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	10/14/2025

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the discharge medication list was appropriate for one of two sampled residents (Resident 3) reviewed for discharge. * Resident 3's discharge medication list did not include the Verapamil (blood pressure medication), Ambien (medication used to treat insomnia) and oxycodone-acetaminophen (pain reliever medication). This failure had the potential for the resident not receiving appropriate care and proper medication management after the discharge. Findings: On 9/18/25, the CDPH, L&C Department received a complaint alleging upon discharge, Resident 3 was not provided with the Verapamil or Ambien medications upon leaving the facility on 6/12/25. On 10/2/25 at 1256 hours, a telephone interview was conducted with Resident 3. Resident 3 stated she left the faciity on 6/12/25, because the facility did not administer her Verapamil or Ambien medications. Closed medical record review for Resident 3 was conducted on 10/2/25. Resident 3 was admitted to the facility on [DATE], and discharged on 6/12/25. Review of Resident 3's Order Summary Report showed the following orders:- dated 6/11/25, Ambien oral tablet 10 mg, give one tablet by mouth every 24 hours as needed for insomnia manifested by inability to sleep- dated 6/11/25, Ambien oral tablet 10 mg, give one tablet by mouth every 24 hours as needed for insomnia manifested by inability to sleep for 14 days.- dated 6/11/25, oxycodone-acetaminophen oral tablet 10-325 mg, give one tablet by mouth every four hours as needed for moderate pain 4-6 (on the pain scale of 0 to 10 with 0 = no pain and 10 = worst), hold if RR (respiratory rate) less than 12- dated 6/11/25, oxycodone-acetaminophen oral tablet 10-325 mg, give two tablets by mouth every four hours as needed for severe pain 7-10, hold if RR less than 12- dated 6/12/25, Verapamil Extended Release oral tablet 120 mg, give one tablet by mouth two times a day for high blood pressure. Hold if SBP greater than 110 mmHg.- dated 6/12/25, Verapamil oral tablet 120 mg, give 120 mg by mouth in the afternoon for hypertension. Review of Resident 3's H&P examination dated 6/12/25, showed Resident 3's diagnoses included PTSD, anxiety, and high blood pressure. Review of Resident 3's Transfer/Discharge Report dated 6/12/25, showed the following medications were listed on the discharge medication list but not marked as given to the resident upon discharge: - Verapamil 120 mg in the afternoon- Verapamil 120 mg Extended Release 120 mg twice daily- oxycodone-acetaminophen oral tablet 10-325 mg On 10/14/25 at 1709 hours, an interview and concurrent closed medical record review was conducted with RN 1. RN 1 verified Resident 3's Verapamil, Ambien, and oxycodone-acetaminophen medications were not provided to the resident upon the resident's discharge. Cross reference F755.

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

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	10/14/2025

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 0684 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to provide the necessary care and services to ensure one of eight sampled residents (Resident 3) attained and maintained the highest practicable physical well-being * The facility failed to provide documented evidence Resident 3's physician was notified of Resident 3's abnormal blood pressure. Additionally, Resident 3's blood pressure was not retaken when it was documented it was above normal. These failures had the potential to negatively impact the resident. Findings: Closed medical record review for Resident 3 was conducted on 10/2/25. Resident 3 was admitted to the facility on [DATE], and discharged on 6/12/25. Review of Resident 3's Current Weights and Vitals dated 6/11/25, showed Resident 3's blood pressure was 142/86 mmHg. Further review of Resident 3's medical record showed the blood pressure reading on 6/11/25, was the only reading obtained for Resident 3. According to the National Library of Medicine Website, a normal blood pressure reading is usually 120/80 mmHg. Readings above 140/90 mmHg are categorized high blood pressure level 2. Review of Resident 3's H&P examination dated 6/12/25, showed Resident 3's diagnoses included PTSD, anxiety, and high blood pressure. Review of Resident 3's Order Summary Report showed the following orders:- dated 6/12/25, Verapamil Extended Release oral tablet 120 mg, give one tablet by mouth two times a day for high blood pressure. Hold if the SBP greater than 110 mmHg.- dated 6/12/25, Verapamil oral tablet 120 mg, give 120 mg by mouth in the afternoon for hypertension. Review of Resident 3's MAR for June 2025 failed to show the Verapamil medication was administered on 6/12/25. Further review of Resident 3's medical record failed to show documented evidence the resident's physician was notified of the blood pressure reading of 142/86 mmHg on 6/11/25, and the Verapamil medication not administered on 6/12/25. On 10/8/25 at 1551 hours, an interview and concurrent closed medical record review was conducted with LVN 2. LVN 2 verified Resident 3's blood pressure on 6/11/25 was 142/86 mmHg. When asked if Resident 3's blood pressure was taken again or if Resident 3's physician was notified of the above normal blood pressure, LVN 2 verified Resident 3's blood pressure was not retaken or rechecked. On 10/10/25 at 1027 hours, a telephone interview was conducted with the DON. The DON verified there was no documented evidence to show Resident 3's physician was notified of Resident 3's blood pressure on 6/11/25.

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	10/14/2025

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 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	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 interview and medical record review, the facility failed to ensure the pharmaceutical services were provided for two of eight sampled residents (Residents 3 and 4) reviewed for medications. * Resident 3's Verapamil (blood pressure medication) and Ambien (medication used to treat insomnia) were not available for Resident 3 to take. * The controlled medication count sheets for Resident 4's oxycodone were not on file. These failures had the potential for the residents to not receive appropriate care and proper medication management. Findings: 1. On 9/18/25, the CDPH, L&C department received a complaint alleging upon discharge, Resident 3 was not provided with the Verapamil or Ambien medications upon leaving the facility on 6/12/25. On 10/2/25 at 1256 hours, a telephone interview was conducted with Resident 3. Resident 3 stated she left the faciity on 6/12/25, because the facility did not administer her the Verapamil or Ambien medications. Resident 3 further stated she was told by the facility she (Resident 3) would need to see a physician before she could be administered the medications. Closed medical record review for Resident 3 was conducted on 10/2/25. Resident 3 was admitted to the facility on [DATE], and discharged on 6/12/25. Review of Resident 3's Hospital Discharge summary dated [DATE], showed Resident 3's diagnoses included high blood pressure and PTSD. Further review of the Hospital Discharge Summary showed Resident 3 was discharged from the acute care hospital with the following medication orders:- Verapamil Extended Release 120 mg twice daily- Verapamil 120 mg every afternoon- Ambien 10 mg at night as needed for sleep Review of Resident 3's Order Summary Report showed the following orders:- dated 6/11/25, Ambien oral tablet 10 mg, give one tablet by mouth every 24 hours as needed for insomnia manifested by inability to sleep- dated 6/11/25, Ambien oral tablet 10 mg, give one tablet by mouth every 24 hours as needed for insomnia manifested by inability to sleep for 14 days.- dated 6/12/25, Verapamil Extended Release oral tablet 120 mg, give one tablet by mouth two times a day for high blood pressure. Hold if SBP greater than 110 mmHg.- dated 6/12/25, Verapamil oral tablet 120 mg, give 120 mg by mouth in the afternoon for hypertension. Review of Resident 3's H&P examination dated 6/12/25, showed Resident 3's diagnoses included PTSD, anxiety, and high blood pressure. Review of Resident 3's MAR for June 2025 failed to show the Verapamil medication was administered on 6/12/25. On 10/8/25 at 1551 hours, an interview and concurrent closed medical record review was conducted with LVN 2. When asked about Resident 3's Verapamil and Ambien medications, LVN 2 stated the admitting nurse was responsible for obtaining all of Resident 3's medications from the pharmacy. On 10/10/25 at 1027 hours, a telephone interview was conducted with the DON. The DON acknowledged Resident 3 was not administered with the Verapamil medication on 6/12/25. 2. Closed medical record review for Resident 4 was conducted on 10/2/25. Resident 4 was admitted to the facility on [DATE], and discharged home on 6/29/25. Review of Resident 4's H&P examination dated 6/14/25, showed Resident 4's diagnoses included post status fall with left lower extremity fracture and mild cognitive impairment. Review of Resident 4's Order Summary Report showed the following orders:- dated 6/12/25, Roxicodone oral tablet 5 mg, give 0.5 tablet by mouth every six hours as needed for moderate pain (4-6, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst) - dated 6/19/25, oxycodone HCL (Hydrochloride) oral tablet 5 mg, give 0.5 tablet by mouth every six hours as needed for moderate pain (4-6) Review of Resident 4's June 2025 MAR showed Resident 4 was administered the following:- Roxicodone 5 mg medication on 6/12, 6/15, and 6/17/25- oxycodone 5 mg medication on 6/21, 6/23, 6/24, 6/26, and 6/27/25. On 10/14/25 at 1626 hours, an interview and concurrent closed medical record review was conducted with the Medical Records Director. Review of Resident 4's medical record failed to show the Controlled Medication Count Sheets for Resident 4's administration of the Roxicodone and oxycodone medications were included in Resident 4's medical record. The Medical Records Director verified these sheets were not on file and verified the findings.

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	10/14/2025

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 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 ensure infection control practices were maintained for one of eight sampled residents (Resident 2) reviewed for infection control. * LVN 1's shoe was touching Resident 2's suprapubic catheter urine drainage bag. * LVN 1 failed to perform hand hygiene after removing dirty gloves and before putting on clean gloves. * Resident 2's suprapubic catheter urine drainage bag was touching the floor. These failures had the potential for cross-contamination and spread of infectious organisms in the facility.Findings: Review of the facility's P&P titled Handwashing/Hand Hygiene dated 2021 showed hand hygiene was to be performed after touching a resident, after removing a used glove, and before applying a clean glove. Review of the facility's P&P titled Catheter Care, Urinary dated 2001 showed under infection control, catheter tubing must be kept off the floor. On 10/7/25, at 1400 hours, an observation of urinary catheter care and concurrent interview was conducted with LVN 1. During the catheter care observation, Resident 2's suprapubic catheter urine drainage bag was observed touching the floor. Additionally, LVN 1's right shoe was touching Resident 1's suprapubic catheter urine drainage bag. LVN 1 removed the dirty gloves after cleaning Resident 2's suprapubic catheter surgical site and then put on a clean pair of gloves without performing hand hygiene. LVN 1 acknowledged Resident 2's urine drainage bag should not be touching the floor and verified he did not perform hand hygiene in between changing his gloves.