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	02/03/2026

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** Based on interview and medical record review, the facility failed to provide the necessary care and services to ensure adequate supervision was provided for one of four sampled residents (Resident 1). * Resident 1 was left unattended outside the facility while waiting for the transportation to take the resident to the doctor's appointment. This failure had the potential to place Resident 1 at risk for accidents and serious injuries.Findings: On 1/9/26, the CDPH L&C Program received a complaint alleging on 1/7/26, Resident 1 was left unattended outside the facility while waiting for the transportation to pick him up for a doctor's appointment. Medical record review for Resident 1 was initiated on 1/26/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 10/18/25, showed Resident 1 had the capacity to make decisions. On 1/27/26 at 1222 hours, an interview was conducted with CNA 4. CNA 4 was asked about Resident 1 being left unattended while waiting for the transportation for a doctor's appointment. CNA 4 stated on 1/7/26, after Resident 1's lunch, she was with Resident 1 outside the facility while waiting for his family to come to pick him up for the doctor's appointment. CNA 4 stated Resident 1 kept telling her to leave him. CNA 4 stated she left to give him space, but she was inside the door. CNA 4 stated she should have stayed with Resident 1. On 1/27/26 at 1400 hours, an interview was conducted with the DON. The DON stated CNA 4 should have stayed with Resident 1 until the family came to pick up the resident.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056169	A. Building B. Wing	02/03/2026

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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** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical record was accurate for one of two sampled residents (Resident 1). * The facility failed to ensure Resident 1's physician's orders for carbidopa-levodopa (medication to treat Parkinson's disease) was clarified with the physician, when there were two duplicate orders with different dates. This failure had the potential for the resident's care needs not being met as the medical information was inaccurate.Findings: Review of the facility's P&P titled Medication Administration - Nursing Clinical revised February 2012 showed only licensed medical and nursing personnel or other lawfully authorized staff member may prepare, administer, and record medications. All the current drugs and dosage schedules must be recorded on the resident's medication administration record (MAR). The nurse administering the medication must initial the resident's MAR on the appropriate line and date. Medical record review for Resident 1 was initiated on 1/26/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed a physician's order dated 1/14/26, for carbidopa-levodopa oral tablet 25-100 mg, give two tablets by mouth a day for Parkinson's. Review of Resident 1's MAR for January 2026 showed there were two physician's orders dated 11/25/25 and 1/14/26, for carbidopa-levodopa oral tablet 25-100 mg give two tablets by mouth a day for Parkinson's scheduled to be administered at 0900 hours. On 1/27/26 at 1200 hours, an interview and concurrent medical record review for Resident 1 was conducted with LVN 1. LVN 1 stated she administered carbidopa-levodopa oral tablet 25-100 mg two tablets at 0900 hours. LVN 1 verified there were two duplicate orders with different dates, and further stated she should have clarified the orders with Resident 1's physician. On 2/3/26 at 1204 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. The DON verified the above findings.