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	05/08/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed medical record review, and the facility P&P, the facility failed to ensure an injury of unknown source was reported for one of nine sampled residents (Resident 1). * The facility failed to report an incident of unknown source when the facility was informed by the acute care hospital of Resident 1's admission to the ICU related to subdural hematoma. This failure had the potential for the injury of unknown origin to go unreported and posed a delay in the injury prevention to other residents.Findings: Review of the P&P titled Accidents and Incidents Investigating and Reporting dated 2001 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 shall promptly initiate and document investigation of the accident or incident. Review of the facility's P&P titled Unusual Occurrence revised 12/2007 showed as required by state or federal regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees, or visitors. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current laws and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations. Review of the facility's P&P titled The Reporting and Abuse Prevention (undated) showed all alleged violations including injuries of unknown source, such as skin tears, bruises, and abrasions on residents who cannot speak for themselves, or misappropriation of resident property as reported to the administrator, or designated representative as outlined in this policy and procedure. Evidence that alleged violations are investigated and necessary correction is maintained in facility files. Notification of the incident of abuse will be reported to the Department of Health licensing and certification unit, within five calendar days of the incident by mail, following a fax reporting the incident. Closed medical record review for Resident 1 was initiated on 5/1/26. Resident 1 was readmitted to the facility on [DATE], and discharged on 4/30/26. Review of Resident 1's H&P examination dated 1/18/26, showed the resident had no capacity to make medical decisions. Review of Resident 1's MDS assessment - Section GG for Functional Abilities dated 4/15/26, showed Resident 1 was dependent in self-care and mobility. Review of Resident 1's Progress Notes showed the following:- dated 4/23/26 at 2120 hours, showed Resident 1 was discharged to the acute care hospital for an elevated heart rate at 140 beats per minute and increased work of breathing (body is exerting extra effort to breathe). The note further showed Resident 1 was tachypneic (rapid breathing) on the ventilator breathing rate of 25-30 breaths per minute; and - dated 4/24/26 at 1131 hours, showed the nurse called the acute care hospital. The facility was informed of Resident 1's admission to the acute care hospital ICU related to subdural hematoma. On 5/1/26 at 1635 hours, an interview was conducted with the DON. The DON stated Resident 1 had a brain injury and was unable to move and was totally dependent on the staff. The DON was made aware about the nurse's documentation of Resident 1's admission to the acute care hospital related to subdural hematoma. The DON verified the incident would be considered an injury of unknown origin, and the reporting would need to be conducted. On 5/8/26 at 1519 hours, an interview (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
	555751	A. Building B. Wing	05/08/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was conducted with the Administrator and the DON. The Administrator and DON was made aware of the unreported incident of injury of unknown source and acknowledged the findings. * Cross Reference F610.

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	05/08/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed medical record review, and the facility P&P, the facility failed to ensure an injury of unknown source was investigated for one of nine sampled residents (Resident 1). * The facility failed to investigate an incident of unknown source when the facility was informed by the acute care hospital of Resident 1's admission to ICU related to subdural hematoma. This failure had the potential for the injury of unknown source to go uninvestigated and posed a risk for the delay of injury prevention to other residents of the facility.Findings: Review of the facility's P&P titled Accidents and Incidents Investigating and Reporting dated 2001 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 shall promptly initiate and document investigation of the accident or incident. Review of the facility's P&P titled Unusual Occurrence revised 12/2007 showed as required by state or federal regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees, or visitors. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current laws and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations. Review of the facility's P&P titled The Reporting and Abuse Prevention (undated) showed all alleged violations including injuries of unknown source, such as skin tears, bruises, and abrasions on residents who cannot speak for themselves, or misappropriation of resident property as reported to the administrator, or designated representative as outlined in this policy and procedure. Evidence that alleged violations are investigated and necessary correction is maintained in facility files. Notification of the incident of abuse will be reported to the Department of Health licensing and certification unit, within five calendar days of the incident by mail, following a fax reporting the incident. Closed medical record review for Resident 1 was initiated on 5/1/26. Resident 1 was readmitted to the facility on [DATE], and discharged on 4/30/26. Review of Resident 1's H&P examination dated 1/18/26, showed the resident had no capacity to make medical decisions. Review of Resident 1's MDS assessment - Section GG for Functional Abilities dated 4/15/26, showed Resident 1 was dependent in self-care and mobility. Review of Resident 1's Progress Notes showed the following:- dated 4/23/26 at 2120 hours, showed Resident 1 was discharged to the acute care hospital for an elevated heart rate at 140 beats per minute and increased work of breathing (body is exerting extra effort to breathe). The note further showed Resident 1 was tachypneic (rapid breathing) on the ventilator breathing rate of 25-30 breaths per minute; and - dated 4/24/26 at 1131 hours, showed the nurse called the acute care hospital. The facility was informed of Resident 1's admission to the acute care hospital ICU related to subdural hematoma. On 5/1/26 at 1635 hours, an interview was conducted with the DON. The DON stated Resident 1 had a brain injury and was unable to move and was totally dependent on the staff. The DON was made aware about the nurse's documentation of Resident 1's admission to the acute care hospital related to subdural hematoma. The DON verified the incident would be considered an injury of unknown source, and the investigation would need to be conducted. On 5/8/26 at 1519 hours, an interview was conducted with the Administrator and the DON. The Administrator and DON was made aware of the uninvestigated incident of injury of unknown origin and acknowledged the findings. * Cross Reference F609.

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	05/08/2026

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 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 observation, interview, medical record review, and facility P&P review, the facility failed to develop and implement the care plan for one of nine sampled residents (Resident 3). * The facility failed to timely develop a care plan and implement the neuro check intervention when Resident 3 had a fall on 4/1/26. In addition, the facility failed to update the care plan interventions when Resident 3 had another fall on 4/24/26. These failures had the potential to place the resident at risk for falls and injury.Findings:Review of the facility P&P titled Falls and Fall Risk Managing dated 2001 showed based on previous evaluation and current data, the staff will identify interventions related to the resident's specific needs and causes to try to prevent the resident from falling and try to minimize complications from falling .The staff, with the input of the attending physician will implement a resident centered fall prevention plan to reduce the specific risk factor(s) a falls for each resident at risk or with a history of falls.If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant.The staff will monitor and document each resident's response to interventions intended to reduce falling or risks of falling.If the resident continues to fall, staff will reevaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff consider possible causes that may not previously have been identified.Medical record review for Resident 3 was initiated on 5/1/26. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE].Review of Resident 3's H&P examination dated 1/15/26, showed Resident 3 does not have the capacity to make medical decisions.Review of Resident 3's Change of Condition (SBAR Communication Form) dated 4/1/26, showed Resident 3 had an unwitnessed fall in the room. a. Review of Resident 3's Care Plan Report showed a care plan focus problem when Resident 3 had an actual fall on 4/1/26. However, the care plan focus, goals and interventions were initiated on 4/28/26, 27 days later. On 5/7/26 at 1607 hours, an interview was conducted with the DON. The DON verified Resident 3's care plan for an actual fall which occurred on 4/1/26 was initiated on 4/28/26. The DON stated it should have been revised right after the fall incident. b. Review of Resident 3's Care Plan Report showed a care plan focus problem when Resident 3 had an actual fall on 4/1/26. The care plan interventions included neuro checks for 72 hours. Review of Resident 3's medical record failed to show documented evidence the neuro checks were conducted for Resident 3's falls episode on 4/1/26. On 5/6/26 at 1434 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated the process for fall episode would include an assessment, start neuro checks, notify the physician, risk management, fall risk assessment, and an IDT. RN 1 stated the neuro checks were conducted for all residents, especially for the residents who were non-verbal. On 5/7/26 at 0925 hours, a follow up interview with RN 1 was conducted. RN 1 stated Resident 3 was non-verbal. On 5/8/26 at 1450 hours, an interview was conducted with the DON. The DON stated she reviewed Resident 3's medical record and verified Resident 3's neuro checks were not done when Resident 3 had a fall on 4/1/26. c. Review of Resident 3's Health Status Note dated 4/24/26 at 2230 hours, showed Resident 3 was found on the floor. Review of Resident 3's Care Plan Report showed a care plan problem created on 11/24/25, for high risk for falls and injury. The care plan further showed the focus problem, goal and interventions were updated when Resident 3 was found on the floor next to the bed on 4/20/26. Further review of Resident 3's care plan failed to show the new focus, goals, and interventions when the resident had another fall on 4/24/25. On 5/8/26 at 0935 hours, an interview was conducted with the DON. The DON stated she could not find the care plan when Resident 3 had another fall on 4/24/26.

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	05/08/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, closed medical record review, and facility P&P (Policy and Procedure) review, the facility failed to provide the necessary care and services to maintain the highest practicable well-being for one of nine sampled residents (Resident 4).* The facility failed to ensure Resident 4 was adequately monitored and provided with the necessary care and interventions to prevent multiple incidents of ingesting foreign objects. In addition, the facility failed to initiate a change in condition and notify the physician when Resident 4 had vomited a foreign object on 4/22/26.These failures resulted in Resident 4's multiple hospitalizations and two surgical procedures for the removal of a foreign object and potentially contributed to diagnosis of sepsis (the body's extreme, life-threatening response to an infection).Findings: Review of the facility's P&P titled Change in Resident's Condition or Status revised 2/2021 showed the following:1. The nurse will notify the resident's attending physician or physician on call when there has been a (an):accident or incident involving the resident;discovery of injuries of unknown source;adverse reaction to medication; significant change in the resident's physical/emotional/ mental condition;need to alter the resident's medical treatment significantly;refusal of treatment or medications two (2) or more consecutive times;need to transfer the resident to a hospital/ treatment center; discharged without proper medical authority; andspecific instruction to notify the physician if changes in the resident's condition.2. Prior to notifying the physician or health care provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the interact SBAR (situation/background/assessment/recommendation) communication form.3. Unless otherwise instructed by the resident, the nurse will notify the residents' representative when:a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source;b. There is a significant change in the residents physical, mental, or psychosocial status there is a need to change the resident's room assignment;c. A decision has been made to discharge a resident from the facility; and/ord. It is necessary to transfer the resident to a hospital/ treatment center. Review of the facility's P&P titled Interdisciplinary Team (IDT)/Resident Care Plan Conference Review (RCC) dated 7/2021 showed the Interdisciplinary Team (IDT) in conjunction with the resident and/or resident representative, as appropriate, shall meet to develop a comprehensive person centered care plan with quantifiable objectives for the highest level of functioning the resident may be expected to attain, to meet the residents medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment and CAA (Care Area Assessment) summary. Closed medical record review for Resident 4 was initiated on 5/5/26. Resident 4 was initially admitted to the facility on [DATE]. Review of Resident 4's H&P (History and Physical) examination dated 2/19/26, showed a past medical history of chromosome eight syndrome (rare disorder characterized by severe intellectual disability). The H&P further showed Resident 4 does not have the capacity to understand and make decisions. Review of Resident 4's Order Summary Report showed the following physicians orders dated 5/9/25 and10/6/25, to monitor for episodes of ingesting non-edible items every shift. Review of Resident 4's Care Plan Report initiated on 5/9/25, showed a care plan problem to address Resident 4's risk of choking as manifested by ingestion of non-edible items. The care plan Goal showed Resident 4 will have no episode of ingestion of non-edible items. The interventions included to apply mitten (similar to boxing gloves, that cover the hands and prevent patients from pulling out any lines or tubes) as ordered, monitoring the episodes of ingesting non-edible objects every shift, provided frequent visual monitoring, and removing non-edible objects within resident's grasp. a. Review of Resident 4's Change of Condition dated 1/24/26, showed the change of condition, symptoms or signs observed were dark brown drainage from tracheostomy (a surgical opening in the trachea (windpipe) and a tube placed into the opening to assist with breathing) and GT (gastrostomy tube- a small tube placed through the abdominal wall into the stomach, used to provide feeding (continued on next page)

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	05/08/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	formula and/or administer medications) with foul stool like odor. Review of Resident 4's Progress Notes dated 1/24/26 at 1407 hours, showed the resident was noted with what appeared to be stool coming from tracheostomy, nose, and GT. The note further showed Resident 4 was transferred to the acute care hospital for further evaluation. Review of Resident 4's Hospitalist Progress Note dated 2/8/26, showed the following:- readmitted on [DATE], with fever/sepsis, thought to be pneumonia (infection of the lungs); - foreign body seen on abdomen/pelvic CT (computed tomography - a scan of the body as part of the diagnosis or treatment of illnesses) done on 1/24 (1/24/26), underwent surgery on 1/27 (1/27/26) to remove, and the object showed tan-green colored crumbled firm material, possibly plastic, resembling gloves and cloth drawstring. Review of Resident 4's admission Summary Progress Notes dated 2/9/26, showed Resident 4 was readmitted back to the facility with a diagnosis of sepsis with foreign body in the gastrointestinal tract (the continuous muscular passageway running from the mouth to the anus). Review of Resident 4's Care Plan Report initiated on 2/10/26, showed a care plan problem addressing Resident 4's use of physical restraint hand mittens due to pulling out is tracheostomy tubes and the resident is picking up items within his reach and swallows them. The interventions included to keep bedside table clean and free from clutter and small object within the resident's reach. b. Review of Resident 4's Change of Condition form dated 2/25/26, showed the change of condition, symptoms, or signs observed was non-edible item found in stool, brief like material. Review of Resident 4's Care Plan Report showed a care plan problem revised on - dated 2/25/26 to address the following: - Resident 4 was noted to eat and swallow object or non-food items within his reach. The interventions included a jumpsuit so he cannot pick up diapers and minimize nonfood items; and- Resident 4's risk of choking as manifested by ingestion of non-edible items. The care plan Goal revised on 2/25/26, showed the resident will have no episode of ingestion of non-edible items. Review of Resident 4's Progress Notes dated 2/25/26, showed the nurse was called to check on Resident 4. The CNA (Certified Nursing Assistant) was observed providing the care and showed the resident's stool. The progress notes showed the stool was noted with non-edible brief like items and the nurse pulled out the item from the anus, plastic like brief/diaper. The progress notes further showed Resident 4 had a physician's order to be sent to the acute care hospital for a CT scan. Further review of Resident 4 medical records failed to show the result of the CT scan done on 2/25/26. Review of Resident 4's Physician's Progress Notes dated 2/26/26, showed Resident 4 was transported to the acute care hospital yesterday (2/25/26) for CT of abdomen and pelvis with follow-up testing and returned in stable condition, and the results were pending. Further review of Resident 4's physician's progress note dated 3/1/26, 3/3/26 and 3/4/26, showed the CT abdomen and pelvis previously performed, results pending review. On 5/12/26 at 0927 hours, a follow-up request for Resident 4's CT scan result was made with the Medical Records Director. On 5/12/26 at 1506 hours, the Director of Medical Records responded there was no CT scan results found in Resident 4's medical record. Review of Resident 4's IDT notes dated 2/26/26, showed the IDT met with the resident's family member over the phone. The note had an entry for the Social Service, Activities and Dietary department. However, the portion for the Nursing department was blank. c. Review of Resident 4's Change of Condition form dated 3/7/26, the nursing notes showed Resident 4 had episode of vomiting and the emesis (the forceful expulsion of stomach contents through the mouth) noted on shirt was brown in color, with pieces of diaper noted in emesis. Review of Resident 4's Care Plan Report dated 3/7/26, showed a care plan problem addressing Resident 4 had vomiting related to [NAME] (an eating disorder characterized by the persistent craving and consumption of non-food substances). The care plan Goal showed Resident 4 will have no episode of ingesting any material and objects within his reach. The care plan interventions included activity as tolerated, avoid foods that cause intestinal hyperactivity caffeine, carbonated beverages, chocolate, or acidic items like orange juice, diet as tolerated, ice chips as tolerated, advance to clear liquids as tolerated, diet consult as PRN (as needed), educate resident/family/caregivers about relationship of nausea and vomiting to food, medicine, treatment regimen, disease process, and (continued on next page)

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	05/08/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	psychosocial factors, teach resident/family/caregivers to identify and avoid causative factors, eliminate smells from the environment. However, the care plan failed to show the interventions to address Resident 4's Pica. d. Review of Resident 4's Medication Administration Note dated 4/22/26 at 2056 hours, showed Resident 4 vomited a foreign object, plastic in appearance. Review of Resident 4's Subacute Nursing assessment dated [DATE], showed a CNA reported Resident 4 had vomited. The emesis observation was found to have a clear rigid plastic object and smaller plastic particles and there was no further vomiting episodes until 0500 hours. The note further showed also worth mentioning that patient had a fever the prior night. Decided with RN (Registered Nurse) supervisor to send patient out to be further checked for residual object. Review of Resident 4's Health Status Progress Note showed the following:- dated 4/23/26 at 0500 hours, Resident 4 had episode of dark colored emesis, with new order to transfer Resident 4 to the emergency department; and- dated 4/23/26 at 2055 hours, showed a call made to the acute care hospital. The note showed Resident 4 was admitted in the sub-acute ICU (Intensive Care Unit) for sepsis with acute organ dysfunction (sudden rapid decline of organ function), and septic shock (severe life-threatening stage of sepsis when an infection causes an extreme immune response leading to dangerously low blood pressure, and widespread organ failure). Review of Resident 4's Operative Note from the acute care hospital dated 4/29/26, showed the following:- Preoperative (the period before a surgical operation) Diagnosis: small bowel obstruction (partial or complete blockage of the small intestine that prevents food, fluids, and gas from passing through), bezoar (a tightly packed, indigestible mass of material that gets trapped most commonly in the stomach), and pica;- Postoperative (the period immediately following a surgical procedure) Diagnosis: same, and gastric foreign body; and- Operative Findings: two nitrile gloves (durable, synthetic rubber gloves) removed from stomach endoscopically (a medical examination or treatment inside the body using an endoscope - a thin, flexible tube with a camera and light). On 5/5/26 at 1007 hours, an observation was made of Resident 4's room. Resident 4 was still in the acute hospital. Resident 4's bed was observed close to the wall, with a glove rack containing two open full boxes of frosty white transparent gloves near the foot of the bed, and a dresser was observed to be on the right side of the bed. On 5/6/26 at 1109 hours, an interview was conducted with LVN (Licensed Vocational Nurse) 5. LVN 5 stated she observed a clear cylindrical plastic, ridged, and lightly opaque substance expelled from Resident 4's emesis on 4/22/26. LVN 5 stated the second time the resident vomited, it had a smell like feces and seemed to have been in Resident 4's system for a while for it to smell like that. When asked if Resident 4 had full mobility of both arms, LVN 5 stated, yes he uses both of his arms. When asked how Resident 4 was monitored, LVN 5 stated we do our best, put everybody on alert to look and check on the resident. LVN 5 stated Resident 4 would need a 1:1 (one-on-one sitter - is a dedicated healthcare staff who would provide constant, direct supervision to high-risk residents to prevent falls, self-injury, or dislodgement of medical tubes), as he is super quick and super smart. When asked if the physician was notified when Resident 4 had vomited a foreign object, which appeared to be plastic on 4/22/26, LVN 5 stated the supervisor did not notify the physician until 4/23/26 at 0500 hours, when Resident 4 was being sent out to the acute care hospital. On 5/6/26 at 1407 hours, an interview was conducted with CNA 1. CNA 1 stated she had observed Resident 4 eating his feces in the past. CNA 1 stated Resident 4 was always in bed. When asked how resident was monitored, CNA 1 stated when we don't have too many residents, we can check more, sometimes we don't have time do rounds. CNA 1 stated further Resident 4 was unable to walk but was able to bend forward, and one foot was strong. On 5/6/26 at 1434 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated Resident 4 could remove his mittens with his mouth, and grabs whatever is around. When asked how mobile Resident 4 was, RN 1 stated normal, like a kid, he can reach and grab things and covers head with a blanket. When asked what other interventions Resident 4 would need, RN 1 stated a 24 hour sitter. On 5/6/26 at 1503 hours, an observation of Resident 4's room and concurrent interview was conducted with RN 1. A drawer was observed with a taped label showing do not leave any items inside the (continued on next page)

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	05/08/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	drawer. RN 1 opened the drawer and noted tracheostomy supplies and gauze packs in a plastic bag were inside the drawer. When asked if the drawer belonged to Resident 4, RN 1 stated yes. When asked if the items in the drawer belonged to Resident 4, RN 1 stated I'm assuming so. On 5/7/26 at 0925 hours, a follow up interview and concurrent medical record review for Resident 4 was conducted with RN 1. When asked if the facility provided sitters to Resident 4, RN 1 stated since she started, she had not seen any sitters. RN 1 stated it was mostly families that would come, but not for the whole 12 hour shift. When asked if the physician was notified on 4/22/26 when Resident 4 vomited plastic as documented, RN 1 verified the physician was not notified until after the second emesis on 4/23/26 at 0500 hours. On 5/7/26 at 1249 hours, an interview was conducted with the RT (Respiratory Therapist) Supervisor. The RT Supervisor stated she had seen Resident 4 picking things up and stated Resident 4 was a resident that would need a 1:1. On 5/8/26 at 0935 hours, an interview and concurrent medical record for Resident 4 was conducted with the DON (Director of Nursing). When asked how the facility would ensure the frequent visual monitoring and non-edible items were not left in the resident's room, the DON stated, she and the licensed nurses would check the rooms. When asked if the physician should have been notified when the resident was observed to vomit plastic on 4/22/26, the DON stated the physician should have been notified. When asked if Resident 4 had a 1:1 sitter, the DON stated no, we don't have any residents with a 1:1. When asked if the facility would provide a 1:1 sitter, the DON responded, that's why it's hard for us to accept him back. When asked if there was an IDT discussion about Resident 4 needing a 1:1 sitter, the DON stated she could not recall. The DON further stated there was a discussion about 1:1 possibly last week, but nothing prior to April 2026. On 5/8/26 at 1519 hours, an interview was conducted with the Administrator and DON. The Administrator and DON was made aware of Resident 4's multiple incidents of ingesting foreign objects and hospitalizations. The Administrator and DON acknowledged the findings.