

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 08/27/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                        |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555751                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                               | (X3) DATE SURVEY<br>COMPLETED<br><br>06/11/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Newport Subacute Healthcare Center                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                 |
| <p>F 0684</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, closed medical record review, and the facility P&amp;P review, the facility failed to provide the necessary treatment and services to maintain the highest practicable well-being for one of 12 sampled residents (Resident 2). * The facility failed to ensure Resident 2's change of condition was monitored every shift for at least 72 hours accordingly. This failure had the potential to negatively affect the resident's health and well-being and increase the risk of not providing the resident with an appropriate and individualized care. Findings: Review of the facility's P&amp;P titled Change in a Resident's Condition or Status dated 2/2021 showed the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Review of the facility's P&amp;P titled Charting and Documentation dated 2001 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. Closed medical record review for Resident 2 was initiated on 6/3/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&amp;P examination dated 2/21/26, showed Resident 2 could make needs known but could not make medical decisions. Review of Resident 2's Change of Condition Report dated 5/6/26 at 0953 hours, showed Resident 2 was observed with redness and moderate drainage to the right eye. Review of Resident 2's Order Summary Report dated 5/10/26, showed a physician's order dated 5/7/26, for Maxitrol Ophthalmic Suspension (a prescription eye drop medication to treat or prevent bacterial infections) 3.5-10000-0.1 to instill one drop to both eyes four times a day for eye redness and discharge. Review of Resident 2's Care Plan Report showed a focus problem dated 5/6/26, for redness and moderate drainage to the right eye with the goal to reduce redness and drainage within three to five days. However, further review of Resident 2's closed medical record failed to show the resident's change in condition was monitored for at least 72 hours after the resident's initial change in condition was observed. On 6/10/26 at 0943 hours, an interview and concurrent closed medical record review for Resident 2 was conducted with RN 2. RN 2 stated that when a resident had a change in condition, there should be a monitoring note every shift for at least 72 hours to evaluate the resident's status and response to the treatment as prescribed. RN 2 further verified Resident 2 had missing monitoring notes for the night shift from 1900 to 0700 hours on 5/6, 5/7, and 5/8/26. On 6/11/26 at 1020 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the findings.</p> |                                                                                        |                                                 |

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<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 08/27/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555751                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                               | (X3) DATE SURVEY<br>COMPLETED<br><br>06/11/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Newport Subacute Healthcare Center                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                        |                                                 |
| F 0842<br><br>Level of Harm - Potential for<br>minimal harm<br><br>Residents Affected - Some                                       | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, closed medical record review, and facility P&amp;P review, the facility failed to ensure the medical record for one of 12 sampled residents (Resident 3) was complete and accurate. * The facility failed to ensure Resident 3's date of death was recorded accurately by different IDT members. This failure had the potential to show inconsistency of care as the clinical information was not accurate. Findings: Review of the facility's P&amp;P titled Charting and Documentation revised 7/2017 showed documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. Closed medical record review for Resident 3 was initiated on [DATE]. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's H&amp;P examination dated [DATE], showed Resident 3 required assistance with decision making capabilities. Review Resident 3's nursing progress notes dated [DATE], showed Resident 3 was found unresponsive on [DATE], at 0540 hours. The paramedics responded to the emergency and Resident 3 was pronounced deceased at 0603 hours. Review of Resident 3's Physician's Discharge Summary showed resident expired in the facility on [DATE]. Further review of Resident 3's progress note showed the following:- dated [DATE], documented by social services, showed resident expired on [DATE];- dated [DATE], documented by activities, showed resident expired on [DATE];- dated [DATE], documented by nursing, showed on [DATE] at 1115 hours, received an order from the physician to release the body to Mortuary Representative. Mortuary picked up the resident's body at approximately 1115 hours. Family at bedside. On [DATE] at 0943 hours, an interview and concurrent closed medical record review for Resident 3 was conducted with RN 2. RN 2 stated Resident 3 expired on [DATE], in the facility. RN 2 verified that the information documented by different staff were inaccurate and inconsistent regarding the resident's date of death . RN 2 further stated that it was important to have accurate documentation of the resident's information as it served as proof of care and professionalism. On [DATE] at 1020 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the findings.</p> |                                                                                        |                                                 |