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	08/29/2025

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 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **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 promote the dignity and respect for two of 21 final sampled resident (Residents 3 and 51). * The facility failed to ensure CNA 8 was seated at an eye-level while assisting Resident 3 with his meal. * The facility failed to ensure CNA 9 was seated at eye-level while assisting Resident 51 with his meal. These failures posed the risk of not treating the residents with the dignity and respect.Findings: 1. Review of the facility's P&P titled Resident Rights revised 10/2010 showed the facility will make every effort to assure the resident is always treated with respect, kindness and dignity. Medical record review for Resident 3 was initiated on 8/25/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's plan of care showed a care plan problem dated 12/21/23, addressing the resident's ADL self-care performance deficit related to blindness to one eye and limited mobility. The interventions included partial assistance with eating. Review of Resident 3's H&P examination dated 12/27/24, showed Resident 3 had the capacity to understand and make medical decisions. On 8/25/25 1239 hours, an observation for Resident 3 and concurrent interview with was conducted with CNA 8. CNA 8 was observed standing next to Resident 3's bedside assisting him with feeding. CNA 8 verified the above findings and stated she should have sat at an eye level with Resident 3 while feeding the resident to ensure the resident was observed more closely. 2. Medical record review for Resident 51 was initiated on 8/25/25. Resident 51 was admitted to the facility on [DATE]. Review of Resident 51's physician's order dated 4/10/21, showed the resident had a Controlled Carbohydrates (CCHO) diet, puree texture and thin consistency, with instructions for one-to-one feeding (aspiration precaution) for breakfast, lunch, and dinner. Review of Resident 51's H&P examination dated 3/27/25, showed Resident 51 had no capacity to understand and make medical decisions. On 8/25/25 1251 hours, an observation for Resident 51 and concurrent interview was conducted with CNA 9. CNA 9 was observed standing next to Resident 51's bedside assisting him with feeding. CNA 9 verified the above findings. CNA 9 stated there was a chair available, however, he did not use it while feeding Resident 51. CNA 9 stated he should have been seated at an eye level at the resident's bedside during the feeding of the resident. On 8/27/25 at 1553 hours, an interview for Residents 3 and 51 was conducted with the DSD. The DSD stated the CNAs and RNAs were expected to sit beside the residents at an eye level when assisting the residents with feeding. The DSD stated the CNAs and RNAs needed to be at an eye level and not hover over them to maintain the residents' dignity. When asked if she provided in-services to the facility staff on dignity or respect since starting at the facility, the DSD stated she had not. On 8/28/25 at 1526 hours, an interview was conducted with the Administrator and DON. The DON stated she expected the facility staff to maintain an eye level while feeding the residents. The Administrator and DON were informed and acknowledged the above findings.

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	08/29/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to properly obtain the informed consent (permission granted in the knowledge of the possible consequences) for the use of psychotropic medications (medications affecting brain activity) and bedrails from the residents or from the responsible party (person designated to make decisions on behalf of the residents). The facility failed to obtain the informed consent for the psychotropic medications for three of five sampled residents (Residents 3, 20, and 70) reviewed for unnecessary medications and one nonsampled resident (Resident 24) reviewed for the use of the bedrails. * The facility failed to obtain renew the informed consents for the Abilify (antipsychotic medication) and Prolixin (antipsychotic medication) medications after six months for Resident 3. * The facility failed to renew the informed consents for the divalproex sodium (used to treat seizures and bipolar disorder), buspirone (antianxiety medication), Remeron (antidepressant), Neudexta (used to treat a neurological condition that causes sudden, frequent, and involuntary episodes of crying or laughing), and Seroquel (antipsychotic medication) medications for Resident 20 six months after the previous informed consents were obtained. * The facility failed to obtain the informed consents for the bilateral 1/4 side rails for Resident 24. The informed consent obtained for the use of the side rails for Resident 24 was for the bilateral 1/2 side rails. * The facility failed to obtain the informed consents for the sertraline (antidepressant), olanzapine (antipsychotic), and trazodone (antidepressant) medications for Resident 70. These failures posed the risk for the residents and or their responsible parties to not be informed of their medications and the potential side effects, and the use of bedrails and the risks of their usage.Findings: Review of the AFL 24-07 titled AB 48 – Nursing Facility Resident Informed Consent Protection Act of 2023 dated 2/28/24, showed the following: - Facilities must renew the written informed consent every six months. At that time, the facility must provide the residents with any recommended dosage adjustments and the option of revoking consent; and - Facilities must review and revise their P&Ps to ensure compliance with the new law. The P&P must specifically consider and plan for how the facility will verify that the resident provided informed consent or refused treatment or a procedure pertaining to the administration of psychotherapeutic drugs. Review of the facility's P&P titled Restraint Assessment: Chemical (Psychotropic) Meds and Physical (undated) showed each resident or responsible party will give consent for the purposes of prescribing and administering psychotherapeutic medications for the purpose of chemically restraining a resident. 1. Medical record review for Resident 20 was initiated on 8/27/25. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 12/11/24, showed Resident 20 had no capacity to understand and make decisions. Review of Resident 20's Order Summary Report for August 2025 showed the following physician's orders: (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	08/29/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 10/8/24, to administer Remeron 7.5 mg one tablet orally at bedtime for major depressive disorder manifested by poor appetite. - dated 2/10/25, to administer buspirone HCL oral tablet 10 mg by mouth three times per day for anxiety manifested by screaming. - dated 3/26/25, to administer Nuedexta oral capsule 20-10 mg by mouth two times a day for pseudobulbar affect (neurological condition that causes sudden, frequent, and involuntary episodes of crying or laughing) manifested by inappropriate laughing and crying. - dated 4/15/25, to administer divalproex sodium oral capsule delayed release 250 mg twice a day for unspecified mood disorder manifested by constant screaming/yelling; - dated 4/15/25, to administer Seroquel 25 mg by mouth two times a day for psychosis manifested by talking to unseen others. Review of Resident 20's informed consents showed the following: - the Seroquel medication consent was obtained on 4/18/24; - the Remeron medication consent was obtained on 10/3/24; - the buspirone HCL medication consent was obtained on 11/8/24; - the Nuedexta medication consent was obtained on 2/12/25; and - the divalproex medication consent was obtained on 2/24/25. However, further review of Resident 20's informed consents for the above psychotropic medications showed the informed consents were past the six-month mark and required a renewal for the informed consents to be current and active. On 8/28/25 at 1347 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the informed consents for the five listed psychotropic medications for Resident 20 were not current and needed to be renewed after six months from when the informed consent was obtained. 2. Review of the AFL 24-07 titled AB 48 - Nursing Facility Resident Informed Consent Protection Act of 2023 dated 2/28/24, showed the following: - Before prescribing a psychotherapeutic drug, the prescriber must personally examine the resident and obtain informed written consent signed by the resident or the resident's representative along with the signature of the health care professional declaring the required material information has been provided. If the resident or resident's representative cannot sign the form, a licensed nurse can sign the form and document the name of the person who gave consent and the date. The personal exam and the signatures of the prescriber, resident, or representative can be completed and signed using remote technology. (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	08/29/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The signed written consent must be recorded in the resident's medical record. Before initiating treatment with psychotherapeutic drugs, facility staff must verify that the resident's health record contains written informed consent with the required signatures. For a prescription written prior to facility admission, the facility staff must verify that the resident or the resident's representative gave informed consent and make a notation in the resident's records. The record does not need to be checked every time the drug is administered. Review of the facility’s P&P titled Restraint Assessment: Chemical (Psychotropic Meds) and Physical (undated) showed the facility shall verify that the attending physician of a resident has obtained consent for the purposes of prescribing and ordering the use of a physical or chemical restraints on a resident, (or increasing an order for antipsychotic medication). This shall be documented in the resident’s health record. Medical record review for Resident 70 was initiated on 8/25/25. Resident 70 was admitted to the facility on [DATE]. Review of Resident 70's Order Summary Report showed the following physician's orders: - dated 8/7/25, to administer olanzapine 10 mg via GT at bedtime; - dated 8/7/25, to administer sertraline 100 mg via GT one time a day; and .- dated 8/7/25, to administer trazodone 50 mg via GT at bedtime. Review of Resident 70’s H&P examination dated 8/12/25, showed Resident 70 had fluctuating capacity to understand and make medical decisions. Review of Resident 70’s MDS admission assessment dated [DATE], showed Resident 70 has a BIMS score of 15, indicating cognitively intact. Further review of Resident 70’s medical record failed to show the informed consents for the above psychotropic medications were obtained from the resident and/or their responsible party. On 8/27/25 at 1212 hours, an interview and concurrent medical review was conducted with RN 2. RN 2 verified there were no informed consents obtained for Resident 70’s use of the olanzapine, sertraline, and trazodone medications. RN 2 stated if the resident’s responsible party was not present in the facility, there should be two licensed nurses to verify the verbal consent was obtained. RN 2 further stated the facility should not have administered the olanzapine, sertraline, and trazodone medications until the informed consents were obtained from the resident or their responsible party. On 8/27/25 at 1518 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the psychotropic medications should not have been administered if there were no informed consents obtained from the resident or their responsible party. 3. Medical record review for Resident 3 was initiated on 8/25/25. Resident 3 was readmitted to the facility on [DATE]. (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	08/29/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 3’s Order Summary Report showed the following physician’s orders: - dated 2/9/24, to administer Abilify 30 mg one tablet by mouth a day; and - dated 7/23/25, to administer fluphenazine (Prolixin) 5 mg by mouth at bedtime. Review of Resident 3’s MAR for August 2025 showed the following: - Resident 3 was administered the Abilify medication from 8/1 to 8/10, and 8/12 to 8/27/25 at 0900 hours; and - Resident 3 was administered the fluphenazine medication from 8/1 to 8/26/25 at 2100 hours. Review of Resident 3’s Informed Consent Verification dated 2/9/24, showed the informed consent for Abilify was obtained from Resident 3. Review of Resident 3’s Informed Consent Verification dated 7/3/24, showed the informed consent for Prolixin was obtained from Resident 3. Further review of Resident 3’s medical record failed to show documented evidence the informed consents for Abilify and Prolixin were renewed after six months. On 8/27/25 at 1149 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 1. RN 1 verified the informed consents for Abilify and Prolixin medications for Resident 3 were not renewed after six months. RN 1 stated the informed consents for psychotropic medications were not renewed after six months, unless the resident was discharged then readmitted with a new chart. On 8/28/25 at 1051 hours, an interview and concurrent medical record review for Resident 3 was conducted with the DON. The DON verified the informed consents for Abilify and Prolixin medications for Resident 3 were not renewed after six months. The DON stated when the facility conducted the quarterly IDT meetings, they also checked the informed consent, to which the medical records department would inform the nursing department about the informed consents needed to be renewed. 4. On 8/27/25 at 0907 hours, on 8/28/25 at 0957 and 1120 hours, Resident 24 was observed lying in bed with bilateral ¼ (quarter) side rails elevated. Review of Resident 24’s Order Summary Report showed a physician’s order dated 8/13/25, for bilateral ¼ side rails. Review of Resident 24’s Informed Consent Documentation (undated) showed the informed consent obtained was for bilateral ½ (half) side rails. On 8/27/25 at 1204 hours, an interview and concurrent medical record review for Resident 24 was conducted with RN 1. RN 1 verified the above findings. On 8/28/25 at 1029 hours, the DON was informed and verified the above findings.

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	08/29/2025

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. (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	08/29/2025

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility document review, the facility failed to ensure the copy of the resident's medical record was provided upon request within two working days for one of three residents reviewed for closed records (Resident 101). * The facility failed to provide Resident 101's requested medical record and facility documents to the legal representative until 13 days after the initial request was received. In addition, the facility's resident care policies and daily posting of the staffing record were not provided as requested to Resident 101's legal representative. This failure had the potential for violating Resident 101's and their legal representative rights to access their medical health information.Findings: On [DATE] at 1038 hours, a telephone interview was conducted with the Legal Assistant. The Legal Assistant stated Resident 101 expired on [DATE] in the facility, so the resident's representative had filed a case through the Law Firm. The Legal Assistant stated the Law Firm required Resident 101's medical record, facility's resident care policies, and the posting of the staffing data for each day of the last 18 months. The Legal Assistant further stated resident's representative had signed the written authorization to release the medical record for Resident 101. The Legal Assistant stated she first mailed the request on [DATE], via federal express and it was hand delivered to the facility staff on [DATE]. The Legal Assistant stated it had been more than 13 days since she requested the records but had not received the requested records from the facility. On [DATE] at 1529 hours, a follow up telephone interview was conducted with the Legal Assistant. The Legal Assistant stated she made multiple attempts to request the medical record for Resident 101. The Legal Assistant stated after she mailed the initial request, she called the facility and left a voice message on 8/14, 8/18, and [DATE]. The Legal Assistant further stated she also emailed the Director of Medical Records on [DATE], regarding the same request but had not received the records yet. Closed medical record review of Resident 101 was initiated on [DATE]. Resident 101 was admitted to the facility on [DATE], and expired on [DATE]. Review of Resident 101's MDS assessment dated [DATE], showed Resident 101 had moderately impaired cognitive function. Review of Resident 101's admission Record dated [DATE], showed Resident Representative 1 had the Power of Attorney for Health Care for Resident 101. Review of Law firm's Medical request dated [DATE], showed the following records were requested:- - Resident 101's medical records, billing records, photographs, charts and writings. In addition, all admission agreements, reviews, utilization review committee records, and x-rays;- - Facility's resident care policies and procedure; and- - Posted nurse staffing data for each day of the eighteen months prior to the date of the letter. Further review of the Law Firm medical record request showed Resident Representative 1 electronically signed the authorization for the release of Resident 101's medical information. On [DATE] at 0815 hours, an interview and concurrent closed medical record review for Resident 101 was conducted with the Director of Medical Records. The Director of Medical Records stated the residents and/or resident's legal representatives were entitled to access their medical records, patient care policies, and posted staffing data. The Director of Medical Records further stated the medical records department would assist with providing the residents and/or their representatives with the copies of the requested records. The Director of Medical Records stated she received the above medical request for Resident 101 on [DATE], and verified Resident Representative 1 had the power of attorney for Resident 101. The Director of Medical Records verified Resident Representative 1 signed the authorization for the release of Resident 101's medical information. The Director of Medical Records verified the above request for the records was not provided to the Law Firm and it was 13 days overdue. The Director of Medical Records stated the above requested records, including Resident 101's medical record, should have been provided to the Law Firm within two working days as per the regulation. On [DATE] at 1133 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings.

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	08/29/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the written information regarding how to formulate an advanced directive for five of 16 final sampled residents (Residents 5, 6, 8, 83, and 90) reviewed for advanced directives. * The facility failed to provide the written information and assistance regarding how to formulate the advanced directive for Residents 5 and 90. * The facility failed to inform, provide, and document the written information regarding the residents' right to formulate the advanced directives for Residents 6 and 83. * The facility failed to provide the written information regarding the right to formulate the advanced directive for Resident 8. These failures had the potential for the residents to receive inaccurate and delayed treatment compatible with the residents' wishes during an emergency. Findings: Review of the facility's P&P titled Advance Directives revised on 9/2022 showed the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. The Determining Existence of Advanced Directive section showed the following: - The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she chooses to do so; - Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative; and - If the resident is incapacitated und unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident’s legal representative. If the resident becomes able to receive and understand this information later, he or she will be provided with the same written materials as described above, even if his or her legal representative has already been given the information. 1. Medical record review for Resident 5 was initiated on 8/26/25. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's MDS assessment dated [DATE], showed Resident 5 had moderate cognitive impairment. Review of Resident 5's POLST dated 12/20/24, showed under Section D-Information and Signatures, Resident 5 had no advanced directive. Further review of Resident 5's medical record failed to show the documented evidence the facility followed up with Resident 5 and/or the resident's representative to provide the information and assistance on formulating the advance directive. 2. Medical record review for Resident 90 was initiated on 8/26/25. Resident 90 was readmitted to the facility on [DATE]. (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	08/29/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 90's H&P examination dated 3/31/25, showed Resident 90 had the capacity to understand and make decisions. Review of Resident 90's MDS assessment dated [DATE], showed Resident 90 was cognitively intact. Review of Resident 90's POLST dated 8/21/24, showed under Section D-Information and Signatures, Resident 90 had no advanced directive. Further review of Resident 90's medical record failed to show the documented evidence the facility followed up with Resident 90 to provide the information and assistance on formulating the advanced directive. On 8/27/25 at 1536 hours, an interview and concurrent medical record review for Residents 5 and 90 was conducted with the MDS Coordinator. The MDS Coordinator stated she just started following up with the residents regarding their advanced directives two weeks ago when the primary staff who was responsible for following up with the advanced directives left. The MDS Coordinator stated she met with the resident and resident’s representative upon admission to discuss the POLST and the advanced directive with them. The MDS Coordinator stated the resident or the resident’s representative would complete the POLST and when the Section D- Information and Signatures showed discussed with the resident or legally recognized decision maker, it meant the information regarding the formulation of the advanced directive was provided. The MDS Coordinator acknowledged the POLST did not show any documented evidence a written information was provided to Residents 5 and 90 regarding how to formulate an advanced directive in a manner that was easily understood by the residents. On 8/29/25 at 1440 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 5 and 90. 3. Review of Resident 6's medical record was initiated on 8/25/25. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 5/20/25, showed Resident 6 had the capacity to understand and make medical decisions. Review of Resident 6's POLST dated 5/17/25, failed to show under Section D for Information and Signatures, if Resident 6 had an advanced directive. Review of Resident 6's Social Services progress notes dated 5/27/25, failed to show documented evidence if the formulation of an advance directive was offered to Resident 6 and/or his representative. Further review of Resident 6's medical record failed to show the Advance Directive Acknowledgment form was completed for Resident 6. On 8/28/25 at 1329 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator acknowledged the above findings and stated the advanced directive was completed upon the resident's admission to the facility by the Social Services staff. The MDS Coordinator stated the facility currently had no SSD and the POLST was completed by the licensed nurses. In addition, MDS Coordinator stated she was unsure if the Advance Directive Acknowledgment form was used in the facility. (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	08/29/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/25 at 1539 hours, the DON was informed and verified the above findings. 4. Medical record review for Resident 83 was initiated on 8/25/25. Resident 83 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 83's POLST dated 5/24/19, failed to show under Section D for Information and Signatures, if Resident 83 had an advanced directive. Review of Resident 83's Social Services progress notes dated 7/16/24, showed the POLST was discussed with the resident's family member who had pending conservatorship. However, the progress notes failed to show further Social Services documentation to follow up if the advance directive formulation was offered to Resident 83’s responsible party. Review of Resident 83's H&P examination dated 8/22/25, showed Resident 83 had anoxic brain injury (condition where the brain is deprived of oxygen for a period of time) and was in persistent vegetative state, contracted, unable to communicate, track, or make needs known. Further review of Resident 83's medical record failed to show the Advance Directive Acknowledgment form was completed for Resident 83. On 8/28/25 at 1313 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator acknowledged the above findings. On 8/28/25 at 1539 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. 5. Medical record review for Resident 8 was initiated on 8/27/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's POLST dated 7/15/25, showed under Section D, “No” was marked for the Advanced Directive. Review of Resident 8's H&P examination dated 7/17/25, showed Resident 8 had no capacity to understand and make decisions. Further review of Resident 8’s medical record failed to show documented evidence the advanced directive was offered and discussed with the resident’s representative. On 8/27/25 at 1552 hours, an interview and concurrent medical record review was conducted with MDS Coordinator for Resident 8’s advanced directive. The MDS Coordinator verified there was no documentation of the acknowledgment to show the advanced directive was offered or discussed with the resident’s representative. On 8/27/25 at 1604 hours, an interview was conducted with the DON. The DON verified there was no advanced directive, acknowledgment and/or documentation in the resident’s medical records to show if the advanced directive was offered or discussed with the resident’s representative.

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	08/29/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to immediately notify the physician and family of a change in condition for one of four final sampled residents (Resident 9) reviewed for pressure ulcers. * The facility failed to notify Resident 9's physician and resident representative regarding Resident 9's change of condition when Resident 9 developed MASD (Moisture-Associated Skin Damage, general term for inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage) to the coccyx (tailbone). This had the potential to negatively impact Resident 9's physical wellbeing and prevent the resident 's representative from being fully aware and understand the resident's treatments and course of actions. Findings: Review of the facility's P&P titled Change in a Resident's Condition or Status revised February 2021 showed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Medical record review for Resident 9 was initiated on 8/25/25. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's Change of Condition dated 8/9/25, showed under the Situation section, the resident had a MASD to the coccyx . Under the Recommendation section showed the following:- Plan of Care: to monitor and report worsening signs and symptoms;- MD Orders: Cleanse with normal saline, pat dry, apply zinc oxide (used to treat or prevent skin irritation) and cover with dry dressing. However, the assessment failed to show if the physician and/or resident's representative were notified regarding the resident's change of condition. The assessment failed to show which physician gave the wound care order documented under the Recommendation section. On 8/28/25 at 1457 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 stated when the resident had a change of condition, the physician and family must be informed. RN 2 stated the physician for Resident 9 had not been involved in resident's care since there was a lack of wound care notes from the physician. RN 2 further stated the treatment nurses would at times place the wound care order on the resident's medical record. Additionally, RN 2 verified the resident's physician and resident representative were not notified regarding Resident 9's change of condition. On 8/29/25 at 1119 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 stated the resident's physician and resident's responsible party or family were not notified of Resident 9's change in condition. Additionally, RN 3 stated the treatment nurses put in the wound care orders themselves in the resident's medical record. On 8/29/25 at 1412 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 9 had a change in the resident's skin condition on 8/9/25. When asked about the facility's expectation for reporting the resident's change of condition, the DON stated the licensed nurses should notify the resident's physician for interventions and the family or the resident's responsible party also needed to be informed. The DON verified the resident's physician and family member were not notified regarding the resident's change of condition on 8/9/25.

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	08/29/2025

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility document review, the facility failed to provide the written Notice of Medicare Non-coverage (NOMNC) form CMS-10123, and the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form CMS-10055 for one of four residents (Resident 37) reviewed for beneficiary notification. The NOMNC and SNFABN forms are used to inform the residents of their potential financial liability, appeal rights, and protection should they wish to receive care and services that may not be covered by Medicare. This failure had the potential of not allowing Resident 37 and/or their representative to make an informed decision regarding their Medicare servicesFindings: Medical record review for Resident 37 was initiated on 8/28/25. Resident 37 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 37's H&P examination dated 8/12/25, showed the resident had the capacity to understand and make medical decisions. Review of the facility's Beneficiary Notice - Residents discharged Within Last Six Months showed Resident 37 was to be discharged from the Medicare Covered Part A stay on 8/26/25, and would remain in the facility using private pay insurance. Review of Resident 37's NOMNC (undated) showed the effective date coverage of Resident 37's skilled nursing service would end on 8/26/25. The section for the signature of the resident or representative was blank. The document also showed the Business Office Manager left a voice message for Resident 37's responsible party, notifying the responsible party of the Medicare Covered Part A stay was ending on 8/26/25. Review of Resident 37's SNF ABN showed Medicare doesn't pay for everything even some care that you and your health care provider think you need. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage or its utilization review committee believes that the care listed below does not meet the Medicare coverage requirement. Beginning 8/27/25, you may have to pay out of pocket for this care if you do not have insurance that may cover those costs. Further review of the document did not show the signature of Resident 37 and/or the resident's representative. Further review of Resident 37's medical record failed to show if Resident 37 and/or the resident's representative were provided with a copy of the NOMNC and SNF ABN when Resident 37 was to be discharged from Medicare Part A services and remain in the facility. On 8/28/25 at 1350 hours, an interview was conducted with the Business Office Manager. The Business Office Manager stated she tried to to give the notice to Resident 37, but he was not available. The Business Office Manager stated she called the resident's responsible party on 8/22/25, and left a voice message to notify her the resident's Medicare Covered Part A services were going to be ending. The Business Office Manager stated she did not have any documentation to show she mailed the NOMNC and/or SNF ABN forms to the resident's responsible party to review, and sign. On 8/28/25 at 1411 hours, a telephone interview was conducted with Resident Representative 3. Resident Representative 3 stated she had not received the NOMNC and SNF ABN written notices in the mail. Resident Representative 3 also stated she did not recall being told by the Business Office Manager she could appeal, or what the appeal process would be. On 8/29/25 at 1440 hours, an interview was conducted with the DON. The DON was notified and acknowledged the above findings.

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	08/29/2025

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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a clean, sanitary and homelike environment for one final sampled resident (Resident 35) and four nonsampled residents (Residents 25, 32, 66, and 93) * Residents 25 and 93 were observed in Room A, and Residents 32, 35, and 93 were observed in Room B. The bathroom shared between Rooms A and B was observed with a hole on the wall, under the bathroom sink. This failure posed the risk of unsanitary conditions and an entry for pests into the facility, which could negatively affect the residents' well-being.Findings: On 8/29/25 at 1006 hours, an interview was conducted with Resident Representative 2. Resident Representative 2 stated she was concerned about the flies observed inside Room B, because the flies could enter the mouths of Residents 32 and 66 who sleep with their mouths open. Resident Representative 2 stated she told the lead maintenance person about the flies, and she was told the flies were a problem in the facility, and the flies were coming from outside. On 8/29/25 at 1023 hours, an interview was conducted with Resident 35. Resident 35 stated she saw flies in the room, and she had been watching her roommates (Residents 32 and 66) because their mouths were open, and the flies could enter their mouths. a. Medical record review for Resident 35 was initiated on 8/25/25. Resident 35 was readmitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 12/20/24, showed Resident 35 had the capacity to understand and make decisions. On 8/30/25 at 1030 hours, an observation was conducted for Residents 32 and 66, and Room B. Residents 32 and 66 were observed asleep in bed. The bathroom shared between Rooms A and B was observed with a hole on the wall located underneath the bathroom sink, and adjacent to the plumbing pipes. b. Medical record review for Resident 32 was initiated on 8/25/25. Resident 32 was admitted to the facility on [DATE]. Review of Resident 35's Progress Note H&P examination dated 7/3/25, showed Resident 32 needed assistance with decision-making capabilities. c. Medical record review for Resident 66 was initiated on 8/25/25. Resident 66 was readmitted to the facility on [DATE]. Review of Resident 66's H&P examination dated 7/15/25, showed Resident 66 had no capacity to understand and make decisions. On 8/30/25 at 1032 hours, an observation was conducted for Residents 25 and 93, and Room A. Residents 25 and 93 were observed asleep in bed. d. Medical record review for Resident 25 was initiated on 8/25/25. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's H&P examination dated 6/24/25, showed Resident 25 had no capacity to understand and make decisions. e. Medical record review for Resident 93 was initiated on 8/25/25. Resident 93 was readmitted to the facility on [DATE]. Review of Resident 93's SNF H&P examination dated 6/22/25, showed Resident 25 had no capacity to understand and make decisions. On 8/29/25 at 1054 hours, an observation of the bathroom shared between Rooms A and B, and concurrent interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified the hole on the wall underneath the bathroom sink. The Maintenance Supervisor stated the maintenance staff had to open the plumbing from the wall last week to fix the clogged toilet but left the hole on the wall open. The Maintenance Supervisor stated the flies could get inside the facility from the opened windows, opened sliding doors, and gaps in the restroom sink.

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	08/29/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure three of five unnecessary medication sampled residents (Residents 2, 20, and 24) were free from unnecessary psychotropic drugs. * The facility failed to ensure Resident 24 was monitored for the behavior manifestation per the physician's order for Risperdal (antipsychotic medication) and failed to monitor the orthostatic hypotension related to the use of antipsychotic medication. In addition, the facility failed to monitor the number of hours of sleep for Resident 24 related to the use of trazodone (antidepressant medication). * The facility failed to ensure the nonpharmacological interventions for the use of the Remeron (antidepressant medication), divalproex (bipolar medication), Nuedexta (used to treat neurological condition that causes uncontrollable episodes of laughing and/or crying), Seroquel (antipsychotic medication) and buspirone HCL (antianxiety medication) medications were provided to Resident 20. In addition, the facility failed to complete the monthly behavior monitoring summaries for the listed medications since April 2025. Furthermore, the facility failed to ensure the side effects for the Remeron, divalproex sodium and Nuedexta medications were monitored. * The facility failed to ensure the nonpharmacological interventions for the use of the buspirone HCL and Seroquel medications were provided to Resident 2. In addition, the facility failed to complete the monthly behavior monitoring summaries for the listed medications since April 2025. These failures had the potential to place the residents at risk of receiving unnecessary medications and an increased risk of serious medication adverse reactions, which could negatively impact the residents' well-being.Findings: 1. Review of the facility’s P&P titled Antipsychotic Medication Use revised 7/2022 showed the following: - Antipsychotic medications will not be used if the only symptoms are one or more of the following: wandering, poor self-care, restlessness, impaired memory, mild anxiety, insomnia, inattention or indifference to surroundings, sadness or crying alone not related to depression or other psychiatric disorders, fidgeting, nervousness, or uncooperativeness; and - Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician the cardiovascular side effects such as orthostatic hypotension, and arrhythmias. Medical record review for Resident 24 was initiated on 8/25/25. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24’s Order Summary Report showed the following physician’s orders dated: - 7/18/25, to monitor for restlessness every shift; - 7/18/25, to monitor for behavior related to insomnia (difficulty falling or staying asleep) every shift; - 7/23/25, to administer Risperdal 2 mg via GT one time a day for psychosis manifested by agitation, kicking staff and pulling tubes; (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	08/29/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 7/23/25, to administer Risperdal 3 mg via GT at bedtime for psychosis manifested by agitation, kicking staff and pulling tubes; and - 7/23/25, to administer trazodone 25 mg via GT at bedtime for depression manifested by inability to sleep. Review of Resident 24’s MAR for August 2025 showed the following: - Resident 24 was administered the Risperdal 2 mg medication on 8/1 to 8/8, 8/10, 8/12 to 8/21, and 8/24 to 8/27/25 at 0900 hours; - Resident 24 was administered the Risperdal 3 mg medication on 8/1 to 8/20, and 8/22 to 8/26/25 at 2100 hours; - Resident 24 was monitored for restlessness on 8/1 to 8/27/25 for the day shift, and from 8/1 to 8/26/25 for the night shift; - Resident 24 was administered the trazodone 25 mg medication from 8/1 to 8/26/25 at 2100 hours; and - Resident 24 was monitored for the behavior related to insomnia from 8/1 to 8/27/25 for the day shift, and from 8/1 to 8/26/25 for the night shift. However, the monitoring did not show the number of hours Resident 24 slept. Further review of Resident 24’s medical record did not show Resident 24 was monitored for the orthostatic hypotension related to the use of antipsychotic medication. On 8/27/25 at 1204 hours, an interview and concurrent medical record review for Resident 24 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated Resident 24 was monitored for restlessness related to the use of the Risperdal medication, instead of the manifestations of agitation, kicking staff, and pulling the tubes per the physician's order . RN 1 verified Resident 24 was also not monitored for the orthostatic hypotension related to the use of the Risperdal medication. RN 1 further verified Resident 24 was not monitored for the number of hours of sleep related to the use of the trazodone medication. RN 1 stated the licensed nurses should have specified the number of hours of sleep, instead of placing checkmarks in the resident's MAR. On 8/28/25 at 1029 hours, an interview was conducted with the DON. The DON stated the behavior monitoring for Resident 24 related to the use of the Risperdal medication should have included the behaviors specific for the medications, as stated in the physician’s order. The DON stated the orthostatic hypotension was one of the side effects of the antipsychotic medication. The DON further stated the monitoring for the sleep should include the number of hours of the resident slept to determine if Resident 24 had insomnia. 2. Medical record review for Resident 20 was initiated on 8/27/25. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 12/11/24, showed Resident 20 had no capacity to understand and make decisions. (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	08/29/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 20's Order Summary Report for August 2025 showed the following physician’s orders: - dated 10/8/24, to administer Remeron 7.5 mg one tablet orally at bedtime for major depressive disorder manifested by poor appetite. - dated 2/10/25, to administer buspirone HCL oral tablet 10 mg by mouth three times per day for anxiety manifested by screaming. - dated 3/26/25, to administer Nuedexta oral capsule 20-10 mg by mouth two times a day for pseudobulbar affect manifested by inappropriate laughing and crying. - dated 4/15/25, to administer Seroquel 25 mg by mouth two times a day for psychosis manifested by talking to unseen others. - dated 4/15/25, to administer divalproex sodium oral capsule delayed release 250 mg twice a day for unspecified mood disorder manifested by constant screaming/yelling. Further review of Resident 20’s medical record review failed to show the documented evidence the nonpharmacological interventions were provided to Resident 20 related to the use of the divalproex sodium, Remeron, Nuedexta, Seroquel, and buspirone HCL medications. In addition, there was no documented evidence the the Monthly Psychotherapeutic Drug Summary Sheets for the listed medications were completed for Resident 20 since April 2025. Furthermore, there was no documented evidence the side effects were monitored for the Remeron, divalproex sodium and Nuedexta medications. 3. Medical record review for Resident 2 was initiated on 8/27/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 4/14/25, showed Resident 2 had the capacity to understand and make decisions. Review of Resident 2's Order Summary Report for August 2025 showed the following physician’s orders: - dated 4/15/25, to administer buspirone HCL oral tablet 15 mg by mouth two times per day for anxiety manifested by chronic irritability. - dated 4/15/25, to administer Seroquel 100 mg by mouth one time a day for schizophrenia manifested by paranoid delusions. Further review of Resident 2’s medical record review failed to show the nonpharmacological interventions were provided to Resident 2 related to the use of the above medications. In addition, there was no documented evidence the Monthly Psychotherapeutic Drug Summary Sheets for Resident 2 since April 2025. On 8/28/25 at 1347 hours, an interview and concurrent medical record review was conducted with the DON for Residents 2 and 20. The DON acknowledged and verified the above findings.

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	08/29/2025

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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	08/29/2025

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to notify the resident and/or their representative of the transfer and reasons for the transfer, and the facility's bed hold policy in writing when the resident was transferred to the acute care hospital for one of three final sampled residents (Resident 37) reviewed for acute care hospitalization. This failure had the potential for the resident and/or their representative of not knowing about the appeal process and the circumstances of the resident's transfer/discharge should the resident and/or their representative believe the transfer or discharge was inappropriate or involuntary, and to be unaware of their rights to request a bed hold and return to the first available bed should the resident's acute care hospital stay exceed the seven-day bed-hold period. Findings: a. Review of the facility's P&P titled Transfer or Discharge, Facility -Initiated (undated) showed the notice of transfer and discharge is provided to the resident and resident representative as soon as practicable before the transfer and to the long-term care Ombudsman when practicable. Notices are provided in a form and manner that the resident can understand, taking into account the resident educational level, language, communication barriers, and physical or mental impairments. Medical record review for Resident 37 was initiated on 8/26/25. Resident 37 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 37's physician's order dated 8/8/25, showed to transfer Resident 37 to the acute care hospital for evaluation related to a fall. Review of Resident 37's progress notes dated 8/8/25 at 0639 hours, showed Resident 37 was sent to the acute care hospital. Review of Resident 37's Notice of Transfer/discharge date d 8/8/25, showed the transfer location as the acute care hospital and the reason for the transfer was for Resident 37's welfare and Resident 37's needs could not be met in the facility. Under the section for the resident or resident representative signature showed Resident 37 was unable to sign at the time. Further review of Resident 37's medical record failed to show if Resident 37 or their representative were provided with the written notice of transfer when Resident 37 was transferred to the acute care hospital on 8/8/25. Review of Resident 37's H&P examination dated 8/12/25, showed Resident 37 had the capacity to understand and make medical decisions. b. Review of the facility's P&P titled bed Hold and Returns dated October 2022 showed all the residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided with written notice about these policies at least twice: - Notice 1: well in advance of the transfer (e.g. in the admission packet); and - Notice 2: at the time of transfer (or, if the transfer was emergency within 24 hours). Further review of the P&P showed multiple attempts to provide the resident representative with notice too should be documented in cases where the staff were unable to reach and notify the representative timely. Review of Resident 37's Bed Hold Informed Consent showed Resident 37 was transferred to the acute care hospital on 8/8/25, and the resident representative for Resident 37 was notified; however, the informed consent did not show the signature of Resident 37 or their representative on 8/8/25. Further review of the Bed Hold Informed Consent showed, you will have the absence of requesting a seven (7) day bed hold to keep a bed vacant and available for return to this facility. Non-Medi-Cal beneficiaries are responsible for reasonable cost not to exceed the beneficiaries daily room rate. Insurance may or may not cover such charges. Medical will cover the cost of the bed if the residence here of cost has been satisfied for the month, unless we receive return notice from the attending physician that they stay in the hospital is expected to exceed seven days. If you desire this option, the facility must be notified within 24 hours of transfer. Further review of Resident 37's medical record for Resident 37 did not show if Resident 37 or their representative was notified in writing of the facility's bed hold policy when Resident 37 was transferred to the acute care hospital on 8/8/25. On 8/27/25 at 1403 hours, an interview and concurrent medical record review for Resident 37 was conducted with RN 1. RN 1 verified Resident 37 was transferred to the acute care hospital on 8/8/25. RN 1 verified Resident 37's representative was informed regarding the bed hold, however, she was not able to find the documentation if the facility's bed hold policy was provided to Resident 37 or their representative in writing. RN 1 further stated the medical records department kept the transfer notices provided to the residents. RN 1 stated she was not sure how the facility provided the transfer/discharge notices, and bed hold policies in writing, when the resident was not able to sign the document and the resident representative was not available at the time of the transfer. On 8/27/25 1415 hours, an interview and concurrent medical record

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	08/29/2025

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 comprehensive person-centered plan of care to reflect the individual care needs for four of 21 final sampled residents (Residents 8, 68, 70, and 99), one of five residents (Resident 20) reviewed for unnecessary medications, and one of three closed record residents (Resident 10) reviewed. * The facility failed to develop a care plan to address Resident 8's use of an enteral feeding. * The facility failed to implement the care plan intervention of checking Resident 10's blood pressure every 12 hours to address Resident 10's hypotension diagnosis. * The facility failed to develop the comprehensive person-centered care plan to address Resident 20's use of divalproex sodium, Remeron, and Nuedexta medications. * The facility failed to develop a care plan to address Resident 68's use of insulin medication. * The facility failed to ensure to develop the comprehensive person-centered care plan to address Resident 70's use of olanzapine (antipsychotic), sertraline (antidepressant), trazodone (antidepressant) and apixaban(anticoagulant) medication. * The facility failed to develop a care plan to address Resident 99's use of anticoagulant medication. These failures had the potential to cause inconsistent, inappropriate and inadequate plans of care for residents in a vulnerable population and result in suboptimal outcomes for the affected residents. Findings: 1. Review of facility’s P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed a comprehensive, person- centered care plan that includes measurable objectives and timetables to meet the resident’s physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Minimum Data Set- standardized assessment tool used in long-term care facilities to collect information about the health and function of residents to provide comprehensive picture of each resident’s need) and no more than 21 days after admission. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Medical record review for Resident 20 was initiated on 8/27/25. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 12/11/24, showed Resident 20 had no capacity to understand and make decisions. Review of Resident 20's Order Summary Report for August 2025 showed the following physician’s orders: - dated 10/8/24, to administer Remeron 7.5 mg one tablet orally at bedtime for major depressive disorder manifested by poor appetite. - dated 3/26/25, to administer Nuedexta oral capsule 20-10 mg by mouth two times a day for pseudobulbar affect manifested by inappropriate laughing and crying. - dated 4/15/25, to administer divalproex sodium oral capsule delayed release 250 mg twice a day for unspecified mood disorder manifest by constant screaming/yelling. (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	08/29/2025

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	Review of Resident 20’s plan of care failed to show a care plan problem addressing the resident’s use of the above psychotherapeutic medications. On 8/28/25 at 1347 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 20’s plan of care failed to address the resident’s use of the psychotherapeutic medications. 2. Medical record review for Resident 70 was initiated on 8/25/25. Resident 70 was admitted to the facility on [DATE]. Review of Resident 70’s H&P examination dated 8/12/25, showed the resident had fluctuating capacity to understand and make medical decisions. Review of Resident 70’s admission MDS assessment dated [DATE], showed Resident 70 had a BIMS score of 15, indicating cognitively intact. Review of Resident 70's Order Summary Report showed the following physician's orders: - dated 8/7/25, to administer olanzapine (antipsychotic medication) 10 mg via GT at bedtime; - dated 8/7/25, to administer sertraline (antidepressant) 100 mg via GT one time a day; - dated 8/7/25, to administer trazodone (antidepressant) 50 mg via GT at bedtime, and - dated 8/7/25, to administer apixaban (blood thinner) 2.5 mg via GT two times a day. Review of Resident 70's plan of care failed to show documented evidence the care plans were developed to address the resident's use of the olanzapine, sertraline, trazodone, and apixaban medications as ordered by the physician. On 8/27/25 at 1212 hours, an interview and concurrent medical record review was conducted with RN 2 for Resident 70. RN 2 verified there were no comprehensive care plans were developed for the use of the olanzapine, sertraline, trazodone, and apixaban medications. On 8/27/25 at 1518 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F757, example #2. 3. On 8/26/25 at 1100 hours, an observation and concurrent interview was conducted for Resident 99. Resident 99 was observed awake and lying in bed. Resident 99 stated she had a stroke in 2016 and had been taking blood thinner since then. Resident 99 stated she had not experienced having episodes of bleeding. Medical record review for Resident 99 was initiated on 8/26/25. Resident 99 was admitted to the facility on [DATE]. (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	08/29/2025

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	Review of Resident 99's Order Summary Report showed a physician's order dated 8/21/25, to administer apixaban oral tablet 5 mg one tablet by mouth two times a day for anticoagulant. Review of Resident 99's H&P examination dated 8/22/25, showed Resident 99 had the capacity to understand and make decisions. Further review of Resident 99’s medical record failed to show documented evidence a care plan was developed for the use of the apixaban medication. On 8/26/25 at 1404 hours, an interview and concurrent medical record review for Resident 99 was conducted with LVN 9. LVN 9 stated a care plan should be initiated for any problems identified for the residents, to have a course of actions to follow and help resolve the issues. LVN 9 verified there was no care plan developed for Resident 99 related to the use of the apixaban medication. On 8/29/25 at 1440 hours, an interview was conducted with the DON. The DON stated the care plan was a guide which could direct the facility staff regarding which interventions to implement for the residents to achieve the goal of resolving the problems identified for the residents. The DON was informed and acknowledged the above findings for Resident 99. Cross reference to F757, example # 1. 4. Medical record review for Resident 68 was conducted on 8/27/25. Resident 68 was admitted to the facility on [DATE]. Review of Resident 68’s Order Summary report dated 8/28/25, showed a physician’s order dated 7/24/25, to administer NPH insulin (Neutral Protamine [NAME]-intermediate acting insulin) 5 units subcutaneously one time a day, 30 minutes before meal related to Type 2 Diabetes Mellitus (a disease that results in too much sugar in the blood). Review of Resident 68’s plan of care failed a care plan problem was developed related to the resident’s use of the insulin. On 8/27/25 at 1426 hours, an interview and concurrent medical record review was conducted with RN 2 for Resident 68. RN 2 reviewed Resident 68’s plan of care and verified there was no comprehensive care plan problem developed for the use of the insulin medication. On 8/27/25 at 1437 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 68’s plan of care and verified there was no care plan problem developed for the use of the insulin medication. The DON stated the resident’s care plan should have been developed to ensure the appropriate interventions were implemented. 5. Medical record review for Resident 8 was conducted on 8/28/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8’s Order Summary report dated 8/28/25, showed a physician’s order to administer Nepro with Carb Steady (type of enteral feeding) 1.8 at 67 ml/hr for 16 hours to provide 1830 calorie per 1072 ml or until dose is completed by enteral feeding pump. (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	08/29/2025

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	On 8/28/25 at 0955 hours, an observation was conducted inside Resident 8’s room. Resident 8 was observed with a GT, connected to a formula via an enteral pump (medical device to deliver liquid formula directly into a person’s digestive tract through feeding tube at a controlled, steady rate). Review of Resident 8’s plan of care failed to show a care plan problem was developed to address the resident’s enteral feeding. On 8/28/25 at 1100 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified there was no comprehensive care plan problem developed to address Resident 8’s enteral feeding. On 8/28/25 at 1116 hours, an interview was conducted with the DON. The DON verified the above findings and stated the facility should have developed a care plan problem addressing the resident’s enteral feeding. 6. Review of the facility’s P&P titled Care Plans – Comprehensive revised 9/2010 showed the facility would develop an individualized comprehensive care plan to meet the resident’s medical, nursing, mental and psychological needs for each resident. Each resident’s comprehensive care plan is designed to incorporate identified problem areas and reflect treatment goals, timetables, and objectives in measurable outcomes. Closed medical record review for Resident 10 was initiated on 8/27/25. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10’s plan of care revised 7/16/25, showed a care plan problem addressing Resident 10’s hypotension diagnosis. The interventions included to check Resident 10’s blood pressure every 12 hours. Review of Resident 10’s MDS assessment dated [DATE], showed Resident 10 had a medical diagnosis of hypotension (low blood pressure). Review of Resident 10’s Blood Pressure Summary for August 2025 showed the following blood pressure readings for Resident 10: - on 8/2/25 at 2317 hours, a blood pressure reading of 124/68 mmHg; - on 8/12/25 at 0650 hours, a blood pressure reading of 130/64 mmHg; - on 8/16/25 at 1603 hours, a blood pressure reading of 130/60 mmHg; and - on 8/18/25 at 1500 hours, a blood pressure reading of 66/33 mmHg. On 8/27/25 at 1330 hours, an interview and concurrent closed medical record review for Resident 10 was conducted with RN 1. RN 1 stated the purpose of the resident's care plans were to ensure the nursing interventions correlated with the resident's diagnoses and to ensure the facility staff knew what interventions needed to be implemented for the resident. RN 1 verified the above findings. (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	08/29/2025

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	On 8/27/25 at 1400 hours, an interview and concurrent closed medical record review for Resident 10 was conducted with the DON. The DON stated the facility staff were expected to implement the interventions in the residents’ care plan. The DON verified the above findings. On 8/29/25 at 1440 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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	08/29/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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 necessary care and services were provided to prevent the development or worsening of the pressure injuries (localized area of skin damage and underlying tissues caused by prolonged pressure or shear forces) for three of four final sampled residents (Residents 9, 62 ,and 83) reviewed for pressure injuries. * The facility failed to ensure the licensed nurses accurately documented the assessment of Resident 9's MASD to the coccyx. * The facility failed to ensure the low air loss mattress setting was consistent with Resident 62's weight and set on the alternate mode setting. * The facility failed to ensure Resident 83's low air loss mattress setting was accurate per the physician's order. In addition, the facility failed to reposition Resident 83 at least every 2 hours per Resident 83's care plan intervention. These failures placed the residents at risk of developing new pressure injuries and/or worsening of the existing ones.Findings: Review of the facility’s P&P titled Charting and Documentation dated 2001 showed the documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Medical record review for Resident 9 was initiated on 8/26/25. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9’s Change of Condition dated 8/9/25, showed Resident 9 had MASD to coccyx. However, review of Resident 9’s Subacute Nursing Assessment showed the licensed nurses documented the resident had bilateral buttocks pressure injuries on the following: - 8/9/25 at 2223 hours; - 8/10/25 at 2219 hours; - 8/15/25 at 2235 hours; - 8/18/25 at 2307 hours; - 8/19/25 at 2322 hours; - 8/21/25 at 2149 hours; - 8/27/25 at 2142 hours; and - 8/30/25 at 1950 hours. On 8/28/25 at 1457 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified the above findings. RN 2 verified the inaccurate documentation of Resident 9’s skin condition and stated the correct documentation was for the MASD to the coccyx. (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	08/29/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/25 at 1030 hours, an observation and concurrent interview was conducted with LVN 16. LVN 16 stated Resident 9 had an MASD to the coccyx. During the observation of Resident 9’s MASD to the coccyx with LVN 16, no sign of a pressure injury was observed. On 8/29/25 at 1412 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the documentation of an assessment should be based on what the licensed nurse assessed and observed. The DON verified the examples of the documentation inaccuracy for Resident 9’s Subacute Nursing Assessment listed above. 2. Review of the National Pressure Ulcer Advisory Panel’s (NPIAP) Guideline titled Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline 2025, under the Repositioning for Pressure Injury Prevention section showed extended periods of lying or sitting on a particular part of the body without redistribution of the pressure could lead to a pressure injury. Furthermore, repositioning and mobilization were essential preventative measures for reducing pressure injury occurrences. The Support Surfaces section showed to follow the manufacturers’ recommendations for the use of full body surfaces according to the individual’s weight and height. Review of the Invacare User Manual for Micro Air MA60 Series (undated) showed the Micro Air MA65 system came with a powered mattress and control unit that provided low air loss, alternate and static pressure redistribution therapy. In addition, under the operation instructions, the patient’s weight determined the comfort pressure level setting on the control unit. Medical record review for Resident 83 was initiated on 8/28/25. Resident 83 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 83’s Pressure Ulcer Risk Assessment 2.0 dated 6/30/25, showed Resident 83 had a score of 16, which indicated a high risk for pressure ulcers due to factors such as his fragile skin, poor activity and mobility, and poor general physical condition. Review of Resident 83’s H&P examination dated 8/22/25, showed Resident 83 was in a persistent vegetative state, contracted (a stiffening at any joint, that reduced the joint’s range of motion), and unable to communicate, track or make needs known. The H&P examination further showed Resident 83 had a diagnosis of anoxic brain injury (a condition where the brain was deprived of oxygen for a period of time) and quadriplegia (paralysis from the neck down, including legs and arms). On 8/28/25 at 1047, 1324, and 1452 hours, Resident 83 was observed lying in his bed in a supine position on a LAL (Low Air Loss) mattress. The control unit for the LAL mattress was set at level 4. Level 4 was for residents who weighed between 175 to 210 pounds. On 8/29/25 at 1022 hours, Resident 83 was observed lying in his bed in a supine position on a LAL mattress. The control unit for the LAL mattress was set at level 4. a. Review of Resident 83’s Order Summary dated 11/19/24, showed a physician's order for the LAL mattress setting at level 3 every shift for maintenance and preventative measures. Review of Resident 83’s Weight Summary dated 8/7/25, showed Resident 83 weighed 130 pounds. (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	08/29/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/25 at 1402 hours, an observation, interview, and concurrent medical record review for Resident 83 was conducted with LVN 3. LVN 3 stated the purpose of the LAL mattresses was to prevent the development of pressure ulcers. LVN 3 further stated the weight of each resident determined the setting of the comfort pressure level. LVN 3 verified Resident 83’s comfort pressure level setting was set at level 4, but the physician’s order showed a setting of level 3. On 8/29/25 at 1440 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. b. Review of Resident 83’s plan of care for altered neurological status related to anoxic brain damage revised on 7/8/24, showed the intervention to reposition Resident 83 at least every two hours. Furthermore, review of Resident 83’s plan of care for ADL self-care performance deficit related to limited mobility, ROM (Range of Motion), and musculoskeletal impairment showed the intervention for the staff participation to reposition and turn Resident 83 in bed. Review of Resident 83’s Documentation Survey Report V2 for August 2025 Section - Turn and Reposition every two hours while in bed, showed Resident 83 was not turned in bed every two hours. For example, the following dates and times showed when Resident 83 was turned in bed: - dated 8/1/25 at 0046, 0421, 1430, 1842, and 2222 hours; - dated 8/10/25 at 0312, 0610, 1345, 1505, and 2047 hours; and - dated 8/23/25 at 0413, 1313, 1955, 2018 and 0026 hours. On 8/29/25 at 1000 hours, an interview and concurrent medical record review for Resident 83 was conducted with the Case Manager. The Case Manager stated Resident 83 was a bedbound with multiple contractures. Furthermore, Resident 83 had crucial interventions to prevent skin issues from occurring, such as turning and repositioning him while in bed. Additionally, the Case Manager stated if the interventions were included in the resident’s care plan, the interventions should be implemented. The Case Manager verified the above findings. On 8/29/25 at 1028 hours, an interview was conducted with CNA 6. CNA 6 stated she could not reposition Resident 83 because it was too hard to move him. CNA 6 further stated she had not notified the licensed nurses because she was too busy with her workload. On 8/29/25 1440 hours, an interview was conducted with the DON. The DON stated she expected the facility staff to inform the licensed nurses if they could not complete the assigned tasks for the resident. The DON was informed and acknowledged the above findings. 3. Review of the facility P&P titled Support Surface Guidelines dated 2001 showed the purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. On 8/25/25 at 1133 hours, during the initial tour of the facility, Resident 62 was observed positioned on her back and lying on a LAL mattress (Drive [NAME] Air) on static mode with the weight setting between 200 to 250 pounds. (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	08/29/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 62 was initiated on 8/25/25. Resident 62 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 62's H&P examination dated 6/12/25, showed Resident 62 had no capacity to make medical decisions. Review of the Quarterly MDS assessment dated [DATE], showed Resident 62 had short-term and long-term memory problem. Review of Resident 62's Order Summary Report for August 2025 showed a physician's order dated 8/25/25, for the LAL mattress per the resident’s weight (149 pounds) every shift for maintenance and preventative measures. On 8/25/25 at 1207 hours, an observation and concurrent interview was conducted with LVN 12 inside Resident 62's room. Resident 62 was observed lying on the LAL mattress on static mode with the weight setting between 200 to 250 pounds. LVN 12 verified the findings and stated the LAL mattress should have been on the alternate mode setting. On 8/27/25 at 1604 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was informed of the above findings and stated the LAL mattress should have been checked by all the staff daily. RN 2 stated the LAL mattress should not have been on static mode and the setting should have been based on the resident’s weight. In addition, RN 2 stated the discrepancies in the LAL mattress setting defeated the purpose of the LAL mattress. On 8/28/25 at 1539 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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	08/29/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to assess the appropriateness and continued use of the indwelling urinary Foley catheter (flexible tube that passes through the urethra and into the bladder to drain urine) for one of two final sampled residents (Resident 37) reviewed for urinary catheter. * The facility failed to ensure Resident 37 was assessed for the appropriateness and continued use of the indwelling urinary Foley catheter. This failure had the potential to predispose Resident 37 to catheter associated urinary tract infection.Findings: Review of the Centers for Disease Control and Prevention's article titled Clinical Safety: Preventing Catheter-Associated Urinary Tract Infection (CAUTIs) dated 6/27/25, showed a UTI is an infection that involves any of the organs or structures of urinary tract (e.g., kidneys, ureters, bladder and urethra). A CAUTI occurs when germs (usually bacteria) enter urinary tract through the urinary catheter and cause infection. Under the section recommendation to all healthcare facilities showed to only use urinary catheter when needed, to place catheters using proper germ-free techniques with sterile equipment, to maintain the catheters closed sterile drainage system, and to remove catheter as soon as patient no longer need them. Further review of the article showed prolonged use is the most important risk factor for CAUTIs. On 8/26/25 at 0836 hours, Resident 37 was observed lying in bed with the indwelling urinary Foley catheter bag hanging on the right side of Resident 37's bed. Medical record review for Resident 37 was initiated on 8/26/25. Resident 37 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 37's MDS assessment dated [DATE], showed Resident 37 was cognitively intact. Review of Resident 37's Order Summary Report showed a physician's order dated 8/11/25, for Foley catheter size FR 16/10 ml attached to bedside closed drainage system. Further review of the physician's order failed to show the indication for Resident 37's indwelling urinary Foley catheter. Review of Resident 37's H&P examination dated 8/12/25, showed Resident 37 had the capacity to understand and make medical decisions. Review of Resident 37's admission Record dated 8/28/25, showed Resident 37 had diagnoses of urinary tract infection and retention of urine with the onset date of 7/8/25. Further review of Resident 37 medical record failed to show if the facility assessed Resident 37 for the appropriateness and continued use of the Foley catheter. On 8/27/25 at 1427 hours, an interview and concurrent medical record review for Resident 37 was conducted with RN 1. RN 1 stated the practice of the facility was to clarify the use of the indwelling urinary Foley catheter with the physician. RN 1 stated the diagnosis of the urinary retention alone was not an adequate indication for the continued use of the indwelling urinary Foley catheter. RN 1 verified the above findings and stated Resident 37 had the diagnosis of urinary retention and urinary tract infection with the onset date of 7/8/25. RN 1 stated she was not able to find the documentation if Resident 37 required the continued use of the indwelling urinary Foley catheter and if any assessment was done to attempt to remove the indwelling urinary Foley catheter. RN 1 further stated Resident 37 should have been reassessed for the removal of the indwelling urinary Foley catheter. RN 1 stated the use of the indwelling urinary Foley catheter without the proper indication could unnecessarily expose Resident 37 to catheter associated urinary tract infection. On 8/28/25 at 1438 hours, an observation and concurrent interview was conducted with Resident 37. Resident 37 was observed lying in bed with the urinary bag hanging on the right lower side of the bed. Resident 37 stated he had the indwelling urinary Foley catheter because he could not urinate by himself and he did not remember how long his had the indwelling urinary Foley catheter in. When asked if the facility attempted to remove the indwelling urinary Foley catheter to assess if he could urinate on his own, the resident stated facility did not attempt to remove his indwelling urinary Foley catheter. On 8/28/25 at 1133 hours, an interview with the DON was conducted. The DON was informed and acknowledged the above findings.

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	08/29/2025

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 0693 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **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 appropriate care and services for the use of the GT for one of five final sampled residents (Resident 72) and one nonsampled resident (Resident 45) reviewed for the GT feeding. * The facility failed to ensure the GT feeding formula was not stored at bedside and the GT formula label was accurate and matched the physician's orders for Residents 45. * The facility failed to ensure the GT feeding Jevity 1.5 Cal (a calorically dense, high-protein, fiber-fortified liquid formula which provides complete, balanced nutrition) was not left unattended at the bedside for Resident 72. These failures posed the risk of complications related to the use of the GT for Residents 45 and 72.Findings: 1. Review of the facility’s P&P titled Enteral Tube Feeding via Gravity Bag revised 11/2018 showed the following: - Check on the enteral nutrition label against the order before administration. Check the following information: (a) Resident name, ID and room number; (b) Type of formula; (c) Date and time formula was prepared. - On the formula label document initials, date and time the formula was hung/administered, and initial that the label was checked against the order. Medical Record Review for Resident 45 was initiated on 8/25/25. Resident 45 was readmitted in the facility on 8/8/25. Review of Resident 45’s Order Summary Report showed a physician's order dated 8/9/25, to administer the bolus enteral feeding with Glucerna 1.5 (type of GT feeding formula), give 237 ml five times a day at 0600, 0900, 1300, 1700, and 2100 hours. Review of Residents 45’s H&P examination dated 8/10/25, showed Resident 45 had no capacity to understand and make decisions. On 8/25/25 at 0925 hours, during the initial tour of the facility, an observation was conducted in Resident’s 45 room. Resident 45 was observed lying in her bed and a bottle of Glucerna 1.5 with 800 ml left in the bottle was observed on the over bed table. The feeding formula bottle was not labeled with resident's name or with the date/time the bottle was open. On 8/25/25 at 1114 hours, an observation and concurrent interview was conducted for Resident 45 with LVN 5. LVN 5 verified Resident 45 was receiving the bolus GT feeding of the Glucerna 1.5. LVN 5 verified the feeding formula bottle on the over bed table was for Resident 45's bolus GT feeding. LVN 5 stated the GT feeding formula bottle should have Resident 45's name and the date/time it was open. On 8/27/25 at 1407 hours, an interview and concurrent medical record review for Resident 45 was conducted with RN 2. RN 2 stated Resident 45 was receiving the bolus GT feeding and the licensed nurses needed to use the GT formula in a can and/or Tetra Pak (aseptic packaging cartons that keep products safe and shelf-stable without refrigeration) for the bolus GT feeding to ensure the resident received the accurate GT feeding amount as ordered. (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	08/29/2025

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 0693 Level of Harm - Potential for minimal harm Residents Affected - Some	On 8/28/25 at 1506 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. According to [NAME] Nutrition manufacturer’s Product Information for Jevity 1.5 Cal, under the Preparation of Tube Feeding section, follow healthcare professional instruction for flow rate, volume and need for additional fluids, and care should be taken to prevent contamination during preparation and administration. On 8/25/25 at 0851 hours, during the initial tour of the facility, Resident 72 was observed in bed receiving Jevity 1.5 cal via GT. Another bottle of Jevity 1.5 cal was also observed at bedside. Medical record review for Resident 72 was initiated on 8/25/25. Resident 72 was readmitted to the facility on [DATE]. Review of Resident 72’s Order Summary Report showed a physician’s order dated 6/29/25, to administer Jevity 1.5 Cal at 63 ml/hr for 20 hours to provide 1890 kcal/1260 ml or until dose is completed via GT by enteral feeding pump. On 8/25/25 at 0913 hours, an observation for Resident 72 and concurrent interview was conducted with the Case Manager. The Case Manager verified a bottle of Jevity 1.5 Cal was observed at Resident 72’s bedside. The Case Manager stated when the tube feeding formula was finished, it needed to be replaced with a clean new bottle of the enteral tube feeding formula. The Case Manager stated an extra bottle of tube feeding formula should not be left at the bedside because “anyone can touch it.”

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	08/29/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **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 necessary care and services to maintain the IV access for one of one final sampled residents (Resident 99) and one nonsampled resident (Resident 100) reviewed for the IV care. * The facility failed to ensure Resident 99's PICC line catheter was measured on 8/23/25, per the physician's order. * The facility failed to ensure the PICC line external catheter and arm circumference measurements were completed and documented in Resident 100's medical record. These failures had the potential to delay the identification of the IV catheter related complications for the residents.Findings: Review of the facility's P&P titled Central Venous Catheter Care and Dressing Changes revised 10/2024 showed the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. Measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare with the length documented at insertion. For PICCs, measure arm circumference and compare to baseline when clinically indicated to assess for edema and possible deep-vein thrombosis. 1. On 8/26/25 at 1100 hours, an observation and concurrent interview was conducted for Resident 99. Resident 99 was observed awake and lying in bed with the PICC line in the left upper arm, with an undated white dressing. Resident 99 stated the PICC line dressing was changed possibly last weekend. Resident 99 stated the PICC line was inserted in the acute care hospital. Medical record review for Resident 99 was initiated on 8/26/25. Resident 99 was admitted to the facility on [DATE]. Review of Resident 99's H&P examination dated 8/22/25, showed Resident 99 had the capacity to understand and make decisions. Review of Resident 99's Order Summary Report showed the following physician's orders: - dated 8/23/25, to measure the length of the PICC tubing on 8/23/25, and weekly with dressing change every Saturday; and - dated 8/23/25, for PICC/Central line dressing change every 7 days to start on 8/30/25. Further review of Resident 99’s medical record failed to show documented evidence the PICC line was measured on 8/23/25, per the physician's order. On 8/26/25 at 1524 hours, an interview and concurrent medical record review for Resident 99 was conducted with RN 1. RN 1 stated the PICC line dressing for Resident 99 was changed in the acute care hospital prior to the resident’s admission in the facility. RN 1 verified the PICC line was not measured on 8/23/25, per the physician’s order. RN 1 stated the baseline measurement of any central venous catheter, or IV catheter should be established upon admission to the facility, to make sure the catheter line was intact and not pulled out for safety. (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	08/29/2025

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/25 at 1440 hours, an interview was conducted with the DON. The DON stated for any residents with an IV line or central venous catheter who was admitted in the facility, the licensed nurses needed to assess the site, monitor for signs and symptoms of infection, and check the baseline measurement of the outside tubing or catheter line because these measurements would be the basis to determine if the catheter line was still in placed/intact or pulled out during the next assessment. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 100 was initiated on 8/25/25. Resident 100 was admitted to the facility on [DATE]. Review of Resident 100's admission MDS assessment dated [DATE], showed Resident 100 had a BIMS score of 10, indicating moderate cognitive impairment. Review of Resident 100's Order Summary Report for August 2025 showed a physician’s order dated 8/22/25, for PICC line dressing change every seven days. However, the Order Summary Report failed to show a physician’s order for the measurement and assessment of the PICC line upon admission to the facility. Review of Resident 100's IV Administration Record for August 2025 showed a physician’s order dated 8/26/25, for PICC line dressing change every seven days, however, there was no information documented regarding the measurement and assessment of the PICC line when the resident was admitted to the facility. Review of Resident 100's Body Assessments dated 8/13 and 8/20/25, failed to show the PICC line length and arm circumference measurements. Further review of Resident 100's medical record failed to show documented evidence of the measurements for the length of the PICC line catheter above the insertion site and arm circumference were obtained upon admission and every seven days with PICC line dressing change. On 8/26/25 at 1600 hours, an interview and concurrent medical record review for Resident 100 was conducted with RN 2. RN 2 stated the dressing change for the PICC line was performed every seven days. RN 2 verified Resident 100's medical record did not show the PICC line external catheter and arm circumference measurements upon the resident's admission to the facility. RN 2 stated there should have been a measurement of the length of the catheter and arm circumference upon the resident's admission to the facility. In addition, RN 2 stated the arm circumference measurement would indicate the signs and symptoms of infiltration (when fluids leak our of the vein and into the surrounding tissues) and the external catheter length would indicate dislodgement. On 8/28/25 at 1539 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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	08/29/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **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 necessary respiratory care services for four of four final sampled (Residents 3, 9, 68, and 70), and two nonsampled resident (Residents 24 and 100) reviewed for respiratory care. * The facility failed to administer the oxygen to Resident 3 per the physician's order and failed to ensure the oxygen concentrator was functioning properly. In addition, the facility failed to ensure Resident 3's nasal cannula was dated and labeled and changed weekly. * The facility failed to ensure Resident 9's oxygen tubing was changed and dated. * The facility failed to ensure Resident 24's set-up bag for the Yankauer (a rigid tonsillar suction device used for suctioning the mouth and oropharynx) suction was changed weekly. * The facility failed to ensure the suction bacterial filter was changed every month for Resident 68. * The facility failed to ensure Resident 70's oxygen and nebulizer tubing were labeled with the date, and the prefilled humidifier was changed as per the physician's order. * The facility failed to ensure a physician's order for Resident 100 was obtained prior to the administration of the oxygen therapy. In addition, the facility failed to ensure Resident 100's nasal cannula tubing was labeled and dated. These failures had the potential for the residents not to receive appropriate respiratory care and for increased risks of infection.Findings: 1. According to UCSF (University of California San Francisco) Health article titled Patient Education: Your Oxygen Equipment (undated) showed to maintain the oxygen equipment, the nasal cannula should be changed every week. a. Medical record review was initiated on 8/25/25. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3’s Order Summary Report showed a physician’s order dated 12/21/23, to apply oxygen via nasal cannula at two liters per minute. May titrate up to five liters to maintain oxygen saturation above 90%. On 8/25/25 at 0839 hours, during the initial tour of the facility, Resident 3 was observed in bed and receiving two liters of oxygen via nasal cannula. The nasal cannula was unlabeled and undated, and the set-up bag was dated 7/7/25. Resident 3 stated he wore the nasal cannula all the time. On 8/25/25 at 0911 hours, an observation for Resident 3 and concurrent interview was conducted with the Case Manager. The Case Manager verified Resident 3 received oxygen via nasal cannula. The Case Manager verified the nasal cannula was undated and the set-up bag was dated 7/7/25. The Case Manager stated the nasal cannula with the set-up bag was supposed to be changed weekly, the nasal cannula should be dated, and in a new set-up bag to prevent cross-contamination. b. On 8/27/25 at 1054 and 1059 hours, Resident 3 was observed in bed receiving one liter of oxygen via nasal cannula. Review of Resident 3’s Weights and Vitals Summary did not show Resident 3’s oxygen saturation was consistently monitored. Further review of Resident 3’s medical record did not show the administration of oxygen was documented consistently. (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	08/29/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/25 at 1109 hours, an interview was conducted with LVN 3. LVN 3 stated Resident 3 was on continuous oxygen, and the licensed nurses checked Resident 3’s oxygen saturation if the resident was off the oxygen. LVN 3 stated Resident 3 had a “drop in oxygen saturation” but was only monitoring him as a nursing intervention and there was no documentation every shift. On 8/27/25 at 1111 hours, an observation for Resident 3 and concurrent interview with LVN 3 was conducted. Resident 3 was observed in bed receiving one liter of oxygen via nasal cannula. LVN 3 checked Resident 3’s oxygen saturation and was observed at 86 to 88%. LVN 3 was observed increasing Resident 3’s oxygen to three liters per minute. LVN 3 checked Resident 3’s oxygen saturation again and was observed at 87 to 89%. LVN 3 was then asked why she was not increasing Resident 3’s oxygen when the oxygen saturation was below 90%. LVN 3 stated the oxygen concentrator could only go up to three liters per minute. LVN 3 attempted to increase the setting by dialing the flow control knob, but the dial only went up to three liters, although the oxygen concentrator had a maximum capacity of five liters per minute. LVN 3 stated the oxygen concentrator was not working and had to replace it. 2. On 8/25/25 at 0833 hours, during the initial tour of the facility, Resident 24 was observed in bed. A Yankauer suction dated 8/25/25, was observed at bedside, however, the set-up bag was not dated and labeled. On 8/25/25 at 0910 hours, an observation for Resident 24 and concurrent interview was conducted with the Case Manager. The Case Manager verified Resident 24’s Yankauer suction was dated 8/25/25, however, the set-up bag was not dated and labeled. The Case Manager stated the facility had to make sure everything was changed including the Yankauer suction with the set-up bag. The Case Manager stated it could be a risk for infection when a new item was placed in an old bag. Medical record review was initiated on 8/25/25. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24’s Order Summary Report showed a physician’s order dated 8/8/25, to suction as needed for excessive secretions every two hours as needed for productive coughing. Review of Resident 24’s MAR for August 2025 did not show Resident 24 was suctioned. On 8/28/25 at 1051 hours, an interview and concurrent medical record review for Residents 3 and 24 was conducted with the DON. The DON verified the above findings. The DON stated the respiratory supplies including nasal cannula, Yankauer suction with the set-up bag should labeled and dated, and changed weekly every Sunday by the charge nurses on the night shift. The DON further stated the oxygen concentrator should be checked by the charge nurses every shift. 3. Review of the facility’s P&P titled Oxygen Administration revised 10/2010 showed the oxygen devise (nasal cannula, mask and nasal catheter) is changed weekly and dated with the date of change. Medical record review for Resident 70 was initiated on 8/25/25. Resident 70 was admitted to the facility on [DATE]. Review of Resident 70’s H&P examination dated 8/12/25, showed the resident had fluctuating capacity to understand and make medical decisions. (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	08/29/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 70’s admission MDS assessment dated [DATE], showed Resident 70 has a BIMS score of 15, indicating cognitively intact. Review of Resident 70's Order Summary Report showed the following physician's orders: - dated 8/7/25, to change the medication nebulizer set up every Monday and as needed to prevent infection; - dated 8/7/25, to change the oxygen tubing every Friday night shift; and - dated 8/7/25, to change the prefilled humidifier every 3 days during the night shift and as needed. On 8/25/25 at 0830 hours, an observation and concurrent interview was conducted with Resident 70. Resident 70 was observed sitting on his bed and eating breakfast, with a T-bar (a T-shaped piece of tubing or a T-bar assembly used in medical oxygen delivery systems) oxygen at three liters per minute. The oxygen tubing and nebulizer bag were observed not labelled with the date the equipment was changed. The prefilled humidifier bottle was observed with a date 8/16/25. Resident 70 stated he did not know when the equipment was changed. On 8/25/25 at 0920 hours, an observation and concurrent interview for Resident 70 was conducted with LVN 6. LVN 6 verified the oxygen tubing and nebulizer bag were not labeled with the date the equipment was changed, and the prefilled humidifier bottle was dated 8/16/25. LVN 6 stated that oxygen tubing and nebulizer should be changed weekly to prevent infection. On 8/28/25 at 1506 hours, an interview was conducted with the Administrator and DON was conducted. The Administrator and DON were informed and acknowledged the above findings. 4. Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed the purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician’s order for this procedure. Review the physician’s orders or facility protocol for oxygen administration. Assemble the equipment and supplies as needed. On 8/25/25 at 1454 hours, during the initial tour of the facility, Resident 100 was observed lying in bed and receiving oxygen at two liters per minute via nasal cannula, which was attached to the oxygen machine concentrator. In addition, the nasal cannula was undated and unlabeled. Medical record review for Resident 100 was initiated on 8/25/25. Resident 100 was admitted to the facility on [DATE]. Review of Resident 100's admission MDS assessment dated [DATE], showed Resident 100 had a BIMS score of 10, indicating moderate cognitive impairment. Review of Resident 100's Order Summary Report for August 2025 failed to show a physician’s order for the oxygen administration. Review of Resident 100's MAR and TAR for August 2025 failed to show a physician’s order for the oxygen administration. (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	08/29/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/25 at 0837 hours, an observation and concurrent interview was conducted with LVN 10. LVN 10 verified Resident 100's nasal cannula was unlabeled and undated, and there was no physician's order for the oxygen administration. LVN 10 stated there should have been a physician's order for the oxygen usage. LVN 10 stated she was unsure how often nasal cannula should be changed. On 8/27/25 at 1521 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was informed of the above findings and stated there should have been a physician’s order for the oxygen administration. RN 2 stated the licensed nurses were responsible for changing the nasal cannula weekly and the nasal cannula should have been labeled and dated for infection control purposes. On 8/28/25 at 1539 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. 5. On 8/26/25 at 0944 hours, an observation was conducted for Resident 9. Resident 9’s oxygen tubing was observed without a date. On 8/27/25 at 0946 hours, a follow up observation was conducted for Resident 9. Resident 9’s oxygen tubing was observed without a date. On 8/27/25 at 0946 hours, an interview was conducted with RT 1. RT 1 stated Resident 9’s oxygen tubing was scheduled to be changed every Friday night, and the oxygen adapter should be dated. RT 1 stated every piece of equipment that was changed would have a date on the equipment itself. RT 1 verified Resident 9’s oxygen adapter was dated 8/12/25, and the oxygen tubing was missing the date it was last changed. RT 1 stated both equipment should have been changed out on 8/15 and 8/22/25. On 8/29/25 at 1412 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 6. On 8/27/25 at 1058 hours, an observation and concurrent interview was conducted with LVN 7 for Resident 68. Resident 68 was observed lying on his bed with the tracheostomy tube (medical device inserted into the trachea -windpipe- to provide a temporary or permanent airway for breathing) connected to the oxygen concentrator. A suction machine was observed at the bedside with the tubing connected to the canister (part of suction machine that collects the suctioned secretions), and the suction bacterial filter was dated 7/23/25. LVN 7 verified the suction bacterial filter was dated 7/23/25. When LVN 7 was asked when the suction canister should be changed, LVN 7 stated his understanding was to change the suction canister every week. Review of Resident 68’s Order Summary dated 8/28/25, showed a physician’s order dated 8/16/25, to change the suction filter every first of the month and PRN to prevent infection (7 am-7 pm). On 8/27/25 at 1114 hours, an observation and concurrent interview was conducted with RT 1. RT 1 verified the suction bacterial filter was dated 7/23/25 and should be changed at least every month or every first day of the month. RT 1 called the RT Supervisor to verify. (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	08/29/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/25 at 1118 hours, an observation and concurrent interview was conducted with the RT Supervisor. The RT Supervisor verified the above findings. The RT Supervisor stated it was the facility’s protocol to change the suction bacterial filter every month, as needed and/or every first day of the month. When the RT Supervisor was asked about the importance of changing the filter at least every month, RT Supervisor stated it was to prevent possible infection going into the machine, which may infect the resident when suctioned. On 8/27/25 at 1123 hours, an interview was conducted with the DON. The DON verified the above findings. The DON stated the bacterial filter should have been changed at least monthly and every first of the month.

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	08/29/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **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 appropriate dialysis care was provided for four of five final sampled residents (Residents 9, 37, 68, and 99) and two nonsampled residents (Residents 67 and 100) reviewed for dialysis services. * The facility failed to ensure Resident 9's physician's order to obtain the pre and post weights on the dialysis days were followed. Resident 9's post dialysis weights were not obtained on the dialysis days. * The facility failed to ensure the emergency dialysis kit kept at bedside was complete and included clamp scissors for Residents 37 and 100. * The facility failed to ensure a dialysis e-kit was available at bedside for Residents 67 and 99. * The facility failed to ensure the emergency dialysis kit was kept at Resident 68's bedside. In addition, the facility failed to ensure the licensed staff did not monitor and document the presence of bruit and thrill for Resident 68's central venous catheter in the dialysis communication record. These failures had the potential for the residents to experience medical complications.Findings: Review of the facility’s P&P titled Pre/Post Dialysis assessment dated 9/2017 showed prior to the initiation of treatment, the patient will be assessed regarding any physical complaints such as chest pain, difficulty breathing, bleeding, or any problems that may prohibit or complicate the dialysis treatment. If such symptoms or complaints are present, the nurse in charge will be notified prior to the initiation of treatment. 1. Medical record review for Resident 68 was initiated on 8/25/25. Resident 68 was admitted to the facility on [DATE]. Review of Resident 68’s H&P examination dated 7/25/25, showed Resident 68 needed assistance with his decision-making capabilities. Review of Resident 68’s admission MDS assessment dated [DATE], showed Resident 68 had a BIMS score of 13, indicating cognitively intact. a. Review of Resident 68's Order Summary Report showed the following physician's order dated 7/23/25, to observe/monitor for tenderness, redness, or bleeding at the site of the Quinton catheter (type of Central Venous Catheter) every shift. On 8/25/25 at 1222 hours, during the initial tour of the facility, Resident 68 was observed awake lying on his bed. Resident 68 was observed with the left upper chest Quinton catheter. Resident 68 stated that he was getting his dialysis every Monday, Wednesday and Friday in the facility. However, there was no dialysis emergency kit observed at the resident’s bedside. On 8/25/25 at 1228 hours, an observation and concurrent interview for Resident 68 was conducted with LVN 14. LVN 14 verified there was no available dialysis emergency kit at Resident 68's bedside. On 8/27/25 at 1518 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the residents who were on dialysis needed to have a dialysis kit at the bedside. (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	08/29/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Review of facility’s P&P titled Home Dialysis Center; Pre & Post Dialysis Assessments, dated 9/2017 showed in partial, establishment of the resident’s baseline status at the beginning of the treatment allows basis for safe and accurate treatment and provides a measurable guideline to ensure stability at the end of the treatment. These assessments also provide information necessary to individualize the treatment to meet identified patient outcomes. Pre and post dialysis assessment will include but not limited to the following: complaints/response to last treatments, heart: rate, rhythm, sounds; lungs: rate of breath, sounds, effort of breathing, access: patency, signs of infection. Review of Resident 68’s physician order showed an order dated 7/23/25, for dialysis schedule every Monday, Wednesday, and Friday at the facility with the address, telephone number of the facility and Nephrologist name documented. Review of Resident 68’s Pre (before) and Post (after) Dialysis Communication forms for July and August 2025 showed the licensed nurses documented “Yes” for the presence of bruit (abnormal sound caused by turbulent blood flow within an artery) and thrill (a rumbling sensation that can feel from a dialysis access site) for the resident’s dialysis access site/ central venous catheter (a thin, flexible tube inserted into a large vein in the chest) on the following dates: - on 7/25 and 7/28/25, for the pre and post dialysis; and - on 7/30, 8/4, 8/6, 8/15 and 8/22/25, for the pre-dialysis. On 8/27/25 at 1359 hours, an interview and concurrent medical record review was conducted with RN 2 for Resident 68. RN 2 reviewed Resident 68’s Pre and Post Dialysis forms for July and August 2025 and verified the above findings. RN 2 stated the licensed nurses should not have documented for presence of bruit and thrill for the resident’s dialysis access site because it was a central catheter. RN 2 stated only the peripheral access sites needed to be checked for the bruit and thrill. On 8/27/25 at 1425 hours, an interview was conducted with the DON. The DON verified the findings and stated the facility staff should not be documenting the bruit and thrill if the dialysis access site was centrally located, like Resident 68’s left upper chest central catheter. 2. On 8/25/25 at 1137 hours, during the initial tour of the facility, Resident 67 was observed awake and lying on the bed. Resident 67 was observed with AV shunt in the left upper arm. Resident 67 stated he had dialysis in the facility every Monday, Wednesday, and Friday. Further observation of Resident 67’s room failed to show a dialysis emergency kit was available. On 8/25/25 at 1202 hours, an observation and concurrent interview for Resident 67 was conducted with the Case Manager. The Case Manager stated the dialysis emergency kit should always be available and accessible at the resident’s bedside in the event the resident would bleed from the dialysis access site. The Case Manager verified there was no available dialysis emergency kit at Resident 67’s bedside. (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	08/29/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 8/25/25 at 1054 hours, during the initial tour of the facility, Resident 99 was observed awake, lying on the bed, and currently having dialysis at bedside, which was provided by an affiliated dialysis company. Resident 99 stated she had been in the facility for a few days only. Further observation of Resident 99’s room failed to show a dialysis emergency kit was available. On 8/25/25 at 1205 hours, an observation and concurrent interview for Resident 99 was conducted with the Case Manager. The Case Manager searched Resident 99’s room and verified there was no available dialysis emergency kit at the bedside for the resident. The Case Manager stated the dialysis emergency kit should be available for residents who were on dialysis. On 8/29/25 at 1440 hours, an interview was conducted with the DON. The DON stated the residents who had dialysis should always be checked for bleeding at the dialysis access site. The DON further stated the dialysis emergency kit was important to always be available and accessible in the resident’s room for any complications observed in the dialysis access site. The DON was informed and acknowledged the above findings for Residents 67 and 99. 4. Medical record review for Resident 37 was initiated on 8/25/25. Resident 37 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 37's H&P examination dated 8/12/25, showed Resident 37 had the capacity to understand and make medical decisions. In addition, Resident 37 had a diagnosis of ESRD (End-Stage Renal Disease, which describes the point where a person's kidneys have failed and can no longer filter waste, excess fluid, and toxins from the blood effectively) with a right Permacath (a type of central venous catheter used for long-term, needle-free access to the bloodstream) access and on renal dialysis. Review of Resident 37's Order Summary Report for August 2025 showed a physician's order dated 8/11/25, for hemodialysis every Monday, Wednesday, and Friday within the facility. Furthermore, a physician’s order dated 8/11/25, showed to observe, monitor for tenderness, redness, or bleeding at the site of the Quinton catheter every shift. On 8/25/25 at 1536 hours, an observation and concurrent interview was conducted with LVN 11 for Resident 37. Resident 37 was observed with a dialysis kit at the bedside. However, the dialysis kit did not include clamp scissors to prevent bleeding. LVN 11 verified the findings and stated the dialysis kit was incomplete because it did not include clamp scissors. On 8/27/25 at 1556 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was informed and acknowledged the above findings. RN 2 stated the dialysis kit should have include clamp scissors to prevent bleeding. 5. Medical record review for Resident 100 was initiated on 8/25/25. Resident 100 was admitted to the facility on [DATE]. Review of Resident 100’s admission MDS dated [DATE], showed Resident 100 had a BIMS of 10, indicating moderate cognitive impairment. (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	08/29/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 100's Order Summary Report for August 2025 showed a physician's order dated 8/12/25, for hemodialysis every Monday, Wednesday, and Friday within the facility. In addition, a physician’s order dated 8/12/25, showed to observe, monitor for tenderness, redness, or bleeding at the site of the Quinton catheter every shift. On 8/25/25 at 1510 hours, an observation and concurrent interview was conducted with RN 1 for Resident 100. Resident 100 was observed with a dialysis kit at the bedside. However, the dialysis kit did not include clamp scissors to prevent bleeding. RN 1 verified the findings and stated the dialysis kit was incomplete and did not include clamp scissors. On 8/27/25 at 1521 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was informed and acknowledged the above findings. RN 2 stated the dialysis kit should have included clamp scissors to prevent bleeding. On 8/28/25 at 1539 hours, an interview was conducted with the DON. The DON was informed and verified the above findings for Residents 37 and 100. 6. Medical record review for Resident 9 was initiated on 8/25/25. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9’s H&P examination dated 6/12/25, showed Resident 9 had a diagnosis of ESRD with a hemodialysis catheter to the right upper chest wall. Review of Resident 9’s Order Summary Report on 8/28/25, showed a physician’s order dated 6/11/25, to obtain Resident 9’s pre and post dialysis weight every day shift on Monday, Wednesday, and Friday. On 8/28/25 at 1049 hours, an interview and concurrent facility documents review was conducted with RNA 1. RNA 1 stated Resident 9’s pre dialysis weights were obtained and documented on the days of dialysis (Monday, Wednesday, and Fridays). However, RNA 1 stated Resident 9’s post dialysis weights were taken every Thursday. On 8/29/25 at 0954 hours, an interview and concurrent facility document review was conducted with RN 3. RN 3 reviewed Resident 9’s physician’s orders and verified the resident’s order to obtain the pre and post weight on the dialysis days. RN 3 also stated the importance of obtaining the pre and post weight was to provide the dialysis RN with how much fluid the resident was retaining so the RN could gauge how much fluid to safely remove. RN 3 verified the dialysis weight log showed the post weight was to be obtained on Thursdays for Resident 9. On 8/29/25 at 1412 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the residents’ weight should be obtained before and after dialysis treatment. The DON also stated the RNA obtained the residents’ weight before and after dialysis. The DON verified the RNA obtained the resident’s post dialysis weight every Thursdays.

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	08/29/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **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 three of three final sampled residents (Residents 6, 37 and 99) and one nonsampled residents (Resident 67) remained free from accident hazards due to the use of the side rails. * The facility failed to ensure the physician's order was obtained for the use of bilateral half side rails for Resident 6. In addition, the facility failed to ensure a care plan was developed to address the use of the bilateral half side rails for Resident 6. * The facility failed to ensure the less restrictive interventions were completed prior to the use of the half side rails for Residents 37 and 67. * The facility failed to ensure a physician's order and consent were obtained prior to the use of bilateral side rails for Resident 99. In addition, no care plan was developed to address the use of bilateral side rails for the resident. These failures had the potential to put the residents at risk for entrapment and serious injuries. Findings: Review of the facility's P&P titled Bed Safety and Bed Rails revised date 8/2022 showed the resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. Review of Resident 6's medical record was initiated on 8/25/25. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's Informed Consent Documentation dated 5/19/25, showed an informed consent from Resident 6’s responsible party and a physician's order for the use of side rails as enabler were obtained. Review of Resident 6's H&P examination dated 5/20/25, showed Resident 6 had the capacity to understand and make medical decisions. Review of Resident 6's Order Summary Report dated 8/28/25, failed to show a physician's order for the use of the bilateral half side rails. Review of Resident 6's plan of care failed to show a care plan intervention for the use of the bilateral half side rails. (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	08/29/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/25/25 at 1047 hours, during an initial tour of the facility, Resident 6's bed was observed with the bilateral half side rails elevated at the head of the bed. On 8/27/25 at 0907 hours, Resident 6 was observed lying on the bed with the bilateral half side rails elevated. On 8/28/25 at 1428 hours, an interview and concurrent medical record review was conducted with RN 4. RN 4 verified the above findings and stated there should be a physician’s order for the resident's bilateral side rails. RN 4 stated the care plan should have been initiated for the use of side rails. On 8/28/25 at 1539 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. Cross reference to F909, example #3. 2. Review of the facility's P&P titled Bed Safety and Bed Rails revised 8/2022 showed the use of bed rails is prohibited unless the criteria for use of bed rails have been met. The Use of bed rails section showed: - Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include roll guards, foam bumpers, lowering the bed, and/or use of concave mattresses to reduce rolling off the bed; - If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes an evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs, the resident's risk associated with the use of bed rails, input from the resident and/or representative, and consultation with the attending physician; and - Before using bed rails for any reason, the staff should inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: the assessed medical needs that will be addressed with the use of bed rails, the resident's risks from the use of bed rails and how these will be mitigated, the alternatives that were attempted but failed to meet the resident's needs, and the alternatives that were considered but not attempted and the reasons. On 8/26/25 at 0845 hours, an observation and concurrent interview was conducted for Resident 37. Resident 37 was observed awake and lying on the bed with the bilateral half side rails elevated. Resident 37 stated he could turn in the bed but needed assistance from the staff and used the side rails to grab and turn. Medical record review for Resident 37 was initiated on 8/26/25. Resident 37 was readmitted to the facility on [DATE]. Review of Resident 37’s Bed Safety Rail assessment dated [DATE], failed to show the least restrictive alternatives were attempted prior to Resident 37’s bilateral side rails use. (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	08/29/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 37's H&P examination dated 8/12/25, showed Resident 37 had the capacity to understand and make medical decisions. Review of Resident 37's Order Summary Report showed a physician's order dated 8/13/25, for the use of the bilateral half side rails as enabler/feelings of safety per patient’s request. On 8/27/25 at 1130 hours, an observation and concurrent interview for Resident 37 was conducted with CNA 12. Resident 37 was observed sleeping on the bed with the bilateral half side rails elevated. CNA 12 stated Resident 37 needs assistance from the staff with turning and getting out of bed. CNA 12 further stated Resident 37 used the side rails to grab and help turn. 3. On 8/26/25 at 0830 hours, an observation and concurrent interview was conducted for Resident 67. Resident 67 was observed awake and lying on the bed with the bilateral half side rails elevated. Resident 67 stated he could turn in the bed, and used the side rails to grab while turning. Resident 67 further stated he needed the facility staff's assistance to get out of bed. Medical record review for Resident 67 was initiated on 8/26/25. Resident 67 was admitted to the facility on [DATE]. Review of Resident 67’s Bed Safety Rail assessment dated [DATE], failed to show the least restrictive alternatives were attempted prior to Resident 67’s bilateral side rails use. Review of Resident 67's H&P examination dated 7/22/25, showed Resident 67 needed assistance with decision making. Review of Resident 67's Order Summary Report showed a physician's order dated 7/22/25, for the use of the bilateral half side rails as enabler per resident's request. On 8/27/25 at 1140 hours, an observation and concurrent interview for Resident 67 was conducted with CNA 12. Resident 67 was observed having dialysis at the bedside. CNA 12 stated Resident 67 was able to grab the rails when being turned or cleaned. CNA 12 further stated Resident 67 could not get out of bed related to the resident's knee surgery. 4. On 8/26/25 at 1100 hours, an observation and concurrent interview was conducted for Resident 99. Resident 99 was observed awake and lying on the bed with the bilateral half side rails elevated. Resident 99 stated she could turn by herself and grab the side rails but needed the facility staff to be there when she was turning in the bed for her safety. Medical record review for Resident 99 was initiated on 8/26/25. Resident 99 was admitted to the facility on [DATE]. Review of Resident 99’s Bed Rail assessment dated [DATE], showed the side rails/assist bars were indicated and served as an enabler to promote independence. Review of Resident 99's H&P examination dated 8/22/25, showed Resident 99 had the capacity to understand and make decisions. (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	08/29/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 99's medical record showed no documented evidence a physician's order and/or informed consent were obtained. In addition, there was no care plan problem initiated to address the use of the side rails for Resident 99. On 8/27/25 at 1205 hours, an observation and concurrent interview for Resident 99 was conducted with CNA 12. Resident 99 was observed awake, lying on the bed with the bilateral side rails elevated. CNA 12 stated Resident 99 was a new resident in the facility. CNA 12 stated she was able to take care of Resident 99. CNA 12 stated Resident 99 needed two-person assistance with turning but the resident could help as well. CNA 12 stated Resident 99 used the side rails to grab on to, and the resident felt safe holding to it. On 8/28/25 at 1045 hours, an interview and concurrent medical record review was conducted with RN 4. RN 4 stated upon admission to the facility, the resident was assessed for the need of the side rails. RN 4 stated the side rails were used only as enabler and the facility usually used the half upper side rails. RN 4 stated some residents would request the use of the side rails. RN 4 stated the least restrictive alternatives would be attempted prior to the use of the side rails. RN 4 stated some examples of the least restrictive alternatives were lowering the bed to the floor, providing frequent staff monitoring to anticipate the needs of the resident, providing assisted toileting, ensuring the call light was within the resident’s reach and frequently reminding the resident to use the call light for assistance. RN 4 stated if these alternatives were not helpful or effective then the licensed nurse would obtain an order from the physician for the use of the side rails. RN 4 stated an informed consent would be obtained from the resident or resident’s representative, after explaining the risks and benefits of the side rails. RN 4 further stated a care plan should be initiated addressing the use of the side rails. RN 4 verified the least restrictive alternatives were not attempted prior to the use of side rails for Residents 37 and 67. RN 4 further verified there was no physician’s order and informed consent, and care plan problem initiated to address the use of side rails for Resident 99. On 8/29/25 at 1440 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F900, examples # 1 and 2.

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	08/29/2025

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on interview and facility document review, the facility failed to ensure the posted staffing information included the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care. In addition, the staffing information did not include actual DHPPD (Direct Care Services Hours Per Patient Day) and CNA DHPPD. This failure had the potential to result in an incomplete staffing information provided to the public.Findings: Review of the AFL 18-27 dated 6/29/18, showed beginning 7/1/18, the facility shall either create a census and DHPPD form or use the Census and Direct Care Service Hours per Patient Day (CDPH 612 and instructions) to report daily DHPPD. The DON (or designee) must sign the form verifying the information is true and accurate. The census and DHPPD form must be typed or printed legible. If the facility chooses to create a form, it must contain substantially similar information to the attached CDPH 612 and instructions. The form must include the following:1. Facility name, address, and license number.2. Patient day date and the patient day start time.3. Total licensed SNF beds.4. Name of administrator and the DON or designee.5. Patient census at start of patient day.6. Scheduled nursing hours and the scheduled DHPPD.7. For the designated census periods: a. Beginning census b. Admissions c. Transfers in d. Other intakes that occurred e. Discharges f. Transfers out g. Deaths, and h. Other decreases that occurred8. Total actual/final nursing hours at the end of each census period.9. Average census.10. The actual/final total nursing hours.11. Actual/Final DHPPD.12. An attestation statement signed by the DON or designee verifying they have reviewed the patient census and nursing hours information and acknowledge the information is true and correct. Review of the facility's document titled Census and Direct Care Service Hours Per Patient Day (DHPPD) for the skilled nursing and subacute unit of the facility from 7/1 to 7/31/25, showed the scheduled direct care service hours, total CNA direct care service hours, beginning patient census, scheduled DHPPD, and scheduled CNA DHPPD. Under the section of the actual direct care service hours showed the average patient census, however, the document did not show the actual total direct care service hours, actual total CNA direct care service hours, actual DHPPD, and actual CNA DHPPD for the month of July 2025 (31 days). On 8/28/25 at 1513 hours, an interview and concurrent facility document review was conducted with the DSD. The DSD verified the above findings and stated the facility had no system that automatically populated the actual hours in the Census and Direct Care Service Hours Per Patient Day form, and she had to manually enter the actual hours at the end of the day. The DSD stated she did not get a chance to enter the actual total direct care service hours, actual total CNA direct care service hours, actual DHPPD, and actual CNA DHPPD for July 2025. On 8/29/25 at 1529 hours, an interview was conducted with the Administrator. The Administrator was informed and acknowledged the above findings.

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	08/29/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **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 two of 21 final sampled residents (Residents 70 and 99) were free from the unnecessary medications. * The facility failed to ensure Resident 70 who was on apixaban (medication used to prevent blood clots) was monitored for signs and symptoms of bleeding. * The facility failed to monitor Resident 99 for the signs and symptoms of bleeding related to the use of apixaban medication (medication used to prevent blood clots). These failures had the potential for the residents to receive unnecessary medications and develop significant adverse effects.Findings: According to the FDA the approved Highlights of Prescribing Information for apixaban issued on 04/2025 showed the most common adverse reaction in adult patients are related to bleeding. Review of the facility's P&P titled Anticoagulation – Clinical Protocol revised 11/2018 under the Monitoring and Follow-Up section, showed for the staff and physician to monitor for possible complications in individuals who were being anticoagulated and would manage related problems. If an individual on anticoagulation therapy showed signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse would discuss the situation with the physician before giving the next scheduled dose of anticoagulant. The physician would order measures to address any complications, including holding or discontinuing the anticoagulant as indicated. 1. On 8/26/25 at 1100 hours, an observation and concurrent interview was conducted for Resident 99. Resident 99 was observed awake and lying in bed. Resident 99 stated she had a stroke (when blood flow to the brain is interrupted, causing brain cells to die) in 2016 and had been taking blood thinner since then. Resident 99 stated she had not experienced having episodes of bleeding. Medical record review for Resident 99 was initiated on 8/26/25. Resident 99 was admitted to the facility on [DATE]. Review of Resident 99's Order Summary Report showed a physician's order dated 8/21/25, to administer apixaban 5 mg one tablet by mouth two times a day for anticoagulant. Review of Resident 99's H&P examination dated 8/22/25, showed Resident 99 had the capacity to understand and make decisions. Further review of Resident 99's medical record did not show documented evidence Resident 4 was observed or monitored for the signs and symptoms of bleeding. On 8/26/25 at 1404 hours, an interview and concurrent medical record review for Resident 99 was conducted with LVN 9. LVN 9 stated the residents who were getting anticoagulant medications should be monitored for the signs and symptoms of bleeding, like unusual bruising, bleeding from the gums or nose, and any signs and symptoms of blood in the urine or stool. LVN 9 further stated the residents who were taking the anticoagulation medications, especially for a long time, could potentially bleed out from inside the body and should be reported immediately to the physician for further evaluation and/or recommendations. LVN 9 verified Resident 99 was not being monitored for the signs and symptoms of bleeding related to the use of apixaban. (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	08/29/2025

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/25 at 1440 hours, an interview was conducted with the DON. The DON stated continuous monitoring of the signs and symptoms of bleeding for those residents who were receiving anticoagulant medications was important to prevent complications and alert the licensed nurses to provide interventions and notify the physician immediately if the signs and symptoms of bleeding were. The DON was informed and acknowledged the above findings for Resident 99. Cross reference to F656, example #3. 2. Medical record review for Resident 70 was initiated on 8/25/25. Resident 70 was admitted to the facility on [DATE]. Review of Resident 70's Order Summary Report showed a physician's order dated 8/7/25, to administer apixaban 2.5 mg via GT two times a day for atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Review of Resident 70’s H&P examination dated 8/12/25, showed the resident had fluctuating capacity to understand and make medical decisions. Review of Resident 70’s admission MDS assessment dated [DATE], showed Resident 70 had a BIMS score of 15, indicating cognitively intact. Review of Resident 70's plan of care failed to show documented evidence a care plan problem was developed to address the resident’s use of the apixaban medication as ordered by the physician. Further review of Resident 70's medical record did not show documented evidence Resident 70 was being observed or monitored for the signs and symptoms of bleeding. On 8/25/25 at 0830 hours, during the initial tour of the facility, Resident 70 was observed sitting and eating his breakfast. Resident 70 stated he was taking a blood thinner medication twice a day. On 8/26/25 at 1430 hours, an interview and concurrent medical review for Resident 70 was conducted with LVN 2. LVN 2 verified the above findings. LVN 2 stated Resident 70 was taking an anticoagulant medication. LVN 2 stated the resident would be at risk for bleeding and should be monitored every shift, with the finding documented in the resident’s medical record. On 8/27/25 at 1518 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified there was no documented evidence to show Resident 70 was monitored for the signs and symptoms of bleeding related to the resident’s use of the apixaban medication. The DON stated the residents who take blood thinner medications should have a monitoring for signs and symptoms of bleeding. On 8/28/25 at 1506 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. Cross reference to F656, example #2.

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	08/29/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (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	08/29/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 12.5%. Two of two licensed nurses (LVNs 3 and 12) were found to have made errors during the medication administration to two nonsampled residents (Residents 54 and 89). * LVN 3 failed to properly administer the potassium chloride tablet (supplement) as per the physician's order to Resident 89 when LVN 3 crushed the potassium chloride tablet and using an improper amount of water to reconstitute the medication. The physician's order specified to dissolve the potassium chloride medication with 60 ml of water, however, LVN 3 only used 10 ml. * LVN 3 failed to properly administer the crushed multivitamin with minerals (supplement) as per the physician's order to Resident 89 when LVN 3 left an excessive amount of residue in the medication cup, after administering the medication through the resident's GT. * LVN 12 failed to properly administer Resident 54's lactulose (used to treat constipation) 20 gm medication when LVN 12 only administered 10 gm. * LVN 12 failed to properly administer Resident 54's vitamin D (supplement) 400 IU medication when LVN 12 administered 1000 IU instead. These failures had the potential to negatively affect the residents' health conditions and posed the risk for possible complications or delay in interventions. Findings: Review of the facility's P&P titled Administering Medications revised April 2019 showed the medications are administered in accordance with prescriber orders, including any required time frames. 1. a. According to DailyMed, an online reference for clinical drug information, the residents should take potassium chloride medication without crushing, chewing or sucking the tablets. If those residents are having difficulty swallowing whole tablets, an alternative method of administration would include preparing an aqueous (water) suspension by placing the whole tablet in approximately 1/2 of water. On 8/25/25 at 0831 hours, a medication administration observation for Resident 89 was conducted with LVN 3. LVN 3 prepared and administered Resident 89's medications, which included the physician's order to dissolve the potassium chloride 10 mEq in 60 ml of water and administer via GT. During the medication administration observation, LVN 3 crushed the potassium chloride tablet and dissolved the crushed potassium chloride in 10 ml of water and administered it to Resident 89. On 8/25/25 at 1142 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified she crushed the potassium chloride medication and then dissolved it in 10 ml of water. LVN 3 verified the physician's order specified to dissolve the medication in 60 ml of water. b. On 8/25/25 at 0831 hours, a medication administration observation for Resident 89 was conducted with LVN 3. LVN 3 prepared and administered Resident 89's medications, which included the physician's order for the multivitamin with minerals via GT. LVN 3 placed the crushed multivitamin with minerals medication in a medication cup, then dissolved it in 10 ml of water and administered it to Resident 89. After the medication administration, the medicine cup was observed with an excessive amount of medication residue. On 8/25/25 at 1142 hours, an interview was conducted with LVN 3. LVN 3 verified she did not fully administer the multivitamin with minerals medication because there was an excessive amount of medication residue left in the medicine cup after the administration. 2. a. On 8/25/25 at 0926 hours, a medication administration observation for Resident 54 was conducted with LVN 12. LVN 12 prepared and administered Resident 54's medications, which included the physician's order to administer lactulose 20 gm by mouth daily. During the medication observation, LVN 12 prepared and administered 10 gm of the lactulose medication to Resident 54. On 8/25/25 at 1200 hours, an interview and concurrent medical record review was conducted with LVN 12. LVN 12 verified Resident 54's physician's order showed to administer lactulose 20 gm, but she administered 10 gm. b. On 8/25/25 at 0926 hours, a medication administration observation for Resident 54 was conducted with LVN 12. LVN 12 prepared and administered Resident 54's medications, which included the physician's order to administer vitamin D 400 IU by mouth daily. During the medication observation, LVN 12 prepared and administered 1000 IU of the vitamin D medication to Resident 54. On 8/26/25 at 1407 hours, an interview and medical record review was conducted with DON. The DON verified the physician's order for Resident 54 showed to administer vitamin D 400 IU daily.

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	08/29/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage, labeling, and disposal of medications. * The facility failed to remove expired medical supplies from Medication Room A. * The facility failed to ensure two prescription topical medications were labeled with the physician's order in Medication Cart A. In addition, the facility failed to ensure the facility staff's over-the-counter medications were not stored in Medication Cart A with the facility's house wound supplies. * The facility failed to ensure two prescription inhalational medications were labeled and dated in Medication Cart B. * The facility failed to ensure an opened insulin vial, and two opened insulin pens were labeled with the date opened in Medication Cart C. * The facility failed to ensure the facility staff's personal item was not stored in Dialysis Cart A. *The facility failed to ensure Resident 68's Venelex wound dressing ointment (used for wound management) and Sea-Clens wound cleanser spray were stored properly and safely. * The facility failed to ensure safe storage of medication observed at the bedside for Resident 73. These failures had the potential to alter the efficacy of the stored medications, pose an infection risk to the residents and result in inappropriate administration of prescription medication.Findings: Review of the facility's P&P titled Storage of Medications revised 1/2018 showed medications and biologicals are stored and labeled safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 1. On [DATE] at 0817 hours, an observation of Medication Room A and concurrent interview was conducted with RN 2. The following was observed: - A box of BD Precision Glide needles had expired on [DATE]; and - a box containing approximately 80 Luer Lok Red Caps had expired on [DATE]. RN 2 verified the findings and stated the medical supplies had expired and should have been discarded. 2. On [DATE] at 0838 hours, an observation of Medication Cart A and concurrent interview was conducted with LVN 13. The following was observed: - A tube of Venelex (prescription-strength topical ointment used as a wound dressing) was observed opened and unlabeled. - Two unopened tubes of prescription medication Derma Syn/Ag (a silver antibacterial hydrogel wound dressing that creates a moist environment, aids healing and helps manage bacteria) were observed unlabeled. - An opened, half empty bottle calcium carbonate antacid (treats upset stomach caused by too much stomach acid) tablets was stored with several containers of topical house wound supplies. (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	08/29/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 13 stated the Venelex and Derma Syn/Ag medications were house supply. LVN 13 verified the the Venelex and Derma Syn/Ag medications were prescription medications and stated the medications should not have been in Medication Cart A without a physician’s order. LVN 13 verified the calcium carbonate antacid were her own and stated the medication should not have been in Medication Cart A. 3. On [DATE] at 0838 hours, an observation of Medication Cart B and concurrent interview was conducted with RT 2. The following was observed: - Approximately 15 ampules of prescription inhalational medication Combivent (used to prevent tightening and narrowing of the airways) were observed opened and unlabeled/undated. Approximately 15 ampules of prescription inhalational medication Proventil (used to treat and prevent breathing difficulties) were observed unopened and unlabeled. RT 2 verified the above medications were opened, unlabeled, and removed from the original package. RT 2 verified per the manufacturer’s package insert, any ampules taken from the original package were to be dated and discarded two weeks from the opening date. 4. On [DATE] at 0838 hours, an observation of Medication Cart C and concurrent interview was conducted with LVN 2. The following was observed: - An opened, unlabeled half empty multi-dose vial of Humulin (medication used to lower blood sugar) insulin; - An opened, undated Lantus (medication used to lower blood sugar) insulin pen with Resident 4’s resident label affixed to it; and - An opened, undated lispro (medication used to lower blood sugar) insulin pen with Resident 61’s resident label affixed to it. LVN 2 verified the above findings and stated the multi-dose vial of insulin and single resident insulin pens should have been labeled with the open date. On [DATE] at 1115 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. 5. On [DATE] at 1145 hours, during an interview with one of the facility’s staff, the Dialysis Technician was observed opening the fourth lowest drawer of Dialysis Cart A. A big black purse was observed inside the fourth lowest drawer of the Dialysis Cart A. The Dialysis Technician was observed removing something out from the big black purse, closing the drawer, locking Dialysis Cart A with the purse still inside the drawer, and leaving. On [DATE] at 1155 hours, an observation and concurrent interview was conducted with the Dialysis Technician and LVN 3. The Dialysis Technician verified the cart was Dialysis Cart A and the big black purse was hers. The Dialysis Technician stated the reason why she kept the purse inside Dialysis Cart A was because she had her wallet in the purse. LVN 3 stated Dialysis Cart A contained items or equipment used for dialysis and no personal items should be kept inside the cart because it could cross contamination the supplies. (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	08/29/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1158 hours, an interview was conducted with the Dialysis RN Supervisor. The Dialysis RN Supervisor stated they were an affiliated dialysis company for the facility. The Dialysis RN Supervisor stated an in-service training was recently provided to the dialysis team regarding only storing the supplies used for dialysis in the dialysis cart and no personal items should be kept inside the dialysis carts. The Dialysis RN Supervisor stated the infection risk of the dialysis residents was high because of their compromised health status. The Dialysis RN Supervisor further stated by having the dialysis staff’s personal items or belongings inside the dialysis cart violated the infection control measures due to cross contamination to the sterile supplies used for dialysis. On [DATE] at 1434 hours, an interview was conducted with the IP and the DON. The IP and DON were informed and acknowledged the above findings. 6. Review of the facility’s P&P titled Bedside Medications Storage revised 2/2018, showed the following: - Bedside medication storage is permitted for resident who wish to self-administer medications, upon the written order of the prescriber and once self administration skills have been assessed and deemed appropriate in the judgement of the facility’s interdisciplinary resident assessment team. - A written order for the bedside storage of medication is present in the resident’s medical record. - All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medication to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of this procedure and related policy when necessary. Medical record review for Resident 68 was initiated on [DATE]. Resident 68 was admitted to the facility on [DATE]. Review of Resident 68’s H&P examination dated [DATE], showed Resident 68 needed assistance with decision making capabilities. Review of Resident 68’s admission MDS assessment dated [DATE], showed Resident 68 has a BIMS score of 13, indicating cognitively intact. On [DATE] at 1222 hours, during the initial tour of the facility, Resident 68 was observed lying on his bed. One tube of Velenex wound dressing ointment and one spray bottle of Sea-Clens wound cleanser were observed at the bedside table. Resident 68 stated he was not aware of the medications stored at the bedside table. On [DATE] at 1228 hours, an observation, interview and concurrent medical record review for Resident 68 was conducted with LVN 14. LVN 14 verified the above findings and stated Resident 68's medical record failed to show documented evidence of the physician’s orders for the Venelex wound dressing ointment and Sea-Clens wound cleanser. LVN 14 further stated Resident 68 should not have any medications at the bedside. (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	08/29/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1518 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated no medications needed to be at the resident’s bedside. 7. On [DATE] at 0859 hours, during the initial tour of the facility, Resident 73 was observed in bed, and a bottle of Forze VF Gold (multivitamin supplement) was observed at the bedside. On [DATE] at 0917 hours, an observation for Resident 73 and concurrent interview was conducted with the Case Manager. The Case Manager verified a bottle of Forze VF Gold was at Resident 73’s bedside. The Case Manager stated the medications should not be left at the bedside, unless the resident was assessed properly and authorized to take their own medications. The Case Manager further stated the resident could overdose from the medication if the resident grabbed and took all the medications at once. The Case Manager added there was a high risk of the resident overmedicating or overdosing himself, and since Resident 73 had a GT, he could potentially choke from the medication. Medical record review for Resident 73 was initiated on [DATE]. Resident 73 was readmitted to the facility on [DATE]. Review of Resident 73’s H&P examination dated [DATE], showed Resident 73 had no capacity to understand make decisions. Review of Resident 73’s Order Summary Report failed to show a physician’s order for the Forze VF Gold medication. Further review of Resident 73’s medical record failed to show documented evidence Resident 73 could keep medications at the bedside. On [DATE] at 1526 hours, an interview and concurrent medical record review was conducted with the DON and Administrator. The DON and Administrator verified the above findings. The DON stated for the resident to keep the medication at the bedside, the facility needed to obtain a physician’s order, and the resident needed to be assessed to make sure the resident could “tolerate” it.

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	08/29/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (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	08/29/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and in good condition. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the cutting boards were kept in a sanitary condition and with a cleanable surface. * The facility failed to ensure the heavy-duty blender used for puree preparation was air dried and free of food residue prior to storing and stacking. * The facility failed to ensure the ice machine drainpipes had an air gap and not touching the drains. * The facility failed to ensure the kitchen staff performed hand hygiene during dishwashing. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the food prepared in the facility's kitchen.Findings: Review of the facility's Diet Type Report dated 8/25/25, showed 54 of 91 residents consumed the food prepared in the kitchen. 1. Review of the facility's P&P titled Hoods, Filters, and Vents dated 2023 showed the hoods must be cleaned every two weeks and must be free of dust and grease. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention, the dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 8/25/25 at 0833 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The kitchen hood over the stove had black and dirt residue. The DSS acknowledged the findings. The DSS stated the dietary staff cleaned the hood every two weeks and was also cleaned by an outside company every six months. The DSS stated the kitchen hood should not be greasy due to fire hazard. 2. Review of the facility's P&P titled Sanitation dated 2023 showed all the utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. The plastic ware, China, and glassware that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. The plastic ware is bleached as necessary to prevent staining. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 8/25/25 at 0833 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed and verified by the DSS:- Basting brush used to spread butter was observed with the bristles frayed, discolored and worn out.- Three stainless steel scoops for food portioning were observed with the cream colored handles discolored and peeling.- Two stainless steel scoops for food portioning were observed with the gray colored handles worn out and peeling.- One stainless steel scoop for food portioning was observed with the black colored handle worn out and peeling.- One dough cutter was observed with the wooden handle discolored and deformed at the corners. The DSS acknowledged the above findings and stated the worn out utensils should have been replaced and discarded. 3. Review of the facility's P&P titled Dishwashing dated 2023 showed gross food particles shall be removed by careful scraping and pre-rinsing in running water. The dishes are to be racked loosely without overlapping. Appropriate chemicals will be used to wash, de-stain, and rinse dishes. The flatware is to be pre-soaked in a solution of water and detergent per manufacturer's instructions. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 8/25/25 at 0833 hours, during the initial kitchen tour, an observation and concurrent

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	08/29/2025

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the garbage was properly stored in two of two garbage dumpsters. * The facility failed to ensure the lids for the two garbage dumpsters were fully closed. This failure had the potential to attract pest/rodents that carried diseases. Findings: Review of the facility's P&P titled Garbage and Trash dated 2023 showed all the food waste must be placed in sealed leak-proof, non-absorbent, tightly closed containers (i.e., plastic bags) and shall be disposed of as necessary to prevent a nuisance or unsightliness. Adequate, clean, vermin-proof areas must be provided for storage of garbage and rubbish. Garbage and trash cans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. The trash collection area is a potential feeding ground for vermin and rodents and must be kept clean. According to the USDA Food Code 2022 Section 5-501.15 Outside Receptables, the receptables and waste handing units for refuse, recyclables, and returnable used with materials containing food residue and used outside the food establishment shall be designed and constructed to have tight-fitting lids, doors and covers. On 8/25/25 at 0928 hours, an observation and concurrent interview was conducted with the Maintenance Supervisor of the facility's two of two outside garbage dumpsters. The garbage dumpsters were observed with the lids partially propped open by the trash bags preventing the lids from fully closing. In addition, there was a bag of trash on the ground. The Maintenance Supervisor verified the findings and stated the dumpster lids should be completely closed at all times for infection control purposes.

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	08/29/2025

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (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	08/29/2025

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary hospice services for one of one final sampled resident (Residents 11) reviewed for hospice services . * The facility failed to ensure Hospice A's plan of care including the physician's orders were integrated into Residents 11's care. * The facility failed to ensure the complete documentation of the hospice staff visits were available for Resident 11. * The facility failed to ensure Resident 11's IDT meeting included the hospice staff. These failures posed the risk for the delay in communication and provision of the hospice care between the hospice provider and facility.Findings: Review of the facility's P&P titled Hospice Program (undated) showed when a resident participates in the hospice program, a coordinated plan of care between the facility, Hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plans shall be revised and updated as necessary to reflect the resident's current status. a. Medical record review for Resident 11 was initiated on 8/25/25. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 5/1/25, showed Resident 11 had no capacity to understand and make decisions. Further review of the Resident 11's plan of care failed to show the hospice care plan was incorporated in the facility's plan of care for the resident. b. Review of Resident 11's Hospice A Current Treatment / Medication/ DME list showed the following Hospice A physician's orders:- dated 4/1/25, to administer ondansetron (medication used to prevent nausea and vomiting) 4 mg orally every four hours as needed for nausea and/or vomiting; and- dated 4/1/25, for the RN to visit once every two weeks for supervisory visits. Review of Resident 11's Order Summary Report showed the following physician's orders:- dated 4/1/25, to admit Resident 11 to Hospice A.- dated 4/1/25, for the Skilled Nursing Visit once a week and one more visit as needed for symptom management. Certified Home Health Aide (CHHA) visit twice a week for hygiene and activities of daily living. However, further review of Resident 11's Order Summary Report did not show Hospice A physician's orders for the ondansetron medication and frequency of hospice RN visit to the facility. c. Review of Resident 11's Hospice A Monthly Schedule showed the following:- Hospice A's LVN to visit on 8/4 and 8/18/25- Hospice A's RN to visit on 8/14 and 8/28/25.- Hospice A's CCHA to visit on 8/5, 8/7, 8/12, 8/14, 8/19, 8/21, 8/26, and 8/28/25. However, review of Resident 11's Hospice A's Clinical Progress Notes showed notes made by Hospice A staff on 8/5, 8/9, 8/12, 8/14, 8/19, 8/23, 8/26, 8/27, and 8/28/25. Further review of the clinical progress notes did not show the professional designation of the hospice staff documenting the notes. In addition, the clinical progress notes did not show if Resident 11 was visited by Hospice A's LVN, RN, and CCHA as scheduled in the monthly schedule. d. Review of Resident 11's Interdisciplinary Team Conference Review showed following:- on 7/2/25 at 1505 hours, the quarter review of the IDT note showed an entry from the nursing, activities, and dietary department. However, further review of the IDT note failed to show if the staff from Hospice A were present in the IDT meeting.- on 5/21/25, the annual review of IDT team participation professional showed the signature of the activities, food and nutrition, and other departments. However, there was no signature on the section for the hospice. Further review of the document failed to show if the staff from Hospice A were present in the IDT meeting. On 8/28/25 at 1026 hours, an interview and concurrent medical record review for Resident 11 was conducted with the MDS Coordinator. The MDS Coordinator stated the care for the residents on hospice should be coordinated with the hospice provider and the care plan including the physician's orders from the hospice provider needed to be incorporated into the resident's care. The MDS Coordinator further stated the hospice staff should be included in every IDT meeting for the residents who were receiving services from the hospice provider and the facility needed to ensure the hospice staff visited the residents as ordered and scheduled by the hospice provider. The MDS Coordinator verified Resident 11 was admitted under the hospice services on 4/1/25, and verified the above findings. The MDS Coordinator verified the care plan from Hospice A was not incorporated into the facility's care plan for Resident 11 and Hospice A physician's orders for the ondansetron medication, and the schedule for RN visits were not included in the facility's physician's orders. The MDS Coordinator also verified the IDT meeting for Resident 11 on 5/21 and 7/2/25, did not include the staff from Hospice A. The MDS Coordinator verified the clinical progress notes entered by the Hospice A staff did not show the professional designation of the hospice staff making the entry on the resident's clinical progress notes. In addition, the MDS Coordinator was not able to show if the staff from Hospice A visited Resident 11 as

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	08/29/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control program and practices to help prevent the development and transmission of diseases and infections. * The facility failed to ensure an infection control surveillance report/log and mapping were completed for the months of May and June 2025. * The facility failed to ensure Resident 24 was placed on EBP (Enhanced Barrier Precautions) per the physician's order. * The facility failed to ensure an EBP sign was placed outside of Room C for Resident 37 who had a Quinton catheter and indwelling urinary catheter, and for Resident 67 who had an AV fistula. * The facility failed to ensure the facility staff did not refill the residents' water from the bathroom sink. In addition, the facility failed to ensure the trash was emptied when filled and a used washable gown was discarded properly for Room B. * The facility failed to ensure Resident 65's water jug was not kept on the floor. * The facility failed to ensure to the licensed nurse donned the proper PPE and performed hand hygiene after picking up the dropped medication cup from the ground during the medication administration observation. These failures had the potential for the facility to not accurately identify, investigate, and prevent new infections from developing within the facility, and posed the risk of the transmission of communicable diseases to the residents and employees throughout the facility.Findings: Review of the facility's P&P titled Antibiotic Stewardship – Review and Surveillance of Antibiotic Use and Outcomes revised 12/2016 showed the antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for the improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. The Policy Interpretation and Implementation section showed all resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The intonation gathered will include resident name and medical record number, unit and room number, date symptoms appeared, name of antibiotic, start date of antibiotic, pathogen identified, site of infection, date of culture, stop date, total days of therapy, outcome, and adverse events. Review of the facility's P&P titled Infection Control Guidelines for All Nursing Procedures revised 8/2012 showed under the General Guidelines all employees must wear personal protective equipment as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious materials and must wash their hands for ten to fifteen seconds using antimicrobial or nonantimicrobial soap and water under the following conditions: - Before and after direct contact with residents; - When hands are visibly dirty or soiled with blood or other body fluids; - After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; - After removing gloves; - After handling items potentially contaminated with blood, body fluids, or secretions; - Before eating and after using a restroom; 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	08/29/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- When there is likely exposure to spores. 1. On 8/28/25 at 1554 hours, an interview and concurrent facility document review was conducted with the IP. Review of the Infection Control Surveillance binder failed to show the infection control surveillance report/log and mapping were completed for May and June 2025. The IP verified these findings and stated he just started a month ago as the IP in the facility. The IP stated he reviewed all the reports from the previous months and did not have the chance to update all the reports or logs for the infection control surveillance. The IP stated without the surveillance report, the facility would not be able to identify the infection within the facility. The IP further stated it was important to complete the infection surveillance report for each month to be able to see the pattern of a certain infection, which would help the facility plan what observations, interventions, and/or in-service trainings to be provided to prevent or control the increased number of infections. On 8/29/25 at 1440 hours, an interview was conducted with the DON. The DON stated it was very important to complete the infection control surveillance and mapping for each month because it would help the facility to identify the infections in the facility. The DON stated the infection surveillance report and mapping could also be used to help the facility complete a root cause analysis, to investigate the causes of the infections present in the facility. This in turn they could plan interventions to prevent or limit those infections from spreading throughout the facility. 2. According to the CDC, assuming contact precautions do not otherwise apply, EBP is recommended for residents with any of the following: 1) infection or colonization with a MDRO or 2) a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO (Multi-Drug Resistant Organism infection is a serious illness caused by microorganisms, primarily bacteria, that have developed resistance to multiple antibiotics, making them difficult or impossible to treat with standard medications). Examples of indwelling medical devices include, but are not limited to, central vascular catheters including hemodialysis catheters, peripherally inserted central catheters, indwelling urinary catheters, feeding tubes, and tracheostomy tubes. EBP involves gown and glove use during high-contact resident care activities such as dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use and wound care. The EBP signs are intended to signal to individuals entering the room the specific actions they should take to protect themselves and the residents. a. Medical record review for Resident 37 was initiated on 8/26/25. Resident 37 was readmitted to the facility on [DATE]. Review of Resident 37's Order Summary Report showed the following physician's orders: - dated 8/11/25, to observe/monitor for tenderness, redness, or bleeding at site of Quinton catheter; and - dated 8/11/25, for indwelling urinary Foley catheter care every shift. b. Medical record review for Resident 67 was initiated on 8/26/25. Resident 67 was admitted to the facility on [DATE]. (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	08/29/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 67's Order Summary Report showed a physician's order dated 8/18/25, to may place the resident on EBP related to an indwelling medical device: hemodialysis, and wound management every shift; to wear the proper PPE during high contact activities. On 8/27/25 at 1420 hours, an observation for Residents 37 and 67 and concurrent interview was conducted with CNA 12. Residents 37 and 67 were observed lying in the bed in Room C. There was no sign observed outside the door of Room C to indicate the residents were on EBP. An isolation cart containing gowns and gloves was observed outside the room. CNA 12 was observed assisting Resident 67 with turning, wearing only a mask and gloves, and not a gown. CNA 12 acknowledged she did not wear a gown and only donned the mask and gloves when turning Resident 67. CNA 12 stated Residents 37 and 67 were just moved to Room C and she missed donning the gown because there was no EBP sign outside the room. CNA 12 stated she knew both residents had dialysis, but she did not know about the type of dialysis access they had. CNA 12 stated for the residents with a Foley catheter, she had to wear the gown, gloves and mask when she had to empty the drainage bag. On 8/27/25 at 1440 hours, an observation for Room C, interview and concurrent medical record review were conducted with the IP. The IP verified there was no EBP sign outside the door of Room C. The IP stated the residents with wounds, surgical stitches, GT, any indwelling medical devices, any dialysis access, and any central lines should be placed on EBP to prevent the spread of MDROs. The IP stated an EBP sign was placed outside the door to remind the facility staff and visitors the residents were on EBP, to wash their hands when going in and out of the room, and for the facility staff to wear the proper PPE when providing high-contact activities such as changing linen, showering, hygiene care to the residents on EBP. On 8/29/25 at 1440 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Medical record review for Resident 24 was initiated on 8/25/25. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24’s Order Summary Report showed a physician’s order dated 8/2/25, to may place the resident on EBP related to the medical indwelling device: PEG/GT. On 8/27/25 at 0907 and 1011 hours, and on 8/28/25 at 0857 hours, Resident 24 was observed in bed. There was no sign observed outside the door of Resident 24’s room to indicate the resident was on EBP. An isolation cart containing gowns, and gloves was observed inside the room. On 8/27/25 at 1011 hours, CNA 4 was observed assisting Resident 24, and changing Resident 24’s incontinence brief. CNA 4 was observed wearing a mask and gloves, however, CNA 4 was not observed wearing a gown. (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	08/29/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/25 at 1120 hours, an observation for Resident 24 and concurrent interview was conducted with CNA 4. Resident 24 was observed in bed. There was no sign observed outside the door of Resident 24’s room to indicate the resident was on EBP. An isolation cart containing gowns, and gloves was observed inside the room. CNA 4 verified the above findings. CNA 4 acknowledged she did not wear a gown but only mask and gloves when providing care to Resident 24. CNA 4 stated she did not receive any information that the resident was on EBP, nor the need to wear a gown when providing high-contact activities to Resident 24. CNA 4 stated she would know a resident was on EBP by looking at the sign outside the door. On 8/28/25 at 1122 hours, an observation for Resident 24, interview, and concurrent medical record review was conducted with the IP. The IP verified there was no EBP sign outside the door of Resident 24’s room. The IP stated the residents with wounds and medical dwelling devices such as a catheter, GT, and fistula were placed on EBP to prevent the spread of the MDROs. The IP stated an EBP sign was placed outside the door to remind the facility staff and visitors the residents were on EBP, to wash their hands when going in and out of the room, and for the facility staff to wear the proper PPE when providing high-contact activities such as changing linen, showering, hygiene care to the residents on EBP. 4. According to the CDC article titled Considerations for Reducing Risk: Water in Healthcare Facilities dated 10/24/24, water can carry germs that threaten resident safety and spread antimicrobial-resistant pathogens or cause HAIs. One of the considerations included healthcare facilities can reduce splashing from sinks and drains that can expose people to pathogens. Splashes can occur when water hits the contaminated drain cover, or a person flushes a toilet or hopper. Splashes can spread droplets containing OPPP (opportunistic premise plumbing pathogens, which are microorganisms that live and grow in building water systems. These infections primarily affect individuals with weakened immune systems) to the surrounding environment, residents and providers. Recent evidence indicates sinks and other drains, such as toilets or hoppers, in healthcare facilitate can become contaminated with MDROs. One of the ways to reduce the risk of OPPP exposure through sinks and drains in healthcare facilities is to avoid placing resident care or personal items on counters next to sink. a. On 8/29/25 at 1006 hours, an interview was conducted with Resident Representative 2. Resident Representative 2 stated she was concerned about the source of water given to Resident 66. Resident Representative 2 stated she asked one of the charge nurses who worked last night if she could refill Resident 66’s water from the water dispenser at the nursing station, but she was told to get the water from the bathroom sink. Resident Representative 2 stated she asked the CNAs where they got the water, and she was told they got the water from the kitchen. On 8/29/25 at 1023 hours, an interview was conducted with Resident 35, with Resident Representative 2 present. Resident 35 stated she walked to the nursing station to ask the facility staff to refill her water pitcher from the water dispenser in the nursing station, however, she had seen the facility staff refill Resident 66’s water pitcher from the bathroom sink. b. On 8/29/25 at 1030 hours, an observation for Residents 32 and 66 in Room B was conducted. Residents 32 and 66 were observed asleep in bed. [NAME] water pitchers were observed at the bedside for Residents 32 and 66. A trash bin was observed full, and a used washable gown was observed on top of the trash bin inside Room B. (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	08/29/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/25 at 1037 hours, an observation for Room B and concurrent interview was conducted with LVN 8. LVN 8 verified the trash bin in Room B was full, and the used washable gown was on top of the trash bin. On 8/29/25 at 1045 hours, an interview was conducted with CNA 2. CNA 2 stated the residents in Room B were part of his assignment. CNA 2 stated all the residents with GT have a water pitcher at the bedside for the licensed nurses to use when flushing the GT, or for the residents to drink if the residents did not have the GT. CNA 2 stated the night shift CNAs changed and refilled the water pitchers every night, then when it was empty, the morning CNAs would refill them by getting the water from the bathroom sink. CNA 2 stated they only got ice and water from the kitchen when the residents wanted cold water. On 8/29/25 at 1054 hours, an observation for Room B and concurrent interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified the trash bin in Room B was full and a used washable gown was on top of the trash bin. The Maintenance Supervisor stated the housekeeping staff were in charge of emptying the trash bin, and the trash bin should be emptied twice in the morning shift. On 8/29/25 at 1336 hours, a telephone interview was conducted with CNA 7. When asked where he got the water for the residents, CNA 7 stated he would get the water from the water dispenser in the nursing station. When asked where he would get the water if the water ran out at during the night, CNA 7 stated he would get the water from the residents' bathroom sink. On 8/29/25 at 1350 hours, an interview was conducted with the DSD and IP. The DSD stated the kitchen staff set up the water dispenser in the nursing station, and the night shift nurse refilled the water pitchers by getting the water from the kitchen. The DSD stated the water dispenser in the nursing station was also refilled by the kitchen staff, and the facility staff also transported the water dispenser from the nursing station near the resident rooms to refill the water pitchers for the residents. The DSD stated the kitchen had been opened for the facility staff to access the water from the kitchen, however, the new DSS had been locking the kitchen. The DSD and IP were informed the water pitchers for the residents were being refilled with the water from the bathroom sink. The IP stated the water pitchers for the residents should not be refilled with the water from the bathroom sink because of cross-contamination (bacteria, E.Coli, feces or urine in the sink could be transferred to the water pitchers). 5. According to the American Journal of Infection Control article titled “Are Hospital Floors an Underappreciated Reservoir for Transmission of Healthcare-Associated Pathogens?” dated 2017, the resident rooms were frequently contaminated with healthcare-associated pathogens, and it was not uncommon for high-touch objects such as medical devices, personal items, and linens to be in direct contact with the floor. Touching these objects frequently resulted in the transmission of pathogens to hands, and because floors are frequently contaminated, it would be reasonable to educate health care personnel and residents to avoid placing high-tough objects on the floor when possible. On 8/25/25 at 0831 hours, during the initial tour of the facility, Resident 65 was observed in bed. A water jug was observed on the floor near the resident's bed. Medical record review for Resident 65 was initiated on 8/25/25. Resident 65 was admitted to the facility on [DATE]. (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	08/29/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 65’s H&P examination dated 5/15/25, showed Resident 65 had the capacity to understand and make medical decisions. On 8/25/25 at 0907 hours, an observation for Resident 65 and concurrent interview was conducted with the Case Manager. Resident 65 was observed in bed, and a water jug was observed on the floor. The Case Manager verified the above findings. The Case Manager was observed picking up the water jug from the floor and placing it on the bedside table, without wiping the water jug clean. The Case Manager acknowledged she did not wipe the water jug before placing it on the bedside table. The Case Manager stated the water jug on the floor was an infection control issue and could be a trip hazard as well. On 8/28/25 at 1445 hours, an interview with the IP was conducted. When asked what the facility's expectation was for the storage of the residents’ personal belongings on the floor, the IP stated the residents’ personal belongings should not be kept on the floor. When asked if the water jug could be placed on the floor, the IP stated the water jug should not be on the floor due to infection control and cross-contamination. On 8/28/25 at 1526 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowledged the above findings. 6. Review of the facility's P&P titled Administering Medications revised April 2019 showed all staff must follow established facility infection control procedures such as handwashing, aseptic technique and isolation precautions when administering medications. Failure to follow these infection control procedures has the potential to compromise highly vulnerable residents’ health. On 8/25/25 at 0831 hours, a medication administration observation was conducted with LVN 3 for Resident 89. Resident 89 had a GT with an EBP signage and PPE cart outside of the resident’s door. LVN 3 was observed administering the resident’s medication via the GT, without donning the gown. In addition, during the medication administration observation, LVN 3 dropped a medication cup on the ground. LVN 3 then retrieved the medication cup from the ground with her gloved hand and continued with the medication administration, without removing her soiled gloves, performing hand hygiene and donning clean gloves. On 8/25/25 at 1142 hours, an interview was conducted with LVN 3. LVN 3 verified she failed to wear the ordered PPE (gown) during the medication administration for Resident 89. LVN 3 also verified she retrieved the dropped medication cup from the floor with her gloved hand and did not remove her soiled gloves, perform hand hygiene and don clean gloves before continuing the medication administration. On 8/29/25 at 1115 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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	08/29/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. (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	08/29/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to monitor and address the use of the antibiotics for two final sampled residents (Residents 68 and 90) and one nonsampled resident (Resident 26) reviewed for antibiotic stewardship. * The facility failed to ensure the McGeer's criteria assessment was completed in a timely manner for Resident 26 when the resident was started with antibiotics on 7/18/25. * The facility failed to ensure the McGeer's criteria were assessed for Residents 68 and 90 when the residents were prescribed with antibiotics. These failures had the potential for the antibiotics to be used when they were not indicated and the development of antibiotic-resistant bacteria. Findings: Review of the facility's P&P titled Antibiotic Stewardship - Orders for Antibiotics revised 12/2016 showed the antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program and in conjunction with the facility's general policy for Medication Utilization and Prescribing. The Policy Interpretation and Implementation section showed the following:- Appropriate indications for use of antibiotics include criteria met for clinical definition of active infection or suspected sepsis and pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending);- Empirical use of an antibiotic based on clinical criteria of suspected sepsis may be appropriate. The staff and practitioner will document the specific criteria that support the suspicion in the resident's clinical record;- If a resident is admitted from an emergency department, acute care facility, or other care facility, the admitting nurse will review discharge and transfer paperwork for current antibiotic/anti-infective orders. Discharge or transfer medical records must include all the above drug and dosing elements; and- When antibiotics are prescribed over the phone, the primary care practitioner will assess the resident within 72 hours of the telephone order. 1. Medical record review for Resident 68 was initiated on 8/28/25. Resident 68 was admitted to the facility on [DATE]. Review of Resident 68's Order Summary Report showed a physician's order dated 8/26/25, to administer vancomycin hydrochloride (antibiotic) oral suspension 50 mg/ml, give 5 ml by mouth four times a day for c-diff (clostridium difficile, a bacterium that could cause an infection of the large intestines causing diarrhea) for seven days. Review of Resident 68's MAR for August 2025 showed Resident 68 received the vancomycin medication on 8/26/25 at 2100 hours, on 8/27/25 at 0900, 1300, 1700, and 2100 hours, and on 8/28/25 at 0900 and 1300 hours. 2. Medical record review for Resident 90 was initiated on 8/26/25. Resident 90 was readmitted to the facility on [DATE]. Review of Resident 90's Order Summary Report showed a physician's order dated 8/22/25, to administer sulfamethoxazole-trimethoprim (antibiotic) oral tablet 800-160 mg one tablet by mouth two times a day for prevention of infection for seven days until finished. Review of Resident 90's MAR for August 2025 showed Resident 90 received the sulfamethoxazole-trimethoprim medication on 8/22/25 at 1700 hours, from 8/23 to 8/27/25 at 0900 and 1700 hours, and on 8/28/25 at 0900 hours. 3. Medical record review for Resident 26 was initiated on 8/28/25. Resident 26 was readmitted to the facility on [DATE]. Review of Resident 26's Order Summary Report showed a physician's order dated 7/17/25, to administer linezolid (antibiotic) oral tablet 600 mg via GT every 12 hours for urinary tract infection for four days. Review of Resident 26's MAR for July 2025 showed Resident 26 received the linezolid medication from 7/18 to 7/21/25 at 0900 and 2100 hours. Review of the facility's document titled Surveillance Data Collection Form showed a surveillance data was completed for Resident 26 on 7/29/25. The Urinary Tract Infection section showed the onset date of the symptoms was on 7/11/25, and the resident had a temperature of 100.3 degree F. The Residents with an Indwelling urinary catheter section showed Resident 26 only met the criteria listed for #1 (fever, rigors or new onset hypotension, with no alternate site of infection) and did not meet the criteria listed for #2 (urinary catheter specimen culture which indicated n/a). Further review of the surveillance data failed to show documented evidence the surveillance data collection or McGeer's criteria was completed for Residents 68 and 90 when the residents were started with antibiotics. On 8/28/25 at 1554 hours, an interview, medical record review and concurrent facility document review was conducted with the IP. The IP stated he used the Surveillance Data Collection Form to determine if the resident on antibiotic medications met or not the McGeer's criteria for a true infection. The IP stated he was notified during the morning huddle by the licensed nurses if the resident had a new physician's order for antibiotic medications. The IP stated he could also check the PCC for the list of the residents with the antibiotic medications. The IP stated he completed the surveillance infection data or screening as soon as possible, once the order for antibiotic medication was

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	08/29/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to administer the pneumococcal vaccine (a vaccine given to protect the resident from pneumococcal disease) to one of five final sampled residents (Resident 35) reviewed for immunizations. * Resident 35's medical record failed to show documented evidence Resident 35 was administered with the pneumococcal vaccine or had refused the pneumococcal vaccine. This failure increased the resident's risk of being infected by the pneumococcal disease and its associated complications.Findings: Review of facility's P&P titled Pneumococcal Vaccine revised 10/2019 showed all the residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of the pneumococcal vaccination status will be conducted with in five (5) working days of the resident's admission if not conducted prior to admission. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effect of the pneumonia vaccine. Provision of such education shall be documented in the resident's medical record. Pneumococcal vaccine will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol. Residents/ representative have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusals of the pneumococcal vaccination. Medical record review for Resident 35 was initiated on 8/28/25. Resident 35 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 35's H&P examination dated 12/20/24, the resident had capacity to understand and make decisions. Review of Resident 35's Health Status Note dated 2/13/25 at 1502 hours, showed the facility staff approached the resident at the bedside to obtain the consent for the influenza, pneumococcal, and Covid-19 vaccines. The note showed the resident consented verbally and she wants them all. However, further review of Resident 35's medical record failed to show documented evidence Resident 35 was administered with the pneumococcal vaccine or had refused the pneumococcal vaccine. On 8/29/25 at 1325 hours, an interview and concurrent medical record review was conducted with the DON and IP. The IP verified the pneumococcal vaccine was not administered to Resident 35. The IP stated the resident had the possible risk of getting infected when the resident was exposed to someone with the pneumonia infection. The DON verified the pneumococcal vaccine was not administered to Resident 35. The DON was observed instructing the IP to ask Resident 35 if the pneumococcal vaccine could be administered.

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	08/29/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to administer the COVID-19 (infectious disease caused by the SARS-CoV-2 virus- Severe Acute Respiratory Syndrome Corona virus 2 that causes COVID 19) vaccine to one of five sampled residents (Resident 35) reviewed for COVID-19 vaccination. * The facility failed to ensure COVID-19 vaccine was administered to Resident 35. This failure increased the resident's risk of being infected by the COVID-19 disease and its associated complications. Findings: Review of facility's P&P titled Covid Vaccine Policy and Procedure, undated, showed in part, to establish the process to comply with the Federal mandate that all staff are vaccinated against COVID-19 unless they have a medical or religious exemption to help reduce the risk residents and staff have of contracting and spreading COVID-19. COVID-19 vaccinations will be offered to all staff and residents (or their representatives if they cannot make health care decisions.) unless such immunization is medically contraindicated, per CDC (Center for Disease Control and Prevention) guidance, or the individual has already been immunized. All staff and residents / representatives will be educated on the COVID-19 vaccine they are offered, in a manner they can understand, including information on the benefits and risks consistent with CDC information. The facility will maintain documentation for all residents and staff on COVID-19 vaccination. For residents, the information will be documented in her medical record. Medical record review for Resident 35 was initiated on 8/28/25. Resident 35 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 35's H&P examination dated 12/20/24, showed the resident had capacity to understand and make decisions. Review of Resident 35's Health Status Note dated 2/13/25 at 1502 hours, showed the facility staff approached the resident at the bedside to obtain the consent for the influenza, pneumococcal, and Covid-19 vaccines. The note showed the resident consented verbally and she wants them all. Further review of Resident 35's medical record failed to show documented evidence Resident 35 refused the COVID-19 vaccine. On 8/29/25 at 1325 hours, an interview and concurrent medical record review was conducted with the IP and DON. The IP verified the COVID-19 vaccine was not given to Resident 35. The IP stated the resident had the potential risk of getting the virus if exposed to someone with the COVID-19 infection. The DON verified the COVID-19 vaccine was not given to Resident 35.

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	08/29/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the resident's zone entrapment assessment was completed and the measurements were recorded upon installation during the admission when identifying areas of possible entrapment with the use of side rails for two final sampled residents (Residents 6 and 37) and one nonsampled resident (Resident 67) reviewed for the use of the side rails. * The facility failed to ensure Residents 6, 37, and 67's entrapment assessments were completed upon the installation of the residents' bilateral half side rails. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapment may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Bed Safety and Bed Rails revised 8/2022 showed the use of bed rails is prohibited unless the criteria for use of bed rails have been met. The Policy Interpretation and Implementation section showed the following: - Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within the safety dimensions established by the FDA; - Maintenance staff routinely inspect all beds and related equipment to identify risks and problems including potential entrapment risks; (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	08/29/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Bed rails are properly installed and used according to the manufacturer's instructions, specifications and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.); and - Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment. 1. On 8/26/25 at 0845 hours, an observation and concurrent interview was conducted for Resident 37. Resident 37 was observed awake and lying in bed with bilateral 1/2 side rails elevated. Resident 37 stated he could turn in bed but needed assistance and he used the side rails to grab. Medical record review for Resident 37 was initiated on 8/26/25. Resident 37 was readmitted to the facility on [DATE]. Review of Resident 37's MDS assessment dated [DATE], showed Resident 37 needed substantial to maximal assistance with mobility. Review of Resident 37's H&P examination dated 8/12/25, showed Resident 37 had the capacity to understand and make medical decisions. Review of Resident 37's Order Summary Report showed a physician's order dated 8/13/25, for the use of bilateral ½ (half) side rails as enabler/feelings of safety per patient’s request. On 8/27/25 at 1130 hours, an observation and concurrent interview for Resident 37 was conducted with CNA 12. Resident 37 was observed sleeping in the bed with bilateral ½ side rails elevated. CNA 12 stated Resident 37 needs assistance with turning and getting out of bed. CNA 12 further stated Resident 37 used the side rails to grab. 2. On 8/26/25 at 0830 hours, an observation and concurrent interview was conducted for Resident 67. Resident 67 was observed awake and lying in bed with bilateral 1/2 side rails elevated. Resident 67 stated he could turn in bed, and he used the side rails to grab while turning. Resident 67 further stated he needed someone’s assistance to get out of bed. Medical record review for Resident 67 was initiated on 8/26/25. Resident 67 was admitted to the facility on [DATE]. Review of Resident 67's H&P examination dated 7/22/25, showed Resident 67 needed assistance with decision making. Review of Resident 67's Order Summary Report showed a physician's order dated 7/22/25, for the use of bilateral ½ side rails as enabler per the resident's request. Review of Resident 67's MDS assessment dated [DATE], showed Resident 67 needed substantial to maximal assistance with mobility. (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	08/29/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/25 at 1140 hours, an observation and concurrent interview for Resident 67 was conducted with CNA 12. Resident 67 was observed having dialysis at the bedside. CNA 12 stated Resident 67 was able to grab rails when being turned or cleaned. CNA 12 further stated Resident 67 could not get out of bed related to knee surgery. On 8/29/25 at 1350 hours, an interview and concurrent facility document review for Residents 37 and 67 was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated his department was the one responsible for installing the side rails. The Maintenance Supervisor stated the nurses informed him if the resident had an order for the side rails. The Maintenance Supervisor stated after verifying the order for the resident’s side rails, he installed it and completed the zone entrapment assessment. The Maintenance Supervisor stated he checked the residents’ bed and bed rails every month to ensure proper functioning, and the gaps needed to check from the side rails met the proper measurement. Review if the facility's document titled Bed Safety Checklist for Residents with Bed Rails for June and July 2025 failed to show documented evidence the zone entrapment assessment was completed for Residents 37 and 67. The Maintenance Supervisor verified the findings. The Maintenance Supervisor stated it was important to complete the zone entrapment assessment for the side rails to avoid any accident because the resident’s head or arms could be entrapped between the mattress/bed and side rails. On 8/29/25 at 1440 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Residents 37 and 67. Cross reference to F700, examples #2 and 3. 3. Review of the facility's P&P titled Bed Safety and Bed Rails date revised 8/2022 showed the use of bed rails is prohibited unless the criteria for use of bed rails have been met. The Policy Interpretation and Implementation section showed the following: - Bed frames, mattresses and bed rails are checked for compatibility and size prior to use. - Regardless of mattress type, width, length, and/or depth, the bed frame, bed rail and mattress will leave no gap wide enough to entrap a resident's head or body. Any gaps in the bed system are within the safety dimensions established by the FDA. - Maintenance staff routinely inspect all beds and related equipment to identify risks and problems including potential entrapment risks. - Bed rails are properly installed and used according to the manufacturer's instructions, specifications and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.). - Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury including bed entrapment. Review of the facility’s Bed Safety Checklist for Residents with Bed Rails for the months of June and July 2025 failed to show documented evidence the zone entrapment assessment was completed for Resident 6. (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	08/29/2025

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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 6's medical record was initiated on 8/25/25. Resident 6 was admitted to the facility on [DATE]. Review of the H&P examination dated 5/20/25, showed Resident 6 had the capacity to understand and make medical decisions. Review of Resident 6's Order Summary Report dated 8/28/25 failed to show a physician's order for the use of bilateral half side rails. Review of Resident 6's plan of care failed to show a care plan intervention for the use of bilateral half side rails. On 8/25/25 at 1047 hours, during an initial tour, Resident 6's bed was observed with bilateral half side rails elevated at the head of the bed. On 8/27/25 at 0907 hours, Resident 6 was observed lying in bed with bilateral half side rails elevated. On 8/28/25 at 1528 hours, an interview with concurrent facility record review was conducted with the Maintenance Supervisor. The Maintenance Supervisor acknowledged the findings and stated there was no physician’s order for the use of side rails, if there was a physician's order he would follow the process of entrapment assessment and would have measured the zones using a tape measure. On 8/28/25 at 1539 hours, the DON was informed and verified the above findings. Cross reference to F700, example #1.