

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>555751</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/06/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>NEWPORT SUBACUTE HEALTHCARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>2570 NEWPORT BLVD COSTA MESA, CA 92627</b>	
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  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<p><b>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on interview and medical record review, the facility failed to ensure the physician and responsible party were promptly notified for one of three sampled residents (Resident 1) when Resident 1 experienced a change in condition. When Resident 1 experienced vomiting and required her tube feeding to be held for over two hours, the facility did not notify the physician nor Resident 1's Responsible Party. This failure had the potential for Resident 1 to experience a delay in necessary care and treatment. Findings: Medical record review for Resident 1 was initiated on 3/4/2020. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's MDS dated [DATE], showed Resident 1 had severely impaired cognition. Review of Resident 1's Admission Record dated 7/3/19, showed Family Member 1 and Family Member 2 were listed as emergency contacts for Resident 1. On 3/3/2020 at 1650 hours, a telephone interview was conducted with Family Member 2. Family Member 2 stated she and Family Member 2 were the responsible party's for Resident 1. Review of Resident 1's Progress Notes dated 2/27/2020, showed Resident 1 had a large amount of tube feeding colored emesis (vomiting) at 0500 hours. The documentation showed Resident 1's tube feeding was held until 0600 hours. LVN 1 checked Resident 1's residual (the amount of fluid/contents in the stomach) volume and it was over 100 ml. LVN 1 continued to hold Resident 1's tube feeding for an additional hour. Review of Resident 1's medical record failed to show Resident 1's physician, Family Member 1, or Family Member 2 were notified of the above change in Resident 1's condition. On 3/6/2020 at 0834 hours, a telephone interview was conducted with Family Member 1. Family Member 1 stated he was at the facility in the morning on 2/27/2020. Family Member 1 stated neither he or Family Member 2 were informed Resident 1 had vomited and needed her tube feeding to be held. Family Member 1 stated he was not informed about Resident 1's vomiting episode until later in the day when Resident 1 again experienced another episode of vomiting, developed a fever, and required a transfer to the acute care hospital for evaluation. On 3/6/2020 at 0930 hours, a telephone interview was conducted with LVN 1. LVN 1 was asked about her actions after Resident 1 vomited in the morning on 2/27/2020. LVN 1 confirmed she did not notify the physician or the Responsible Party because it was only one episode of vomiting. LVN 1 stated Resident 1 did not have a history of vomiting so this was a change in condition for her. LVN 1 stated when her shift ended at 0700 hours, Resident 1's tube feeding remained off. On 3/6/2020 at 0949 hours, a telephone interview was conducted with LVN 2. LVN 2 verified he observed Family Member 1 was at the bedside during the day on 2/27/2020. LVN 2 was asked if he notified Family Member 1 about Resident 1's vomiting or her tube feeding being held for over two hours in the morning of 2/27/2020. LVN 2 stated he did not. Review of Resident 1's Progress Notes dated 2/27/2020, showed Resident 1 vomited a moderate amount of feeding colored emesis at 1605 hours. Resident 1's physician was notified and an order was received for [MEDICATION NAME] (a medication used to treat nausea and vomiting) 4 mg every six hours. Further review of Resident 1's Progress Notes dated 2/27/2020, showed 911 was called at 1720 hours and Resident 1 was transferred to the acute care hospital for fever and possible aspiration (a condition in which food, liquids, saliva, or vomit is breathed into the airways).</p>		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE (X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.