| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555751 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Newport Subacute Healthcare Center | 2570 Newport Blvd<br>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) |
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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**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 five sampled residents (Resident 1) reviewed for restraints was free from physical restraints. * The facility failed to ensure the use of physical restraints was based upon identified medical symptoms. Additionally, the facility failed to conduct an assessment to determine the existence of medical symptoms, attempt less restrictive measures, and develop a care plan for Resident 1's bilateral hand mittens. * The facility failed to inform Resident 1's responsible party of the potential risks and benefits and obtain consent for the use of Resident 1's bilateral hand mittens. * The failed to document the length of time the restraint was anticipated to be used, failed to identify who could apply the restraint, when the restraint could be applied and how the restraint was to be used. In addition, the facility failed to document Resident 1's circulation, mobility, and skin when bilateral mittens were used. These failures posed the risk of compromising the resident's independence and psychosocial well-being.Findings: Review of the facility's P&P titled Use of Restraints, revised on 4/2017 showed the following:- physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot move easily, which restricts freedom of movement or restricts normal access to one's body;- examples of 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;- restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to treat the medical symptom, protect the resident's safety, and help resident attain the highest level of his/her physical or psychological well-being;- 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 symptoms and to determine if there are less restrictive interventions that may improve the symptoms;- treatment restraints may be used for the protection of the resident during treatment and diagnostic procedures if the resident and/or representative has consented to the treatment or procedure and the use of treatment restraints;- restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. The order shall include the specific reason for the resident as it relates to the resident's medical symptom, how the restraint will be used to benefit the resident's medical symptom, and the type of restraint and period for the use of the restraint;- the following safety guidelines shall be implemented and documented while a resident is in restraints. The opportunity for motion and exercise is provided for a period of not less than 10 minutes during each two hours in which restraints are employed;- restraints and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration,<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | including the use of restraints, not using restraints, and the alternatives to restraint use;- restrained individuals shall be reviewed regularly at least quarterly to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination;- care plans for residents in restraints will reflect interventions that address not only the immediate medical symptoms, but the underlying problems that may be causing the symptoms. Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use; and- documentation regarding the use of restraints shall include full documentation of episode leading to the use of physical restraint, a description of the resident's medical symptoms that warranted the use of restraints, how the restraint use benefits the resident by addressing the medical symptom, type of the physical restraint used, the length of effectiveness of the restraint time, and observation, range of motion, and repositioning flow sheets. On 2/10/26 at 0940 hours, during the initial tour, Resident 1 was observed lying in bed, awake, and nonverbal. Resident 1 was observed with bilateral hand mittens on. Medical record review for Resident 1 was initiated on 2/10/26. Resident 1 was admitted to the facility on [DATE], readmitted on [DATE]. Review of Resident 1's H&P examination dated 10/7/25, showed Resident 1 did not have the capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1's BIMS score was 0 indicating severe cognitive impairment. Review of Resident 1's Order Summary Report showed physician's order dated 2/10/25, for hand mittens to prevent from pulling out medical devices. However, the physician's order failed to show medical symptoms, frequency, duration, and monitoring for the use of bilateral hand mittens. Further review of Resident 1's medical record failed to show an assessment was conducted for the use of bilateral hand mittens. Additionally, there was no documented evidence the least restrictive measures were used prior to using the restraints. There was no documented evidence Resident 1's responsible party was notified of the potential risks and benefits and consented to the use of the restraints. Resident 1's medical record failed to show a care plan was developed for the use of bilateral hand mittens. On 2/10/26 at 1119 hours, an observation of Resident 1 and concurrent interview was conducted with LVN 1. LVN 1 verified Resident 1 was wearing bilateral hand mittens. LVN 1 stated Resident 1 had episodes of pulling the tracheostomy tubing. On 2/10/26 at 1505 hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 1. LVN 1 verified Resident 1's medical record failed to show the medical symptoms, frequency, duration, and monitoring for the use of bilateral hand mittens. In addition, Resident 1's medical record failed to show an assessment was conducted for the use of bilateral hand mittens, documentation of least restrictive measures used before using the restraints, notification of Resident 1's responsible party for the potential risks and benefits and obtaining the consent. Furthermore, a care plan was not developed for the use of bilateral hand mittens. LVN 1 verified the above findings. Furthermore, LVN 1 stated it was considered a physical restraint when required assessments were not completed and consent was not obtained. On 2/11/26 at 1432 hours, an interview was conducted with the DON. The DON stated all licensed staff must follow facility's restraint policy for new admit and readmit residents. In addition, the DON stated the facility staff must start with least restrictive measures prior to applying the restraint. On 2/11/26 at 1630 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**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 the medical records were complete for two of seven sampled residents (Residents 2 and 5). * The facility failed to ensure Resident 2's MAR and TAR were complete. * The facility failed to ensure Resident 5's progress notes were complete. These failures had the potential for the residents' health care needs to not be met as the medical records were incomplete.Findings:<br><br>Review of the facility's P&P titled Charting and Documentation revised 7/2017 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. The Policy Interpretation and Implementation section showed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.The following information is to be documented in the resident medical record: medications administered and treatments or services performed.<br><br>1. Review of the facility's P&P titled Administering Medications revised 4/2019 showed the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next one.<br><br>Medical record review for Resident 2 was initiated on 2/10/26. Resident 2 was admitted to the facility on [DATE].<br><br>Review of Resident 2's Order Summary Report showed the following orders:<br><br>- dated 11/26/25, Polyethylene Glycol 3350 powder (laxative medication), give 17 grams via GT one time a day for bowel management;<br><br>- dated 11/26/25, Pro-Stat Sugar Free oral liquid (protein supplement), give 30 ml via G-Tube one time a day for supplement;<br><br>- dated 11/26/25, Sennosides oral tablet 8.6 mg (laxative medication), give two tablets via GT at bedtime for bowel management;<br><br>- dated 11/26/25, Famotidine oral tablet 20 mg (indigestion medication), give one tablet via GT two times a day for GERD;<br><br>- dated 11/26/25, Sinemet Oral Tablet 25-100 mg (tremor medication), give one tablet via GT every eight hours for Parkinson's Disease;<br><br>- dated 11/26/25, Chlorhexidine Gluconate Mouth/Throat Solution 0.12% (mouthwash), give 5<br><br>ml orally every shift for oral care;<br><br>- dated 11/26/25, Ammonium Lactate External Lotion 12% (moisturizer lotion), apply to generalized body topically every day shift for generalized dryness; and<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - dated 12/11/25, GT site care, cleanse with normal saline and pat dry, apply T-drain dressing daily and as needed for maintenance every shift.<br><br>Review of Resident 2's H&P examination dated 11/27/25, showed the resident did not have the capacity to understand and make decisions.<br><br>Review of Resident 2's MAR for January to February 2026 showed the following medications were not signed as administered on the following dates:<br><br>- Polyethylene 17 grams was not signed as administered on 1/2, 1/16, 1/17, 1/18, 1/28, 2/4, 2/6, 2/8, 2/9/26 at 1700 hours;<br><br>- Pro-Stat Sugar Free Oral Liquid 30 ml was not signed as administered on 1/2, 1/16, 1/17, 1/18, 1/28, 2/4, 2/6, 2/8, 2/9/26 at 1700 hours;<br><br>- Sennosides Oral Tablet 8.6 mg was not signed as administered on 1/13, 1/16, 1/17, 1/24, 1/30, 1/31, 2/1, 2/6, 2/7, 2/8, 2/9/26 at 2100 hours;<br><br>- Famotidine oral tablet 20 mg was not signed as administered on 1/13, 1/16, 1/17, 1/24, 1/30, 1/31, 2/1, 2/6, 2/7, 2/8, 2/9/26 at 2200 hours;<br><br>- Sinemet Oral Tablet 25-100 mg was not signed as administered on 1/13, 1/16, 1/17, 1/24, 1/30, 1/31, 2/1, 2/6, 2/7, 2/8, 2/9/26 at 2200 hours; and<br><br>- Chlorhexidine Gluconate Mouth/Throat Solution 0.12% was not signed as administered on 1/16, 1/30, 1/31, 2/1, 2/6, 2/7 and 2/8/26 at night time.<br><br>Review of Resident 2's TAR for January to February 2026 showed the following treatments were not signed as administered on the following dates:<br><br>- Ammonium Lactate External Lotion 12% was not signed as administered on 1/1, 1/2, 1/15 and 2/4/26; and<br><br>- GT site care was not signed as administered on 1/1, 1/2, 1/15 and 2/4/26.<br><br>On 2/10/26 at 1601 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 1. RN 1 stated staff should document after they administered the medications or treatments.<br><br>On 2/11/26 at 1432 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified the multiple gaps and incomplete documentation in the MAR and the TAR for January and February 2026.<br><br>2. Closed medical record review for Resident 5 was initiated on 2/10/26. Resident 5 was admitted to the facility on [DATE], and discharged on 2/6/26.<br><br>Review of Resident 5's H&P examination dated 9/18/25, showed the resident did not have the capacity to understand and make decisions.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident 5's Progress Notes from 10/23/25 to 1/4/26, showed six health status notes and one IDT note was incomplete.<br><br>On 2/11/26 at 1406 hours, an interview and concurrent closed medical record review for Resident 5 was conducted with the DON. The DON stated view draft in Resident 5's progress notes meant the staff did not sign their notes. The DON verified Resident 5's six health status notes and the IDT note from 10/23/25 to 1/4/26 were incomplete. The DON stated the staff should have gone back, sign, and close the charting. The DON further stated the medical record was open for somebody to alter because it was not signed. The DON stated the medical record staff should have audited the medical record and the audit should have been done every day. |