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	04/06/2026

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 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 observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical record was accurate for one of five sampled residents (Resident 1). * The facility failed to ensure Resident 1's physician's progress notes were accurate. In addition, Resident 1's Task Documentation had multiple missing entries. These failures had the potential for the resident's care needs to not be met as their medical information was inaccurate and incomplete. Findings: Review of the facility's P&P titled Charting and Documentation dated 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. Documentation in the medical record will be objective, complete and accurate. Medical record review for Resident 1 was initiated on 4/1/26. Review of Resident 1's Facesheet dated 4/1/26, showed Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 6/27/25, showed Resident 1 had the capacity to understand and make decisions. a. Review of Resident 1's Progress Notes showed the following:- dated 3/26/26 at 1331 hours, MD 1 documented a system review, laboratory and chest x-ray results. System review for Resident 1 showed a Shiley XLT size 7 cuffed (tracheostomy) on the neck, ongoing treatment to the tracheostomy, GT skin, Foley catheter, with diagnosis of chronic respiratory failure, perforation of the esophagus, pyothorax without fistula, oxygen at a rate of three liters per minute FIO2 via T-bar with humidifier as tolerated daytime only and enhanced barrier precaution for history of candida auris;- dated 3/20/26, a late entry for 3/3/26 at 1310 hours, MD 1 documented a system review for Resident 1 which showed a Shiley XLT size 7 cuffed (tracheostomy) on the neck, ongoing treatment to the tracheostomy, GT skin, Foley catheter, with diagnosis of chronic respiratory failure, perforation of the esophagus, pyothorax without fistula, oxygen at a rate of three liters per minute FIO2 via T-bar with humidifier as tolerated daytime only and enhanced barrier precaution for history of Candida Auris; and- dated 2/24/26 at 1449 hours, MD 1 documented a system review for Resident 1 which showed a Shiley XLT size 7 cuffed (tracheostomy) on the neck, ongoing treatment to the tracheostomy, GT skin, indwelling urinary Foley catheter, with diagnosis of chronic respiratory failure, perforation of the esophagus, pyothorax without fistula, oxygen at a rate of three liters per minute FIO2 via T-bar with humidifier as tolerated daytime only and enhanced barrier precaution for history of Candida Auris. Review of Resident 1's Order Summary Report dated 4/1/26, did not show Resident 1 had orders for tracheostomy, GT, indwelling urinary Foley catheter, oxygen to be administered via T-bar, and enhanced barrier precaution due to history of Candida Auris. On 4/1/26 at 1523 hours, an observation was conducted for Resident 1 in his room. Resident 1 was observed with no tracheostomy, GT, indwelling urinary Foley catheter, oxygen via T-bar and did not have a sign for enhanced barrier precaution outside of Resident 1's door. On 4/2/26 at 1103 hours, an interview with concurrent medical record review for Resident 1 was conducted with the Medical Records Director. The Medical Records Director verified the physician's progress notes written on 2/24, 3/10, and (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/26/26 were inaccurate. Medical Records Director stated, that's a big mistake, I will speak to MD 1. The Medical Records Director further stated, I know the resident never had a tracheostomy and all of these, maybe he was thinking of another resident. On 4/2/26 at 1120 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified the documentation in the physician's progress notes dated 2/24, 3/10, and 3/26/26 were inaccurate. The DON stated the MDS nurses check the progress notes, H&P documentations during assessment. When asked what happened to these notes, DON stated it was not read. b. Review of Resident 1's CNA Task Document Survey Report showed the following:* dated 3/21/26, on the day shift for the bathing, there were missing entries for Resident 1's self- performance, support provided and the CNA initials.* dated 3/21/26, on the day shift; 3/13 and 3/29/36, on the evening shift; and 3/31/26, on the night shift, there were missing entries for the following tasks:- bladder continence - Resident 1's urinary continence, toileting used, perineal care provided and the CNA initials, and if Resident 1 had indwelling urinary catheter, the amount of the urine output, and the CNA initials; and - bowel movements - Resident 1's bowel movement, the number of, size and consistency of the bowel movements and the CNA initials.* dated 3/21/26, on the day shift; and 3/13 and 3/29/36, on the evening shift, there were missing entries for the following tasks: - bed mobility - Resident 1's self-performance, the support provided and CNA initials;- bowel continence - Resident 1's bowel continence, toileting used and the CNA initials; - corrective lenses - if Resident 1 is wearing the lens, refused, lenses not available or not applicable and the CNA initials;- dental - if Resident 1 had dentures and the CNA initials; - dressing - Resident 1's self- performance, the support provided and CNA initials;- locomotion off unit - Resident 1's self- performance, the support provided and CNA initials;- locomotion on unit - Resident 1's self- performance, the support provided and CNA initials;- personal hygiene - Resident 1's level of assistance in hair care, nail care, oral care and shaving and the CNA initials.- rejection of care - if Resident 1 refused or rejected ADL care and the CNA initials;- skin observation - if Resident 1 had new skin problems noted and the CNA initials; - toilet use - Resident 1's self- performance, the support provided and CNA initials;- transfers - Resident 1's self-performance, the support provided and CNA initials;- walk in corridor - Resident 1's self- performance, the support provided and CNA initials;- walk in room - Resident 1's self- performance, the support provided and CNA initials;- amount eaten / eating performance - Resident 1's percentage of meal eaten, self-performance and the support provided and CNA initials; and- nourishments - Resident 1's percentage of snacks taken, if nourishment was offered, and fluids were taken, and the CNA initials. On 4/2/26 at 1103 hours, an interview and concurrent medial record review for Resident 1 was conducted with the Medical Records Director. The Medical Records Director verified the missing entries in Resident 1's Task Documentation Summary. The Medical Records Director stated CNAs should have completed the documentation. On 4/2/26 at 1245 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.