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	04/30/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **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 and help prevent the development and transmission of diseases and infections for two of four sampled residents (Residents 2 and 3). * The facility failed to ensure LVN 1 wore a gown when providing catheter care to Resident 2. In addition, the facility failed to ensure Resident 2 was placed on EBP related to the use of the indwelling urinary catheter. Furthermore, the facility failed to ensure an EBP signage was posted on the resident's door, and an orange dot was placed by the resident's name by the door. * The facility failed to ensure Resident 3's indwelling urinary catheter drainage tubing was not touching the floor. In addition, the facility failed to ensure Resident 3 was placed on EBP related to the use of the indwelling urinary catheter, and an orange dot was placed by the resident's name by the door. These failures had the potential for cross-contamination and spread of infectious organisms in the facility.Findings: 1. Review of the CMS QSO-24-08-NH dated 3/20/24, for Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of MDROs, showed MDRO transmission is common in long-term care facilities such as nursing homes, contributing to substantial resident morbidity and mortality and increased healthcare costs. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. EBP refers to an infection control intervention designed to reduce transmission of MDROs that employ targeted gown and glove use during high-contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. According to CDC's Implementation of PPE use in Nursing Homes to Prevent Spread of MDROs, under the Implementation Section, showed when implementing EBP, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use, initial and refresher training, and access to appropriate supplies. To accomplish this: post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE such as gown and gloves. Review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions revised 4/2025 under EBP section, showed the examples of high-contact resident care activities requiring gown and gloves use for EBP included device care or use of indwelling urinary catheter. On 4/30/26 at 0915 hours, an isolation cart containing gowns and gloves was observed by Room A. There were no signages posted outside Room A. Resident 2 was observed in bed with an indwelling urinary catheter. Medical record review for Resident 2 was initiated on 4/30/26. Resident 2 was admitted to the facility on [DATE], and was readmitted on [DATE]. Review of Resident 2's Plan of Care showed a care plan problem dated 4/22/26, to address Resident 2's indwelling catheter. The interventions/tasks included using EBP. Review of Resident 2's Order Summary Report showed the following physician's orders dated 4/27/26, for Foley catheter size 14 Fr with 10 ml normal saline, to drainage every shift. Review of Resident 2's medical record did not show a physician's order for EBP and any documented evidence to show Resident 2 was placed on EBP related to the indwelling urinary catheter. On 4/30/26 at 1005 hours, an observation for Resident 2 and concurrent interview was (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with CNA 2. When asked about Resident 2's indwelling urinary catheter and catheter care, CNA 2 verified Resident 2 had an indwelling urinary catheter and CNA 2 stated the CNAs were responsible for providing the catheter care to the residents with an indwelling urinary catheter; however, she has not provided hygiene care to the resident yet. On 4/30/26 at 1036 hours, a follow-up observation for Resident 2 and concurrent interview was conducted with CNA 2. An EBP signage was posted outside Room A, and an orange dot was placed by Resident 2's name. CNA 2 who was wearing a gown and gloves was observed providing care to Resident 2, and CNA 2 stated a catheter care will be provided by the treatment nurse. On 4/30/26 at 1038 hours, an observation for Resident 2 and concurrent interview and medical record review was conducted with LVN 1. LVN 1 verified an EBP signage was posted outside Room A, and an orange dot was placed by Resident 2's name. LVN 1 stated maybe the QIC/IP have placed the EBP signage and the orange dot. The EBP signage alerted the providers and staff to wear gloves and a gown for high-contact resident care activities such as catheter care. When asked about the orange dot by Resident 2's name, LVN 1 stated the orange dot was placed by the resident's name to indicate the resident was on EBP. On 4/30/26 at 1047 hours, a catheter care observation for Resident 2 and concurrent interview was conducted with LVN 1. LVN 1 was observed only wearing gloves and not donning a gown when performing the catheter care to Resident 2. LVN 1 verified the above findings. 2. On 4/30/26 at 0921 and 1000 hours, Resident 3 was observed in bed with an indwelling urinary catheter attached to a urinary drainage bag. The indwelling urinary catheter tubing was observed on the floor. On 4/30/26 at 1014 hours, an observation for Resident 3 and concurrent interview was conducted with CNA 1. CNA 1 verified Resident 3's indwelling urinary catheter tubing was touching the floor. When asked about Resident 3's catheter care, CNA 1 stated the treatment nurses were in charge of performing catheter care to residents with the indwelling urinary catheter. Medical record review for Resident 3 was initiated on 4/30/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Order Summary Report showed the following physician's order dated 4/2/26:- For Foley catheter size 16 Fr with 10 ml for neurogenic bladder, and foley catheter care every shift;- To change foley catheter including drainage bag if leaking, dislodged, non-patency or prior to urine specimen collection (if insertion date is more than two weeks) as needed for Foley catheter management; and- May flush the Foley catheter with 60 ml normal saline if clogged or non-patency as needed for Foley catheter management. To call the physician if not resolved. Review of Resident 3's Plan of Care showed a care plan problem dated 4/22/26, to address Resident 2's indwelling urinary catheter. The interventions/tasks included to use EBP. Review of Resident 3's medical record did not show a physician's order for EBP, and any documented evidence to show Resident 2 was placed on EBP related to the indwelling urinary catheter. On 4/30/26 at 1134 hours, an observation for Residents 2 and 3 and concurrent interview and medical record review was conducted with the QIC/IP. The QIC/IP stated EBP should be in place for the residents with medical devices such as indwelling urinary catheter. When asked about EBP for Resident 2, the QIC/IP verified she posted the EBP signage and the orange dot by the resident's name on the door just this morning. When QIC/IP reviewed Resident 2's medical record, the QIC/IP also verified the physician's order to place Resident 2 on EBP was just entered this morning. When asked about the EBP signage, the QIC/IP stated to alert the provider and staff that when a resident was on EBP, the staff should wear gloves and a gown when providing the high-contact care activities such as indwelling urinary catheter care. When asked about the orange dot placed by the resident's name on the door, the QIC/IP stated it was the facility's procedure to indicate the residents on EBP. The QIC/IP verified there was no orange dot placed on Resident 3's name by the door. When QIC/IP reviewed Resident 3's medical record, the QIC/IP also verified the physician's order to place Resident 3 on EBP. On 4/30/26 at 1452 hours, an interview was conducted with the Administrator and QIC/IP. The Administrator and QIC/IP were informed and acknowledged the above findings.