STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056169	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamitos West Health & Rehabilitation	3902 Katella Avenue Los Alamitos, CA 90720

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 0558 Level of Harm - Potential for minimal harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on observation, interview, and facility P&P review, the facility failed to provide reasonable accommodations to meet the care needs for one of four sampled residents (Resident 2). * The facility failed to ensure Resident 2 had the correct dental toothbrush for oral hygiene. This failure had the potential to negatively impact Resident 2's well-being. Findings: Review of the facility's P&P titled Accommodation of Needs reviewed on 10/7/24, showed the facility shall evaluate and make reasonable accommodations for the individual needs and preferences of a resident. Under the Policy Explanation and Compliance Guidelines, based on individual needs and preferences, the facility will assist the resident in maintaining and/or achieving independent functioning, dignity, and well-being to extent possible. Medical record review for Resident 2 was initiated on 10/25/24. Resident 2 was originally admitted to the facility on [DATE], and readmitted on [DATE]. On 11/6/24 at 0915 hours, a concurrent observation and interview was conducted with Resident 2 and CNA 2. Resident 2 removed the dentures and placed them on a paper towel. CNA 2 brought the emesis basin, short handle brush with bristles on both sides, a cup of water and a bottle of blue solution for mouthwash. Resident 2 used the short handle brush with bristles on the sides to brush their teeth when CNA 2 brought a regular toothbrush. Resident 2 stated CNA 2 gave the short handle brush so Resident 2 used that brush to brush the teeth. CNA 2 stated the small handle brush with bristles on both sides is normally used to clean the dentures, and the regular toothbrush is normally used to clean the resident's teeth. CNA 2 verified they did not provide the regular toothbrush for Resident 2 to brush the teeth. CNA 2 further verified Resident 2 used the short handle brush with bristles to brush the teeth. On 11/6/24 at 1312 hours, an interview was conducted with LVN 4. LVN 4 stated Resident 2 preferred to use the regular toothbrush to brush the teeth. Furthermore, LVN 4 confirmed the short handle brush with bristles on both sides was normally used to clean the dentures. On 11/6/24 at 1515 hours, an interview was conducted with the DON. The DON verified Resident 2 was to use two brushes, the brush with bristles on both sides was used to clean the dentures and the regular toothbrush was for the teeth.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48844 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services for two of four sampled residents (Residents 1 and 2). * The facility failed to notify the physician when Resident 1 had no bowel movements for more than three days. * The facility failed to apply the splints three times a day on Resident 2's feet as ordered by the physician. These failures had the potential to negatively impact these residents' well-being. Findings: 1. Review of the facility's P&P titled Constipation Management reviewed on 10/14/24, showed constipation problems are prevented through a bowel management program. The procedure includes secondary management consists of obtaining MD orders for the use of stool softeners, laxatives or suppositories. Document in the medical record the frequency of bowel movements and the resident's response to the effectiveness of the program. The program may consist of primary and/or secondary measures. These are documented in the medical record. Closed medical record review for Resident 1 was initiated on 10/30/24. Resident 1 was admitted to the facility on [DATE], and discharged on [DATE]. Review of Resident 1's H&P examination dated 9/28/24, showed Resident 1 had diagnosis of unspecified fracture of right femur (break in the uppermost part of thighbone). Review of Resident 1's Bowel Monitoring Log showed the resident did not have a bowel movement from 9/29/24 to 10/3/24. Review of Resident 1's Physician Orders showed an order dated 9/27/24, for the following bowel management medications: - docusate sodium 100 mg given two times a day. - polyethylene glycol 3350 powder mixed with six to eight ounces of water once a day. Review of Resident 1's MAR for September 2024 showed Resident 1 was administered the following bowel management medications: - docusate sodium two times a day from 9/28/24 to 9/30/24. - polyethylene glycol 3350 one time a day was refused on 9/28/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- polyethylene glycol 3350 one time a day from 9/29/24 to 9/30/24. Review of Resident 1's MAR for October 2024 showed Resident 1 was administered the following bowel management medications: - docusate sodium two times a day from 10/1/24 to 10/4/24. - polyethylene glycol 3350 once a day from 10/1/24 to 10/4/24. - bisacodyl suppository (a small, solid capsule inserted into the rectal area to treat constipation) was administered on 10/5/24 at 1300 hours. Review of Resident 1's Progress Note dated 10/5/24 showed the following documentation: - at 1415 hours, a physician's order was received for Milk of Magnesia 30 cc by mouth and Dulcolax suppository as needed. - at 1446 hours, Resident 1 had been experiencing constipation. The physician's order was received to start bowel protocol. The suppository medication was administered, which was ineffective. The physician was informed and ordered to transfer Resident 1 to an acute care hospital. On 10/30/24 at 1400 hours, a concurrent interview and medical record review was conducted with LVN 1. LVN 1 stated the facility monitored the residents' bowel movement and had a bowel movement protocol. LVN 1 confirmed Resident 1's last bowel movement was on 9/28/24, as shown in the Bowel Monitoring Log and verified the physician was not notified of Resident 1 not having a bowel movement by the third day. On 10/30/24 at 1509 hours, a concurrent interview and medical record review was conducted with the DON. The DON stated the facility monitored the bowel movement of each resident and had a bowel movement protocol to notify the physician if a resident had not had a bowel movement for three days. The DON confirmed there was no documentation the nurses had notified the physician for Resident 1 not having bowel movement for three days. 2. Review of the facility's P&P titled Use of Assistive Device reviewed on 10/14/24 showed the policy is to provide a reliable process for the proper and consistent use of assistive devices for those residents requiring equipment to maintain or improve function and/or dignity. Assistive devices are tools, products, types of equipment, or technology that help individuals perform tasks and activities. Assistive devices include among others the orthotic or prosthetic equipment. A nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Medical record review for Resident 2 was initiated on 10/25/24. Resident 2 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including of Parkinson's Disease (progressive brain disorder leading to movement problems), contractures (permanent tightening of the muscles, tendons and skin that causes the joints to shorten and become stiff) of unspecified joint and difficulty in walking among other diagnoses. Review of Resident 2's Physician Orders showed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 10/2/24, an order for bilateral dynamic splint for plantar flexion (movement of the foot that occurs when ankle is extended and the foot points away from the leg) contracture. -On 10/9/24, an order to apply dynamic splints (medical device that immobilizes and protects a displaced body part) three times a day starting at 30 minutes on 10/9/24, and progressing to two hours three times a day by 10/18/24; to check feet after each application and use tracking log for each application. Review of Resident 2's Physical Therapy Treatment Encounter Note dated 10/9/24, showed Resident 2 received bilateral lower extremity dynamic splints. Resident 2's family member, LVN, RNAs, and CNAs were present for training in application of dynamic splints that needed to be worn three times a day, starting 20 minutes and progressing to 2 hours each session over the next week. The schedule would be posted for team to apply dynamic splint then after third session and overnight, static splints would be applied to maintain new range of motion gains. Review of Resident 2's splint tracking log showed the number of times in a day and the hours the splint was worn by Resident 2. The hours not shown on the log should be documented in the Progress Notes. Review the log and progress notes showed from 10/15-11/5, the splints were not applied as ordered on the following dates and times: - On 10/15/24 at 0649 to 0748 hours. - On 10/17/24 at 1500 to 1600 hours. - On 10/18/24 at 1830 to 1930 hours. - On 10/19/24 at 1100 to 1220 hours, and 1940 to 2010 hours. - On 10/20/24 at 0720 to 0920 hours, and 1320 to 1530 hours. - On 10/23/24 at 1745 to 1910 hours. - On 10/24/24 at 1515 to 1630 hours, and 1800 to 1930 hours. - On 10/25/24 at 0800 to 0930 hours, 1300 to 1330 hours, and 1745 to 1930 hours. - On 10/27/24 at 1220 to 1420 hours, and 1900 to 2053 hours. - On 10/30/24 at 0722 to 0900 hours. - On 11/4/24 at 0710 to 2110 hours. - On 11/5/24 at 1400 to 1600 hours, and 1900 to 2100 hours. Review of the progress notes showed the following: - The progress notes for 10/30/24, showed the dynamic splints were put on at 1850 hours, and removed on 2050 hours. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The progress notes for 11/1/24, showed the dynamic splints were put on at 1820 hours, and removed at 2020 hours. On 11/6/24 at 1050 hours, an interview was conducted with the PT. The PT stated the dynamic splint should be worn three times a day for 2 hours each time. The PT stated the splint was important for Resident 2 to have best chances of improving functional transfers and ambulation. On 11/6/24 at 1352 hours, a concurrent interview and medical record review was conducted with LVN 4. LVN 4 stated the splint should be worn three times a day for two hours each time. LVN 4 was asked what happened if Resident 2 refused to wear the splint. LVN 4 stated the refusal should be documented in the progress notes and they should educate Resident 2 on the benefits of the splint. LVN 4 confirmed some days the splint was put on only once or twice in a day to Resident 2 and with no documentation of the refusal and benefits of the splint. On 11/6/24 at 1515 hours, a concurrent interview and medical record review was conducted with the DON. The DON confirmed the above findings.