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	12/23/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * RN 1 and LVN 2 failed to wear a gown during the wound care treatment for Resident 3, who had a Stage 3 pressure injury (a full-thickness skin loss where fat tissue is visible, but the bone, tendon, or muscle are not exposed). In addition, there was no EBP signage near the resident's room doorway or bedside to alert the facility staff and/or visitors of the precautions. These failures posed the risk of potential for cross-contamination and spread of infectious organisms in the facility.Findings: Review of the facility's P&P titled Enhanced Barrier Precautions dated 2001 showed the Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms to residents. The Policy Interpretation and Implementation showed the following:- EBPs refer to infection prevention and control interventions designed to reduce the transmission of multi-drug resistant organisms during high contact resident care activities;- EBPs apply when a resident is not known to be infected or colonized with any multi-drug resistant, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained;- Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status;- EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gowns are applied to performing the high contact resident care activity;- Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include: dressing, bathing/showering, providing hygiene or grooming, changing briefs or assisting with toileting, transferring, providing bed mobility, changing linens, prolonged high contact with items in the resident's room, with resident's equipment or with resident's clothing or skin, device care (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.), and wound care (any skin opening requiring a dressing); and- Signs are posted on the door or wall outside the resident's rooms which communicate the type of precautions and PPE required. Medical record review for Resident 3 was initiated on 12/18/25. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3 had moderate cognitive impairment. Review of Resident 3's Wound Care Consult Note dated 12/17/25, showed under the Wound Progress/Details section, Resident 3 was on hospice (specialized care for residents with terminal illnesses) and the skin breakdown was expected and unavoidable at end of life. The wound was reclassified to a Stage 3 pressure injury after debridement (removal of damaged tissue or foreign objects from a wound). Review of Resident 3's plan of care revised on 12/19/25, showed a care plan problem addressing Resident 3's requirement of enhanced barrier precautions (EBP) during high-contact resident care activities due to the presence of sacrococcyx [fused sacrum and coccyx (tailbone)] wound. The interventions included to ensure items for following EBP were in placed (gloves, gown, alcohol-based hand rub, face-shield, signage, trash receptacle, etc.), hand hygiene utilizing alcohol-based hand rub, place EBP notification/signage near resident room doorway to alert staff/visitors of precautions, and to utilize PPE (gown and gloves; face-shield as indicated) during high-contact resident care activities (e. g., dressing, bathing/showering, transferring, hygiene, linen changes, brief changes, toileting assistance, device care, wound care). On 12/19/25 at 0935 hours, a wound care treatment observation for Resident 3 and concurrent interview was conducted with RN 1 and LVN 2. No EBP signage was observed in the resident's room door or at the bedside of Resident 3. RN 1 stated LVN 2 would be assisting in turning Resident 3 during the wound care treatment. RN 1 stated Resident 3 had a Stage 3 pressure injury in the sacrococcyx area, which was reclassified by the wound consultant after the debridement on 12/17/25. RN 1 was observed removing Resident 3's old dressing from the sacrococcyx area while LVN 2 was holding Resident 3. RN 1 and LVN 2 were observed only wearing gloves but no isolation gown. RN 1 was stopped when she was about to clean Resident 3's wound. RN 1 and LVN 2 were asked if they needed to observe any precautions during the wound care treatment. RN 1 and LVN 2 verified the EBP was to be observed for Resident 3, since they were providing high contact resident care. RN 1 and LVN 2 verified they needed to wear the isolation gown and an EBP signage needed to be posted by the resident's room door to alert the facility staff or visitors of the precautions needed to observe or followed to prevent the spread of infection. On 12/19/25 at 1450 hours, an interview was conducted with the IP. The IP stated the EBP was needed to be