STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(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	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR VILLA CARE CENTER	861 S. HARBOR BLVD , ANAHEIM, California, 92805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the Abbreviated Survey for Complaint Number: 2565275. The survey team entered the facility on 7/30/25 at 1230 hours. The facility identified the census as 92. The survey sample size was 6. Inspection was limited to the complaint investigated and did not represent the findings of a full inspection of the facility. * FOR COMPLAINT NUMBER: 2565275, DEFICIENCIES WERE IDENTIFIED AND CITED AT F689. GLOSSARY AND DEFINITIONS: BIMS – Brief Interview for Mental Status (a tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) DON - Director of Nursing H&P – History and Physical LVN - Licensed Vocational Nurse MDS – Minimum Data Set (an assessment tool) Neuro Checks - refer to systematic assessments used to evaluate a patient's neurological functions including their ability to think, speak, move and respond to sensory stimuli. P&P – Policy and Procedure	F0000	Harbor Villa Care Center submits this response and plan of correction as part of the requirements under state and federal law. This plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action of proceedings against the provider or it's employees, agents, officers, directors or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.	8/30/2025

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 reverse for further 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
		8/22/25

Accepted 8/22/25

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F0000	Continued from page 1 RN – Registered Nurse	F0000		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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	F0689	How corrective actions will be accomplished for those residents found to have been affected by the deficient practice; For Resident 1, who was directly affected, corrective actions were taken immediately. On 8/1/25, the resident was re-educated by the DON and SS on the facility's out-on-pass policy, including the requirement to notify staff before leaving the premises. The charge nurse will monitor the signing in and out book. The resident was also informed of the potential dangers and/or risks associated with going out on pass, including the possibility of accident or injury. Specific safety concerns were addressed, such as nearby streets with vehicle traffic, and environmental hazards like uneven pavement, gravel, curbs, driveways, sidewalk cracks, steps, and stairs. This education was provided verbally and acknowledged in writing by the resident. A smoking assessment for Resident 1 was accurately completed by the LN per facility procedure, and all documentation was placed in the medical record on August 1, 2025. Residents 2 and 3 did not experience any harm as a result of the missed post-fall neuro checks. Both residents have since been discharged from the facility in accordance with their individual discharge plans.	8/30/2025

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F0689 SS = D	Continued from page 2 - 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 8/9/19, and was readmitted on 7/21/25. 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.	F0689	How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; On August 1, 2025, the Medical Records audited residents who has an order for going out on pass. Licensed nurses were in-serviced by the DON on August 1, 3, and 5, 2025 on providing/documenting unsupervised leave risk education, including the monitoring of the sign in and out book for completeness and accuracy. On August 1, 2025, the Medical Records identified and audited the residents who smoke. All smoking assessments were audited for completeness and accuracy. Licensed nurses were in-serviced by the DON on August 1, 3, and 5, 2025 on smoking assessment completion at admission, re-admission, and quarterly. On August 1, 2025, the Medical Records audited resident with similar risk factors and confirmed timely neuro checks for the other fall case. Licensed nurses were in-serviced by the DON on August 1, 3, and 5, 2025 on following care plans, completing neuro checks after falls. What measures will be put in to place or what systemic changes will the facility make to ensure that the deficient practice does not recur; To prevent recurrence, Licensed Nurses were in-serviced by the DON on August 1, 3, 5, 2025 regarding their responsibility to initiate and document all resident education about the risks of leaving the facility without staff notification and monitoring the sign in and out book. The RN Supervisor or designee reviews the resident signing in and out book daily for completeness and accuracy. To prevent recurrence, Licensed Nurses were in-serviced by the DON on August 1, 3, 5, 2025 to complete smoking assessment for all identified smokers at admission, re-admission, and quarterly. Medical Records verifies weekly that all residents identified as smokers have a current smoking assessment for completeness and accuracy. The DON and Medical Records director are responsible for ensuring these processes are maintained.	8/30/2025

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F0689 SS = D	Continued from page 3 Review of Resident 1's MDS assessment dated 7/25/25, 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 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 5/14/25. 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.	F0689	To prevent recurrence, Licensed Nurses were in-serviced by the DON on August 1, 3, 5, 2025 to initiate post fall neuro checks in accordance with facility's policy. The RN supervisor or designee now reviews all changes of condition daily to ensure neuro checks are initiated and documented. The DON and Medical Records Director are responsible for ensuring these processes are maintained. How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; To ensure sustained compliance, the Medical Records conducts daily audits of the residents with an out on pass orders. RN Supervisor or designee will monitor the completeness and accuracy of signing in and out book. Any omissions are reported immediately to the DON for corrective action and follow-up re-education. The DON compiles monthly audit results, tracks trends, and presents them to the QAPI Committee for review, discussion, and recommendations. The Interdisciplinary Team reviews the out-of-the-facility education and monitoring of sign in and out book for completeness and accuracy. Monitoring will continue for at least three consecutive months (Aug-Sep-Oct) of sustained compliance before any change in audit frequency is considered. To ensure sustained compliance, the Medical Records completes a weekly review of smoking safety assessments for all identified smokers, ensuring they are complete, accurate, current and incorporated into the care plan. The DON compiles monthly audit results, tracks trends, and presents them to the QAPI Committee for review, discussion, and recommendations. The Interdisciplinary Team reviews the smoking assessment are complete, accurate, current and incorporated to the care plan. Monitoring will continue for at least three consecutive months (Aug-Sep-Oct) of sustained compliance before any change in audit frequency is considered. To ensure sustained compliance, the Medical Records conducts daily audits of all new falls to verify neuro checks and resident education are documented. Any omissions are reported immediately to the DON for corrective actions and follow up re-education.	8/30/2025

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F0689 SS = D	Continued from page 4 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 7/15/25. 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.	F0689	The DON compiles monthly audit results, tracks trends, and presents them to the QAPI Committee for review, discussion, and recommendations. The Interdisciplinary Team reviews care plan compliance quarterly to confirm interventions for falls. Monitoring will continue for at least three consecutive months (Aug-Sep-Oct) of sustained compliance before any change in audit frequency is considered. Compliance will be submitted to the QA committee monthly (Aug-Sep-Oct) or until substantial,compliance is maintained. Administrator will ensure compliance.	08/30/2025

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F0689 SS = D	Continued from page 5 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.	F0689		