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	12/12/2024

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

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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 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** 48853 Based on interview and medical record review, the facility failed to meet the needs and preferences for one of three sampled residents (Resident 1). * The facility failed to provide Resident 1 a bath when he requested a bath on 11/24/24. This failure led to the resident feeling frustrated, which posed the risk to negatively impact the resident's physical and emotional 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, except when the health and safety of the individual or other residents would be endangered. Medical record for Resident 1 was initiated on 12/4/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's History and Physical examination dated 9/26/24, showed Resident 1 had a fluctuating capacity to understand and make decisions. Review of Resident 1's MDS Annual assessment dated [DATE], showed the BIMS score of 12 (moderate cognitive impairment). On 12/3/24 at 1645 hours, a telephone interview was conducted with Resident 1's family member. Family Member 1 stated Resident 1 returned from the hospital on 11/23/24, and refused the shower as scheduled on that day. Family Member 1 further stated Resident 1 requested for a bath on 11/24/24;however, Resident 1 was not given a shower until 11/25/24, because the CNA assigned to the resident worked a double shift and needed to go to break. Review of Resident 1's Task ADL - Bathing failed to show a bath was given to Resident 1 on 11/24/24 as requested. On 12/4/24 at 1259 hours, an interview was conducted with Resident 1. Resident 1 stated he felt frustrated when he requested for a bath because he wanted to feel clean, and the staff did not help him. (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 0558 Level of Harm - Potential for minimal harm Residents Affected - Some	On 12/11/24 at 1507 hours, an interview and concurrent medical record review was conducted with the DSD. The DSD verified the task would only show the bathing on the day when a bath was given to the resident. The DSD verified Resident 1's Task ADL - Bathing failed to show a bath was given to Resident 1 on 11/24/24, as requested. On 12/12/24 at 0900 hours, a follow-up interview was conducted with the DSD. The DSD stated the facility would accommodate the resident's request. If a bath was given to the resident, it should have been documented. On 12/12/24 at 0919 hours, a telephoneinterview was conducted with LVN 4. LVN 4 stated he asked the RNA to give a bath to Resident 1 on 11/24/24; however, LVN 4 didnot remember who the RNA was on 11/24/24. LVN 4 further stated he did not know if Resident 1 received a bath on that day. On 12/12/24 at 1545 hours, an interview and a concurrent medical record review was conducted with the DON. The DON stated the facility would accommodate any request for a bath. The DON verified Resident 1's Task ADL - Bathing failed to show a bath was given to Resident 1 on 11/24/24, as requested. The DON was informed and acknowledged of the above findings.

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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 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record, and facility P&P review, the facility failed to develop the comprehensive plan of care to reflect the individual care needs for one of three sampled residents (Resident 1). * The facility failed to develop a care plan problem to address Resident 1's change in condition on 11/11/24, when Resident 1 had mild weakness and flushed face. This failure posed the risk of Resident 1 not to receive the appropriate, consistent, and individualized care. Findings: Medical record review for Resident 1 was initiated on 12/4/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 9/26/24, showed Resident 1 had a fluctuating capacity to understand and make decisions. Review of Resident 1's MDS Annual assessment dated [DATE], showed the BIMS score of 12 (moderate cognitive impairment). Review of Resident 1's Progress Notes dated 11/11/24 at 0923 hours, showed Resident 1 had mild weakness and flushed face. Review of Resident 1's Care Plan failed to show a plan of care problem was developed to address Resident 1's change in condition on 11/11/24, when the resident had mild weakness and flushed face. On 12/5/24 at 1124 hours, an interview and concurrent record review was conducted with LVN 2. LVN 2 stated Resident 1 had mild weakness and his face appeared flush on 11/11/24. LVN 2 verified Resident 1's plan of care failed to show a care plan problem was initiated for Resident 1's change of condition on 11/11/24. On 12/5/24 at 1153 hours, an interview and concurrent record review was conducted with RN 1. RN 1 verified Resident 1's care plan problem was not initiated for Resident 1's change in condition. On 12/12/24 at 1545 hours, an interview was conducted with the DON. The DON was informed and acknowledged of the above findings.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 1) received the appropriate treatment and services to prevent the urinary tract infections to the extent possible. * The facility failed to provide the daily indwelling urinary care to Resident 1 after his indwelling urinary catheter was inserted on 11/21/24. This failure posed the risk for Residents 1 to develop catheter-associated urinary tract infections. Findings: Review of the facility's P&P titled Urinary Catheters reviewed 10/14/24, showed documentation in the medical record should show continual assessment for use of the catheter. Staff will follow current standards of practice when handling catheters, the urine collection bag is kept below the level of the bladder and off the floor, the urinary catheter tubing is unobstructed and free of kinking, and appropriate technique is used when emptying the catheter bag. Medical record review for Resident 1 was initiated on 12/4/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 9/26/24, showed Resident 1 had a fluctuating capacity to understand and make decisions. Review of Resident 1's MDS Annual assessment dated [DATE], showed the BIMS score of 12 (moderate cognitive impairment). Review of Resident 1's TAR for November 2024 showed the following physician's orders: - on 11/21/24, may insert indwelling urinary catheter 16 Fr/10 cc due to urinary retention. - on 11/25/24, to cleanse the indwelling urinary catheter site with NSS and provide perineal care QD and PRN. On 12/3/24 at 1645 hours, an interview was conductedwith Family Member 1. Family Member 1 stated the indwelling urinary catheter was inserted on 11/21/24, and was never checked and cleaned. Family Member 1 further stated Resident 1 had a bruise (purplish discoloration) on the penis observed when Family Member 1 accompanied the resident to the urologist appointment, and no one had reported about it. 12/4/24 at 1259 hours, an interview was conducted with Resident 1. Resident 1 stated he had an indwelling urinary catheter for few days and the staff had never checked and cleaned the site. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 1438 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified the indwelling urinary catheter care was not ordered until 11/25/24. LVN 3 stated the indwelling urinary catheter was inserted on 11/21/24, and no catheter care treatmentwas rendered until 11/26/24, five days after it was inserted. On 12/12/24 at 1545 hours, an interview was conducted with the DON. The DON stated the indwelling urinary catheter care should have been ordered upon theinsertion of the indwelling urinary catheter. The DON further stated she expectedthe nurses to assess the catheter site for redness, discoloration, and signs and symptoms of infection when providing the treatment for the indwelling urinary catheter. The DON was informed and acknowledged of the above findings.

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F 0755 Level of Harm - Potential for minimal 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** 48853 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the accurate administration of the medications was provided to one of three sampledresidents (Resident 1). * The facility failed to ensure Resident 1's psyllium (a soluble fiber used primarily as a gentle bulk-forming laxative) wasadministered as ordered by the physician. This failure had the potential to negatively affect Resident 1's well-being. Findings: Review of the facility's P&P titled Medication Administration reviewed 10/14/24, showed medications are administered in accordance with the written orders of the attending physician. Medical record review forResident 1 was initiated on 12/4/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 9/26/24, showed Resident 1 had a fluctuating capacity to understand and make decisions. Review of Resident 1's MDS Annual assessment dated [DATE], showed the BIMS score of 12 (moderate cognitive impairment). Review of Resident 1's Order Summary Report showed a physician's order dated 11/21/24, to administer psyllium one capsule by mouth two times a day. Review of Resident 1's MAR for November 2024 showed the psyllium medication was to be administered at 0900 and 1700 hours, starting 11/21/24 hours. Review of Resident 1's Progress Notes on 11/26/24 at 1231hours, showed the pharmacy delivered a wrong medication bubble pack containing two psyllium capsules. Further review of Resident 1's progress notes dated 11/26/24 at 1302 hours, showed Resident 1 received extra one capsule of psyllium on 11/21, 11/22, 11/24 and 11/25/24 at 1700 hours. On 12/12/24 at 1545 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 1 received one extra capsule of psyllium on the above dates.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 1) was free from the unnecessary drugs. * Resident 1 was administered the docusate sodium (stool softener) medication when Resident 1 had loose bowel movement or diarrhea. This failure had the potential for Resident 1 to receive unnecessary medication and experience adverse effects from the medication. Findings: Review of the facility's P&P titled Medication Administration reviewed 10/14/24, showed the medications are administered in accordance with the attending physician's written orders. Medical record review for Resident was initiated on 12/4/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 9/26/24, showed Resident 1 had a fluctuating capacity to understand and make decisions. Review of Resident 1's MDS Annual assessment dated [DATE], showed the BIMS score of 12 (moderate cognitive impairment). Review of Resident 1's Order Summary Report showed a physician's order dated 9/24/24, to administer docusate sodium 100 mg one tabletby mouth two times a day for supplement and hold the medication for loose bowel movement. Review of Resident 1's Task for Bowel Elimination showed the resident had loose stool or diarrhea on the following dates and times: - 11/20/24 at 1934 hours; - 11/21/24 at 0659, 0933, 1334, and 1345 hours; - 11/22/24 at 0655 and 1128 hours; and - 11/24/24 at 1018 hours. Review of Resident 1's MAR for November 2024 showed the docusate sodium medication was administered on the following dates and times: - 11/21/24 at 0900 and 1700 hours; - 11/22/24 at 0900 hours; - 11/23/24 at 0900 and 1700 hours; and (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 11/24/24 at 0900 and 1700 hours. On 12/12/24 at 1122 hours, an interview and a concurrent medicalrecord review was conducted with LVN 2. LVN 2 verified she worked on 11/21/24. LVN 2 stated she did not receive a report from the previous shift that Resident 1 having diarrhea or loose stools; and the CNA did not report anything to her during her shift. LVN 2 verified she administered the medication on 11/21/24 at 0900 hours. On 12/12/24 at 1545 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 1's MAR for November 2024 showed Resident 1 received docusate sodium when the resident had loose bowel movement or diarrhea as documented in Resident 1'sTASK - Bowel Elimination. The DON stated the nurses should have checked the resident's bowel movement pattern prior to the administration of docusate sodium.

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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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical records for three of three sampled residents (Residents 1, 2, and 3) were accurate. * The facility failed to ensure the CNAs' documentation in the Task-Bladder elimination when residents had an indwelling urinary catheter were accurate. This failure had the potential for the residents' care needs not being met as their medical information were inaccurate. Findings: 1. Medical record review for Resident 1 was initiated on 12/4/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 9/26/24, showed Resident 1 had a fluctuating capacity to understand and make decisions. Review of Resident 1's TAR showed a physician's order dated 11/21/24, to insert indwelling urinary catheter 16 Fr/10 cc due to urinary retention. Review of Resident 1's Task for Bladder Elimination showed Resident 1 was incontinent on 11/24/24 at 1418 and 2144 hours, when theresident had an indwelling urinary catheter. 2. Medical record review for Resident 2 was initiated on 12/4/24. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 9/26/24, showed Resident 2 had the capacity to understand and make decisions. Review of Resident 2's Order Summary Report showed a physician's order dated 12/29/22, for the indwelling urinary catheter 20 Fr/10 cc. Review of Resident 2's Task for Bladder Elimination showed Resident 2was incontinent on the following dates and times: - 11/19/24 at 2251 hours; - 11/20/24 at 1340 hours; - 11/26/24 at 0639 hours; - 11/27/24 at 0421 hours; - 11/29/24 at 0657 hours; (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	- 12/1/24 at 1526 hours; - 12/2/24 at 0645 and 1228 hours; - 12/4/24 at 0659 hours; - 12/5/24 at 0640 hours; - 12/6/24 at 0215 and 2219 hours; - 12/7/24 at 0621 and 2159 hours; - 12/8/24 at 0604 hours; and - 12/11/24 at 0544 hours. 3. Medical record review for Resident 3 was initiated on 12/4/24. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's Order Summary Report showed a physician's order dated10/15/23, for the indwelling urinary catheter 16 Fr/10 cc. Review of Resident 3's Task for Bladder Elimination showed Resident 3 was incontinent on the following dates and times: - 11/16/24 at 2002 hours; - 11/23/24 at 0056 and 2233 hours; - 11/24/24 at 0902 and 2143 hours; - 11/26/24 at 1459 hours; - 11/27/24 at 1009 hours; - 11/28/24 at 1305 hours; - 12/2/24 at 0149 hours; - 12/3/24 at 0404 hours; - 12/6/24 at 0909 and 1914 hours; - 12/7/24 at 2136 hours; - 12/8/24 at 0439 and 1913 hours; - 12/9/24 at 0620 hours; (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	- 12/10/24 at 1017 and 2137 hours; - 12/11/24 at 0836 hours; and - 12/12/24 at 0955 hours. On 12/12/24 at 1545 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Residents 1, 2 and 3's Task for Bladder elimination showed the CNAs were documenting incontinent inaccurately while the residents had an indwelling urinary catheter.