

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Alamitos West Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0557</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of four sampled residents (Resident 1) was treated with dignity and respect. This failure had the potential to negatively affect Resident 1's well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Promoting/Maintaining Resident Dignity revised 10/2022 showed to speak respectfully to the residents.</p> <p>Medical record review for Resident 1 was initiated on 3/7/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 was cognitively intact with a BIMS score of 15 (cognitively intact).</p> <p>On 4/1/25 at 1059 hours, an observation was conducted of Resident 1. Resident 1 was observed sitting in his wheelchair at his doorway, calling CNA 3 asking for her name. CNA 3 turned around and stated her name. Resident 1 was observed calling CNA 3 by her name; however, CNA 3 did not respond and walked into another resident's room. When CNA 3 exited the other resident's room, Resident 1 began calling CNA 3 by her name again. CNA 3 turned around and responded to Resident 1 by stating what.</p> <p>On 4/1/25 at 1106 hours, an interview was conducted with CNA 3. When asked how she responded to Resident 1 when he called her name, CNA 3 stated, she said what. When asked if the response was respectful, CNA 3 stated, oh, we are always just chill. When asked if CNA 3 had cared for Resident 1 before, CNA 3 stated, oh yeah, all the time.</p> <p>On 4/1/25 at 1109 hours, an interview was conducted with Resident 1. When asked how he felt about CNA 3's response when he called her name, Resident 1 stated, I've been waiting for 30 minutes. When asked how he felt with CNA 3's response, Resident 1 stated, not 100%, I feel like I am working for her.</p> <p>On 4/2/25 at 1346 hours, an interview was conducted with CNA 2. When asked how the CNA would respond when a resident has a request, CNA 2 stated, to ask what do you need. When asked if responding what was respectable, CNA 2 stated, no, that's not okay.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Alamitos West Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0557</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>On 4/3/25 at 1505 hours, an interview with RN 1 was conducted. When asked if a staff member responded to a resident's call by stating what was appropriate, RN 1 stated no, and if it was witnessed, RN 1 further stated he would pull the staff out of the room and let them vent out their frustrations to him and not in the resident's room.</p> <p>On 4/3/25 at 1601 hours, an interview was conducted with the DON. The DON stated, responding to the residents stating what was not acceptable, the staff should go up to the resident and say, can I help you, do you need anything.</p> <p>On 4/4/25 at 1546 hours, the Administrator and DON was made aware and acknowledged the above findings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Alamitos West Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0803</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348</p> <p>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food preferences were followed for one of four sampled residents (Resident 1). This failure had the potential to negatively impact the resident's well-being.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Food and Nutrition Services revised 4/2025 showed is the policy of this facility to assure that the menus are developed and prepared to meet the nutritional needs of the residents, and resident choices including their nutritional, religious, cultural, and ethnic needs while using established national guidelines.</p> <p>Medical record review for Resident 1 was initiated on 3/7/25. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]</p> <p>Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 was cognitively intact with a BIMS score of 15 (indicating cognitively intact).</p> <p>On 4/2/25 at 1218 hours, a concurrent meal observation, interview, and meal ticket review was conducted with Resident 1 and CNA 2. Resident 1 stated his meal tray was missing the whole milk. Review of Resident 1's Meal Ticket for lunch on 4/2/25, showed the beverages of 4 oz. orange juice, 4 oz. prune juice, and 8 oz. whole milk. CNA 2 verified the whole milk was missing from Resident 1's meal tray. CNA 2 further stated she also had to retrieve Resident 1's whole milk from the kitchen for his breakfast.</p> <p>On 4/3/25 at 1443 hours, an interview and concurrent review of Resident 1's Meal Ticket for lunch on 4/2/25 was conducted with the DSS. The DSS verified Resident 1 was to receive the whole milk and all the items listed on the meal ticket should be served.</p> <p>On 4/4/25 at 1546 hours, the Administrator and DON was made aware and acknowledged the above findings.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Alamitos West Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348</p> <p>Based on observation, interview, and medical record review, the facility failed to maintain the safe environment for three nonsampled residents (Residents A, B, and C).</p> <p>* The facility failed to ensure Residents A, B, and C's bed wheels werelocked while the residents were in bed. This failure had the potential to result to injury while care was being provided.</p> <p>Findings:</p> <p>1. Medical record review for Resident A was initiated on 3/7/25. Resident A was admitted on [DATE]. Resident a had a diagnosis of unspecified dementia with psychotic disturbance.</p> <p>Review of Resident A's Care Plan Report dated 7/9/24, showed a care plan problem for self-care deficit addressing Resident A requires assistance from the staff with ADL care. The interventions included the following:</p> <ul style="list-style-type: none"> - dependent with bed mobility: roll left to right; - dependent with chair/bed to chair transfer; - dependent with personal hygiene; - dependent with shower transfer; - dependent with toilet transfer; - dependent with toileting hygiene. <p>Further review of Resident A's Care Plan Report dated 9/17/21, showed the resident was potential for falls.</p> <p>On 3/7/25 at 1502 hours, an observation was conducted for Resident A. Resident A was observed lying in bed, and the bed wheels were unlocked.</p> <p>On 3/7/25 at 1507 hours, an observation and interview was conducted with CNA 1. CNA 1 verified Resident A's bed wheels were unlocked.</p> <p>2. Medical record review for Resident B was initiated on 3/7/25. Resident B was admitted to the facility on [DATE], and readmitted on [DATE]. Resident B [NAME] diagnosis of obesity, difficulty walking, hemiplegia, and hemiparesis.</p> <p>Review of Resident B's Care Plan Report dated 11/11/24, showed a care plan problem was initiated on the following dates:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2025
NAME OF PROVIDER OR SUPPLIER Alamitos West Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0909</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- dated 11/11/24, for at risk due to trapeze bar as an enabler for positioning in bed. The interventions included for a trapeze bar while in bed to aid in mobility, and to define parameters for safety;</p> <p>- dated 8/12/23, for self-care deficit requires assist with ADL care. The interventions included the following: assistance with ADL care, positioning, and mobility; and substantial maximal assistance with bed mobility: roll left to right; and</p> <p>- dated 3/8/24, resident has potential for falls, had an assisted fall on 3/8/25.</p> <p>On 3/7/25 at 1514 hours, an observation was conducted for Resident B. Resident B was observed lying in bed with a trapeze bar over the head of bed, and the bed wheels unlocked.</p> <p>On 3/7/25 at 1516 hours, an observation and interview was conducted with LVN 1. LVN 1 verified Resident B's bed wheels were unlocked.</p> <p>3. Medical record review for Resident C was initiated on 3/7/25. Resident C was admitted to the facility on [DATE]. Resident C had a diagnosis of dementia.</p> <p>Review of Resident C's Care Plan Report showed the following care plan problems:</p> <p>- dated 1/10/24, for resident has bowel incontinence related to immobility. The interventions included to provide the bedpan/bedside commode, and</p> <p>- revised 1/10/24, for self-care deficit, requiring assistance with ADL care. The interventions showed the resident was dependent on staff assistance with chair/bed to chair transfers; shower transfers; and toileting hygiene; and</p> <p>- revised 1/10/25, for potential for falls. The interventions included to educate and/or provide cues, prompts, and reminders regarding safety precautions.</p> <p>On 3/7/25 at 1520 hours, a concurrent observation and interview was conducted with LVN 1. LVN 1 verified Resident C was observed in bed, and the bed wheels were unlocked.</p> <p>On 4/2/25 at 1346 hours, an interview was conducted with CNA 2. CNA 2 stated to ensure the safety of the residents in bed included the bed wheels to be locked.</p> <p>On 4/3/25 at 1505 hours, an interview was conducted with RN 1. RN 1 stated the process to ensure the resident's safety while in bed was to ensure the bed wheels were locked.</p> <p>On 4/4/25 at 1546 hours, the Administrator and DON was made aware and acknowledged the above findings.</p>		