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	08/08/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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 0604 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 interview, medical record review, and facility P&P review, the facility failed to ensure one of five sampled residents (Resident 1) was free from physical restraints. * The Facility failed to ensure Resident 1 had a physician's order, consent, and completed assessment prior to the use of the right hand mittens. Additionally, the facility failed to initiate a care plan when the right hand mitten was provided to Resident 1. These failures posed the risk for Resident 1 and her responsible party not to be informed of her treatment and potentially compromising the resident's independence and psychosocial well-being.Findings: Review of the facility's P&P titled Use of Restraints revised 12/2007 showed the restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. Examples of the devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, and lap cushions and trays that the resident cannot remove.Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms.Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following:a. The specific reason for the restraint (as it relates to the resident's medical symptom);b. How the restraint will be used to benefit the resident's medical symptom; andc. The type of restraint, and period of time for the use of the restraint.Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use. On 8/6/25 at 1320 hours, Resident 1 was observed in bed with bilateral bedrails by the head of the bed and had a mitten on the right hand. On 8/6/25 at 1325 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 1 had been using the right hand mitten to prevent the resident from pulling her tracheostomy. Medical record review for Resident 1 was initiated on 8/6/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 5/29/25, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed the resident had no functional limitation in her range of motion in both upper and lower extremities. Review of Resident 1's Health Status Notes dated 8/1/25 at 1115 hours, showed the resident had hand mitten on. Review of Resident 1 Order Summary Report dated 8/6/25, failed to show a physician's order for Resident 1's use of the right hand mittens. Further review of Resident 1's medical records failed to show documentation if Resident 1 was assessed and any least restrictive measures were implemented prior to the application of the right hand mitten. Additionally, there was no care plan problem initiated when Resident 1 was provided with the right hand mitten. On 8/6/25 at 1441 hours, an interview and a concurrent record review was conducted with RN 1. RN 1 verified Resident 1's medical record failed to show a consent was obtained, an assessment was completed, and the least restrictive measures were provided prior to the use of the right hand mitten. RN 1 also verified a care plan was not developed to address Resident 1's use of the right hand mitten. On 8/8/25 at 1035 hours, a telephone interview was conducted with Family Member 1. Family Member 1 stated when she went to visit Resident 1, Resident 1 already had a right hand mitten on. Family Member 1 further stated she did not give any consent for the staff to apply the right hand mitten to Resident 1. On 8/8/25 at 1145 hours, an interview was conducted with the Administrator and DON. The Administrator and DON was informed and acknowledged the above findings.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 develop the comprehensive plan of care to reflect the individualized respiratory care needs for one of five sampled residents. * The facility failed to ensure a plan of care was developed to address Resident 1's episodes of pulling out the tracheostomy tube, putting the nasal cannula in the mouth, biting the cannula, and chewing the oxygen tubing. This failure had the potential for not providing Resident 1 the appropriate, consistent, and individualized care and negatively impact the resident's health and well-being.Findings: Review of the facility's P&P titled Care Plan (undated) showed the facility develops a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. The comprehensive care plan has been designed to:a. Incorporate identified problem areas;b. Incorporate risk factors associated with identified problems;c. Build on the resident's strengths;d. Reflect treatment goals and objectives in measurable outcomes;e. Identify the professional services that are responsible for each element of care;f. Prevent declines in the resident's functional status and/or functional levels; andg. Enhance the optimal functioning of the resident by focusing on a rehabilitation program. Medical record review for Resident 1 was initiated on 8/6/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 5/29/25, showed Resident 1 had no capacity to understand and make decisions. The H&P examination further showed Resident 1 had tracheostomy and using supplemental oxygen. Review of Resident 1's Health Status Notes showed the following:- dated 7/27/25 at 1827 hours, resident self-decannulated; - dated 7/28/25 at 0112 hours, since initial night rounds resident was observed biting own cannula multiple times and had caused a displacement of the oxygen;- dated 7/28/25 at 0213 hours, resident was observed chewing the oxygen tubing; - dated 7/30/25 at 1815 hours, the RT observed a white cap in the resident's back of the throat; however, two other RT came to help and saw nothing;- dated 7/30/25 at 1837, the RT reported about the patient possibly chewing and swallowing the trach lavage port;- dated 8/1/25 at 1115 hours, Resident 1's tracheostomy tube was found halfway out; and- dated 8/2/25 at 1429 hours, the white cap were found on 7/31/25 in the resident's mouth. Review of Resident 1's plan of care failed to show if the facility developed a care plan problem to address resident's behavior of pulling out the tracheostomy tube, putting nasal cannula in the mouth, biting the cannula, and chewing the oxygen tubing. On 8/6/25 at 1120 hours, a telephone interview was conducted with Family Member 1. Family Member 1 stated when she visited Resident 1 on 7/27/25 at 1730 hours, Resident 1 was observed with excessive respiratory secretion and coughing more than usual. Family Member 1 stated she called the RT to suction the resident. The RT came and found Resident 1's tracheostomy tube was out and did not know for how long. Family Member 1 stated the RT was unable to put the tracheostomy tube back because the stoma had closed. Family Member 1 further stated when she visited Resident 1 on 7/31/25, she observed Resident 1 was chewing on something. She had called for the RT to check the resident and found a piece of white cap inside the resident's mouth. On 8/6/25 at 1441 hours, an interview and a concurrent record review was conducted with RN 1. RN 1 verified resident got decannulated on 7/27/25. RN 1 verified Resident 1's plan of care failed to show a care plan was developed to address Resident 1's pulling out the tracheostomy tube, putting nasal cannula in the mouth, and biting own cannula, and chewing the oxygen tubing. On 8/6/25 at 1510 hours, an interview and a concurrent record review was conducted with the DON. The DON verified Resident 1's Health Status Notes as above and there was no care plan developed to address the concerns regarding Resident 1's respiratory supplies. The DON stated a care plan should have been developed to ensure the appropriate care was provided for Resident 1. On 8/8/25 at 1145 hours, an interview was conducted with the Administrator and DON. The Administrator and DON 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. (continued on next page)

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F 0689 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 interview and medical record review, the facility failed to ensure the necessary care and services was provided to one of five sampled residents (Resident 1) who was at risk for fall. * The facility failed to notify the physician and responsible party, and initiate a care plan when Resident 1 had an incident where her head was found hanging on the bed. This failure had the potential for the delay in providing the necessary care and services and posed a risk for Resident 1 to sustain serious injury.Findings: Review of the facility's P&P titled Accidents and Incidents - Investigating and Reporting (undated) showed all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The following data, as applicable, shall be included on the Report of Incident/Accident form:a. The date and time the accident or incident took place;b. The nature of the injury/illness (e.g., bruise, fall, nausea, etc.);c. The circumstances surrounding the accident or incident;d. Where the accident or incident took place;e. The name(s) of witnesses and their accounts of the accident or incident; Review of Facility's P&P titled Change in a Resident's Condition or Status revised 12/2016 showed the facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and /or status. The nurse will notify the resident's Attending Physician or physician on call when there has been an accident or incident involving the resident. Review of the facility's P&P titled Falls and Fall Risk, Managing revised on 03/2018 showed based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The section for Resident-Centered Approaches to Managing Falls and Fall Risk showed the staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. Medical record review for Resident 1 was initiated on 8/6/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 5/29/25, showed Resident 1 had no capacity to understand and make decisions. On 8/7/25 at 1147 hours, an interview was conducted with CNA 1. CNA 1 stated on 7/29/25, he remembered Resident 1 was leaning towards the right side of the bed and the RT asked for his assistance to reposition Resident 1. CNA 1 thinks the medication nurse was aware. When asked for Resident 1's position, CNA 1 stated the head and chest towards the right side, leaning close towards the bed. CNA 1 further stated he did not remember everything. On 8/7/25 at 1200 hours, an interview was conducted with LVN 4. LVN 4 stated Resident had no episode of fall in his shift and did not hear or received a report of Resident 1 falling. On 8/7/25 at 1205 hours, a telephone interview was conducted with Family Member 1. According to Family Member 1, she was informed by a family member who stated, Resident 1 was left with her head hanging on the floor and the legs were still on the bed on 7/27/25 at approximately 1840 hours. Family Member 1 further stated she was not informed of the incident until 8/6/25. On 8/7/25 at 1357 hours, an interview was conducted with Family Member 2 who visited a resident in the same room as Resident 1. Family Member 2 stated on 7/29/25 as he walked in the room, he saw a medical personnel went out of the room. He observed Resident 1 with her head hanging off the bed and touching the floor. Family Member 2 stated no one had returned to the room after 10 minutes, and the resident head was still hanging; he thought the medical personnel called for help for the resident. Family Member 2 further stated he went out the door to call for someone to help Resident 1. Family member 2 stated two facility staff came in to assist the resident. Family Member 2 further stated he reported the incident to the Administrator a day or two after, then to the DON the following day. Review of Resident 1's Health Status Notes showed the following:- dated 8/6/25 at 1932 hours, Family Member 1 reported an incident to the nurse. According to Family Member 1 she was told by a visitor of an incident where Resident 1's head tilted downwards and dangling from the bed, after several minutes the facility staff came and repositioned Resident 1 back to bed in safe position. The note further showed the RN and LVN completed a full body assessment and there were no new findings to report;- dated 8/6/25 at 1951 hours, the nurse was told by Family Member 1 Resident had a fall on a Tuesday (7/29/25) evening around 1900 hours. The note further showed a body assessment was performed on Resident 1 and there were no new visible wounds, swelling or bruising; and- dated 8/6/25 2100 hours, a new order was received from the physician for Resident

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **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 necessary care/services were performed prior to the use of the bedrails for one of five sampled resident (Resident 1). * The facility failed to ensure Resident 1 had a physician's order, consent, and assessment prior to the use of the bilateral upper bedrails. Additionally, the facility failed to initiate a care plan when the bilateral upper bedrails were provided to Resident 1. These failures had the potential to put Resident 1 at risk for serious injury.Findings: Review of the facility's P&P titled Proper Use for Bed Rails revised 8/2022 showed the use of the bed rails is prohibited unless the criteria for use of the bed rails have been met. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. The resident assessment also determines potential risks to the resident associated with the use of bed rails, including the following:a. Accident hazards:(1) The resident could attempt to climb over, around, between, or through the rails, or over the foot board; and/or (2) A resident or part of his/her body could be caught between rails, the openings of the rails, or between the bed rails and mattress.b. Restricted mobility:(1) Hinders residents from independently getting out of bed thereby confining them to their beds; (2) Creates a barrier to performing routine activities such as going to the bathroom or retrieving items in his/her room, eating, hydration and/or walking; (3) Decline in resident function, such as muscle functioning/balance; and/or(4) Skin integrity issues. c. Psychosocial outcomes: (1) Creates an undignified self-image and alters the resident's self-esteem; (2) Contributes to feelings of isolation; and/or (3) Induces agitation or anxiety.Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent:a. The assessed medical needs that will be addressed with the use of bed rails;b. The resident's risks from the use of bed rails and how these will be mitigated;c. The alternatives that were attempted but failed to meet the resident's needs; andd. The alternatives that were considered but not attempted and the reasons. On 8/6/25 at 1320 hours, Resident 1 was observed in bed with the bilateral upper bedrails elevated. On 8/6/25 at 1325 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 1 had been using the bilateral upper bedrails to prevent Resident 1 from falling. Medical record review for Resident 1 was initiated on 8/6/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 5/29/25, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed resident had no functional limitation in her range of motion in both upper and lower extremities. Review of Resident 1's Order Summary Report dated 8/6/25, failed to show a physician's order for Resident 1's use of the bilateral upper bedrails. Further review of Resident 1's medical records failed to show documentation if Resident 1 was assessed and any least restrictive measures were implemented prior to the application of the bilateral upper bedrails. Additionally, there was no care plan problem initiated to address Resident 1's use of the bilateral upper bedrails. On 8/7/25 at 1426 hours, an interview and concurrent record review was conducted with the DON. The DON verified Resident 1's medical record failed to show documentation of the assessment, physician's order, and informed consent prior to Resident 1's use of the bilateral upper bedrails. On 8/8/25 at 1145 hours, an interview was conducted with the Administrator and DON. The Administrator and DON was informed and acknowledged the above findings.