STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055518	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newport Nursing and Rehabilitation Center	1555 Superior Avenue Newport Beach, CA 92663

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 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 observation, interview, medical record review, and facility P&P review, the facility failed to protect the resident's rights to be free from the physical abuse when Resident 4 was punched in the face and all over the body at two separate incidents by Resident 3. This failure caused Resident 4 to sustain bleeding from his nose, redness above his right eyebrow and on the bridge of his nose, and a bluish/purplish discoloration on his left eye extending to his left cheekbone.Findings:Review of the facility's P&P titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised 4/2021 showed the residents have the rights to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse. Review of the SOC 341 Report of Suspected Dependent Adult/Elder Abuse dated 7/7/25, showed Resident 3 physically assaulted Resident 4 by striking Resident 4 in the face. Shortly thereafter, Resident 3 physically assaulted Resident 4 a second time, striking Resident 4 multiple times in the body. Resident 4 sustained a bloody nose. a. Closed medical record review for Resident 3 was initiated on 7/8/25. Resident 3 was admitted to the facility on [DATE], and discharged to the acute care hospital on 7/6/25.Review of Resident 3's H&P examination dated 3/27/25, showed Resident 3 had the capacity to understand and make decisions. Resident 3 had a diagnosis of schizophrenia (chronic brain disorder that affects a person's ability to think clearly, manage emotions, make decisions and relate to others).Review of Resident 3's Order Summary Report from 3/27 to 7/7/25, showed a physician's order dated 6/25/25, to administer clozapine (antipsychotic medication) 300 mg by mouth at bedtime for schizophrenia. Review of Resident 3's progress notes showed the following:- On 7/2/25 at 1823 hours, Resident 3 was observed pacing and appearing more anxious. Resident 3 reported to the staff he was hearing auditory hallucinations, commanding him to annihilate the people who want to harm you (meaning the staff). Resident 3 was able to communicate to the staff when he was hearing voices. Resident 3 was administered Zyprexa (antipsychotic medication) 10 mg by mouth one time for auditory hallucinations. - On 7/3/25 at 1043 hours, Resident 3 verbalized to the licensed nurse he was feeling paranoid and hearing voices a little.- On 7/6/25 at 1341 hours, Resident 3 remained on every 15 minutes checks for safety. Resident 3 denied hearing voices and remained quiet and self-guarded. - On 7/6/25 at 1640 hours, RN 2 observed Resident 4 sitting in a chair close to the medication cart and Resident 3 walking in the hallway close to the nurse's station when Resident 3 punched Resident 4 in the face. Both residents were separated right away by the staff, and Resident 3 was brought to the dining area. When Resident 3 was asked about the incident, Resident 3 stated he was feeling paranoia (mental state characterized by intense suspicion and distrust of others) for the past two weeks. Resident 3 informed the staff that Resident 4 touched him on the back, so when he saw Resident 4 in the hallway, he punched Resident 4 in the face. Resident 3 was currently on close monitoring for change of behavior/mood/feeling. - On 7/6/25 at 1640 hours, when RN 3 interviewed Resident 3, Resident 3 stated for the past one to two weeks, he had been feeling paranoid and increased the thought that people were trying to harm him and did not feel safe around the other residents. Resident 3 stated Resident 4 was outside with him earlier in the day and had touched him on his back. Resident 3 stated he felt threatened but did not share his feelings with the staff or other residents. Resident 3 stated when he saw Resident 4 sitting on the chair by the nurse's station, he decided to react and defend himself against Resident 4. Resident 3 stated he punched Resident 4 on the left side of his cheek and eye. Resident 3 was placed on the one-to-one care by the staff. - On 7/6/25 at 1730 hours, RN 3 observed Resident 3 running at a high rate of speed and jumping on Resident 4 who was still sitting in a chair by the nurses' station. Resident 3 began punching Resident 4 all over his body multiple times. The CNA who was providing the one-to-one care for Resident 3 in the dining room was running behind Resident 3 but could not catch up with Resident 3 before Resident 3 jumped on Resident 4.Review of Resident 3's plan of care dated 7/6/25, showed a care plan problem addressing Resident 3's two episodes of aggressive behaviors (punching Resident 4 multiple times on the face and body). The interventions included safeguarding the others by removing Resident 3 from the situation and/or providing the one-to-one supervision and for the staff to position themselves closely to supervise the resident and peers when in high traffic areas and allow space between peers. b. Medical record review for Resident 4 was initiated on 7/8/25. Resident 4 was admitted to the facility on [DATE].Review of Resident 4's H&P examination dated 4/3/25, showed Resident 4 could make needs known but could not make medical decisions. Review of Resident 4's

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 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 P&P review, the facility failed to maintain a safe and secured environment for two of five sampled residents (Residents 1 and 2).* The facility failed to ensure there were systems in place to prevent Residents 1 and 2 from eloping. This failure placed the residents at risk for harm or injury. Findings:Review of the facility's P&P titled Behavioral Health Elopement revised on 5/1/24, showed the definition of elopement as a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision. This situation represents a risk to the resident's health and safety and places the resident at risk of heat or cold exposure, dehydration and/or other medical complications, drowning or being struck by a motor vehicle.Review of the incident report of the DON dated 6/23/25, showed at approximately 1950 hours on 6/20/25, Residents 1 and 2 had left the premises through the west exit door. 1. Closed medical record review for Resident 1 was initiated on 7/8/25. Resident 1 was admitted to the facility on [DATE], and discharged on 6/20/25. Review of Resident 1's Elopement Risk dated 3/26/25, showed Resident 1 was placed in a locked/secured (egress) facility. Review of the Resident 1's Care Plan Report initiated on 4/21/25, showed a care plan problem addressing the resident's risk for elopement related to involuntary placement and history of elopement.Review of Resident 1's MDS assessment dated [DATE], showed the resident was independent in making decisions regarding tasks of daily life. Review of Resident 1's eINTERACT Change of Condition Evaluation dated 6/20/25, showed Resident 1 was observed leaving AMA through the back door during the smoke break. The resident left the facility by kicking the exit door. 2. Closed medical record review for Resident 2 was initiated on 7/8/25. Resident 2 was admitted to the facility on [DATE], and discharged on 6/20/25.Review of Resident 2's H&P examination dated 6/19/25, showed Resident 2 could make needs known but could not make medical decisions.Review of Resident 2's eINTERACT Change of Condition Evaluation dated 6/20/25, showed Resident 2 was observed leaving through the alarmed back door during the smoke break. Resident 2 had a history of leaving the previous facility with her partner.Review of Resident 2's Care Plan Report initiated on 6/19/25, showed a care plan problem addressing the resident's risk for elopement related to involuntary placement.On 7/8/25 at 0925 hours, a video of the elopement incident on 6/20/25 was shown by the Administrator. Resident 2 was seen trying to climb over the white fence and Resident 1 was kicking the exit door. Both Residents 1 and 2 were able to get out of the facility through the exit door. After a minute or two, two facility staff were observed running after the residents.On 7/8/25 at 1016 hours, an observation and concurrent interview was conducted with the Maintenance Director. The Maintenance Director showed the two exit doors in the smoking area. The Maintenance Director stated an alarm could be heard if the door was forcefully opened and without a key. On 7/9/25 at 0924 hours, an interview was conducted with Resident 5. Resident 5 stated he saw Resident 1 kick the exit door and left the facility with Resident 2. Resident 5 stated there was no licensed nurse or facility staff by the exit door. Resident 5 stated the facility staff then ran after Residents 1 and 2 when they heard the banging of the exit door.On 7/9/25 at 1034 hours, a telephone interview was conducted with CNA 1. CNA 1 stated Residents 1 and 2 were observed walking around the courtyard until the facility staff heard a big bang towards the back gate/exit door. CNA 1 then observed Residents 1 and 2 running through the exit door. CNA 1 stated the exit door would make an alarm sound when someone tried to open, push, or touch it. However, at the time when Residents 1 and 2 left through the exit door, the facility staff just heard the banging of the exit door, but no alarm sound was heard.On 7/9/25 at 1136 hours, an interview was conducted with MHW 2. MHW 2 stated the elopement incident happened around 1950 hours on 6/20/25. MHW 2 stated he heard a door banging. MHW 2 then ran towards the exit door and saw Residents 1 and 2 running towards the street. MHW 2 stated if the exit door was pushed open, an alarm would sound. However, at the time of the incident, MHW 2 stated he just heard the banging of the door, and no alarm sound was heard.On 7/9/25 at 1627 hours, a telephone interview was conducted with the Maintenance Director. The Maintenance Director stated he checked all the doors everyday, especially the exit doors. When asked if there was a maintenance log to show when the exit doors were checked for proper function, the Maintenance Director stated no. On 7/9/25 at 1640 hours, an interview was conducted with the Administrator and DON. The Administer and DON was informed and acknowledged the above findings.