STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055518	A. BUILDING _____ B. WING _____	**03/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0842 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **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 accuracy of the discharge records for two of two sampled residents (Residents 1 and 2). Residents 1 and 2 were documented as independent in their functional status. This had the potential for the residents' discharge care needs not being met as their medical records were inaccurate. Findings: 1. Closed medical record review for Resident 1 was initiated on 2/13/20. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 1's PT Discharge Summary dated 11/1/19, showed Resident 1 was totally dependent for bed mobility and transfers. Review of Resident 1's OT Discharge Summary dated 11/3/19, showed the resident needed supervision with feeding, stand-by assistance with daily hygiene care and grooming, and maximum assistance with upper body dressing. Resident 1 was assessed to be totally dependent on others for dressing their lower body, daily bathing, toileting, and daily homemaking skills. However, review of Resident 1's Discharge Summary/Comprehensive assessment dated [DATE], showed Resident 1 was independent in dressing, eating, personal hygiene, transfers, bed mobility, toilet use, and ambulation. Resident 1 was assessed as needed assistance with bathing. On 2/27/20 at 1300 hours, a telephone interview was conducted with LVN 1. LVN 1 stated she completed the Discharge Summary/Comprehensive Assessment for Resident 1 and then printed out the medication list. When asked where LVN 1 referenced the information for Resident 1's functional status. LVN 1 stated she could not recall. On 3/4/20 at 1138 hours, a telephone interview and concurrent closed medical record review for Resident 1 was conducted with the DON. The DON reviewed the medical record and verified the above findings. The DON verified the assessments did not match and the information in the Discharge Summary was incorrect. 2. Closed medical record review for Resident 2 was initiated on 2/21/20. Resident 2 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 2's PT Discharge Summary dated 11/1/19, showed Resident 2 required setup assistance with transfers. Review of Resident 2's OT Discharge Summary dated 11/1/19, showed Resident 2 required supervision for eating, minimal assistance with dressing their upper body, moderate assistance for brushing their teeth, bathing, toileting and dressing their lower body. However, review of Resident 2's Discharge Summary/Comprehensive assessment dated [DATE], showed Resident 2 was independent in dressing, eating, personal hygiene, transfers, bed mobility, toilet use, and ambulation. Resident 2 needed assistance with bathing. On 3/4/20 at 1138 hours, a telephone interview and concurrent closed medical record review for Resident 2 was conducted with the DON. The DON reviewed the medical record and verified the above findings. The DON verified the assessments did not match and the information in the Discharge Summary was incorrect.

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.