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	04/21/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **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 provide the pharmaceutical services to meet the resident's needs for one of nine sampled residents (Resident 2). * The facility failed to obtain a physician's order for the administration of cough medication for Resident 2. In addition, the facility failed to follow its Medication Administration P&P when Resident 2's cough medicine was left at bedside table, despite the resident not being assessed or approved to self-administer medications. These failures had the potential to result in negative outcomes for the resident.Findings: Review of facility's P&P titled Medication Administration revised 4/2019 showed medications are administered in accordance with prescriber orders, including any required time frame. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. On 4/15/26 at 0858 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 2. Resident 2 was observed awake in bed and stated she was not feeling well, with occasional coughing observed. A medicine cup containing a half-full amount of cherry-colored liquid and a second medicine cup containing two unlabeled red capsules were observed on top of the bedside table. When asked about the medications, Resident 2 stated the liquid was cough medicine and the capsules were her stool softeners. Resident 2 stated the licensed nurse provided the medications that morning and left them at her bedside because she preferred to take the cough medicine a little at a time. Medical record review for Resident 2 was initiated on 4/15/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS dated [DATE], showed Resident was cognitively intact. Review of Resident 2's Self Administration assessment dated [DATE], showed the resident did not wish to self-administer her own medications and not capable of self-administering medication. Review of Resident 2's Order Summary Report dated 4/15/26, showed a physician's order dated 6/12/24, to administer docusate sodium (stool softener) oral capsule 250 mg by mouth two times a day for bowel management. Further review of Resident 2's Order Summary Report failed to show a physician's order for cough medication or an order for Resident 2's to self-administer medication. On 4/15/26 at 1121 hours, an interview and concurrent medical record review for Resident 2 was conducted with LVN 1. LVN 1 stated she observed the medications at the start of her shift. LVN 1 stated the resident told her she was coughing and the night shift nurse gave her cough medication. LVN 1 stated she had not received any report from the night shift that the resident was coughing or that cough medication had been administered. LVN 1 was asked to show documentation Resident 2 had a change of condition related to coughing. LVN 1 reviewed the resident's medical record, which failed to show documentation about resident coughing. LVN 1 verified the physician had not been notified, no order had been obtained for cough medication, and the medication should not have been left at the bedside. On 4/15/26 at 1425 hours, an interview and concurrent review of medical record for Resident 2 was conducted with RN 1. RN 1 stated she did not receive any endorsement from the previous shift regarding Resident 2's coughing or administration of cough medication. RN 1 reviewed the communication logbook and found there was no related information about the resident's cough. RN 1 verified the night shift did not notify (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the physician or obtain an order for cough medication. RN 1 stated the day shift nurse later notified the physician and obtained an order. RN 1 verified the cough medication had been administered without a physician's order and acknowledged there was no order for the resident to self^administer medications. On 4/15/26 at 1550 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON was informed and verified the above findings.