including heart failure (a life threatening condition that occurs when the heart suddenly can't pump enough blood not the body) and chronic respiratory failure (a serious condition that makes it difficult for a person to breathe on his/her own).<br><br>During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 1/10/2025, the MDS indicated Resident 1 was able to make decisions that were consistent and reasonable and he required a one person assist to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily).<br><br>During a review of Resident 1's Care Plan dated 5/3/2024, the Care Plan indicated Resident 1 wished to remain in the facility long term and/or under custodial care (facility providing with basic, non-medical assistance with everyday tasks such as bathing, dressing, eating, and getting around to people who need help due to age, disability, or illness, usually provided by a caregiver without formal medical training). The Care Plan indicated Resident 1 and his Responsible Party (RP) had no intentions of being discharged to any other location. The Care Plan's goal was for Resident 1 to stay in the facility long term and the interventions included meeting with Resident 1 and his representative to reassess discharge to the community at regular intervals.<br><br>During a review of Resident 1's Change of Condition Evaluation (COC) dated 1/21/2025 and timed at 9:20 a.m., the COC indicated on 1/21/2025 at 8:10 a.m. Resident 1 was SOB and was transferred to a GACH at 8:38 a.m.<br><br>(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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| NAME OF PROVIDER OR SUPPLIER Harbor Post Acute Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 21521 S. Vermont Avenue Torrance, CA 90502 | |

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| F 0626<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 1's Order Summary dated 1/21/2025 and timed at 8:14 a.m., the Order Summary indicated to transfer Resident 1 to a GACH by paramedics because of SOB. The Order Summary indicated there was no order to hold Resident 1's bed for 7 days.<br><br>A review of Resident 1's Clinical Record indicated there was no Notice of Transfer Discharge available for review.<br><br>During a review of the GACH's Admission Record (Face sheet), the Face sheet indicated Resident 1 was admitted to the GACH on 1/21/2025 with diagnosis of hypoxia (a life threatening condition where the body doesn't have enough oxygen because of chronic heart and lung conditions) related to acute or chronic congestive heart failure (a life threatening condition that occurs when the heart suddenly can't pump enough blood not the body).<br><br>During a review of the GACH's Case Manager/Social Work Notes, dated 1/31/2025 and timed at 1:02 p.m., the Case Manager/Social Work Notes indicated the Administrator (ADM) did not want to readmit Resident 1 to the facility because Resident 1 owed the facility more than $14,500. A subsequent note by the GACH's Case Manager dated 2/6/2025 and timed at 3 p.m., indicated a follow up call to the facility's ADM and a subsequent note by the GACH's Case Manager dated 2/11/2025 and timed at 3:27 p.m., indicated Resident 1 was medically stable to be discharged from the GACH for transfer to a skilled nursing facility that day (2/11/2025).<br><br>During a telephone interview on 2/19/2025 at 4:46 p.m., Resident 1's RP stated she received a call from the facility's business office staff on the day Resident 1 was transferred to the hospital (1/21/2025) informing her that Resident 1 would be evicted from the facility because he owed the facility money. The RP stated she was not given a bed hold or discharge notice prior to or when Resident 1 was transferred to the GACH or before she was informed Resident 1 would not be readmitted to the facility. The RP stated she was worried that Resident 1 would become homeless.<br><br>During an interview on 2/20/2025 at 9:49 a.m., and a subsequent interview on 2/21/2025 at 1:49 p.m., the Director of Nursing Services (DON) stated Resident 1 should have been allowed to come back to the facility for continuity of his care and to prevent him from feeling abandoned. The DON stated Resident 1 was not provided a bed hold when he was transferred to the GACH or a notice of transfer discharge 30 days prior to being transferred to the GACH because Resident 1's transfer was not anticipated.<br><br>During an interview on 2/20/2025 at 12:02 p.m., the Administrator (ADM), confirmed there was no Bed Hold or Notice of Discharge Transfer provided to Resident 1 or his RP. The ADM stated the facility would readmit Resident 1 to the facility, if Resident 1 and his family paid the money owed to the facility. The ADM acknowledged Resident 1's quality of life would be affected if his care was discontinued.<br><br>During a review of the facility's undated Policy and Procedure (P/P) titled, Transfer or Discharge Documentation the P/P indicated each resident would be permitted to remain in the facility, and not to be transferred or discharged unless:<br><br>a. The transfer or discharge was necessary for the resident's welfare and the resident's needs could not be met in the facility<br><br>(continued on next page) |

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| F 0626<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | b. The transfer or discharge was appropriate because the resident's health had improved sufficiently so the resident no longer needed the services provided by the facility<br><br>c. The safety of individuals were endangered due to the clinical or behavioral status of the resident<br><br>d. The health of the other individuals in the facility would be otherwise endangered<br><br>e. The resident failed after reasonable and appropriate notice, to pay for (or have paid under Medicare or Medicaid) a stay at the facility<br><br>f. The facility ceased to operate.<br><br>The resident and his or her representative are given a 30 day advance written notice of an impending transfer or discharge from the facility.<br><br>During a review of the facility's undated P/P titled, Bed holds and Returns the P/P indicated prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed hold and return policy. The P/P indicated residents may return to and resume residence in the facility after hospitalization or therapeutic leave and shall apply to all Medicaid residents in the facility.<br><br>During a review of the facility's undated P/P titled, Transfer or Discharge Notice the P/P indicated residents and/or representatives are notified in writing, and in language and format they understand, at least 30 days prior to a transfer or discharge with the specific reason for transfer or discharge, effective date of discharge and the location to which the resident is being transferred or discharged . |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537<br><br>Based on observation, interview and record review, the facility failed the volume on their call lights was not turned down and audible. to ensure one of the facility's call light system was efficiently functioning. On 2/19/2025, the call light system in one of two nursing stations in the facility was not audible in Resident 3's care area and the facility's hallways.<br><br>This deficient practice resulted in the facility's call light system not being audible in Resident 3's care areas and throughout the hallway. This deficient practice had the potential for the Resident 3's care needs to be neglected.<br><br>Findings:<br><br>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] with diagnoses including heart failure (a life threatening condition that occurs when the heart suddenly can't pump enough blood not the body) and chronic respiratory failure (a serious condition that makes it difficult for a person to breathe on his/her own).<br><br>During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 1/10/2025, the MDS indicated Resident 1 was able to make decisions that were consistent and reasonable, and he required a one person assist to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily).<br><br>During an interview on 2/19/2025 at 2:45 p.m., Resident 3 stated her call light does light up when she presses it but she was not sure if the facility staff could hear the sound of the call light in the hallway. Resident 3 stated one time during the 11 p.m., to 7 a.m., shift (time unknown) she pressed her call light and waited for 30 minutes before anyone came to assist her. Resident 3 stated that night/morning she had to call for assistance using her personal phone, she had to use the restroom and was uncomfortable waiting.<br><br>During an observation at one of the two nursing stations in the facility and concurrent interview with Registered Nurse Supervisor 1 (RNS 1) on 2/19/2025 at 2:57 p.m., the call light system was observed with multiple lights corresponding to each resident room. The call light board lit up when a resident activated the call light in their room, however the audible sound was barely heard. RNS 1 stated the call light system had been this way for a long time and staff were usually in the hallway and could see when the lights above the resident's rooms turned on.<br><br>During an observation of one of the two nursing stations in the facility and concurrent interview with the facility's Maintenance Director (MD) on 2/19/2025 at 3:02 p.m., the Maintenance Director (MD) the call light system was observed with a knob that was used to adjust the volume of the call light system. The MD turned the knob of the call light system, and a loud and audible sound could be heard. The MD stated the volume of the call light system should have been at a maximum level so staff could hear it throughout the facility.<br><br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 2/20/2025 at 9:49 a.m., the Director of Nursing (DON) stated the facility's call lights should be seen and heard and the safety, well-being and dignity of the residents could get affected if the residents' needs are not met when call lights were not answered in a timely manner.<br><br>During a review of the facility's undated Policy and Procedure (P/P) titled Resident Rights the P/P indicated the facility must care for the residents in a manner and in an environment that promotes maintenance or enhancement of each resident's dignity, respect in full recognition of his/her individuality and their goal for a quality life. |