STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555751	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newport Subacute Healthcare Center	2570 Newport Blvd Costa Mesa, CA 92627

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 - Minimal harm or potential for actual harm Residents Affected - Few	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, medical record review, facility document review, and facility P&P review, the facility failed to provide the written information on the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which received such requests to the residents and/or their representatives; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request upon the resident transferring to an acute care hospital for three of three sampled residents (Residents 1, 2, and 3) reviewed for discharge. This failure had the potential for the residents to not receive accurate information to determine if they wanted to appeal the transfer or discharge and return to the facility. Findings: Review of the facility's P&P titled Transfer or Discharge Documentation revised December 2016 showed if a resident exercises his or her right to appeal a transfer or discharge notice he or she will not be transferred or discharged while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. When a resident is transferred or discharged from the facility, an appropriate notice is provided to the resident and/or legal representative. a. Closed medical record review for Resident 1 was initiated on 5/23/25. Resident 1 was admitted to the facility on [DATE], and transferred to the acute care hospital on 4/27/25. Review of Resident 1's H&P examination dated 3/4/25, showed the resident did not have the capacity to make decisions. Review of Resident 1's medical record failed to show documented evidence the resident and/or their family member wereprovided the written information of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests. On 5/30/25 at 1216 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified she filled out the Notice of Transfer/Discharge form; however, she did not mail or provide a copy to the family or the resident at the time of the transfer or after the transfer. RN 2 further stated she did not know if someone else provided a written notice or had mailed the copy to the family member. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 1038 hours, a telephone interview was conducted with Family Member 3. Family Member 3 stated she did not receive any written information about the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives the requests. Family Member 3 further stated she was not aware that the facility would not readmit the resident to the facility after discharged to the acute care hospital. Family Member 3 stated Resident 1 was in the acute care hospital until she could find a facility to accept the resident. b. Medical record review for Resident 2 was initiated on 6/4/25. Resident 2 was admitted to the facility on [DATE], and transferred to acute care hospital on 5/2/25. Resident 2 returned to the facility on 5/16/25. Review of Resident 2's H&P examination dated 5/2/25, showed the resident needed assistance in the capacity to make decisions. Review of Resident 2's medical record failed to show documented evidence the resident was provided the written information of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which received such requests. On 6/3/25 at 1530 hours, an interview and concurrent medical record review was conducted with the Subacute Supervisor. The Subacute Supervisor verified Resident 2 was transferred to the acute care hospital on 5/2/25. The Subacute Supervisor verified the Notice of Transfer/Discharge form was filled out; however, it was not signed by the resident or their representative. The Subacute Supervisor stated he did not mail or provide the copy to the resident at the time of the transfer or after the transfer. The Subacute Supervisor further stated he did not know if the MRD provided the written notice of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests or had mailed the copy to the resident or resident's representative. c. Medical record review for Resident 3 was initiated on 6/4/25. Resident 3 was admitted to the facility on [DATE], and transferred to theacute care hospital on 4/6/25. Resident 3 returned to the facility on 4/18/25. Review of Resident 3's H&P examination dated 3/4/25, showed the resident did not have the capacity to make decisions. Review of Resident 3's medical record failed to show documented evidence the resident and/or their representative was provided the written information of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25 at 1121 hours, an interview and a concurrent medical record review was conducted with the Subacute Supervisor. The Subacute Supervisor verified Resident 3 was transferred to the acute care hospital on 4/6/25, and Notice of Transfer/ Discharge form was filled out; however, it was not signed by the resident's representative. The Subacute Supervisor stated the original copy of the Notice of Transfer/Discharge form was sent to the acute care hospital and the duplicate copy was left in the resident's medical record. The Subacute Supervisor stated he did not mail or provide the copy to the resident'srepresentative at the time of the transfer or afterthe transfer. The Subacute Supervisor further stated he did not know if the resident's representative was provided with a written notice about a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests, or if the MRD had mailed a copy to the resident representative. On 6/3/25 at 1325 hours, an interview was conducted with the MRD. The MRD verified Resident 1 was transferred to acute care hospital on 4/27/25, and a copy of the Notice of Transfer/ Discharge form was in Resident 1's medical record. The MRD verified Resident 2 was transferred to the acute care hospital on 5/2/25, and a copy of the Notice of Transfer/ Discharge form was in the resident's medical record. The MRD verified Resident 3 was transferred to the acute care hospital on 4/6/25, and a copy of the Notice of Transfer/Discharge form was in the resident's medical record. The MRD stated the original copy of the Notice of Transfer/Discharge form was sent to the acute care hospital when Residents 1, 2, and 3 were transferred. The MRD further stated the duplicate copy was filed in Residents 1, 2 and 3's medical records. The MRD stated she did not provide any written copy or mail a copy of the Notice of Transfer/Discharge form to Residents 1, 2 and 3 and/or their responsible parties. On 6/3/25 at 1505 hours, a telephone interview was conducted with Family Member 2. Family Member 2 stated he was not provided the written notice about a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests. Family Member 2 further stated the transfer to the acute care hospital was not always clear. The facility would notify him when the resident was already transferred and sometimes, he believed the transfer to the acute care hospital might not have been necessary. On 6/3/25 at 1624 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 follow their post fall protocol for two of 10 sampled residents (Residents 8 and 9). * Resident 8 experienced the falls on 4/20 and 4/22/25. The facility did not implement additional interventions for fall prevention after Resident 8's second fall on 4/22/25. Additionally, Resident 8's post fall neurological assessments were not completed as ordered for the fall on 4/20/25. * Resident 9's post fall neurological assessments were not completed as ordered for falls on 5/16 and 5/29/25. These failures had the potential for the residents to experience additional preventable falls and a potential delay in identification and interventions for post fall head injuries. Findings: 1. Review of thefacility's P&P titled Falls and Fall Risk, Management revised March 2018 showed if fall recursdespite initial interventions, staff will implement additional interventions or indicate why the current approach remains in relevant. Closed medical record review for Resident 8 was initiated on 5/8/25. Resident 8 was admitted to the facility on [DATE], and transferred to an acute care hospital on 4/23/25. a. Review of Resident 8's Health Status Note dated 4/20/25 at 0835 hours, showed at 0750 hours, the resident was found on the floor with his head by his nightstand. Review of Resident 8's Health Status Note dated 4/22/25 at 2215 hours, showed RN 1 was informed by a staff thatthe resident was found on the floor. Review of Resident 8's Health Status Note dated 4/23/25 at 0850 hours, showed the resident was found on the floor. Review of Resident 8's Care Plan Report showed a focus care plan problem initiated on 4/18/25, for a high risk for falls. The care plan problem was revised on 4/20/25, for the resident's bed to be at the lowest position, and for floor mats to be utilized. The care plan problem was revised on 4/21 and 4/23/25, after the resident's third fall. Review of Resident's 8 medical record failed to show additional fall prevention interventions were implemented or indicate showingwhy the current approach remained in use as per the facility's P&P after the resident's second fall on 4/22/25. On 6/4/25 at 1118 hours, an interview and concurrent medical record review was conducted with the Subacute Supervisor. The Subacute Supervisor verified Resident 8's medical record failed to show additional fall prevention interventions were implemented after the resident's second fall on 4/22/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 1154 hours, a telephone interview was conducted with RN 1. RN 1 stated she did not recall the resident and the falls specifically, but stated her process was to document fall interventions. b. Review of Resident 8's Health Status Note dated 4/20/25 at 0835 hours, showed at 0750 hours, the resident was found on the floor with his head by his nightstand. The Health Status Note further showed the physician was notified and ordered a 72-hour neurological assessment. Review of Resident 8's Physicians' Orders showed an order dated 4/20/25, for post-fall neurological assessments to be completed for 72 hours. Review of Resident 8's Health Status Note dated 4/20/25 at 1241 hours, showed the resident was transferred to the acute care hospital for post fall evaluation due to new complaint of a headache. Review of Resident 8's Health Status Note dated 4/20/25, showed at 1700 hours, the resident returned to the facility. Review of Resident 8's Neuro Assessment form initiated 4/20/25, showed the post fall neurological assessments were to be completed at the scheduled times from 4/20/25 at 0750 hours, through 4/22/25 at 2020 hours, for a total of 48 hours. The log showed Resident 8 was at the acute care hospital for the scheduled assessments at 1420 and 1620 hours. The next scheduled neurological assessment at 2020 hours, was not completed when Resident 8 returned to the facility at 1700 hours. In addition, the Neuro Assessment log schedule only was up to 48 hours, not 72 hours, as per the physician's order. On 6/4/25 at 1056 hours, an interview and concurrent medical record review was conducted with the Subacute Supervisor. The Subacute Supervisor verified Resident 8's scheduled post fall neurological assessment was not completed as scheduled on 4/20/25 at 2020 hours, and should have been done. The Subacute Supervisor was unable to find whether the neurological assessment was completed elsewhere in the resident's medical record. On 6/4/25 at 1118 hours, a follow-up interview and concurrent medical record review was conducted with the Subacute Supervisor. The Subacute Supervisor verified Resident 8's Physicians' Orders dated 4/20/25, showed to complete post fall neurological assessments for 72 hours, and the Neuro Assessment log was only up to 48 hours. 2. Medical record review for Resident 9 was initiated on 6/3/25. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's Change of Condition (New) assessments showed the following: - on 5/16/25 at 0715 hours, the resident had an unwitnessed fall. - on 5/29/25 at 1828 hours, the resident had a fall. Review of Resident 9's Physicians' Orders showed the following: - dated 5/16/25, for 72-hour post-fall neurological assessments. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 5/29/25, for 72-hour post-fall neurological assessments. Review of Resident 9's Neuro Assessment log initiated 5/16/25 at 0600 hours, showed the final neurological assessment was completed on 5/18/25 at 0600 hours, for a total of 48 hours of neurological assessments, not 72 hours as ordered. Review of Resident 9's Neuro Assessment log initiated 5/29/25 at 1830 hours, showed the following: - For the three scheduled assessments to be completed every two hours, starting at 2200 hours, the next assessment was completed at 0100 hours (one hours after the scheduled 2400 hours), and the final one was at 0400 hours (three hours later). - The final neurological assessment was completed on 5/31/25 at 1630 hours, 46 hours after the first assessment, not 72 hours as ordered. On 6/4/25 at 1056 hours, an interview and concurrent medical record review was conducted with the Subacute Supervisor. The Subacute Supervisor verified Resident 9's scheduled post fall neurological assessment (for the fall on 5/29/25) was not completed timely. On 6/4/25 at 1118 hours, a follow-up interview and concurrent medical record review was conducted with the Subacute Supervisor. The Subacute Supervisor verified Resident 9's physician's orders dated 5/16 and 5/29/25, for thepost fall neurological assessments to be completed for 72 hours, and verified the Neuro Assessment log only went up to 48 hours.