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	01/24/2025

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 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on interview, medical record review, and the facility P&P review, the facility failed to ensure the resident's rights were respected for one of four sampled residents (Resident 1). * The facility failed to ensure Resident 1's medications were administered as per Resident 1 and family member's request. This failure had the potential to negatively affect the residents' well-beinig. Findings: Review of the facility's P&P titled Resident Rights revised 1/11/25, showed the resident has the right to and the facility must promote and facilitate self-determination through supporting the resident's choices including the resident's right to make choices about aspects of his life in the facility. Medical record review for Resident 1 was initiated on 1/3/25. Resident 1 was initially admitted to the facility on [DATE]. Review of Resident 1's MAR for January 2025 showed Resident 1's medications were administered at the following dates and times: - on 1/1 to 1/4/25 at 1300 hours, Resident 1 received the cholecalciferol (a supplement) 2000 units by mouth daily and cyanocobalamin (a supplement) 1000 mcg by mouth daily. - on 1/12/25 at 0900 hours, Resident 1 received the cholecalciferol 2000 units by mouth daily and cyanocobalamin 1000 mcg by mouth daily. However, there was no documented evidence why the administration time had changed from 1300 hours to 0900 hours, after 1/4/25. Additionally, Resident 2's MAR for January 2025 showed the following medications were administered on 1/12/25 at 0900 hours: - folic acid (a supplement) one tablet by mouth daily; (continued on next page)

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

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	01/24/2025

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 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	- finasteride (a medication to treat an enlarged prostate) 5 mg by mouth daily; and - carbidopa-levodopa (a medication used for Parkinson's, a chronic brain disorder that causes movement problems, stiffness, and tremors) 25-100 mg two tablets by mouth daily. Therefore, Resident 1 received these five medications at 0900 hours. On 1/23/25 at 0851 hours, an interview and concurrent record review was conducted with the DON. The DON was asked why Resident 1's medication administration times were changed. The DON stated the facility had changed Resident 1's medication schedules a few months ago to spread out the medication administration times per the resident and family's request. The DON stated Resident 1 was transferred to the hospital on 1/5/25, and retuned on 1/11/25. The DON further stated when Resident 1 returned from the hospital, the medication administration time for the cholecalciferol and cyanocobalamin medications were changed from the previously administered times. The DON stated Resident 1's medications should have been resumed at the previously scheduled time per Resident 1 and family's request. On 1/24/25 at 1101 hours, an interview was conducted with LVN 3. LVN 3 stated she administered Resident 2's medication on 1/12/25 at 0900 hours, as scheduled in the electronic MAR. LVN 3 stated Family Member 1 called to make sure Resident 1's medication administration times were still spread out like how they were previously. LVN 3 stated somehow the medication administration times were scheduled at 0900 hours, when Resident 1 returned from the hospital. LVN 3 further stated Resident 1 was also on antibiotics and receiving even more medications than the previous week. On 1/24/25 at 1138, a telephone interview was conducted with Family Member 1. Family Member 1 stated he called the facility prior to Resident 1's readmission to discuss Resident 1's medications, but the facility would not talk to him since Resident 1 was still in the hospital. Family Member 1 stated when he called the facility again on 1/12/25, the nurse had already administered the 0900 hours medications, including the medications that should have been administered at a later time to space out all the medication.

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	01/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on interview, medical record review, and the facility P&P review, the facility failed to notify the physician of thechanges in the resident's status for one of four sampled residents (Resident 1). * The facility failed to notify the physician that Resident 1 had been refusing the bowel management medications from 1/1-1/3/25. This failure had the potential for the resident not to receive the necessary care and services which would negatively affect the resident's well-being. Findings: Review of the facility's P&P titled Change in Resident Condition dated 10/14/24, showed a change in the resident condition is reported as soon as practical Medical record review for Resident 1 was initiated on 1/3/25. Resident 1 was initially admitted to the facility on [DATE]. Review of Resident 1's Bowel Elimination record showed the resident had a bowel movement on 1/1/25 at 0830 hours. Further review of the bowel elimination record showed Resident 1's next bowel movement was on 1/4/25 at 2051 hours. Review of Resident 1's MAR for December 2024, showed the following physician's orders: - on 9/24/24, for docusate sodium (a stool softener) by mouth twice a day, bisacodyl (a laxative) one 10 mg suppository as needed for bowel protocol, and Lactulose Oral Solution 10 gm/ml 30 ml by mouth as needed for constipation; - on 10/22/24, for Milk of Magnesia Suspension (laxative) 2400 mg by mouth every 24 hours as needed for constipation; - on 10/31/24, for Fleets Saline enema 7-19 GM/197 ml rectally for constipation if the suppository ineffective; and - on 11/21/24, for psyllium (a fiber supplement) one capsule twice a day for bowel management; Review of Resident 1's Progress Notes showed the following: - on 1/1/25 at 2312 hours, Resident 1 refused the stool softener three times; - on 1/2/25 at 2246 hours, Resident 1 refused the stool softener three times; - on 1/3/25 at 1531 hours, Resident 1 was offered and refused the prn bowel management medications for no bowel movement. The note further showed the resident's family member requested the medication to be administered on 1/4/25, because it was Resident 1's shower day. (continued on next page)

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	01/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, there was no documented evidence the physician was informed of the resident's refusal of stool softener medication from 1/1 - 1/3/25. Further review of the progress notes showed the following: - on 1/3/25 at 2254 hours, Resident 1 was administered the stool softener but still had not had a bowel movement. The noted further showed Resident 1 wanted the bowel management prn medications on 1/4/25, before his shower; - on 1/4/25 at 1536 hours, Resident 1 still did not have a bowel movement but wanted to wait until tonight to see if he could have a bowel movement; - on 1/4/25 at 2331 hours, Resident 1 had one large, formed bowel movement and one medium soft bowel movement; - on 1/5/25 at 0130 hours, Resident 1 was administered acetaminophen (a pain medication) 750 mg for mild pain; and - on 1/5/25 at 0430 hours, the resident complained of pain level of 10 (based on 0-10 pain scale, 0 = no pain and 10 = severe pain) between his lower ribs and pelvis and wanted to go to the hospital. The staff called Family Member 1 who came to the facility and stated the resident did not look well and requested the resident go to the hospital. The physician was notified and the resident was transferred out to the hospital at 0530 hours. Review of Resident 1's ED Note dated 1/5/25, showed the CTimaging showing diverticulitis (inflammation or infection of the digestive tract) with an abscess (a confined pocket of pus) and an associated ileus (inability of the intestine to contract normally and move waste out of the body) versus a small bowel obstruction (intestines becomes blocked, preventing stool from passing.) On 1/23/25 at 0851 hours, an interview and concurrent record review was conducted with the DON. The DON stated if the resident had no bowel movement and refusing the bowel management medications, the physician should have been notified.

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	01/24/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39683 Based on interview, medical record review, and the facility P&P review, the facility failed to ensure the necessary care and services for two of two sampled residents (Resident 2 and 4) to prevent the elopement. * The facility failed to update the elopement assessment when Resident 2 had an increased on wandering behavior resulting in the use of Wander Guard. * The facility failed to ensure Resident 4's elopement risk assessments were completed quarterly as per the facility's P&P. These failures posed a risk for Residents 2 and 4 not to receive the necessary care and services to prevent elopement. Findings: Review of the facility's P&P titled Accident Prevention and Supervision revised 10/7/24, showed the resident environment remains as free of accident hazards as possible; and each resident will receive adequate supervision to prevent accidents and will include the following: - identifying hazard(s) and risk(s); - evaluating and analyzing hazard(s) and risk(s); - implementing interventions to reduce hazard(s) and risk(s); and - monitoring for effectiveness and modifying interventions when necessary. Review of the facility's P&P titled Elopement Risk Evaluation revised on 10/14/24, showed the residents will be assessed for elopement and throughout their safety by the interdisciplinary care planning team. The facility is equipped with door locks/alarms to help avoid elopements. Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so. The section for Efforts to Prevent Elopement included the interdisciplinary care team will assess resident for risk of elopement risk on admission, readmission, quarterly with the MDS processand as needed, when a change of condition occurs where the resident might seek out exit doors of the facility. 1. Medical record review for Resident 2 was initiated on 1/22/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Initial H&P examination dated 1/17/25, showed Resident 2 had dementia and did not have capacity to understand and make decisions. (continued on next page)

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	01/24/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Elopement Risk Scale dated 1/15/25, showed Resident 2 was at low risk for elopement. The section for History for Wandering showed Resident 2 had episode of wandering/seeking to find someone or something and no history of elopement or leaving the facility without assistance. Review of Resident 2's Clinical Note dated 1/17/25 at 1634 hours, showed Resident 2 had multiple episodes of getting out of bed unassisted, going into other residents' rooms and walking down the hallway. Review of Resident 2's Clinical note dated 1/17/25 at 1742 hours, showed the staff notified Family Member 2 that a Wander Guard alarm was placed on the Resident 2's left wrist. On 1/23/25 at 0851 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated an elopement assessments should be done on admission, quarterly and as needed for changes in wandering/elopement behaviors. The DON verified Resident 2's elopement risk evaluation was completed upon admission on 1/15/25. However, when Resident 2 exhibited increased wandering behaviors resulting in the use of Wander Guard on 1/17/25, the DON further stated a new elopement risk evaluation should have been completed. 2. Medical record review for Resident 4 was initiated on 1/22/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Elopement Risk Scale dated 3/31/23, showed the Resident 4 was not at risk for elopement. Review of Resident 4's H&P examination dated 4/18/24, showed Resident 2 had dementia. Review of Resident 4's Clinical Note dated 6/28/24 at 1211 hours, showed Resident 4 was seen outside the facility's back door, and Resident 4 did not know where he was. The note further showed a Wander Guard braceletwas attached to Resident 4's wheelchair. Review of Resident 4's Elopement Risk Scale dated 1/19/25 at 1358 hours, showed Resident 4 was a high elopement risk. The assessment showed Resident 4 kept wheeling his wheelchair to the exits, attempted to leave the facility, and verbalized wanting to go home. The section for interventions showed a Wander Guard was in place. Further review of Resident 4's medical record showed no other elopement risk assessments were completed. Review of Resident 4's Clinical Noted dated 1/19/25 at 1557 hours, showed around 1300 hours, the CNA reported the resident attempted to leave the facility, and a Wander Guard braceletwas placed on Resident 4's left ankle. Review of Resident 4's MDS assessments showed the following: - on 4/6/23, an admission assessment was completed, with a correlating elopement assessment done 3/31/23; and (continued on next page)

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	01/24/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 7/5 and 10/4/23; 1/3, 4/3, 7/3 and 10/2/24; and 1/1/25, the quarterly or annual MDS assessment showed the elopement risk assessment were not completed. On 1/23/25 at 0851 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the elopement risk assessments in Resident 4's medical record were the admission assessment completed on 3/31/23, and another assessment on 1/19/25, when the Resident 4 had an actual elopement attempt. The DON verified the resident's Elopement Risk Assessments were not completed quarterly. The DON verified Resident 4 had an elopement attempt on 6/28/24, with a Wander Guard in place, which was discontinued on 8/1/24. The DON stated the elopement risk assessments should have been completed on 6/28/24 and 8/1/24, to capture the changes in Resident 4's elopement risk and needed interventions.