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	07/02/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary G-tube care and services for three of six sampled residents (Residents 4, 5, and 6) reviewed for enteral feeding. * The facility failed to ensure Residents 4 and 5's G-tube medication ports were kept clean and patent. * The facility failed to ensure the physician's orders to flush enteral feeding with 30 ml before and after medication were followed for Resident 6. These failures posed the risk of developing complications related to enteral feeding. Findings: Review of the facility's P&P titled Maintaining Patency of a Feeding Tube (Flushing) revised 11/2018 showed the purpose of this procedure is to maintain patency of a feeding tube. The person performing this procedure should record the following information in the resident's medical record: 1. The date and time the procedure was performed. 2. Verification of tube placement. 3. Total amount used to flush tube. 4. The name and title of the individual(s) who performed the procedure. 5. All assessment data obtained during the procedure. 6. How the resident tolerated the procedure. 1. Medical record review for Resident 4 was initiated on 7/2/25. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's Order Summary Report showed the following orders: (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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 11/24/20, may change the G-tube feeding administration sets with each bottle as needed. On 7/2/25 at 0850 hours, an observation and concurrent interview for Resident 4 was conducted with CNA 1. Resident 4 was observed lying in bed with a G-tube feeding. The medication port on the G-tube tubing was observed with black substance inside the tubing. CNA 1 stated she did not know about it and verified the findings. On 7/2/25 at 0930 hours, an observation and concurrent interview for Resident 4 was conducted with LVN 1. Resident 4 was observed lying in bed with a G-tube feeding. The medication port on the G-tube tubing was observed with black substance inside the tubing. LVN 1 stated she did not give the medications to Resident 4 this morning and stated the tubing's medication port should be kept clean and needed to be changed. LVN 1 verified the findings. 2. Medical record review for Resident 5 was initiated on 7/2/25. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's H&P examination dated 3/23/25, showed Resident 5 had a G-tube. On 7/2/25 at 1120 hours, an observation and concurrent interview for Resident 5 was conducted with LVN 5. Resident 5 was observed sitting up in bed with a G-tube feeding. The G-tube tubing, specifically the medication port, was observed with black substances inside the tubing. LVN 5 stated the black substances were possibly from the medication stains. LVN 5 stated the G-tube tubing should be changed or kept clean. LVN 5 verified the findings. 3. Medical record review for Resident 6 was initiated on 7/2/25. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's physician's order dated 7/30/24, showed the enteral tubing: flush tubing with 50 ml of water before and after tube feeding two time a day. May use carbonated liquid if water flush is ineffective as needed. Review of Resident 6's physician's order dated 4/15/25, showed the enteral tubing: flush tubing with 30 ml of water before and after medications. Review of Resident 6's MAR for 4/2025 failed to show documentation Resident 6's G-tube was flushed with 30 ml of water before and after medications as ordered by the physician on 4/15/25. Review of Resident 6's physician's order dated 5/14/25, showed to discontinue the order to flush the enteral tubing with 30 ml of water before and after medications. Review of Resident 6's MAR for 5/2025 failed to show documented evidence the staff had flushed the enteral feeding with 30 ml of water before and after the medication administration from 5/1 to 5/10/25. On 7/2/25 at 1300 hours, an interview and concurrent medical record review for Resident 6 was conducted with RN 2. RN 2 stated the admission orders were clarified with Resident 6's physician and carried out by the admission nurse. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/25 at 1400 hours, an interview and concurrent medical record review for Resident 6 was conducted with the DON. The DON stated there was a physician's order to flush tubing with 30 ml of water before and after medications on 4/15/25, and the order to discontinue was received on 5/14/25. The DON stated the licensed nurse who entered the order should have entered the frequency for the flush and clarified the order with Resident 6's physician. The DON was unable to locate documentation of the 30 ml flush before and after medication from 4/15/25 to 5/9/25. The DON acknowledged the licensed nurse should have documented when they flushed the water and followed the physician's order. Resident 6 was sent out to the acute care hospital on 5/10/25. The DON stated the purpose of the water flush before and after medication administration was to maintain the patency and prevent clogging of the enteral tubing. The DON verified and acknowledged the above findings.