

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Alamitos Belmont Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3901 E Fourth Street Long Beach, CA 90814	
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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to follow it's policy and procedures (P&P) titled Cardiopulmonary Resuscitation ([CPR] an emergency lifesaving procedure performed when the heart stops beating), which indicated the facility will provide CPR, to any resident requiring such care prior to the arrival of the emergency medical personnel, in the absence of an advance directives or a do not resuscitate (DNR) order for one of three sampled Residents (Resident 93).The Facility failed to:Activate the EMS system by paging or yelling loudly for Code Blue (an emergency alert signaling that a person was experiencing a life-threatening situation, typically cardiac (heart) or respiratory arrest, requiring immediate resuscitation) on [DATE] at 5:00 a.m., when Resident 93 was observed by Certified Nurse Assistant (CNA) 1 unresponsive (not reacting to touch, sound or smell), not breathing, and without a pulse (heartbeat) in bed.Call 911 within five minutes after Resident 93 was observed unresponsive on [DATE] at 5:00 a.m.Ensure Certified Nursing Assistant (CNA) 1, Licensed Vocational Nurse (LVN) 1 and LVN 2 initiated CPR as soon as Resident 93 was observed unresponsive and without a pulse on [DATE] at 5:00 a.m. This deficient practice resulted in a delay of life-saving CPR for Resident 93, who was pronounced dead on [DATE] at 6:15 a.m. and placed 40 current residents, who had a full code (residents' choice of level of life saving treatment if found unresponsive) status of not receiving life saving measures immediately without loss of valuable time for being successfully revived.On [DATE] at 4:59 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation had cause, or is likely to cause serious injury, harm, impairment, or death to a resident) was called due to the facility's failure to ensure CNA 1, LVN 1 and LVN 2 performed CPR without delays after finding Resident 93 unresponsive, in the presence of the Administrator (ADM) and the Director of Nursing (DON). On [DATE] at 3:35 p.m., the ADM submitted an acceptable IJ removal plan ([IJRP], an intervention to immediately correct the deficient practices). After verification of the IJRP's implementation through interview, and record review, the IJ was removed on [DATE] at 4:29 p.m., in the presence of the ADM. The IJRP included the following: 1.The interdisciplinary team (IDT healthcare team composed of various specialties') implemented a wristband identification system for code status for all residents Black dot: Do Not Resuscitate (DNR resident wishes no life saving measures if found with nor heart beat and not breathing), No dot : Full Code; If a resident is found unresponsive, staff will immediately initiate CPR. 2. The DON and the Director of Staff Development (DSD) will in-service all Registered Nurses (9), LVN's (23) and CNA's (68) regarding indications for CPR and American Heart Association (AHA) recommendations by [DATE].3. The in-services included the wristband identification system to immediately identify code status, and the updated CPR policy. 4. On [DATE], the IDT, including Social Services, Medical Records, DSD, and MDS, reviewed and verified all Physician Orders for Life-Sustaining Treatment (POLST is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency) POLST forms and code status orders in the electronic medical records system to update the resident wristbands. All 77 residents' (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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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wristbands were updated.5.The admission Nurse will place a wristband indicating code status on each new admission. 6. The Treatment Nurse or Designee will conduct a follow-up daily review of new admission code status orders to verify the wristbands. 7. The DSD or Designee will in-service staff upon hire, annually, and as needed regarding the wristband identification system to immediately identify code status and the updated CPR policy 8. The Medical Records Director or Designee will conduct a daily review of the code status report to compare it to the resident wristbands. Any identified discrepancies will be immediately updated and reported to the DON. 9. The DON or Designee will report the progress of the monitoring to the Quality Assurance and Performance Improvement (QAPI a systematic, interdisciplinary, and comprehensive method for improving safety, quality of care, and resident quality of life) Committee monthly for 6 months or until substantial compliance has been achieved. Findings:During a review of Resident 93's admission Record, the admission Record indicated Resident 93 was admitted to the facility on [DATE] with diagnoses including end stage renal disease ([ESRD], irreversible kidney failure), anemia (a condition where the body does not have enough healthy red blood cells), diabetes mellitus ([DM], a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities).During a review of Resident 93's Minimum Data Set ([MDS], a resident assessment tool) dated [DATE], the MDS indicated Resident 93 was severely cognitively (thinking process) impaired . The MDS indicated Resident 93 was dependent on staff for activities of daily living (ADL) such as hygiene, getting dressed and putting on footwear.During a review of Resident 93's physician order for life sustaining treatment ([POLST], a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) dated [DATE], the POLST indicated Resident 93 was a full code with resuscitation/CPR, trial period of artificial nutrition including feeding tube (a flexible, medical device used to deliver liquid nutrition, fluids, and medication directly into the stomach or small intestine when a person cannot eat or swallow safely).During a record review of Resident 93's Nurses Progress Notes dated [DATE], at 7:03 a.m., the Nurses Progress Notes indicated on [DATE] at 5:30 a.m., CNA 1 found Resident 93 cold to touch (indicating heart stopped circulating blood) and unresponsive. The Nurses Progress Notes indicated CNA 1 left Resident 93 and went to find LVN 1 to assess Resident 93. The Nurses Progress Notes indicated LVN 1 found Resident 93 with no heartbeat upon auscultation (listening for a heartbeat using a stethoscope [device used to detect and listen to heartbeat). The Nursing Progress Notes indicated Resident 93 had no detectable vital signs (measurements of the body's basic function, heartbeat, respiration rate [breathing], and blood pressure that indicate the state of a patient's essential body functions), no rise and fall of chest (not breathing). The Nursing Progress Notes indicated before being found unresponsive Resident 93 was last seen by CNA 1 around 4:30 a.m., coughing. The progress note indicated Resident 93 was a Full Code. The Nursing Progress Notes indicated emergency medical Technician (EMT)'s arrived at 5:45 a.m., and called Time of Death at 6:00 a.m.During a review of the EMT's run sheet (official document completed by EMT for every dispatched (sent) call dated [DATE], the run sheet indicated the EMT's were dispatched at 6:05 a.m., arrived at the facility at 6:10 a.m. and Resident 93 was pronounced dead at 6:15 a.m.During a telephone interview on [DATE] at 5:51 p.m., with LVN 1, LVN 1 stated on [DATE], at approximately 5:00 a.m., CNA 1 notified her (LVN 1) that Resident 93 was not responding, and CNA 1 could not wake the resident up. LVN 1 stated she got her stethoscope and asked LVN 2 to come with her to check on Resident 93 in his room. LVN 1 stated she (LVN 1) checked Resident 93's vital signs and the machine could not detect any vital signs. LVN 1 stated she (LVN 1) used her index and middle fingers to feel Resident 93's carotid pulse (the beating of blood flow in the vein that supplies oxygenated blood to the brain) and there was no pulse. LVN 1 stated Resident 93 was a full code, and she (LVN 1) initiated CPR on Resident 93 at approximately 5:30 a.m., (30 minutes after the resident was found unresponsive), until the emergency medical services arrived at 5:45 a.m LVN 1 stated the emergency medical services did not perform CPR. LVN 1 stated the emergency medical staff pronounced (continued on next page)		

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident 93 dead at 6:00 a.m. During an interview on [DATE] at 8:38 a.m., with LVN 2, LVN 2 stated on [DATE] at approximately 5:15 a.m., LVN 1 informed her she (LVN 1) could not detect any vital signs on Resident 93 and asked her (LVN 2) to verify the lack of vital signs on Resident 93. LVN 2 stated LVN 1 went to check Resident 93's chart for the resident's code status and called the emergency services. LVN 2 stated she (LVN 2) checked his vital signs twice and the machine could not find a reading. LVN 2 stated the second time she (LVN 2) checked Resident 93's vital signs, around 5:40 a.m., LVN 1 was back in the room, and started CPR. LVN 1 asked LVN 2 to go to the front door to wait for emergency medical services to arrive. LVN 2 stated if staff knew the resident's code status, they could have started CPR as soon as Resident 93 was observed unresponsive and without a heartbeat. LVN 2 stated there was a delay in initiating CPR. During an interview on [DATE] at 11:28 a.m., with the Director of Staff Development (DSD), the DSD stated LVN 1, LVN 2 and CNA 1 should have performed CPR on Resident 93, right away when Resident 93 was pulseless and not breathing. The DSD stated staff starting CPR right away would have a higher chance of saving the residents' life. The DSD stated the facility's system was for licensed staff to check a resident's code status in the electronic medical record, and initiate CPR, until emergency medical services personnel take over. During a concurrent interview and record review on [DATE] at 3:25 p.m., with the Director of Nursing (DON), the Nurses Progress Note dated [DATE] was reviewed. The DON stated the Nurses' Progress Note did not indicate the staff members started CPR immediately on Resident 93 when three different staff members, CNA 1, LVN 1 and LVN 2 found the resident unresponsive. The DON stated when CNA 1 found Resident 93 unresponsive and with no knowledge of the resident's code status, CNA 1, LVN 1 and LVN 2 should have tried to find out if Resident 93 was a full code, and initiated CPR right away. The DON stated there was no system in place for emergency situations such as Resident 93's to ensure timely CPR. During a review of the American Heart Association [DATE] CPR and Emergency Cardiovascular Care (ECC) Guidelines (https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/adult-basic-life-support), the guidelines indicated after identifying an individual that was not responsive and not breathing, the rescuer should activate the emergency response system first, then immediately begin CPR, beginning with chest compressions at a rate of 100 to 120 a minute and delivering 2 breaths in between compressions. The guidelines indicated immediate chest compression was critical to improve the individual's outcomes by providing high-quality CPR. During a review of the American Red Cross Training Services Program article (https://www.redcross.org/take-a-class/cpr/performing-cpr/what-is-cpr), the article indicated CPR increased the likelihood of surviving cardiac arrest, when the heart stopped beating or and fails to circulate (to move in a circle) blood to the brain and other vital organs. CPR can double or triple the chance of survival by giving continuous chest compressions. During a review of the facility's policy and procedures (P&P) titled Cardiopulmonary Resuscitation (CPR), revised 12/2023, the P&P indicated it was the policy of this facility to provide basic life support (BLS), including CPR, to any resident requiring such care prior to the arrival of emergency medical personnel in the absence of an advance directive. The P&P indicated staff should check for responsiveness, quality of breathing and pulse simultaneously and if the Resident was unresponsive, not breathing (occasional gasps are not breathing) and no pulse, activate EMS system: 1. Page or yell loudly for Code Blue to the area 2. Call 9113. Designate an individual to bring code cart and if available, bring Automated External Defibrillator (AED a portable life-saving device used in emergencies when someone is experiencing sudden cardiac arrest) to unresponsive person, start CPR per American Heart Association guidelines for any resident in cardiac or respiratory arrest.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: a. Ensure one of three resident's (Resident 10) Potassium Chloride Oral Solution (mineral and electrolyte that regulates fluid balance, sends nerve signals, and regulates muscle contractions) was administered in the correct form.b. Ensure Licensed Vocational Nurse (LVN) 2 indicated the date and time a Lidocaine patch (medication for pain) was applied for one of one resident (Resident 39).c. Document the correct remaining quantity of Morphine Sulfate (potent pain medication), for one of one resident's (Resident 78)The deficient practices had the potential to result in medication errors including residents' diagnoses not being treated, or too much medication being administered.Findings: a. During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was originally admitted to the facility on [DATE] with diagnoses including weakness, and peripheral vascular disease (circulation disorder where blood vessels outside the heart and brain narrow or become blocked, reducing blood flow to the limbs). During a review of Resident 39's Minimum Data Set ([MDS] resident assessment tool), dated 12/26/2025, the MDS indicated Resident 39's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making were moderately impaired. Resident 39 needed assistance with eating and supervision with other activities of daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 39's Order Summary Report, the Order Summary Report indicated Lidocaine HCI External Patch 4 %, apply to bilateral knee topically one time a day, ordered 12/17/2025. During an observation on 1/26/2026 at 9:24 a.m., with LVN 2, in Resident 39's room, LVN 2 applied the Lidocaine patches on Resident 39's knees without labeling the patches with a date and time. b. During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was originally admitted to the facility on [DATE] with diagnoses including anemia (a condition where the body does not have healthy red blood cells), sick sinus syndrome (heart rhythm disorder) , atherosclerotic (buildup of fats and other substances in and on the artery walls), heart disease, and atrial fibrillation (irregular heartbeat). During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10's cognitive skills for daily decision-making were intact. The MDS indicated Resident 10 needed set-up assistance when eating, oral hygiene, and substantial assistance (helper does more than half the effort) with personal hygiene, and showering. During a review of Resident 10's Order Summary Report, the Order Summary Report indicated Potassium Chloride Oral Solution, Give 15 milliliters by mouth two times a day for potassium supplement on Lasix (water pill used to treat edema associated with heart failure) dated 1/23/2026. During an observation on 1/26/2026 at 9:45 a.m., with LVN 2, in Resident 10's room, LVN 2 administered the Potassium in pill form not liquid form (as indicated in the dated 1/23/2026) to Resident 10. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/27/2026 at 3 p.m., with LVN 2, LVN 2 stated the wrong potassium form was administered; the liquid form and not the pill form should have been administered to Resident 10. LVN 2 stated she did not indicate the date and time on the Lidocaine patch for Resident 39. During an interview on 1/29/2026 at 12:24 p.m. with the Director of Nursing (DON), the DON stated Resident 39's medication orders need to be administered in the correct form as ordered by the physician for resident safety. The DON stated Resident 10's lidocaine patch needs to be removed when it is time, but there was not time and date of when it was administered. The DON stated the lidocaine patches could not stay on the Resident 10's knees all day and the facility needs to follow pharmacy policies and procedures. During a review of the facility's policy and procedure (P&P) titled, Medication Administration- General Guidelines, dated 5/2022, the P&P indicated medications shall be administered as prescribed in accordance with good nursing principles and practices. The right drug is applied for each medication. During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 78's diagnoses included anemia (a condition where the body does not have enough healthy red blood cells), diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension ([HTN]-high blood pressure). During a review of Resident 78's History and Physical (H&P), dated 9/4/2024, the H&P indicated Resident 78 had fluctuating capacity to understand and make decisions. During a review of Resident 78's MDS, dated [DATE], the MDS indicated Resident 78 was rarely/never understood. The MDS indicated Resident 78 was dependent on facility staff for activities of daily living such as hygiene, showering, dressing, putting on/taking off footwear. During a review of Resident 78's Order Summary Report, dated 1/16/2026, the Order Summary Report indicated morphine sulfate oral solution 20 mg/mL (milligram per milliliter, a unit of measurement for medication) give 0.25 mL orally every 2 hours as needed for mild pain (1-3 pain level) or shortness of breath with respiration rate between 21-25 breaths per minute (BPM) 0.25 mL equal 5 mg and give 0.5 mL orally every 2 hours as needed for moderate pain (4-6 pain level) or shortness of breath with respiratory rate of 26- 30 BPM 0.5 mL = 10 mg and give 0.75 mL orally every 2 hours as needed for severe pain (7-10 pain level) or shortness of breath with respiratory rate of more than 30 per minute, 0.75 mL equals 15 mg. During a concurrent observation, interview and record review on 1/28/2026 at 9:47 a.m., with Licensed Vocational Nurse (LVN) 4 with the East Station Medication Cart 4, Resident 78's morphine sulfate oral medication bottle, and the facility's liquid controlled medication tracking system for morphine sulfate oral medication were reviewed. Resident 78's morphine sulfate medication bottle contained approximately 10 mL's. The facility's controlled medication tracking system indicated a quantity of 10.50 mL remaining on 1/27/2026 at 11:03 a.m.(the previous day) with the last dose administered on 1/28/2026 at 1:24 a.m. with no indication of how much was left in the bottle. LVN 4 stated the licensed nurses were pulling the medication out from the bottle but did not indicate how much was left in the bottle on the tracking form. LVN 4 stated there was 15 mL in the bottle to start, minus each dose taken out of the bottle according to the tracking form came to 9.25 mL that should be left in the bottle but the tracking form indicated there was 10.50 mL left on 1/27/2026 and no indications of how much was in the bottle with the last administration date of 1/28/2026 at 1:24 a.m. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 4 stated licensed nurses should be documenting how much was pulled out and how much was left in the bottle consistently and accurately on the tracking form. LVN 4 stated pulling out the medication and not documenting it accurately can leave the next licensed staff confused with how much was in the bottle and the count would not be correct. During an interview on 1/29/2026 at 11:55 a.m., with the Director of Nursing (DON), the DON stated when licensed staff are giving pain medications like morphine, licensed staff should document accurately on the tracking form and the electronic Medication Administration Record (eMAR). The DON stated licensed staff should be writing the amount taken out of the bottle and the amount that's left in the bottle onto the tracking form. The DON stated the importance of accurate documentation of the amount of medication taken out of the bottle and the amount that's left in the bottle was to be accountable of the medication so there was no confusion on how much was left in the bottle when the next licensed staff draws up the medication from the bottle. The DON stated the staff should be pulling out the dosage ordered and documented how much was given to the residents, and how much was left in the bottle, staff should be doing the math. DON stated the licensed staff should not be looking at the bottle and eyeing it to see how much was left in the bottle, that was not the correct way to do it because not all licensed staff will see the same amount. During a review of the facility's policy and procedures (P&P) titled Preparation and General Guidelines of Controlled Substances, dated May/2022, indicated, medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. accurate accountability of the inventory of all controlled drugs is always maintained. when a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record (CDR) and the medication administration record (MAR) such as date and time of administration (MAR, and Accountability Record), the amount administered (Accountability Record), the remaining quantity (Accountability Record), and initials of the nurse administering the dose, completed after the medication is actually administered (MAR, and Accountability Record).		

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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. Based on observation interview and record review the facility failed to handle or store food in a sanitary manner by the following:a. Facility kept 30 salt and pepper shakers without labels, covers, and dates after use in the dry food storage area.b. [NAME] 1 and [NAME] 2 did not wear a hair net to fully cover their hair while handling food.These failure has the potential to increase the risk of cross-contamination and foodborne illness.Findings:a. During a concurrent observation and interview on 1/26/2026 at 9:00 a.m., with the Dietary Supervisor (DS) in the dry food storage area, there were 15 white and 15 black powdery substances inside glass shakers without labels, covers, and dates with holes on the metal tops. The covers fell off from the shakers by being placed upside down. The DS stated those were salt and pepper shakers. The DS stated dietary staff should empty the containers and wash them after every single use before putting them back to store them to prevent foodborne illness. The DS stated they should not store opened and unlabeled food items in the dry food storage area. b. During a concurrent observation and interview on 1/27/2026 at 11:48 a.m., with the Registered Dietician (RD) in the kitchen, [NAME] (CK) 1's hair net did not fully cover her head. The RD stated there were hairs that were not contained in the hair net on both sides and back of CK 1's head. CK 2 was wearing hair cover with exposed hair, confirming hair on both sides and back of her head out of the cover.During an interview on 1/27/2026 at 12:54 p.m., with the DS, the DS stated if staff does not cover hair fully, the hair can fall into the food, and can cause food borne illness.During an interview on 1/29/2026 at 1:51 p.m., with the Director of Nursing (DON), the DON stated kitchen staff need to cover all their hair with hair nets while working in the kitchen to prevent infection control and sanitary reasons.During a review of the facility's policy and procedure(P&P), titled Dress Code, dated 2023, indicated proper dress for staff in food and nutrition services departments are: Hat for hair, if hair is short, which completely covers the hair and hair net for hair, if hair is long (over the ears or longer).During a review of the facility's P&P, titled Storage of food and supplies, dated 2023, indicated dry bulk foods (flour, sugar, dry beans, food thickener, spices, etc.) should be stored in seamless metal or plastic containers with tight covers, or in bins which are easily sanitized. Bins/containers are to be labeled, covered and dated. The P&P indicated dry food items which have been opened, such as pudding, gelatin, biscuit mix, pancake mix, dry cereal, spices, coffee, noodles, etc., will be tightly closed, labeled and dated, open, non-food items are to be tightly closed to prevent exposure to pests. The P&P also indicated All food will be dated - month, day, year.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's Quality Assessment and Assurance ([QA&A] develop and implement appropriate plans of action to correct identified quality deficiencies) and Quality Assurance Performance Improvement ([QAPI] takes a systemic, interdisciplinary, comprehensive, and data driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) committee failed to identify facility and resident care issues, develop and implement appropriate plans of action to ensure QAA/QAPI committee systemically implemented and evaluated measures to maintain a system to immediately identify residents' code status in an emergency situation that warrants initiation of a resident's CPR without loss of valuable time to implement life saving measures. These deficient practices have the potential to cause delay in life saving measures for 40 current residents who wish to have full treatment in a life-threatening situation. Findings: During a telephone interview on [DATE] at 5:51 p.m., with LVN 1, LVN 1 stated on [DATE], at approximately 5:00 a.m., CNA 1 notified her (LVN 1) that Resident 93 was not responding, and CNA 1 could not wake the resident up. LVN 1 stated she got her stethoscope and asked LVN 2 to come with her to check on Resident 93 in his room. LVN 1 stated she (LVN 1) checked Resident 93's vital signs and the machine could not detect any vital signs. LVN 1 stated she (LVN 1) used her index and middle fingers to feel Resident 93's carotid pulse (the beating of blood flow in the vein that supplies oxygenated blood to the brain) and there was no pulse. LVN 1 stated Resident 93 was a full code, and she (LVN 1) initiated CPR on Resident 93 at approximately 5:30 a.m., (30 minutes after the resident was found unresponsive), until the emergency medical services arrived at 5:45 a.m. LVN 1 stated the emergency medical services did not perform CPR. LVN 1 stated the emergency medical staff pronounced Resident 93 dead at 6:00 a.m. During an interview on [DATE] at 8:38 a.m., with LVN 2, LVN 2 stated on [DATE] at approximately 5:15 a.m., LVN 1 informed her she (LVN 1) could not detect any vital signs on Resident 93 and asked her (LVN 2) to verify the lack of vital signs on Resident 93. LVN 2 stated LVN 1 went to check Resident 93's chart for the resident's code status and called the emergency services. LVN 2 stated she (LVN 2) checked his vital signs twice and the machine could not find a reading. LVN 2 stated the second time she (LVN 2) checked Resident 93's vital signs, around 5:40 a.m., LVN 1 was back in the room, and started CPR. LVN 1 asked LVN 2 to go to the front door to wait for emergency medical services to arrive. LVN 2 stated if staff knew the resident's code status, they could have started CPR as soon as Resident 93 was observed unresponsive and without a heartbeat. LVN 2 stated there was a delay in initiating CPR. During an interview on [DATE] at 11:28 a.m., with the Director of Staff Development (DSD), the DSD stated LVN 1, LVN 2 and CNA 1 should have performed CPR on Resident 93, right away when Resident 93 was pulseless and not breathing. The DSD stated staff starting CPR right away would have a higher chance of saving the residents' life. The DSD stated the facility's system was for licensed staff to check a resident's code status in the electronic medical record, and initiate CPR, until emergency medical services personnel take over. During a concurrent interview and record review on [DATE] at 3:25 p.m., with the Director of Nursing (DON), the Nurses Progress Note dated [DATE] was reviewed. The DON stated the Nurses' Progress Note did not indicate the staff members started CPR immediately on Resident 93 when three different staff members, CNA 1, LVN 1 and LVN 2 found the resident unresponsive. The DON stated when CNA 1 found Resident 93 unresponsive and with no knowledge of the resident's code status, CNA 1, LVN 1 and LVN 2 should have tried to find out if Resident 93 was a full code, and initiated CPR right away. The DON stated there was no system in place for emergency situations such as Resident 93's to ensure timely CPR. During an interview on [DATE] at 4:24 p.m. with the Administrator (ADM), the ADM stated he heard about Resident 93 passing during the early morning of [DATE]. The ADM stated (continued on next page)		

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff had to check the resident's code status before initiating chest compressions. The ADM stated the staff did CPR, but staff did not immediately do CPR when they found Resident 93 unresponsive. The ADM stated the QAPI/QA&A committee was not aware of the systemic failure of immediately identifying the resident's code status. During a review of the facility's policy and procedure (P/P) titled QA&A Committee and QAPI Plan dated 2025 indicated to provide excellent quality care to the residents served. meet to exceed the needs, expectations and requirements of our residents while maintaining good outcomes and perceptions of resident care in a cost-effective manner. The principals of QAPI are taught to facility staff and volunteers on an ongoing basis. QAPI activities aim for the highest levels of safety, excellence in Resident Choice, Quality of Life, Clinical Care, Management Practices, Facility Standards, Resident and Family Satisfaction Surveys and Audits.		

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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, and record review, the facility failed to implement infection control measures by failing to: A. Ensure visitors and the staff wore Personal Protective Equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) properly for one of three sampled residents (Resident 78) who was on Enhanced Barrier Precaution [EBP-an infection control measures, primarily in nursing homes, requiring staff to wear gowns and gloves during high-contact care for residents with multidrug-resistant organisms or increased risk factors like wounds/devices, expanding beyond Standard Precautions to prevent multidrug-resistant organism(MDRO) spread where direct contact is likely]. B. Ensure two of two residents (Resident 10 and 11) were tested for Corona virus disease ([COVID-19] contagious infectious disease) and placed on transmission-based precautions ([TBP] infection control measures used in healthcare settings, in addition to standard precautions, for patients known or suspected of being infected) when they presented with respiratory infection symptoms. These failures had the potential to result in compromised infection control measures and the spread of infection among residents, staff, and visitors. Findings: A. During a review of Resident 78's admission record, the admission record indicated Resident 78 was initially admitted to the facility on [DATE] and last re-admission was on [DATE] with urinary tract infection (UTI- an infection in the bladder/urinary tract), uterine cancer (a cancer that starts in the uterus, the organ where a fetus grows during pregnancy), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic kidney disease (the kidneys have become damaged over time). During a review of Resident 78's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 78 had fluctuating capacity to understand and make decisions. During a review of Resident 78's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 78 required dependent assistance (Helper does all of the effort) from two or more staff for shower/bath, dressing, toilet hygiene, transfer, hygiene, bed mobility, and set up or clean-up assistance (Helper sets up or cleans up) from one staff for eating. During a concurrent observation and interview on [DATE], at 12:41 p.m., with Licensed Vocational Nurse (LVN) 4 in Resident 78's room, LVN 4 was checking Resident 78's blood pressure and her nursing uniform was touching Resident 78's bed linen. LVN 4 was wearing a mask, but she did not wear a gown and gloves. Resident 78's Family Member (FM) 1 was at the bedside holding Resident 78's hands after LVN 4 finished checking Resident 78's blood pressure. FM 1 did not wear any PPE. There was EBP signage by the entrance for Resident 78. LVN 4 stated, Resident 78 was on EBP, and she should have worn a gown and gloves because checking blood pressure was a high contact resident care activities, and required a mask, gown and gloves to be worn to prevent spreading infection. LVN 4 stated, she should have educated FM 1 regarding wearing PPE while touching Resident 78's hands. During an interview on [DATE], at 12:45 p.m., with FM 1, FM 1 stated, she has been visiting Resident 78 many times, but the staff did not tell her to wear PPE when/if she was touching Resident 78. FM 1 stated, no one provided her with any education or information regarding wearing PPE in EBP room to prevent infection from spreading. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE], at 12:42 p.m., with the Infection Preventionist Nurse (IPN), the IPN stated, the staff should wear mask, gown, and gloves before performing high contact activities with a resident on infection prevention precautions, such as bathing, hygiene care, changing, transferring, and checking blood pressure to prevent cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) when they were caring for the residents who were on EBP. The IPN stated, the staff should have provided education for visitors and asked them to wear PPE as well. During an interview on [DATE], at 12:07 p.m., with the Director of Nursing (DON), the DON stated, PPE should be worn correctly based on the requirements for different kinds of infections. The DON stated, Resident 78 was on EBP due to having a foley catheter (or indwelling catheter- a thin, flexible tube inserted through the urethra into the bladder to drain urine continuously) which was an invasive line. The DON stated EBP required wearing a mask, a gown, and gloves before performing high contact care that required touching the residents. The DON stated, the staff must wear proper PPE to protect themselves and vulnerable residents. During a review of Resident 78's Order Summary Report (OSR), dated [DATE], the OSR indicated, place Foley catheter size 16 French (Fr) by gravity drainage ordered on [DATE]. The OSR indicated, place a privacy bag in place for foley catheter and monitor placement every shift ordered on [DATE]. During a review of Resident 71's Care Plan Report (CPR) titled, Resident 78 was at risk for UTI related to Foley Catheter Placement revised [DATE], the CPR Goal indicated, Resident 78 will not have UTI by the target review date of [DATE]. The CPR Interventions indicated, use Enhanced Barrier Precautions. During a review of the facility's Policy and Procedure (P&P) titled, IPCP Standard and Transmission-Based Precautions, revised 3/2024, the P&P indicated, Policy: It is the policy of this facility to implement infection control measures to prevent the spread of communicable disease and conditions. Procedure: 3. Enhanced Barrier Protection (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gowns and gloves during high-contact resident care activities that provide opportunities for indirect transfer of Multi Drug Resistant Organisms (MDRO infectious organisms that are resistant to different medications) to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs). B. During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was originally admitted to the facility on [DATE] with diagnoses including anemia (a condition where the body does not have healthy red blood cells), sick sinus syndrome (heart rhythm disorder), atherosclerotic (buildup of fats and other substances in and on the artery walls), heart disease, and atrial fibrillation (irregular heartbeat). During a review of Resident 10's ([MDS] resident assessment tool), dated [DATE], the MDS indicated Resident 10's cognitive (ability to make decisions of daily living) skills for daily decision-making were intact. The MDS indicated Resident 10 needed set-up assistance when eating, oral hygiene, and substantial assistance (helper does more than half the effort) with personal hygiene, and showering. During a review of Resident 10's Situation Background Assessment Recommendation (SBAR) (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Communication Form, dated [DATE], the form indicated Resident 10 presented with a productive cough (also known as a wet cough, brings up mucus [phlegm or sputum] from the lungs to help clear the airways). During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was originally admitted to the facility on [DATE] with diagnoses including cellulitis (skin condition that causes swelling and redness), asthma (chronic lung condition), and chronic kidney disease (condition where the kidneys become damaged and lose their ability to filter blood, leading to a buildup of waste and fluid in the body). During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11's cognitive skills for daily decision-making was intact. Resident 11 need set-up assistance when eating, oral hygiene, and substantial assistance with personal hygiene. During a review of Resident 11's SBAR Communication Form, dated [DATE] at 2:30 p.m., the form indicated Resident 11 presented with mild sore throat. During a review of Resident 11's SBAR Communication Form, dated [DATE] at 6:18 p.m., the form indicated Resident 11 presented with non-productive dry cough. During a concurrent interview and record review on with the Infection Prevention Nurse (IPN), Resident 10 and 11's medical records and Medication Administration Records (MARs) were reviewed. Resident 10 and 11's MAR indicated to monitor any Covid-19 signs and symptoms which included cough and sore throat. Resident 10 and 11's MAR indicated no Covid-19 test was conducted. The IPN stated Residents 10 and 11 presented with respiratory symptoms as indicated in the SBAR Communication forms and Residents 10 and 11 should have been tested for Covid-19 for early treatment and mitigation of possible spread. Resident 10 and 11 should have been placed on droplet/contact isolation (TBP to prevent spread of germs) until Covid-19 was ruled out according to Long Beach Public Health guidelines. During an interview on [DATE] at 12:24 p.m., with the DON, the DON stated the facility should follow the local public health departments' guidelines for residents' safety. During a review of the facility's policy and procedure (P&P) titled, Covid-19 Testing revised 10/2023, the P&P indicated testing will be performed according to current local and state health departments and Centers for Disease Control and Prevention (CDC) prevention guidelines. During a review of the facility's untitled P&P, revised 10/2023, the P&P indicated testing will be performed With residence who had symptoms consistent with COVID-19 regardless of vaccination status. During a review of Long Beach Health and Human Services document titled, Skilled Nursing Facility Covid-19 Guidance, dated [DATE], indicated residents or health care personnel (HCP) with signs or symptoms of Covid-19 like illness, regardless of vaccination status, should be: Isolated immediately (i.e., HCP sent home, residents remain in current room on transmission-based precautions Test immediately (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If first test was antigen and negative, test again 48 hours after the first test.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interview and record review the facility failed to provide documented evidence of all employees, including physicians, COVID-19 (contagious disease) vaccine (medications used to prevent diseases usually given by injection or by mouth) status and the provision of education on benefits and potential side effects and offering of the 2025 to 2026 COVID-19 vaccine. This failure had the potential to result in staff and residents contracting COVID-19 which can cause serious illness, hospitalization, and death. Findings: During a concurrent interview and record review on 1/28/2026 at 12:38 p.m., with the Infection Prevention Nurse (IPN), the facility's Covid Staff Vaccination Status, undated, was reviewed. The IPN stated there was no documented evidence for physician or licensed practitioners' education on benefits and side effects was provided and the offering of 2025 to 2026 Covid-19 booster vaccine. The IPN stated the roster did not include physicians and it should include everyone that has direct access to the residents. During an interview on 1/29/2026 at 12:24 p.m. with the Director of Nursing (DON), the DON stated staff need to be educated and the current COVID-19 booster should be offered to staff. During a review of the facility's policy and procedure (P&P) titled, Immunizations - Staff, revised 7/2023, the P&P indicated staff includes licensed practitioners.		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to validate 9 of 9 Registered nurses, 23 out of 23 Licensed Vocational Nurses (LVNs), and 68 out of 68 Certified Nurse Assistants (CNAs)'s competency for what to do when taking care of an unresponsive resident who was not breathing and had no pulse. The deficiency resulted in a delay in initiation of Cardiopulmonary Resuscitation ([CPR]) an emergency, life-saving procedure performed when the heart stops beating, to maintain blood circulation to the brain) to one of one resident (Resident 93) and the deficient practice placed 40 residents at risk for a delay in receiving immediate CPR interventions. Findings:During a review of Resident 93's admission Record, the admission Record indicated Resident 93 was admitted to the facility on [DATE] with diagnoses including end stage renal disease ([ESRD], irreversible kidney failure), anemia (a condition where the body does not have enough healthy red blood cells), diabetes mellitus ([DM], a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 93's Minimum Data Set ([MDS], a resident assessment tool), dated [DATE], the MDS indicated Resident 93 was severely cognitively (thinking process) impaired and was dependent on activities of daily living such as hygiene, dressing and putting on footwear. During a review of employee personnel files for CNA1, CNA 2, LVN 1, and LVN 2, the personnel files indicated no documented evidence of facility validation of staff competency on CPR and how to respond to residents who were unresponsive, had no pulse, and had no respirations. During a review of the facility Skills Awareness and Competency form, revised [DATE], the form did not indicate staff CPR skills validation and how to respond to residents who were unresponsive, had no pulse, and had no respirations. During an interview on [DATE] at 8:38 a.m., with LVN 2, LVN 2 stated even though Resident 93 was found cold, unresponsive, with no pulse, and not breathing, LVN 1 and 2 waited to verify each others findings that Resident 93 was indeed not breathing, and had no pulse, then to find out Resident 93's code status (a medical order determining the extent of resuscitation efforts a patient wishes to receive if their heart or breathing stops) by going to the computer before initiating CPR. LVN 1 stated CPR was not started immediately.During an interview on [DATE] at 11:28 a.m., with the Director of Staff Development (DSD), the DSD stated the facility does not ensure or validate staff competency regarding CPR and how to respond to unresponsive residents with no pulse and no respirations. During an interview with the Director of Nurses (DON) on [DATE] at 3:54 p.m., the DON stated the facility did not ensure and validate staff competency for performing CPR timely and how to handle residents who were unresponsive, had no pulse, and had no respirations. During a review of the facility's policy and procedure (P&P) titled, Nursing Staff Competency, Revised 4/2025, the P&P indicated the facility will have appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. The P&P indicated all licensed nurses shall have training in cardiopulmonary resuscitation (CPR). The P&P indicated Director of Staff Development, Nurse Manager or designee must validate all skills listed on the form for competent performance.During a review of the facility's 2025 Facility Assessment, revised [DATE], the facility's assessment indicated during emergency situations, the facility will develop and update annually or as needed an emergency preparedness plan, and the facility will train staff on emergency procedures and their roles during emergencies.Cross reference F678		

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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 and record review, the facility failed to ensure a psychotropic medication (medications that affect brain activities associated with mental processes and behavior) was not used unnecessarily for one of three sampled residents (Resident 13) by failing to define and monitor resident specific, measurable target behaviors related to the use of Zyprexa [an atypical antipsychotic that's used to improve mood, thoughts, and behaviors for people with schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs)]for Resident 13.This deficient practice of failing to ensure antipsychotic medication was used to treat a resident's specific, diagnosed condition, and monitor target behaviors related to the use of psychotropic medication increased the risk that Resident 13 could have experienced adverse effects (unwanted or dangerous medication-related side effects) related to psychotropic medication therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status.Findings:During a review of Resident 13's admission Record, the admission Record indicated, Resident 13 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought), and cerebral infarction (loss of blood flow to a part of the brain).During a review of Resident 13's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 13 had no capacity (ability) to understand and make decision.During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 13 required dependent assistance (Helper does all of the effort) from two or more staff for hygiene, shower, transfer, maximal assistance (Helper does more than half the effort) from one staff for dressing, bed mobility, and setup or clean-up assistance (Helper sets up or cleans up) from one staff for eating. During a review of Resident 13's Order Summary Report (OSR) dated [DATE], the OSR indicated, give Zyprexa 10 milligram (mg) by mouth at bedtime and 2.5mg by mouth in the evening related to schizophrenia manifested by hallucination (an experience involving the apparent perception of something not present) were ordered on [DATE]. The OSR indicated, monitor manifested behavior hallucinations every shift for Zyprexa use related to Schizophrenia was ordered on [DATE].During a concurrent interview and record review on [DATE], at 11:30 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 13's Medication Administration Record (MAR), dated from [DATE] to [DATE] was reviewed. The MAR indicated, monitor behavior manifested by hallucination every shift for Zyprexa use related to Schizophrenia. The MAR indicated, Resident 13 had no hallucinations and there were no hallucinations documented from [DATE] to [DATE]. RNS 1 stated, she did not witness any signs and symptoms of hallucinations for Resident 13. RNS 1 stated, she was not sure what hallucinations that Resident 13 was experiencing because the term hallucinations were very general and not a specific targeted behavior for Zyprexa use. RNS 1 stated, target behavior should be specific and measurable, so psychiatrist or Nurse Practitioner (a medical practitioner specializing in the diagnosis and treatment of mental illness) could refer to the documentation of behavior occurrences, and medication dosage to consider a Gradual Dose Reduction (GDR- a systematic approach to stepwise tapering of medication dosage to assess if a lower dose can effectively manage symptoms, conditions, or risks, or if the medication can be discontinued entirely). RNS 1 stated, the staff should have clarified with Psychiatric Nurse Practitioner (PNP)1 who prescribed Zyprexa for what specific target behaviors to monitor Resident 13 for. During a phone interview on [DATE], at 5:45 p.m., with PNP1, PNP 1 stated, she ordered Zyprexa for schizophrenia manifested by hallucinations because Resident 13's Family Member (FM) told PNP 1that Resident 13 (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	believed people were pulling her legs to prevent her from getting up from her wheelchair. PNP 1 stated, this was the reason she disagreed with a GDR for Resident 13. PNP 1 stated, clinical documentation should have reflected the resident's condition and monitored target behaviors accurately because a GDR was based on clinical evidence. PNP 1 stated, if accurate target behaviors were not documented and monitored, Resident 13 might receive unnecessary psychotropic medications and would suffer from adverse reaction (an undesired or harmful effect of a drug). PNP 1 stated, she was aware that unnecessary medication use could be a chemical restraint (the use of medications to restrict a person's movement or freedom of action, or to control behavior, when the medication is not part of a standard treatment for their condition) as well. During a concurrent interview and record review on [DATE], at 8:53 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 13's Minimum Data Set (MDS), dated [DATE], [DATE], [DATE], [DATE] were reviewed. The MDS indicated, Resident 13 did not have any hallucinations and delusions (misconceptions or beliefs that are firmly held, contrary to reality). The MDS indicated, Resident 13 did not have any physical, verbal, and other behavioral symptoms toward others. The MDSC stated, she did not witness any behavioral issues, hallucinations and delusions for Resident 13. The MDSC stated, the target behaviors should be resident specific and measurable to reflect in clinical documentation. During an interview on [DATE], at 12:07 p.m., with the Director of Nursing (DON), the DON stated, target behavior should be specific and measurable to the resident's diagnosis. The DON stated, hallucinations could be caused by many things, and this should be clarified with PNP 1. The DON stated, monitoring specific target behavior was important, because GDR would be performed based on these data. The DON stated, inaccurate data would lead to delays on treatment, and the residents continuing to receive unnecessary medication. The DON stated, the resident might suffer from unnecessary side effects/adverse reactions. The DON stated, unnecessary medication could be considered as chemical restraint as well. During a review of Resident 13's Psychiatric Visit Progress Report (PVPR), dated [DATE], the PVPR indicated, GDR was contraindicated and no psychotropic medication adjustments needed. The PVPR indicated, continued with same dose of Zyprexa due to schizophrenia management for persistent psychotic symptoms such as auditory and visual hallucinations per daughters. During a review of Resident 13's Care Plan Report (CPR) titled, Resident 13 use psychotropic medication Zyprexa (also known as Olanzapine) related to behavior management for hallucination, initiated [DATE] and revised [DATE], the CPR Goal indicated, Resident 13 will reduce the use of psychotropic medication and will have fewer episodes of hallucination by target date of [DATE]. The CPR Interventions indicated, administer medications as ordered, and monitor and document for side effects and effectiveness. The CPR Interventions indicated, consult with pharmacy and PNP 1 to consider dosage reduction when clinically appropriate. During a review of the facility's Policy and Procedure (P&P) titled, Chemical Restraints and Psychotropic Medication Management, revised 4/2025, the P&P indicated, Policy: It is the policy of this facility to ensure that residents are free from chemical restraints imposed for purposes of discipline or convenience or that are not required to treat a specific condition as diagnosed and documented in the clinical record. Procedure: 3. The Licensed Nurse (LN) shall review the classification of the drug, the appropriateness of the diagnosis, its indication, behavior monitors and related adverse side effects prior to verification of admission orders with the Attending Physician. 8. The facility's Interdisciplinary Team (IDT) will review to ensure; a. Psychotropic medication was prescribed to treat a specific diagnosed condition, as documented in the clinical record; b. Not in excessive dosage; c. Behavior is not related to delirium or other reversible conditions; d. Monitoring for adverse consequences and effectiveness of medications are in place.		

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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. Based on interview and record review the facility failed to create a comprehensive person-centered care plan in a timely manner for one of three sampled residents' (Resident 7) Stage II (Partial-thickness loss of skin, presenting as a shallow open sore or wound) pressure ulcer (damage to the skin and underlying tissue caused by constant, long-term pressure, usually on bony areas like the hips, heels, or tailbone) on the sacrococcygeal (tailbone) area. This failure had the potential to result in delays with the necessary care and services to address Resident 7's wound care needs. During a review of Resident 7's admission Record, the admission Record indicated the facility readmitted Resident 7 on 11/28/2025 with diagnoses including metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance from underlying illness) and Stage II pressure ulcer of sacral (tailbone) region. During a review of Resident 7's Minimum Data Set (MDS- a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 7's cognition (functions your brain uses to think, pay attention, process information, and remember things) was moderately impaired. The MDS indicated Resident 7 required supervision assistance (helper provides verbal cues and/ or touching/ steadying and/or contact guard assistance as resident completes activity) with eating, moderate assistance (helper does less than half the effort to complete the task) with personal hygiene, maximal assistance (helper does more than half the effort to complete task) with getting dressed and putting on/taking off footwear, dependent (helper does all of the effort) with oral hygiene and toileting hygiene. During a concurrent interview and record review on 1/29/26 at 12:00 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 7's care plan titled, Potential for Pressure Ulcer development/ skin breakdown, created 11/28/2025 was reviewed. RNS 1 stated, Resident 7 was readmitted with a stage 2 pressure ulcer on her sacrococcyx on 11/28/2025. RNS1 stated the care plan did not indicate and have interventions for Resident 7's pressure ulcer upon admission. RNS1 stated the care plan did not address Resident 7's stage 2 pressure ulcer until 12/8/2025. RNS 1 stated the sacrococcyx pressure ulcer care plan was not developed in a timely manner, timely care plan development was essential as it guides staff in providing appropriate care and addressing patient needs and failure to have an updated care plan may result in unmet patient needs. During an interview on 1/29/2026 at 1 p.m., with the Director of Nursing (DON), the DON stated developing a comprehensive person-centered care plan promptly upon noticing the concerns, rather than waiting 10 days, is crucial. The DON stated this care plan is what the staff will follow. During a review of the facility's policy and procedure titled Skin and Wound Monitoring and Management, revised 4/2025, the P&P indicated facility nursing staff will identify and document in the resident's clinical records, the condition and pressure injury risk factors related to the development of unavoidable pressure injury. The P&P indicated this identification and implementation of a plan of care will begin at admission with the initial care plan and be completed throughout assessment process for developing a comprehensive plan of care.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to ensure appropriate coordination with the hospice (care focused on providing comfort and support to people who are in the final stages of a terminal illness, rather than trying to cure the disease) provider for one of two sampled residents (Resident 44). This failure had the potential to result in gaps in monitoring, and unmet hospice-related care needs for residents. Findings: During a review of Resident 44's admission Record, the admission Record indicated the facility admitted Resident 44 on 9/22/2025 with diagnoses including atherosclerotic heart disease (thickening or hardening of the arteries caused by a buildup of plaque in the inner lining of an artery) and phimosis (a condition where the foreskin is too tight to be pulled back over the head of the penis). During a review of Resident 44's History and Physical (H&P), dated 9/26/2025, the H&P indicated, Resident 44 had fluctuating capacity to understand and make decisions. During a review of Resident 44's Minimum Data Set (MDS- a resident assessment tool), dated 12/28/2025, the MDS indicated Resident 44's cognition (think, pay attention, process information, and remember things) was severely impaired. The MDS indicated Resident 44 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, moderate assistance (helper does less than half the effort to complete the task) with oral hygiene, maximal assistance (helper does more than half the effort to complete task) with dressings, personal hygiene, dependent with toileting hygiene, showering and putting on/taking off footwear. During a review of Resident 44's Order Summary Report, dated 9/22/2025, the Order Summary Report indicated an order to admit Resident 44 to hospice with an admitting diagnosis of atherosclerotic heart disease. During a review of Resident 44's care plan titled Hospice, revised 12/30/2025, the care plan indicated interventions to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs were met and work with nursing staff to provide maximum comfort for the Resident 44. During a review of Resident 44's hospice Client Calendar Report and Sign-In/Notes for December 2025 and January 2026, the report and notes indicated the corresponding hospice visit records did not match the scheduled visits on 12/18/25, 12/22/2025, 12/25/2025, 1/1/2026 for aide (certified nursing assistant) hospice visits and on 1/19/2026 for Registered Nurse hospice visit. There was no documentation indicating that the visits were rescheduled, completed later, or otherwise accounted for. During an interview on 01/28/2026 at 11:48 a.m., with the Social Service Director (SSD), the SSD stated her role in hospice coordination was limited to contacting the hospice provider to invite them to care planning meetings. During a concurrent interview and record review on 1/28/2026 at 12:05 p.m., with Registered Nurse Supervisor (RNS) 1, Resident 44's medical records were reviewed. RNS 1 stated hospice coordination is generally handled by social services and nursing. RNS 1 stated corresponding hospice visit sign-in documentation (indicating the hospice agency staff came to see the patient) did not match the scheduled visits on the hospice calendar, and there was no documentation indicating that missed visits were rescheduled or completed. RNS 1 stated lack of coordination and oversight of hospice resulted in interruption of hospice care goals and unmet resident needs. During an interview on 01/29/2026 at 1:51 p.m. with the Director of Nursing (DON), the DON stated facility is expected to coordinate with the hospice agency, including monitoring scheduled visits and ensuring services are provided as arranged to meet hospice residents' needs. During a review of the facility and the hospice provider's hospice services agreement (HSA), dated 2/1/2023, the HSA indicated clinical record should contain information including complete documentation of all services and events. During a review of the facility and the hospice provider's HSA, signed 9/23/2025, the HSA indicated, they have to facilitate cooperative efforts in performance of their respective obligations under this agreement.		

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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 interview and record review, the facility failed to measure and document one of two sampled resident's (Resident 9) Stage II (Partial-thickness loss of skin, presenting as a shallow open sore or wound) pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) on the sacrococcygeal (tailbone) area at least on a weekly basis after being admitted on [DATE]. The deficient practice resulted in poor tracking of the pressure ulcer's healing progress and had the potential to result in delayed care and services. Findings: During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was originally admitted to the facility on [DATE] with diagnoses including chronic kidney disease (long-term, irreversible, and gradual loss of kidney function, often causing waste and fluid buildup in the body), anemia (a condition where the body does not have enough healthy red blood cells), and protein calorie malnutrition (nutritional status in which reduced availability of nutrients leads to changes in body composition and function). During a review of Resident 9's Minimum Data Set (MDS) resident assessment tool, dated 12/15/2025, the MDS indicated Resident 9's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making were intact. Resident 9 needed set-up assistance with eating, oral hygiene, substantial assistance (helper does more than half the effort to complete the task) with personal hygiene, dependent on staff (helper does all the effort) with toileting hygiene and showering. The MDS indicated Resident 9 was at risk for developing pressure injuries and had one unhealed Stage II pressure injury present on admission. During a review of Resident 9's Clinical admission [DATE] at 11:11 p.m., the admission form indicated Resident 9 had a Stage II pressure injury in the sacrococcygeal area measuring 4 centimeters in length by 3 centimeters in width, and 0 depth, 100 percent granulation tissue (new, moist, red, or pink connective tissue with new capillaries on the surface of a wound) and with light serosanguinous exudate (thin, watery, pink-to-light-red wound drainage). During a concurrent interview and record review on 1/28/2026 at 10:26 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 9's medical records were reviewed. LVN 3 confirmed and stated the only wound measurement of Resident 9's Stage II was conducted on admission [DATE]. LVN 3 stated as of 1/28/2026 (28 days) the pressure injury had not been measured to monitor progress. LVN 3 stated measurements and description of pressure injury need to be conducted on at least a weekly basis to track its progress. During an interview on 1/29/2026 at 12:24 p.m., with the Director of Nursing (DON), the DON stated the pressure injuries need to be measured minimally on a weekly basis to track the wound's progress. During a review of the facility's policy and procedure (P&P) titled, Skin and Wound Monitoring and Management dated 4/2025, the P&P indicated the resident with a pressure injury will receive necessary services to prevent infection, and prevent new, avoidable pressure injuries from developing. The P&P indicated a licensed nurse will assess/ evaluate at least weekly each area of alteration should include but not limited to measuring the skin injury.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, failed to follow their policy to replace missing dentures and provide a dentist visit for one of three sampled residents (Resident 15). This Failure had the potential to result in Resident 15 having discomfort while eating or chewing foods that could lead to unintended weight loss and lower self-esteem. Findings: During a review of Resident 15's admission Record, the admission Record indicated, Resident 15 was initially admitted to the facility on [DATE] and last re-admission was on 1/12/2026 with diagnoses including dysphagia (difficulty swallowing), breast cancer (a disease where cells in the breast grow uncontrollably and form a tumor [abnormal growth]), and dementia (a progressive state of decline in mental abilities). During a review of Resident 15's History and Physical (H&P), dated 1/13/2026, the H&P indicated, Resident 15 had no capacity (ability) to understand and make decisions. During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool), dated 1/29/2025, the MDS indicated Resident 66 required dependent assistance (Helper does all of the effort) from two or more staff for bed mobility, toilet hygiene, maximal assistance (Helper does more than half the effort) from one staff for dressing, personal hygiene, and supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance) from one staff for eating. During a concurrent observation and interview on 1/26/2026, at 11:27 a.m., with Resident 15 in her room, Resident 15 did not have natural teeth. There were no dentures at the bedside. Resident 15 stated, she did not know where her dentures were. Resident 15 stated, she came in to the facility with both upper and lower dentures upon admission. Resident 15 stated, she asked facility staff to help her locate her dentures but no one has updated her on the status of her dentures. Resident 15 stated, she was having discomfort while she was trying to eat or chew food due to missing dentures. Resident 15 stated, she felt embarrassed when she was talking to other people with no teeth. During a concurrent interview and record review on 1/28/2026, at 11:06 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 15's Resident's Clothing and Possessions (also known as Belongings List) dated on 12/5/2025 and 1/12/2026 were reviewed. The Resident's Clothing and Possessions indicated, Resident 15 had dentures on 12/5/2025 upon initial admission, but had no dentures on 1/12/2026 upon readmission from the General Acute Care Hospital (GACH). RNS 1 stated, Resident 15 lost her dentures during the hospitalization, and she should have notified the Social Service Director (SSD) for replacement. RNS 1 stated, if the resident did not have proper fitted dentures, the resident might have unintended weight loss. During a concurrent interview and record review on 1/28/2026, at 11:59 a.m., with the Social Service Director (SSD), Resident 15's Social Service Summary (SSS), dated from 1/16/2026 was reviewed. The SSS indicated, Resident 15 had upper and lower dentures. The SSD stated, she was not aware of the missing dentures. The SSD stated, the missing dentures should have been replaced as soon as possible to prevent unintended weight loss and discomfort while eating. The SSD stated, the nursing staff did not notify her regarding missing dentures, and she believed Resident 15 had the dentures when she visited her on 1/16/2026. The SSD stated, Resident 15 should be seen by dentist for missing dentures within three days. During an interview on 1/29/2026, at 12:07 p.m., with the Director of Nursing (DON), the DON stated, the SSD should have arranged a dental visit for Resident 15, to get the missing dentures replaced as soon as possible. The DON stated, the nursing staff should have communicated with the SSD regarding the missing dentures. The DON stated, providing dentures in a timely manner was important because it could affect Resident 15's ability to eat, and it could lead to social isolation. During a review of Resident 15's Order Summary Report (OSR), dated 1/12/2026, the OSR indicated, provide dental consultation and treatment as needed was ordered on 1/12/2026. During a review of Resident 15's Care Plan Report (CPR), titled Resident 15 had oral/dental health problems related to edentulous (no natural teeth) and the dentures were lost in the GACH, initiated 1/20/2026, the CPR Goal indicated, Resident 15 will be free from infection, pain or (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bleeding in the oral cavity. The CPR Interventions indicated, coordinate arrangements for dental care as needed. During a review of the facility's Policy and Procedure (P&P) titled, Ancillary Services, revised 12/2023, the P&P indicated, Policy: It is the policy of this facility that Social Services staff will coordinate ancillary services to promote residents' optimal well-being. i.e. Dental, Optometry, Ophthalmology, Audiology, Podiatry evaluations for residents. Procedures: 1. Social Services will maintain a system to monitor ancillary services. 4. Social Services staff member will request that nursing obtain a physician's order for evaluation(s) prior to scheduling of appointments. During a review of the facility's Policy and Procedure (P&P) titled, Dental Services, revised 4/2025, the P&P indicated, Policy: It is the policy of this Facility to ensure that its residents who require dental services on a routine or emergency basis have access to such services without barrier. It is likewise the policy of the Facility to repair or replace the dentures of a resident except in those situations where the loss or damage directly results from the action of an alert and oriented resident who is responsible for his/her own medical decisions. Procedure: 2. In the event that a Facility resident requires emergency dental services, for the repair or replacement of dentures or otherwise, the Facility will: Promptly and, in any event, no later than three (3) business days from the date of loss/damage, refer to the resident for dental services. Assist the resident in making the necessary dental appointments, when necessary or requested. 3. If a referral for dental services does not occur within three (3) business days from the date of loss/damage, the Facility will: Document what actions were taken to ensure the resident could eat, drink and communicate (if applicable) adequately while awaiting dental services. Document the nature of the extenuating circumstances which led to the delay.		