

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: 055518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Newport Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1555 Superior Avenue Newport Beach, CA 92663	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and were in good condition. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure one heavy-duty blender and one plastic blender used for the puree preparation was air dried and free of water residue prior to storing and stacking. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the food prepared in the facility's kitchen. Findings: Review of the facility's Diet Type Report dated 12/4/25, showed 61 of 61 residents consumed the food prepared in the kitchen. 1. Review of the facility's P&P titled Sanitization revised date 11/2022 showed all the utensils, counters, shelves, and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. The seals, hinges and fasteners are kept in good repair. The plastic ware, China and glassware that cannot be sanitized or are hazardous because of chips, cracks or loss of glaze are discarded. The damaged or broken equipment that cannot be repaired is discarded. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 12/3/25 at 0927 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed:- four rubber spatulas with red handles were chipped, cracked at the edges and discolored;- one stainless steel whisk was deformed; and- one stainless steel whisk with purple-gray rubber handle was cracked and worn out. The DSS acknowledged the above findings and stated the spatulas should not be used because the chipped particles can get mixed with the resident's food. The DSS further stated the whisks should have been replaced and not used for infection control purposes. 2. Review of the facility's P&P titled Sanitization revised date 11/2022 showed all the equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non-Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 12/3/25 at 0927 hours, during the initial kitchen tour, an (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation and concurrent interview was conducted with the DSS. The following was observed:- two stainless steel scoops with black handles used for food portioning had dry, crusted residue and watermarks;- two stainless steel scoops with gray handles used for food portioning had dry, crusted residue and watermarks; and- one stainless steel scoop with a white handle used for food portioning had dry, crusted residue and watermarks. The DSS acknowledged the above findings and stated all the dirty and crusted scoops should have been washed for infection control purposes. 3. Review of the facility's P&P titled Sanitization revised date 11/2022 showed food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Drying food preparation equipment and utensils with a towel or cloth may increase risks for cross contamination. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 12/3/25 at 0924 hours, during the initial kitchen tour, an observation, and concurrent interview was conducted with the DSS. One heavy-duty blender and one clear plastic blender used for puree preparation was still moist and wet with visible water inside and stored on top of the countertop shelf. The DSS verified the findings and stated all kitchen equipment should be air dried to prevent bacteria growth.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility record review, and facility P&P review, the facility failed to protect the resident's rights to be free from the physical abuse by a resident for one nonsampled resident (Resident 31) investigated for abuse. * Resident 31 was hit on the left eyebrow by another resident (Resident 32), resulting in a small laceration with bleeding. Resident 32 was identified with a history of attacking others out of anger due to delusions. However, there were no specific interventions in the care plan regarding the attacking behavior. This failure had the potential for not protecting the resident and negatively impact the resident's well-being. Findings: 1. Review of the facility's P&P titled Abuse Prohibition and Prevention dated 11/2017 showed the facility strives to provide an environment which prohibits and prevents abuse, neglect, and exploitation of residents and misappropriation of resident property. The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other residents' rooms, residents with self- injurious behaviors, residents with communication disorders, those that require heavy nursing care and/or are totally dependent on staff. Review of the facility's SOC 341 Report of Suspected Dependent Adult/Elder Abuse dated 12/9/25, showed a resident to resident altercation between Residents 31 and 32 was reported by the Administrator. On 12/9/25 at around 0835 hours, Resident 32 was at the water station and was getting water while Resident 31 was behind him waiting to get water. Resident 31 was awaiting to take his supplement with water from LVN 2. Resident 31 asked LVN 2 if he could get some water and verbalized Resident 32 had five cups of water. Resident 32 turned and stated he had only two cups of water. Resident 31 replied to Resident 32 cool, and Resident 32 said we cool with a blank stare and closing the distance between them and then hit Resident 31 in the left eyebrow. Resident 31 sustained a slight cut. A code green (an emergency alert for behavioral issues) was initiated and both residents were immediately separated. Resident 32 was taken outside to cool off with the Administrator and the behavioral clinician while Resident 31 was taken to his room and was assessed by the nurses who immediately addressed his eyebrow cut. Review of the facility's Patient-to-Patient Aggression Five-Day Follow-Up Report dated 12/10/25, showed the facility had notified the conservators of Residents 31 and 32. Resident 32 had a diagnosis of Schizophrenia, with episodes of anger and striking out with delusions. Corrective actions and follow-up implemented were:- Immediate 1:1 observation was implemented for Resident 32 following the assault;- Both residents were put on every 15 minutes monitoring of behavior and location for 72 hours;- [NAME] Beach Police Department was engaged, and proper documentation was completed (case number was provided)- Post-incident monitoring for Resident 31 was implemented, and the resident remained stable; and- An additional water station was added for Cart 2 to separate the residents a little more. a. Medical record review for Resident 31 was initiated on 12/9/25. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's H&P examination dated 6/5/25, showed Resident 31 could make needs known but could not make medical decisions, and had a significant diagnosis of schizoaffective disorder with catatonia (a disorder which disrupts a person's awareness of the world around them). Review of Resident 31's MDS assessment dated [DATE], showed Resident 31 was cognitively intact. Further review of the MDS assessment showed Resident 31 had no behavioral symptoms exhibited such as physical behavioral symptoms directed toward others (for example-hitting, kicking, pushing, scratching, grabbing, or abusing others sexually) and verbal behavioral symptoms directed toward others (for example-threatening others, screaming at others, or cursing at others). Review of Resident 31's eInteract Change in Condition Evaluation dated 12/9/25, showed at 0845 hours, Resident 31 was punched by another resident. Resident 31 stated he needed to drink water to take his medications while another resident took his (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time to drink water. A body assessment of Resident 31 was performed by the nurse. Resident 31's vital signs were within normal limits. Resident 31 obtained laceration to left side of eyebrow with scant bleeding and was treated with triple antibiotic and icepack. Resident 31's nurse practitioner was notified and no new order given. A neurological assessment was initiated for 72 hours to assess delayed injury for Resident 31. b. Medical record review for Resident 32 was initiated on 12/9/25. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's H&P examination dated 9/20/25, showed Resident 32 could make needs known but could not make medical decisions, and had a significant diagnosis of schizoaffective disorder. Review of Resident 32's plan of care initiated on 9/24/25, showed a care plan problem addressing Resident 32's history of attacking people out of anger due to delusions. However, there were no specific interventions included in the care plan regarding the behavior of attacking other people. Review of Resident 32's MDS assessment dated [DATE], showed Resident 32 had moderate impaired cognition. Further review of the MDS assessment showed Resident 32 had no behavioral symptoms exhibited such as physical behavioral symptoms directed toward others (for example-hitting, kicking, pushing, scratching, grabbing, or abusing others sexually) and verbal behavioral symptoms directed toward others (for example-threatening others, screaming at others, or cursing at others). Review of Resident 32's eInteract Change in Condition Evaluation dated 12/9/25, showed at 0845 hours, Resident 32 was drinking water after taking morning medications when another resident came close to take water. Resident 31 was triggered due to another resident getting too close to him and punched the other resident on the left side of the eyebrow. Resident 31 was put on every 15 minutes monitoring. On 12/9/25 at 1130 hours, an observation and concurrent interview was conducted with Resident 31. Resident 31 was observed with band aid in his left eyebrow. Resident 31 stated it was his first time to be hit by another resident in the facility. Resident 31 stated he was waiting in line in the water station for Resident 32 to finish getting and drinking water because he had to take his medications. Resident 31 stated he asked LVN 2 if he could get water since Resident 32 had been drinking a lot of water from the water container. Resident 31 stated he told Resident 32 that there were also other residents who needed to drink water and then Resident 32 suddenly hit him on the left side of his face. Resident 31 stated he obtained a cut in his left eyebrow, and it was bleeding at that time. Resident 31 stated the facility staff separated them immediately. Resident 31 further stated he was feeling fine, and he just informed his nurse if possible, during mealtime in the dining area if he could be seated at a table far away from Resident 32. On 12/9/25 at 1408 hours, an observation and concurrent interview was conducted with Resident 32. Resident 32 stated he was getting water when resident 31 came to him and told him not to get water and to watch out. Resident 32 stated he drank some more water, filled up another cup of water then Resident 31 told him to hurry up. Resident 32 admitted he hit Resident 31 on his cheek, and he just backed away. Resident 32 stated the facility staff separated them immediately after the incident. Resident 32 stated it was his first incident of hitting someone in the facility and he had no thoughts of hurting others again. Resident 32 further stated he apologized to Resident 31 and told him it would never happen again. On 12/9/25 at 1426 hours, an interview was conducted with LVN 2. LVN 2 stated Resident 32 was alert and oriented times 2-3 and able to make his needs known. LVN 2 stated it was the first time Resident 32 exhibited aggression in the facility. LVN 2 stated the resident to resident altercation between Residents 31 and 32 occurred this morning at around 0845 hours. LVN 2 stated she was in her medication cart when Resident 32 was getting water from the water station and Resident 31 was making multiple remarks regarding Resident 31's too much water drinking. LVN 2 stated she could not intervene on time. LVN 2 stated she tried to stop both residents from arguing and called for help, but unfortunately Resident 32 was quick and hit Resident 31 in the face. On 12/10/25 at 1100 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 stated Resident 32 was alert with confusion, delusions, and could be agitated. RN 2 stated Resident 32 apologized to Resident 31, was referred to the behavioral clinician for follow-up monitoring, was seen by the psychiatrist on 12/9/25, after the (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident, was given a dose of prescribed anti-anxiety medication, and was placed on 1:1 monitoring to ensure his safety and other residents. RN 2 stated Resident 31 never had any argumentative issue with other residents. RN 2 stated Resident 31 was assessed immediately by the nurses after the incident and was on continuous monitoring for change in condition, was seen as well by the psychiatrist. RN 2 further stated both residents were being followed up by the social worker and were on every 15 minutes monitoring for their behavior and location to ensure safety.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and facility P&P review, the facility failed to report an abuse allegation to the CDPH and law enforcement for an unidentified number of residents investigated for abuse. * The facility failed to report an allegation of excessively rough staff providing care to the residents. This failure of not reporting abuse allegation had the potential to put the residents at risk for further abuse. Findings: Review of the facility's P&P titled Abuse Prohibition and Prevention dated 11/2017, showed the facility has policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, exploitation, mistreatment, including injuries of unknown source and misappropriation of resident property. The purpose is to assure the facility is doing all that is within its control to prevent occurrences. The P&P further showed the facility personnel will investigate different types of incidents including:a. Identification of staff member(s) responsible for the initial reporting;b. Investigation of alleged violations; andc. Reporting of results to the proper authorities.The facility will provide protection of residents from harm during an investigation including, but not limited to:a. Suspension of facility personnel involved in the suspected or actual abuse allegation;b. Separation of residents involved in a resident to resident altercation(s);c. Interventions to calm the situation and support the involved resident(s); andd. Measures to protect the resident in the event the alleged or suspected abuser is a person other than facility staff. Additionally, the P&P showed the facility shall report all alleged violations and all substantiated incidents:a. To the state agency and to all other agencies as required;b. And take all necessary corrective actions depending on the results of the investigation;c. Report to the state nurse aide registry or licensing authorities any knowledge it has of any action s by a court of law which would indicate an employee is unfit for service; andd. Analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences. The P&P further showed the facility shall ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than two hours after the allegation is made. Review of the SOC 341 - Report of Suspected Dependent Adult and/or Elder Abuse form dated 2/2024 showed the purpose of the form is to document the information given by the reporting party on the suspected incident of abuse or neglect of an elder or dependent adult. Information to complete the form showed if any item of information nis unknown, enter unknown. Furthermore, the form showed any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect has occurred, shall complete this form for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult immediately or as soon as practicably possible. Lastly, the form further showed to report to the local law enforcement agency, Ombudsman, and the California Department of Public Health. On 12/3/25 at 0827 hours, a telephone interview was conducted with Ombudsman A. Ombudsman A stated there were anonymous reports of two staff who were excessively rough with residents and favoritism. Ombudsman A stated the name of one CNA; however, was unable to provide the name of the other CNA named in the allegation. Ombudsman A stated the DSD was notified of the allegations on 11/24/25. Ombudsman A stated per the DSD, the facility did not have a CNA by the name provided by Ombudsman A. Ombudsman A then stated the DSD acknowledged the facility had two staff with the first name of one CNA and the last name of another CNA. On 12/3/25 at 0900 hours, an interview was conducted with the Administrator. The Administrator stated although he was not at the facility on the day Ombudsman A informed the DSD of (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the abuse allegation, he was made aware. The Administrator further stated he did not have a CNA by the name provided by Ombudsman A; however, there were two CNAs (CNAs 2 and 3) who each had a same name identified by Ombudsman A. CNA 2 had the same first name, and CNA 3 had the same last name as the alleged CNA in the abuse allegation. The Administrator stated the facility was not provided with a definitive name of the CNAs involved in the abuse allegation and believed the complaint was due to workplace gossip. Moreover, the Administrator denied reporting the allegation to CDPH or law enforcement agencies and stated the facility did not submit a SOC 341. On 12/3/25 at 0922 hours, an interview was conducted with the DSD. The DSD verified Ombudsman A notified him of the abuse allegation on 11/24/25, and stated CNA 2 had the same first name and CNA 3 had the same last name as the alleged CNA involved in the abuse allegation. The DSD further stated the abuse allegations by Ombudsman A were favoritism and rough handling of residents, and he reported the information to the Administrator. The DSD stated he investigated the abuse allegation and closed out the investigation after interviews with the residents and staff. When asked if CNAs 2 and 3 were still on schedule during the investigation process, the DSD stated yes and denied removing them off the schedule. The DSD stated the abuse allegations were to be reported to the Administrator, law enforcement, CDPH, Ombudsman, and DON. The DSD further added the SOC 341 form must be completed. When asked if allegation of the staff being excessively rough with residents was considered abuse, the DSD stated yes and the investigation process should be initiated as everyone is a mandated reporter. Moreover, the DSD denied completing a SOC 341 form and verified the abuse allegation reported by Ombudsman A was not reported to CDPH and law enforcement as per the facility's P&P. On 12/9/25 at 1435 hours, an interview was conducted with LVN 2. LVN 2 stated abuse allegations are reported to the Administrator, DON, police, Ombudsman, and CDPH. LVN 2 stated if staff were part of the abuse allegations, they would be sent home pending the investigation. When asked if an allegation of excessive roughness would be considered abuse, LVN 2 stated yes and stated she would report the allegation immediately to the Administrator. On 12/10/25 at 1425 hours, an interview was conducted with the Administrator, DON, and DSD. The Administrator verbalized disagreements with findings and stated Ombudsman A did not provide the correct names of the CNAs involved in the abuse allegation and stated the complaint originated from a disgruntled employee. When asked if the process of investigating an abuse allegation was to report and then investigate or investigate and then report, the Administrator, DON, and DSD acknowledged the process of reporting abuse was to report to the agencies as per the facility's P&P and investigate. The DON stated she understood the concerns and the facility should have reported the abuse allegation despite incomplete information by Ombudsman A and the facility could have continued with their investigation process. The Administrator, DON, and DSD were informed and acknowledged the above findings.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the physician's orders matched the medication label provided by the pharmacy for one of four nonsampled residents (Residents 58) reviewed for the medication administration. * The facility failed to ensure Resident 58's physician's order for haloperidol decanoate (antipsychotic medication) matched the instructions shown on the medication label provided by the pharmacy. This failure posed the risk for negative health outcome to the resident. Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed the medications are administered in a safe and timely manner, and as prescribed. The medications are administered in accordance with prescriber orders, including any required time frame. Medical record review for Resident 58 was initiated on 12/4/25. Resident 58 was admitted to the facility on [DATE]. Review of Resident 58's H&P examination dated 10/6/25, showed Resident 58 could make needs known, but could not make medical decisions. Review of Resident 58's Order Summary Report showed a physician's order dated 10/3/25, for Haldol decanoate intramuscular solution 100 mg/ml inject 2 ml (200 mg) intramuscularly one time a day every 14 days for schizophrenia. However, review of the medication label by the pharmacy showed instructions to administer Haldol decanoate 50 mg/ml inject 4 ml (200 mg) intramuscularly one time every 14 days. Review of Resident 58's admission MDS assessment dated [DATE], showed Resident 58 had a BIMS score of 13, meaning the resident's cognition was intact. On 12/4/25 at 1000 hours, a medication administration observation for Resident 58 was conducted with LVN 2 in the resident's room and with the IP present. LVN 2 verified she administered two syringes filled with 2 ml of Haldol decanoate 50mg/ml in each syringe. On 12/5/25 at 1445 hours, an observation, interview and concurrent medical record review for Resident 58 was conducted with LVN 2. LVN 2 verified Resident 58's physician's order for Haldol decanoate did not match the pharmacy label on the bottle. LVN 2 stated the physician's order and the pharmacy label should match to reduce the potential for medication errors. LVN 2 further stated the licensed nurses should have contacted the pharmacy or the physician for clarification. On 12/10/25 at 1425 hours, an interview was conducted with the Administrator, DON, and DSD. The Administrator, DON, and DSD were informed and acknowledged the above findings.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to store the drugs, biologicals, and medical supplies in a safe manner. * The facility failed to ensure LVN 2 did not leave two syringes filled with two ml Haldol decanoate (antipsychotic medication) unattended at Resident 58's bedside. * The facility failed to ensure the medications in the bin for the medication disposal in Medication Room A were properly stored and disposed of. These failures had the potential for the medications to be accidentally administered or used inappropriately. Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed the medications are administered in a safe and timely manner, and as prescribed. Medications should only be removed from the cart at the time of administration and must not be left unattended. Review of the facility's P&P titled Discarding and Destroying Medications revised 6/2025 showed both controlled and non-controlled substances may be disposed of in the collection receptacle. The collector is responsible for managing the collection receptacles, including picking up and properly disposing of medications collected in the receptacles. For unused, non-hazardous controlled substances not disposed of by an authorized collector, the EPA recommends destruction and disposal of the substance with other solid waste following the steps below: a. Take the medication out of the original containers. b. Mix medication, either liquid or solid, with an undesirable substance. Undesirable substances include sand, coffee grounds, kitty litter, or other absorbent materials. Place the waste mixture in a sealable bag, empty can, or other container to prevent leakage. 1. Medical record review for Resident 58 was initiated on 12/3/25. Resident 58 was admitted to the facility on [DATE]. Review of Resident 58's H&P examination dated 10/6/25, showed Resident 58 could make needs known, but could not make medical decisions. Review of Resident 58's admission MDS assessment dated [DATE], showed Resident 58 had a BIMS score of 13, indicating intact cognition. Review of Resident 58's Order Summary Report for December 2025 showed the following a physician's order dated 10/3/25, to administer Haldol decanoate intramuscular (injecting medication or vaccine directly into the muscle tissue) solution 100 mg/ml, give two ml (200 mg) intramuscularly one time a day every 14 days for schizophrenia (a mental illness that affects how a person thinks, feels, and behaves). On 12/4/25 at 1000 hours, a medication administration observation was conducted with LVN 2 in Resident 58's room, with the IP present. LVN 2 was observed with two syringes filled with two ml of Haldol decanoate medication for Resident 58. While in Resident 58's room, LVN 2 drew the curtains for privacy and stated she was going to use the resident's bathroom to perform hand hygiene. The IP was observed standing next to the resident's bathroom door behind the curtains and Resident 58 was not within the eyesight of the IP. Upon returning from the resident's bathroom, LVN 2 was observed without the two syringes of the Haldol decanoate medication. The two medication filled syringes were observed on Resident 58's bed unattended. On 12/4/25 at 1017 hours, an interview was conducted with LVN 2. LVN 2 verified she returned from Resident 58's bathroom without the two medication filled syringes. LVN 2 stated she thought the IP would watch the medication when she left to perform hand hygiene. LVN 2 then stated, she should have brought both of the syringes with her and stated the medications were not to be left unattended at the resident's bedside. LVN 2 stated leaving the medications unattended at bedside had the risk of the residents administering the medications inappropriately. LVN 2 stated Resident 58 could not self-administer the medications and stated the resident would need assistance with medication administration. On 12/4/25 at 1019 hours, an interview was conducted with the IP, with LVN 2 present. When the IP was asked if he maintained observation of Resident 58's two medication filled syringes while LVN 2 left the room to perform hand hygiene, the IP stated he did not. The IP verified he was behind the curtains and not within the eyesight of the two medication filled syringes. (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Newport Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1555 Superior Avenue Newport Beach, CA 92663	
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The IP then asked LVN 2, you did not have the medications with you when you washed your hands? The IP verified the two syringes filled with the Haldol deanoate medication were left unattended at Resident 58's bedside. 2. On 12/3/25 at 1119 hours, an observation and concurrent interview was conducted with RN 1 in Medication Room A. Multiple, unidentified whole pills were observed in the medication disposal bin. Further observation showed the lid of the medication disposal bin was not secured. RN 1 verified the findings and stated the medications should be secured and diluted with fluids to ensure the medications were properly disposed of. On 12/3/25 at 1142 hours, an observation and concurrent interview was with the DON in Medication Room A. The DON verified the above findings. The DON stated she expected the licensed nurses to mix the disposed tablets with fluids to ensure the disposed medications were dissolved. On 12/10/25 at 1425 hours, an interview was conducted with the Administrator, DON, and DSD. The Administrator, DON, and DSD were informed and acknowledged the above findings.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on interview, facility document review, and facility P&P review, the facility failed to ensure the P&P for the Outside Food met the current federal regulation. This failure had the potential to cause foodborne illnesses to the medically vulnerable residents population who received food items from outside sources. Findings: Review of the CMS S&C-09-39 dated 5/29/09, showed the residents have the right to choose to accept food from the visitors, family, friends, or other guests according to their rights to make choices. According to the Code of Federal Regulations, Section S483.60(i)(3) Food Safety Requirements, the facility must have a policy regarding use and storage of food brought to residents by family and other visitors to ensure safe and sanitary, handlings, and consumption. However, review of the facility's P&P titled Behavioral Health Outside Food revised 9/6/24, showed under Storage, the food brought into the facility cannot be stored or saved. The P&P further showed the food brought by the visitors must not be stored or kept in residents' personal areas. On 12/3/25 at 0945 hours, an interview with the DSS was conducted. The DSS stated the facility did not have a refrigerator to store the residents' food items brought in from outside sources. The DSS further stated the food items brought in from outside sources were for immediate consumption. On 12/10/25 at 1344 hours, an interview was conducted with RNA 1. RNA 1 stated the residents were not allowed to bring food from the outside sources and/or store them for later consumption. RNA 1 stated the families could order food from the outside sources for the residents for same day consumption. RNA 1 further stated the facility did not have a refrigerator to store the residents' food items brought in from outside sources. On 12/10/25 at 1525 hours, an interview was conducted with the RN 2. RN 2 acknowledged the above findings and stated the food items brought in for the residents from the outside sources had to be sealed and were for immediate consumption. RN 2 further stated the residents were not allowed to store food items brought in from outside sources for later consumption and the facility did not have a refrigerator designated for the residents to store these food items.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the refuse was stored in a sanitary manner. * The facility failed to ensure the garbage was properly stored in one of three garbage dumpsters. This failure had the potential to attract pest/rodents that carried diseases. Findings: According to the 2022 FDA (Food and Drug Administration) Food Code, the outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Review of the facility's P&P titled Sanitization revised date 11/2022 showed kitchen wastes that are not disposed of by mechanical means are kept in clean, leakproof, nonabsorbent, tightly closed containers and disposed of daily. Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/ compactors with lids (or otherwise covered). Areas used for garbage disposal are free from odors and waste fats and maintained to prevent pests. On 12/3/25 at 1501 hours, an observation and concurrent interview was conducted with the Environmental Services Director. One of three garbage dumpsters was observed with the lid partially propped open by the cardboard boxes, preventing the lid from fully closing. The Environmental Services Director verified the findings and stated the dumpster lids should be completely closed at all times for infection control purposes.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and facility document review, the facility failed to ensure essential equipment were maintained in proper working condition. * The facility failed to ensure the serial number on the glucometer and the serial number on the Daily Quality Control Record for Medication Cart A was accurate. * The facility failed to ensure the glucometer for Medication Cart B was calibrated and quality control was performed. These failures had the potential for the residents requiring blood glucose checks to have inaccurate readings. Findings: Review of the facility's document For GD50 Glucose Monitoring System Manual, undated, showed blood glucose monitoring plays an important role in diabetes control. Long-term study showed that maintaining blood glucose levels close to normal can reduce risk of diabetes complications by up to 60%. The results provided by this system can help the healthcare professional monitor and adjust treatment plan to gain better control of diabetes. The meter provides you with plasma equivalent results. The manual further showed the control solution contains a known amount of glucose that reacts with the test strips and is used to ensure meter and test strips are working together correctly. 1. On 12/8/25 at 1030 hours, an inspection of Medication Cart A, interview and concurrent facility document review was conducted with LVN 1. Review of Medication Cart A's Daily Quality Control Record for December 2025 showed the glucometer serial number on the Daily Quality Control Record 428622027000812C, did not match the glucometer serial number 4286223230001023. LVN 1 verified the above findings and stated the license nurse changed the glucometer but did not update the Daily Quality Control Record. LVN 1 further stated glucometers and the Daily Quality Control Record should match to ensure the residents' blood glucose checks are accurate. 2. On 12/3/25 at 1147 hours, an inspection of Medication Cart B, interview and concurrent facility document review was conducted with LVN 2. LVN 2 stated the license nurses on night shift (2300 to 0700 hours shift) perform glucometer checks to ensure accurate blood glucose readings of the residents. Review of Medication Cart B's Daily Quality Control Record for December 2025 showed on 12/3/25 at 12 AM, the low control reading was 52 and high control reading was 295. The glucometer did not show a low control reading of 52 and high control reading of 295. LVN 2 verified the above findings. On 12/3/25 at 1215 hours, an inspection of Medication Cart B's glucometer, interview, and concurrent facility document review was conducted with RN 1. RN 1 verified the glucometer did not show the low control glucose reading of 52 and the high control glucose reading of 295. RN 1 stated glucometers were calibrated and quality control was completed to ensure the functionality of the glucometer device. On 12/10/25 at 1425 hours, an interview was conducted with the Administrator, DON, and DSD. The Administrator, DON, and DSD were informed and acknowledged the above findings.		

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F 0880 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and facility P&P review, the facility failed to implement their infection control program in accordance with the facility's P&P. * The facility failed to ensure LVN 3 performed appropriate hand hygiene during a medication administration observation. This failure put the residents at risk for increased risk of infection and transmissions of diseases. Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed medications are administered in a safe and timely manner, and as prescribed. The P&P further showed the staff follows established facility infection control procedures including handwashing and antiseptic techniques for the administration of medications. On 12/5/25 at 1600 hours, a medication administration observation and concurrent interview was conducted with LVN 3 at Medication Cart B. During the medication administration, LVN 3 did not perform hand hygiene before and after administering oral medications to Resident 25. LVN 3 verified he did not perform hand hygiene before and after administering the medications to Resident 25 and to two other residents. LVN 3 stated he should have performed hand hygiene to ensure infection control protocols were maintained. On 12/10/25 at 1425 hours, an interview was conducted with the Administrator, DON, and DSD. The Administrator, DON, and DSD were informed and acknowledged the above findings.		