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	07/09/2025

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility P&P review, and facility document review, the facility failed to ensure two sampled residents (Residents 3 and 4) was provided the necessary care and services as evidenced by: * The facility failed to continuously monitor Resident 3 after the resident had developed a right buttock pressure injury. * The facility failed to have the specific direction for the settings of the LAL mattress for Resident 4. These failures had the potential for the residents not to receive the appropriate care and services to promote skin healing.Findings: According to National Pressure Injury Advisory Panel (NPIAP) 2019 Clinical Practice Guideline, a support surface is a specialized device designed for pressure redistribution, microclimate management, and other therapeutic functions. These devices include mattresses, bed systems, overlays, and seat cushions. In low air loss mattresses, alternating air pressure mode provides pressure relief and redistribution by cyclically inflating and deflating air cells, promoting circulation and preventing pressure ulcers. Static mode, on the other hand, keeps the cells inflated at a constant pressure, offering a stable surface for patient care activities and transfers. Review of the facility's P&P titled Change in Condition revised 4/2025 showed the nurse will perform and document an assessment of the resident and identify the need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident/s provider using SBAR or similar process to obtain new orders or interventions. The resident will then be placed on the 24 hour report and nursing will provide no less than three days of observation, documentation, and response to any interventions. Review of the facility's P&P titled Quality of Care, Subject: Skin Management System revised 5/2020 showed to prevent the development of skin breakdown or prevent existing pressure injuries from worsening, nursing staff shall implement preventative approaches as appropriate and consistent with the resident's condition and preferences. Use pressure relieving/reducing and redistributing devices (including but not limited to low air loss mattresses, wedges, pillows, etc.). For air mattresses, settings will be based on resident's weight, if not, it will be set based on resident's comfort and/or preference. 1. On 7/3/25 at 1120 hours, an observation and concurrent interview was conducted with Resident 3. Resident 3 was observed awake and lying in bed. Resident 3 stated she had wound at her bottom and was receiving treatment for it. Resident 3 stated she refused being repositioned at times. Medical record review for Resident 3 was initiated on 7/3/25. Resident 3 was readmitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 12/13/24, showed Resident 3 had the capacity to understand and make decisions. Review of Resident 3's plan of care revised on 7/2/25, showed a care plan problem addressing Resident 3's actual impairment to skin integrity. On 5/23/25, Resident 3 had a right buttock pressure injury and was reclassified as sacro-coccyx Stage 4 pressure injury on 6/10/25. The interventions included to observe and document the location, size and treatment of skin injury, report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. , and report to the physician and notify Resident 3 and responsible party. Review of Resident 3's Progress Note on 5/23/25 at 1354 hours, showed Resident 3 was sent out to the acute care hospital ED due to low hemoglobin level, and at 2355 hours, Resident 3 returned to the facility in a stable condition. The body assessment was done with a new right buttock pressure injury. Further review of Resident 3's medical record failed to show documented evidence of continued monitoring/assessment for Resident 3's new right buttock pressure injury by the licensed nurses. Review of Resident 3's Skin Pressure Ulcer Weekly dated 5/27/25, showed Resident 3 had discoloration to the wound bed in the sacral coccyx, and the classification was unstageable. No drainage present, no foul odor, defined wound edges, and the peri-wound tissues was within normal limit of Resident 3. On 7/3/25 at 1426 hours, an interview and concurrent medical record review for Resident 3 was conducted with LVN 1. LVN 1 stated the treatment nurse did the skin weekly assessment every Tuesday. LVN 1 stated he was the one who did the weekly skin assessment for Resident 3 on 5/27/25. LVN 1 stated the correct location of the pressure injury found in Resident 3 on 5/23/25, was in the resident's sacral coccyx area and it was a DTI. LVN 1 stated it was considered a change in condition, and it should have been monitored every shift for 72 hours. LVN 1 verified the new pressure injury found in Resident 3 on 5/23/25, was not monitored continuously as per the facility protocol. On 7/8/25 at 1352 hours, a concurrent interview, medical record and facility document review was conducted with RN 1. RN 1 stated a new skin injury or abnormality was considered a change in condition. RN 1 stated the licensed nurses had to monitor the resident's wound for the measurement, severity of the wound, presence of discharges, bleeding

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment for one of one sampled resident (Resident 2) observed for wound care treatment. * LVN 1 and CNA 3 failed to don the gowns before starting the wound care treatment for Resident 2 who was on the EBP. This failure posed the risk of not preventing the transmission of infection to the other residents throughout the facility.Findings:Review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions revised 4/2025 showed it is the policy of the facility to implement infection control measures to prevent the spread of communicable diseases and conditions. The Enhanced Barrier Protection (EBP) section showed the EBP is used in conjunction with the standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident (example: residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs). The use of gowns and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents. Wounds and/or indwelling medical devices regardless of known MDRO infection or colonization. Wounds include, but are not limited to chronic wounds, pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. On 7/3/25 at 1000 hours, an observation was conducted for Resident 2. An EBP sign was observed outside Resident 2's room. The EBP sign showed the providers and staff must also wear gloves and gowns for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, devices care or use, and wound care for any skin opening requiring a dressing. Resident 2 was observed awake but non-verbal and lying in bed. On 7/3/25 at 1030 hours, a wound care treatment observation for Resident 2 was conducted with LVN 1. LVN 1 stated CNA 3 would be assisting in turning Resident 2 during the wound care treatment. LVN 1 stated Resident 2 had a KTU in sacrococcyx area. LVN 1 was observed preparing all the wound care supplies at the bedside. CNA 3 was observed turning Resident 2 to the right side with gloves on but not wearing a gown. LVN 1 was observed donning new gloves after performing hand hygiene. LVN 1 was stopped when he was about to remove the old wound dressing of Resident 2. When asked if a gown was needed to be worn during the wound care treatment, LVN 1 stated they did not have to wear a gown during wound care treatment if the wound was not draining. LVN 1 proceeded with the wound care treatment without donning a gown. Medical record review for Resident 2 was initiated on 7/3/25. Resident 2 was readmitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 6/23/25, showed Resident 2 did not have the capacity to understand and make decisions. Review of Resident 2's Order Summary Report showed a physician's order dated 7/3/25, to wear the following PPE for EBP for direct care (to refer to EBP sign for specific details): clean, non-sterile gown and gloves every shift. On 7/3/25 at 1245 hours, an interview was conducted with LVN 1. LVN 1 stated he and CNA 3 should have worn the gown as part of the PPE during the wound care treatment for Resident 2. LVN 1 verified Resident 2 needed to have an EBP for her chronic wound whether it was draining or not. LVN 1 further stated utilization of proper PPE for procedures like wound care treatment was very important for infection prevention and safety. On 7/9/25 at 1648 hours, an interview was conducted with the IP. The IP stated an EBP was needed to be observed during high-contact resident care activities like wound care, for residents with the indwelling medical devices or catheters, MDRO, and chronic wounds such as pressure or diabetic ulcers. The IP stated the staff needed to wear the gloves and gown during the wound care treatment when the resident was on EBP. The IP further stated there could be possible transmission of infection when the proper PPE was not utilized by the staff. The IP was informed of and acknowledged the above findings. On 7/9/25 at 1730 hours, an interview was conducted with the DON. The DON was informed of and acknowledged the above findings for Resident 2.