

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055929	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Crystal Cove Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0657</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the care plan reflected the individual care needs for one of six sampled residents (Resident 1).</p> <p>* The facility failed to develop additional or different interventions in the care plan to reduce the risk of falls for Resident 1. This failure posed the risk of not providing the appropriate, consistent, and resident-centered care to the resident.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Falls and Fall Risk, Managing revised 3/2018 showed the staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of fall for each resident at risk or with a history of falls. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant.</p> <p>Closed medical record review for Resident 1 was initiated on 6/10/25. Resident 1 was admitted to the facility on [DATE], and was discharged on 6/9/25.</p> <p>Review of Resident 1's care plan for falls initiated 4/2/25, showed the resident was at risk for falls with or without injury related to altered mental status, antidepressant medication, antihypertensive medication, cardiovascular disease, history of falls, and unsteady gait. The interventions included the Falling Star fall prevention program, educating/reminding the resident to call for assistance with all transfers, keeping the call light within reach, keeping within supervised view as much as possible, and providing verbal reminders/cues to ask for assistance when needed and safety devices as ordered.</p> <p>Review of Resident 1's Change in Condition Evaluation dated 5/3/25, showed Resident 1 had a witnessed fall in front of the nurses' station at 1550 hours. Resident 1 was noted to be agitated and attempting to transfer and get up without staff assistance while in her room. Resident 1 was assisted to the nurses' station for monitoring. Resident 1 continued with the behavior, slid down the wheelchair, and fell on her bottom.</p> <p>Review of Resident 1's Transfer Form dated 5/4/25, showed Resident 1 was transferred to the acute care hospital due to unwitnessed fall at 0300 hours. Resident 1 was readmitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055929
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<p>F 0657</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 1's IDT Note dated 5/8/25, failed to address Resident 1's behavior of episodes of attempting to transfer and get up without staff assistance, and regarding the falls on 5/3 and 5/4/25. The IDT Note further failed to show any action or plan on how to prevent the resident from further fall incidents.</p> <p>Review of Resident 1's MDS assessment Section C &ndash; Cognitive Patterns dated 5/14/25, showed a BIMS score of 2 which meant with severe cognitive impairment.</p> <p>Further review of Resident 1's closed medical record failed to show for an additional or different interventions in the care plan problem and interventions to prevent the resident from further fall incidents.</p> <p>On 6/12/25 at 1057 hours, an interview and concurrent closed medical review was conducted with the DON and ADON. The ADON was asked if any new interventions were provided to prevent the resident from further falls. The ADON was not able to answer. The DON stated they should have reassessed the resident's plan of care for falls. Furthermore, the DON confirmed Resident 1 did not have an updated care plan after the falls on 5/3 and 5/4/25.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services for one of six sampled residents (Resident 1).</p> <p>* The facility failed to ensure the proper interventions were implemented when Resident 1 did not have a BM for more than three days. This failure had the potential to negatively impact the resident's well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Bowel Regimen Management (undated) showed to ensure all the residents in the skilled nursing facility maintain the optimal bowel function through individualized, evidence-based bowel management programs that promote comfort, dignity, and prevent constipation, impaction, or incontinence. The facility shall assess, monitor, and manage each resident's bowel function. The nursing staff shall review the bowel records daily and monitor for no bowel movement for more than or 72 hours, for signs of discomfort, abdominal distention (visible enlargement of the abdomen), or nausea (feeling of sickness in the stomach). Interventions taken and resident responses must be recorded. To notify the MD for any bowel movement abnormalities, or ineffective bowel management regimen.</p> <p>Closed medical record review for Resident 1 was initiated on 6/10/25. Resident 1 was originally admitted to the facility on [DATE], and discharged on 6/9/25.</p> <p>Review of Resident 1's Physician Orders showed the following orders for the bowel management:</p> <ul style="list-style-type: none"> - dated 4/3/25, sennosides-docusate sodium (laxative) tablet 8.6-50 mg, two tablets by mouth two times a day for bowel management. - dated 4/2/25, milk of magnesia suspension (laxative) 400 mg/5 ml, give 30 ml by mouth as needed for constipation once a day. - dated 4/2/25, Dulcolax rectal suppository (medication inserted into a body cavity such as rectum) 10 mg every 24 hours as needed for constipation if milk of magnesia not effective. - dated 4/2/25, Fleet Enema (type of saline used to relieve constipation) 7-19 gm/118 ml, insert rectally as needed for constipation once a day, if Dulcolax suppository was ineffective. <p>Review of Resident 1's Bowel Monitoring Log showed the resident had no BM from 6/1 to 6/6/25.</p> <p>Review of Resident 1's MAR for June 2025 showed Resident 1 was administered the following bowel management medications:</p> <ul style="list-style-type: none"> - Fleet enema 7-19 gm/118 ml as needed for constipation once a day from 6/7/25 to 6/8/25. - Fleet enema 7-19 gm/118 ml at bedtime on 6/9/25. <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Senna-plus (laxative) oral tablet, one time a day from 6/1/25 to 6/9/25.</p> <p>- Enulose Solution (laxative) 10 gm/15 ml, give 30 cc by mouth one time only for constipation for 1 day on 6/7/25.</p> <p>- mineral oil enema rectally, one time only for constipation on 6/7/25.</p> <p>Review of Resident 1's Progress Note dated 6/7/25, showed at 1336 hours, the resident had not had BM in 72 hours. The MD was notified and the new orders included for KUB x-ray to evaluate for constipation.</p> <p>Review of Resident 1's Change in Condition Evaluation dated 6/7/25, showed Resident 1 had no BM for 72 hours. The abdomen appeared slightly distended. The PRN medications were administered for constipation without full effectiveness.</p> <p>Review of Resident 1's Progress Note dated 6/8/25, showed at 2153 hours, the KUB results showed moderate constipation. The resident continued to show increased agitation and screaming episodes. The MD was notified, and the resident was sent to an acute care hospital for disimpaction.</p> <p>Review of Resident 1's Change in Condition Evaluation dated 6/8/25, showed Resident 1 had no sufficient BM in seven days. Resident 1 was having abnormal frequent behaviors, evidence of distress, screaming and grunting, and abdominal distention noted. Resident 1 was administered stool softeners, milk of magnesia, enema, and none had resolved the issue. The MD was notified, and the resident was sent out to the acute care hospital for disimpaction (medical procedure of removing hard and compacted material).</p> <p>On 6/12/25 at 1057 hours, a concurrent interview and closed medical record review was conducted with the DON and ADON. The DON stated the CNAs did the daily bowel movement monitoring of the residents. If the resident had no BM within 48 hours, the system would alert the nurses. The DON confirmed Resident 1 had no BM from 6/1/25 and the interventions were not implemented until 6/6/25.</p>		

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<p>F 0761</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper safe storage of drugs for one of six sampled residents (Resident 6).</p> <p>* LVN 1 left three medications inside a clear cup unattended on Resident 6's bedside table. This failure posed the risk of other residents, visitors or unauthorized facility staff gaining access to the medication.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Administering Medications (undated) showed the medications are administered in a safe and timely manner and as prescribed. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medications.</p> <p>On 6/11/25 at 1204 hours, an observation and concurrent interview was conducted with LVN 1 at Resident 6's bedside. There were yellow, white, and pink tablets observed inside an unlabeled clear cup on top of Resident 6's bedside table. LVN 1 verified the findings and stated the medications should not have been left on the resident's bedside table. Furthermore, LVN 1 stated he should have taken the medications back and administered it when Resident 6 was ready.</p> <p>On 6/12/25 at 1057 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed of the above findings. The DON stated the medications should not be left in the resident's room. The DON stated a self-administration of medication assessment was completed for Resident 6. Resident 6 could not administer their own medication.</p>		