

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555751	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2025
NAME OF PROVIDER OR SUPPLIER Newport Subacute Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**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 ensure the safe practices were followed for two of four sampled residents (Residents 1 and 2) when: * The facility failed to provide two staff's assistance as required during a mechanical lift for Resident 1. As a result, Resident 1 fell from the mechanical lift and sustained the acute spinal processes fractures in the cervical and thoracic spines. * The facility failed to ensure the facility's P&P for safe transfers was followed when Resident 2's shower bed was not locked during the resident's transfer from bed to the shower bed. These failures resulted in the actual harm for Resident 1 and placed Resident 2 at risk of serious injuries. Findings: Review of the facility's P&P titled Hoyer Lift dated 2001 showed at least two nursing assistants are needed to safely move a resident with a mechanical lift. Prepare the environment: clear an unobstructed path for the lift machine, ensure there is enough room to pivot, position the lift near the receiving surface, and place the lift at the correct height; place the sling under the resident. Visually check the size to ensure it is not too large or too small; lower the sling bar closer to the resident; attach sling straps to sling bar, according to the manufacturer's instructions; make sure the sling is securely attached to the clips and that it is properly balanced; check to make sure the resident's head, neck and back are supported; before the resident is lifted, double check the security of the sling attachment; examine all hooks, clips or fasteners; check the stability of the straps; and ensure the sling bar is securely attached and sound. 1. Medical record review for Resident 1 was initiated on 7/15/25. Resident 1 was admitted to the facility on [DATE], and discharged to an acute care hospital on 6/28/25. Review of Resident 1's Quarterly MDS assessment under Section GG dated 5/13/25, showed Resident 1 was dependent on the staff's assistance for ADL care. Review of Resident 1's Fall Risk assessment dated [DATE], showed Resident 1 was at high risk for falls. Review of Resident 1's Progress Note dated 6/28/25 around 0845 hours, showed the staff was preparing the medications by the medication cart in front of Room A when the staff had witnessed the resident falling from the sling while being transferred to the shower bed via Hoyer lift by one CNA. Review of Resident 1's Progress Note dated 6/28/25 at 1921 hours, showed in subsequent conversation, the CNA reported she had already transferred Resident 1 from the bed to the Hoyer lift sling and was navigating the lift to position the resident to be transferred to the shower bed when through the momentum of the movement, the sling swung enough to tip Resident 1 out of the sling and on to the floor. The LVN reported being at the medication cart with her back at the resident's room preparing the medications when a loud noise and CNA's voice alerted her. The LVN turned around and witnessed the resident falling from the sling and landing directly on the floor on her back. Review of Resident 1's IDT note dated 6/30/25, showed on 6/28/25 around 0845 hours, while the CNA was preparing the resident for the shower, the resident fell from the Hoyer lift. Upon the investigation, according to the CNA, while she was checking the hook of the sling attached to the Hoyer lift, Resident 1 made a big wiggle of her shoulder and body. The sling made a big swing, resulting in Resident 1 falling on the floor. Review of Resident 1's Hospitalist Discharge Summary note from the acute care hospital dated 7/7/25, showed Resident 1 was being lifted with a lift and accidentally dropped on her back. Upon the evaluation in the acute care hospital, Resident 1 was discovered to have the acute spinal processes fractures in the cervical and thoracic spines. On 7/15/25 at 0950 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON was asked about Resident 1's fall from the mechanical lift used during the transfer on 6/28/25. The DON stated CNA 1 was working with the Hoyer lift and had transferred Resident 1 from the bed to the shower bed by herself. The DON stated there must be two people when transferring a resident using the Hoyer lift. CNA 1 told her that she should have called another staff member for help. On 7/15/25 at 1200 hours, Resident 1 was observed lying on a low air-loss mattress and appeared to be overweight. Resident 1 stated she was back from the acute care hospital. Resident 1 stated she fell from the mechanical lift. Resident 1 was asked if the staff were transferring her with a mechanical lift. Resident 1 stated one staff member was trying to transfer her from the bed to the shower bed with the lift and she fell on her back. On 7/15/25 at 1215 hours, an interview was conducted with LVN 1. LVN 1 stated the resident was bedbound and totally dependent on the staff's assistance for care, including transfers. On 7/15/25 at 1240 hours, an interview and concurrent medical record review for Resident 1 was conducted with the MDS Coordinator. The MDS Coordinator stated Resident 1 was totally dependent on the staff's assistance for care and needed two or more people's assistance for transfers. The</p>		