STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055929	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Cove Care Center	1445 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plan was developed and implemented for one of two sampled residents (Resident 1). * The facility failed to implement Resident 1's care plan for the use of dental appliances (dentures) during meals and for the coordination of a dental consult, to assist Resident 1 with obtaining lower dentures, after his readmission to the facility. * The facility failed to develop a comprehensive care plan to address Resident 1's hard of hearing status. These failures placed the resident at risk of not being provided appropriate, consistent, and individualized care. Findings: Review of the facility's P&P titled Care Plans Comprehensive Person Center (undated) showed a comprehensive, person-centered care plan for the resident should be developed by the interdisciplinary team with the input from the resident and his family or legal representative. The comprehensive, person-centered care plan should describe the services that are to be furnished in an attempt to assist the resident attain or maintain that level of physical, mental, and psychosocial wellbeing that the resident desires or that is possible. Medical record review for Resident 1 was initiated on 7/16/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. 1. Review of Resident 1's Care Plan titled Nutritional Risk initiated on 6/26/24, showed Resident 1 had the potential for altered nutrition and/or hydration status related to recent infection and acute hospital stay. Resident 1 was at risk for weight loss. The care plan interventions included to ensure the dental appliances in good repair and in place for meals. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Care Plan problem for dentures revised 6/13/24, showed Resident 1 had upper and lower dentures and was at risk for gum irritation, difficulty chewing, and malnutrition. The care plan goal showed Resident 1 would not have any dental complications through next review. The interventions included dental consult as indicated and Social Services will follow-up with the dental appointment. On 7/16/24 at 1324 hours, an interview was conducted with Resident 1. Resident 1 was asked if he wore dentures. Resident 1 stated he had upper and lower dentures. Resident 1 stated since he was readmitted to the facility on [DATE], he had not had his lower dentures. Resident 1 stated he was uncertain as to where his lower dentures were. Resident 1 stated the staff was aware he did not have his lower dentures. Resident 1 stated he wanted the lower dentures to assist him with eating as it was difficult to eat without his lower dentures. Resident 1 stated however, his lower dentures did not fit well and would like the lower dentures to fit better. On 7/24/24 at 1332 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 1's care plan interventions showed to ensure Resident 1's dental appliances were in good repair and in place for meals and social services would follow up dental consults as indicated. The DON stated she was aware Resident 1 did not have lower dentures since his readmission to the facility on [DATE]. The DON reviewed Resident 1's medical record and verified with the SSD a dental consult for Resident 1 had yet to be arranged. 2. On 7/16/24 at 1324 hours, an observation and concurrent interview was conducted with Resident 1. Resident 1 was observed sitting in his wheelchair in the hallway in front of his room. Resident 1 stated he had difficulty hearing when people spoke to him. Resident 1 stated he needed people to speak loudly and to be positioned close to him when they spoke. Resident 1 stated he believed he was examined in the past for hearing aids. Resident 1 stated he would like to try hearing aids. Review of Resident 1's Social Service Note dated 11/17/23 at 1359 hours, showed the SSA received a text message from Resident 1's RP. Resident 1's RP had requested an update regarding Resident 1. The SSA then provided Resident 1's RP with an update. The update included the following information: an audiologist appointment could be scheduled with Physician 1 who previously suggested hearing aids for Resident 1. Review of Resident 1's Speech-Language Pathology Dysphagia Clinical Bedside Swallowing Evaluation from Acute Care Hospital 1 dated 7/5/24 at 1004 hours, showed per bedside clinical swallow evaluation on 6/17/24, Resident 1 was difficult to assess today due to hard of hearing and poor participation. Review of Resident 1's Speech Therapy Treatment Encounter Notes dated 7/15/24, showed the following precautions: Resident 1 was hard of hearing (no aids). Review of Resident 1's medical record failed to show a comprehensive care plan specific to Resident 1's hard of hearing status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24 at 1332 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 1's medical record showed documentations of Resident 1 hard of hearing. The DON stated at the time when the facility's speech language pathologist documented Resident 1 was hard of hearing on 7/15/24,a care plan specific to Resident 1's hard of hearing status should have been initiated. The DON stated the purpose of initiating a care plan for Resident 1's hard of hearing status was to ensure the facility had a resident specific plan of care to address and provide appropriate interventions for Resident 1's hard of hearing status.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37726 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide dental services to meet the needs of one of two sampled residents (Resident 1). * The facility failed to assist Resident 1 with obtaining the lower dentures since his readmission to the facility. * The facility had failed to conduct a loss or theft investigation specific to Resident 1's lower dentures and failed to coordinate a dental consult for Resident 1. These failures had the potential to negatively affect Resident 1's well-being. Findings: Review of the facility's P&P titled Dental Services (undated) showed the routine and emergency dental services are available to meet the resident's oral health needs in accordance with the resident's assessment and plan of care. The social services representatives will assist the residents with the appointments, transportation arrangements, and reimbursement of the dental services under the State plan if eligible. The dentures will be protected from loss or damage to the extent practicable, while being stored. If the dentures are damaged or lost, residents will be referred for dental services. Documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services, and the reason for the delay. Review of the facility's P&P titled Investigating Incidents of Theft and/or Misappropriation of Resident Property (undated) showed all reports of theft or misappropriation of resident property shall be promptly and thoroughly investigated. The investigation shall consist of at least the following: an interview with the person reporting the missing items; an interview with any witnesses that may have knowledge of the missing items; and a search of the resident's room for the missing items. Medical record review for Resident 1 was initiated on 7/16/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's Care Plan titled Nutritional Risk initiated on 6/26/24, showed Resident 1 had the potential for altered nutrition and/or hydration status related to recent infection and acute hospital stay. Resident 1 was at risk for weight loss. The care plan interventions included to ensure dental appliances in good repair and in place for meals. Review of Resident 1's Care Plan problem for dentures revised 6/13/24, showed Resident 1 had upper and lower dentures and was at risk for gum irritation, difficulty chewing, and malnutrition. The care plan goal showed Resident 1 would not have any dental complications through next review. The interventions included the dental consult as indicated and the Social Services staff to follow up with the dental appointment. Review of Resident 1's Nurse's Note dated 7/3/24 at 1102 hours, showed Resident 1 was transferred to Acute Care Hospital 1. The notes further showed the lower dentures were sent with Resident 1. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Speech-Language Pathology Dysphagia Clinical Bedside Swallowing Evaluation from Acute Care Hospital 1 dated 7/5/24 at 1004 hours, showed Resident 1's bottom dentures were ill-fitting/choking hazard despite use of adhesive. The evaluation recommended forResident 1 not wear the lower dentures and Ok to wear the upper dentures but must have adhesive. Resident 1 was readmitted from Acute Care Hospital 1 on 7/5/24. Review of Resident 1's Inventory of Personal Effects dated 7/5/24, showed Resident 1 was admitted with the upper dentures; however, the form failed to show thedocumentation Resident 1 was admitted with the lower dentures. Review of Resident 1's Speech Therapy Treatment Encounter Note dated 7/15/24, showed Resident 1 refused the lower dentures because they were too loose and did not fit. On 7/16/24 at 1324 hours, an interview was conducted with Resident 1. Resident 1 was asked if he wore dentures. Resident 1 stated he had the upper and lower dentures. Resident 1 stated since he was readmitted to the facility on [DATE], he had not had his lower dentures. Resident 1 stated he was uncertain as to where his lower dentures were. Resident 1 stated the staff was aware he did not have his lower dentures. Resident 1 stated he wanted the lower dentures to assist him with eating as it was difficult to eat without his lower dentures. Resident 1 stated however, his previous lower dentures did not fit well and would like the lower dentures to fit better. On 7/16/24 at 1337 hours, an interview was conducted with CNA 1. CNA 1 stated Resident 1 informed her that he lost his bottom teeth (dentures). CNA 1 stated Resident 1 had not had his lower dentures since having been readmitted to the facility on [DATE]. On 7/24/24 at 1124 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 stated since Resident 1 was readmitted to the facility on [DATE], he had not had his lower dentures. Resident 1 was observed sitting in his wheelchair and LVN 1 asked Resident 1 if he wanted the lower dentures, to which Resident 1 replied, yes . LVN 1 stated in the past Resident 1 had claimed his lower dentures did not fit well. LVN 1 stated the social services was responsible for coordination of replacement the dentures for Resident 1. On 7/24/24 at 1148 hours, an interview was conducted with the DSS. The DSS stated her duties included the coordination of the dental service for residents at the facility, which included Resident 1. The DSS stated Resident 1 was readmitted to the facility on [DATE], and she was aware Resident 1 no longer had his lower dentures. The DSS was asked if she spoke with Resident 1 regarding his lower dentures after the resident was readmitted to the facility on [DATE], to which the DSS replied she had not. The DSS was asked to describe the facility's process specific to when the resident's dentures were missing or lost. The DSS stated she would conduct a theft or loss investigation. The DSS stated the investigation would include an attempt to locate Resident 1's dentures through interviewing the individuals who may have knowledge specific to the location of Resident 1's lower dentures. Interviewees would include Resident 1, facility staff, Resident 1's RP, and Acute Care Hospital 1. The DSS was asked if she had conducted a theft or loss investigation for Resident 1's lower dentures, to which the DSS replied she had not. The DSS was asked if she had set up a dental consult for Resident 1, to which the DSS replied, she had not. Cross reference to F656.