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	08/22/2025

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 0684 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 provide the necessary care and services to ensure one of three sampled residents (Resident 1) attained or maintained their highest practical physical well-being. * The facility failed to ensure Resident 1 was turned and repositioned every two hours as ordered by the physician. This failure had the potential to negatively impact the resident's well-being.Findings: Review of the facility's P&P titled Physicians Orders, Telephone Orders, and Recapitulation Process revised 7/2025 showed all orders must be specific and complete with all necessary details to carry out the prescribed order without question. Review of the facility's P&P titled Activities of Daily Living revised 5/2023 showed the interventions will be provided by the staff in accordance with the professional standards of qualify and clinical practice. The nursing assistants will provide assistance with the ADL's based on the resident's individualized plan of care. Medical record review for Resident 1 was initiated on 8/8/25. Resident 1 was admitted to the facility on [DATE]. Resident 1 had a diagnosis of Parkinson's disease (a chronic, progressive disorder of the brain that primarily affects movement due to the loss of dopamine-producing cells, resulting in symptoms like tremors, slowness of movement, and poor balance), contracture of the right ankle, and abnormalities in gait and mobility. Review of Resident 1's Order Summary Report showed a physician's order dated 4/18/25, to reposition the resident two hours on the left side, and two hours on the right side every four hours while in bed, every shift for to help leg involuntary contraction. Review of Resident 1's MDS assessment dated [DATE], the section for GG Functional Abilities showed the following:- 1 (indicating the resident is dependent) for lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, tub/shower transfer;- 2 (indicating the resident needed substantial/maximal assistance) for rolling left to right, and sit to lying; and On 8/15/25 at 0847 hours, an observation was conducted in Resident 1's room. Resident 1 was observed lying on his back, with the head of the bed elevated On 8/15/25 at 0859 hours, an interview was conducted with CNA 1. When asked if Resident 1 is able to turn himself in bed, CNA 1 stated no, I have to help him. When asked how often he helps him, CNA 1 stated as needed, when he tells us. On 8/15/25 at 1028, 1128, and 1500 hours, Resident 1 was observed lying on his back, with the head of the bed elevated. On 8/15/25 at 1508 hours, an interview was conducted with CNA 1. When asked if Resident 1 had been repositioned, CNA 1 stated Resident 1 was only pulled up on the bed. On 8/19/25 at 1132 hours, an interview was conducted with CNA 3. When asked if Resident 1 was repositioned, CNA 3 stated yes. CNA 3 stated he tells me to put the pillow under his arms so he doesn't lean too much to one side. When asked if CNA 3 only rotates the pillow under his arms from left to right, CNA 3 stated yeah. When asked if CNA 3 repositioned Resident 1's body to the left or right side, CNA 3 stated no he doesn't like it. On 8/20/25 at 1647 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings. The DON stated Resident 1 preferred to be on his back. The DON further stated the order to reposition Resident 1 two hours on the left side, and two hours on the right side every four hours while in bed should have been discontinued.

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 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** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical record was complete and accurately maintained for one of three sampled residents (Resident 1). * The facility failed to ensure Resident 1's TAR (Treatment Administration Record) was complete for August 2025. * The facility failed to accurately document the oral hygiene provided to Resident 1. These failures had the potential for Resident 1's care needs not being met as their medical information was incomplete. Findings: Review of the facility's P&P titled Documentation revised 1/2019 showed the resident's clinical is a concise and accurate account of treatment, care, response to care, signs, symptoms, and progress of the resident's condition. Medical record review for Resident 1 was initiated on 8/8/25. Resident 1 was admitted to the facility on [DATE]. a. Review of Resident 1's TAR for August 2025 showed the following physician's orders without the entries from the licensed nurses:- on 8/9 and 8/10/25 at 0900 hours, to apply the fluocinonide (used to manage inflammation, itching, and redness associated with various skin conditions) external cream two times a day for generalized body itching;- on 8/9 and 8/10/25 at 0900 hours, to get the resident out of the bed to the wheelchair;- on 8/9/ and 8/10/25 for the day shift, to float the heels every shift due to the blanchable (a patch of red skin that turns white or pale when you press on it and returns to its normal color once pressure is removed, indicating that blood flow to the area is only temporarily restricted) redness on the bilateral heels;- on 8/10/25 for the NOC (night) shift, to float the heels every shift due to the blanchable redness on the bilateral heels;- on 8/9 and 8/10/25 at 0830 and 1330 hours, to brush/floss the resident's teeth after each meal;- on 8/9 and 8/10/25 for the day shift, to have the foot brace on at all time during the day shift;- on 8/9 and 8/10/25 for the day shift and 8/9/25 for the NOC shift, to monitor the left first digit ingrown toe nail every shift;- on 8/9 and 8/10/25 for the day shift and 8/9/25 for the NOC shift, to have the PRAFO (Pressure Relief Ankle Foot Orthosis) on the bilateral lower extremities at all times while in bed as tolerated. On 8/14/25 at 1609 hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 1. When asked what the missing documentation meant on the resident's TAR for August 2025, LVN 1 stated the licensed nurses did not chart (document). LVN 1 stated the TAR would show a check mark when the task was completed. However, when asked how the facility determined if the tasks were completed as ordered if the TAR was missing documentation, LVN 1 stated, I'm not sure. On 8/20/25 at 1647 hours, an interview was conducted with the DON. The DON verified the above findings. b. On 8/19/25 at 1104 hours, an interview was conducted with Resident 1. When asked if he had brushed his teeth, Resident 1 stated no they didn't not bring it to me. On 8/19/25 at 1140 hours, an observation and concurrent interview was conducted with CNA 3 of Resident 1's toothbrush and set-up. When asked where Resident 1's oral care set-up was, CNA 3 pointed to the top of the dresser on the right side of the bed. During the observation, CNA 3 was asked if she had set up the oral care supplies for Resident 1, CNA 3 stated, I don't think I did, I had two showers today. Review of Resident 1's Documentation Survey Report for August 2025 under the section for Intervention/Task - oral care brushing and flossing with dental cleaning after meals dated 8/19/25, showed a Y (yes) documentation at 0842 hours. On 8/20/25 at 1110 hours, a follow-up telephone interview was conducted with CNA 3. CNA 3 stated she documented Resident 1 was provided oral care on 8/19/25, during the day shift; however, CNA 3 acknowledged she did not provide an oral care to Resident 1. On 8/20/25 at 1647 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings.

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F 0880 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure the appropriate infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of infections were implemented. * The facility failed to dispose the used gloves inside Shower room [ROOM NUMBER]. * The facility failed to place the soiled towel inside the dirty linen barrel. These failures posed the risk for the transmission of disease-causing microorganisms.Findings: Review of the facility's P&P titled Infection Prevention and Control Program revised 4/2025 showed the facility personnel will handle, store, process, and transport linens so as to prevent the spread of infection. The facility will use effective methods for the safe storage, transport and disposal of garbage, refuse and infectious waste, consistent with all applicable local, state, and federal requirements for such disposal. a. On 8/14/25 at 1229 hours, an observation and concurrent interview was conducted with the Account Manager in Shower room [ROOM NUMBER]. One used glove was observed on the sink and top of the toilet tank in Shower room [ROOM NUMBER]. The Account Manager verified and acknowledged the used gloves should have been disposed of properly. b. On 8/14/25 at 1256 hours, an observation and concurrent interview was conducted with the Account Manager in Shower room [ROOM NUMBER]. A white towel with grey and yellow-brownish stain was observed on the floor inside Shower room [ROOM NUMBER]. The Account Manager verified and acknowledged the towel should have been placed in the dirty linen barrel. On 8/20/25 at 1647 hours, an interview was conducted with the DON. The DON was made aware of the above findings. The DON stated the process for cleaning the shower rooms would include ensuring the shower rooms were free of used gloves and washcloths.

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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 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure to clean and disinfect three of three shower rooms. * The facility failed to clean the shower heads for Shower rooms [ROOM NUMBER]. This failure had the potential risk of affecting the residents' health condition.Findings: On 8/13/25 at 1527 hours, an interview was conducted with Resident 2. Resident 2 stated inside Shower room [ROOM NUMBER], the showers look like there's poop. Medical record review for Resident 2 was initiated on 8/13/25. Resident 2 was admitted to the facility on [DATE]. On 8/14/25 at 1229 hours, an observation and concurrent interview was conducted with the Account Manager. An observation was conducted inside Shower rooms [ROOM NUMBER]. A dark brown residue on the lower half of the shower heads surrounding the water spickets was observed inside Shower rooms [ROOM NUMBER]. In addition, Shower room [ROOM NUMBER] was observed to have brown stains on the wall and on the shower head holder in the two shower stalls. When asked what the brown residue was, the Account Manager stated the water from the shower heads had a constant leak and needed to be replaced. The Account Manager verified the above findings. On 8/14/25 at 1515 hours, an interview was conducted with the Administrator, and DON. The Administrator stated there was discoloration on the shower heads, and the maintenance staff was stripping it and replacing the shower heads. The Administrator and DON acknowledged the above findings.