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	12/09/2025

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. (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 0693 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, medical record review, and facility P&P review, the facility failed to ensure one of seven sampled residents (Resident 1) was provided the necessary GT services. * The facility failed to ensure Resident 1 was administered the TwoCal HN (a nutritional supplement that is calorie and protein dense) enteral feeding as per the physician's order and failed to ensure it was documented in the MAR. These failures had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Enteral Tube Feeding via Gravity revised November 2018 showed the person performing this procedure should record the following information in the resident's medical record:- The date and time the procedure was performed.- Verification of tube placement.- Amount and type of enteral feeding and amount of flush.- The name and title of the individual(s) who performed the procedure.- All assessment data obtained during the procedure.- How the resident tolerated the procedure.- If the resident refused the procedure, the reason(s) why and the intervention taken.- The signature and title of the person recording the data. Review of the facility's P&P titled Charting and Documentation revised July 2017 showed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Review of the facility's P&P titled Administering Medications revised April 2019 showed the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. On 12/1/25, the CDPH, L&C Program received a complaint alleging Resident 1 was denied a food supplement that was supposed to be given every three hours. Medical record review for Resident 1 was initiated on 12/4/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 9/18/25, showed the resident had no capacity to understand and make decisions. Review of Resident 1's Order Summary Report showed the following physician's enteral feed orders:- dated 10/17/25, to provide 3300 kcal/1659 ml TwoCal HN 237 ml every two hours daily; and- dated 11/22/25, to provide 3300 kcal/1659 ml TwoCal HN 237 ml every three hours daily. Review of Resident 1's Progress Note dated 11/10/25, showed per the resident's family, the resident ate a big lunch and bolus feeding was not necessary. Review of Resident 1's MAR for November 2025 showed the above enteral feed orders were not administered to Resident 1 on the following dates:- 11/10, 11/12, 11/16, 11/22, and 11/26/25 at 1800 hours;- 11/14/25 at 2100 hours; and- 11/15/25 at 1200 hours. Review of Resident 1's Progress Note dated 11/26/25, showed the resident's enteral feeding scheduled at1800 hours was given at 1900 hours due to Resident 1's family member requesting the nurse to come back in 20 minutes. The nurse continued with medication administration and came back at 1900 hours to administer the enteral tube feeding. On 12/9/25 at 0914 hours, a telephone interview was conducted with LVN 4. LVN 4 stated she was just hired two weeks ago and did not recall the resident. On 12/9/25 at 1001 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified the MAR showed the enteral feed orders were not administered to Resident 1 on 11/10, 11/12, 11/16, 11/22, and 11/26/25 at 1800 hours, 11/14/25 at 2100 hours, and 11/15/25 at 1200 hours. RN 3 stated she was not sure why the MAR was blank on the those dates. RN 3 further stated the licensed nurses sometimes gave the enteral tube feeding and then forgot to sign. RN 3 stated the licensed nurse should have signed the MAR. RN 3 stated if the MAR was not signed, it was not done. On 12/9/25 at 1241 hours, a telephone interview was conducted with LVN 5. LVN 5 stated she did not remember what she documented. LVN 5 further stated sometimes when that happens, her guess was she forgot to sign. LVN 5 stated Resident 1's family member usually tell the licensed nurse when to give Resident 1's enteral tube feeding. LVN 5 stated she always gave Resident 1's enteral tube feeding unless the resident was not in the facility. LVN 5 stated she should have documented or signed the MAR right away. On 12/9/25 at 1405 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged above findings. The DON stated the licensed nurse should also document if the resident refused and should not leave the MAR blank.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **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 seven sampled residents (Resident 1) had accurate and complete medical records. * The facility failed to ensure Resident 1's MAR documentation regarding multiple medication orders were completed. This failure had the potential for the resident's health care needs not be met as the medical record was incomplete and inaccurate. Findings: Review of the facility's P&P titled Administering Medications revised April 2019 showed the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. Review of the facility's P&P titled Charting and Documentation revised July 2017 showed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Medical record review for Resident 1 was initiated on 12/4/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 9/18/25, showed the resident had no capacity to understand and make decisions. Review of Resident 1's Order Summary Report showed the following physician's orders:- dated 9/17/25, to administer multivitamin-minerals (supplement) oral tablet. Give one tablet by mouth one time a day for supplement;- dated 9/17/25, to administer lactobacillus (a medication to aid digestive system) oral tablet. Give one tablet by mouth one time a day for supplement;- dated 9/17/25, to administer famotidine (antacid) oral tablet 20 mg. Give one tablet via GT two times a day related to GERD without esophagitis; and- dated 11/2/25, to administer Docuprene (stool softener) oral tablet 100 mg (docusate sodium). Give one tablet via GT two times a day for bowel management. Review of Resident 1's MAR for November 2025 showed the above medications were not administered to Resident 1 on 11/26/25. On 12/9/25 at 0914 hours, a telephone interview was conducted with LVN 4. LVN 4 stated she was just hired two weeks ago and did not recall the resident. When asked if she missed a dose of a resident's medication, LVN 4 answered no. On 12/9/25 at 1001 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified the MAR showed the multivitamin-minerals, lactobacillus, famotidine, and Docuprene medications were not administered to Resident 1 on 11/26/25. RN 3 stated Resident 1's family told LVN 4 to give the medications after Resident 1's shower. RN 3 stated Resident 1's family member followed up with LVN 4 and she saw LVN 4 prepared the medications before giving it to Resident 1. RN 3 stated the licensed nurse should have documented the medication she administered the medications in the MAR. On 12/9/25 at 1405 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged the above findings. The DON stated the licensed nurse should have signed the MAR, put a progress note to prove, and document the resident received the medication.