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	06/10/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **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 resident's responsible party or Power of Attorney (POA) was informed of a change on the resident's condition for one of six sampled residents (Resident 1). * The facility failed to notify Resident 1's POA of the change in condition on 6/4/26. This failure had the potential for Resident 1's responsible party uninformed of the resident's status.Findings: Review of the facility's P&P titled Change of Condition (COC) Reporting dated 5/2019 showed the responsible party will be notified that there has been a change in the resident's condition and what steps are being taken. All attempt to reach the physician and responsible party will be documented in the nursing progress notes. Documentation will include time and response. Medical record review for Resident 1 was initiated on 6/4/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's H&P examination dated 10/18/25, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's Advance Health Care Directive dated 2/11/26, showed You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. The explanation showed the Part 1 of the form was a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. Unless the form you sign limits the authority of your agent, your agent may make all health care decision for you. Further review of Resident 1's Advance Health Care Directive - Part 1 - Power of Attorney for Health Care showed Family Member 1 was the designated agent to make the resident health care decisions. Moreover, the form showed Family Member 1 was authorized to make health care decisions effective immediately. Review of Resident 1's eINTERACT Change in Condition Evaluation - V 5.1 dated 6/4/26, showed Resident 1 alleged CNA 1 of not assisting with care and closing the door on him. Further review of the COC evaluation failed to show documented evidence if Resident 1's POA was notified of the COC. On 6/9/26 at 1600 hours, a telephone interview was conducted with the IP. The IP verified she documented Resident 1's COC on 6/4/26. The IP stated she did not notify Family Member 1 of the resident's COC. The IP further stated the residents' responsible parties should have been notified to ensure they were aware of the residents' conditions. On 6/9/26 at 1614 hours, an interview and concurrent medical record review of Resident 1 was conducted with the ADON. The ADON verified Resident 1's COC dated 6/4/26, failed to show Resident 1's POA was notified of the change in the resident's condition. The ADON verified Resident 1's power of attorney for health care decisions showed Family Member 1 was the designated agent and should have been notified of any changes in the resident's condition. On 6/10/26 at 1655 hours, an interview with the Administrator, DON, and MDS Resource was conducted. The Administrator, DON, and MDS Resource was made aware and acknowledged the above findings.

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview, facility document review, and facility P&P review, the facility failed to implement their P&P for pre-employment investigations for one of three sampled employees (CNA 1) prior to working with the elderly or vulnerable individuals. * The facility failed to conduct a background check for CNA 1 prior to the date of hire. This failure had the potential to put the residents at risk for elder abuse.Findings: Review of the facility's P&P titled Pre-Employment Investigations California - SNF revised 1/2022 showed reasonable and prudent pre-employment investigations, including reference checks, applicable licensing and certification verifications, criminal background checks and other necessary or desirable pre-employment checks are conducted on applicants for employment. The purpose showed to ensure that all applicants for employment have all credentials, experience and skills appropriate to the position applied for and to verify that the applicant has not been convicted of an offense or any other negative government finding that would preclude employment by a provider to federal or state health care programs or working with elderly or vulnerable individuals or as a vehicle driver. Employment may not commence unless the Accurate Background Check disposition is Pass. The P&P further showed if the applicant completed a paper Disclosure and Authorization form, it should be uploaded to the applicant's record in the Accurate system at the time the package is requested and the originals maintained in the applicant's confidential personnel file. The Accurate Background Check consists of state (county) and federal criminal records checks, a Healthcare Sanctions and Exclusions check, and a national Sex Offender Record Search. Review of CNA 1's employee file showed CNA 1's date of hire was 4/16/26. Review of CNA 1's Disclosure Regarding Background Investigation dated 4/15/26, showed CNA 1 signed and agreed for an Accurate Background check to be conducted. Further review of CNA 1's employee file failed to show documented evidence an Accurate Background check was conducted prior to the start of employment as per facility's P&P. On 6/5/26 at 0904 hours, an interview and concurrent employee file review of CNA 1 was conducted with the DON. The DON verified CNA 1 signed and agreed for a background check on 4/15/26; however, there was no documented evidence of the background check results in CNA 1's employee file. On 6/5/26 at 1150 hours, an interview and concurrent employee file review of CNA 1 was conducted with the HR. The HR verified CNA 1's employee file did not have a background check prior to date of hire and that a background check was done on 6/5/26. The HR stated background checks were conducted before an employee was hired and were done to ensure the employees working with the residents do not have prior criminal charges. The HR stated the background check for CNA 1 was missed. On 6/5/26 at 1700 hours, an interview with the Administrator was conducted with the DON present. The Administrator stated the background checks should be done before the date of hire. On 6/10/26 at 1655 hours, an interview with the Administrator, DON, and MDS Resource was conducted. The Administrator, DON, and MDS Resource was made aware and acknowledged the above findings.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **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 necessary physician services was provided for one of six sampled residents (Resident 1). * The facility failed to ensure the cardiologist recommendations for Resident 1's diagnostic tests were signed by the physician for the staff to ensure the appointments were scheduled in a timely manner. This failure had the potential for the resident to not receive the necessary services in a timely manner. Findings: Review of the facility's P&P titled Physician Services revised 2/2022 showed physician services shall mean those services provided by physicians responsible for the care of individual residents in the facility. All persons admitted or accepted for care by the facility must be under the care of a physician selected by the resident, the resident's authorized representative, or the medical director. The physician services include, but are not limited to:B. A medical evaluation of the resident and review of orders for care and treatment;E. Written or signed orders for diet, care, diagnostic tests and treatment of residents by others. Review of the facility's P&P titled Resident Appointment and Transportation revised 8/2023 showed it is the policy of the facility to assist the residents in arranging appointments and transportation to and/or from when necessary. The facility social services and/or designee will assist residents or responsible representatives in scheduling appointments including, but not limited to diagnostic procedures outside the facility. Medical record review for Resident 1 was initiated on 6/4/26. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE].Review of Resident 1's H&P examination dated 10/18/25, showed Resident 1 had the capacity to understand and make decisions.Review of Resident 1's Nursing Progress Note dated 5/14/26 at 0834 hours, showed the nocturnal desaturation study with the diagnosis of sleep apnea, and Lexiscan MIBI stress test with the diagnosis of chest pain were ordered by Resident 1's cardiologist. The note further showed the orders were noted and carried out. Review of Resident 1's Order Summary Report for June 2026 showed the following physician's orders: - dated 5/14/26, nocturnal desaturation study (measures the blood oxygen levels and heart rate while asleep) for diagnosis of sleep apnea; - dated 5/14/26, Lexiscan MIBI stress test for diagnosis of chest pain; and - dated 5/26/26, echocardiogram for diagnosis of abnormal EKG and chest pain.Further review of Resident 1's medical records failed to show the scheduled appointments or results for the ordered tests. On 6/10/26 at 0820 hours, an interview and concurrent record review for Resident 1 was conducted with RN 1. RN 1 verified Resident 1 had a cardiologist appointment on 5/11/26, and returned with new orders. RN 1 stated the facility contacted Resident 1's cardiologist office to verify the orders for a Lexiscan MIBI stress test, nocturnal desaturation study, and the echocardiogram. RN 1 stated for the facility to schedule the appointments, Resident 1's attending physician at the facility needed to sign off on the orders and approve of the cardiologist's recommendations. RN 1 further stated multiple attempts to contact Resident 1's physician and the physician's office were made and the cardiologist orders were faxed to the physician's office for physician's approval. RN 1 verified Resident 1's orders were not signed until 5/26/26, by another attending physician. RN 1 stated this could cause a delay in care. On 6/10/26 at 1531 hours, an interview and medical record review for Resident 1 was conducted with the Medical Office Staff from Resident 1's physician's office. The Medical Office Staff stated the office received the orders for the Lexiscan stress test, nocturnal desaturation study, and echocardiogram on 5/14/26, and the signed physician's orders were faxed back to the facility on 5/20/26. When the fax number was verified with Medical Office Staff, the signed orders were faxed to the wrong fax number. The Medical Office Staff verified it was not accurately faxed to the facility. On 6/10/26 at 1655 hours, an interview with the Administrator, DON, and MDS Resource was conducted. The Administrator, DON, and MDS Resource was made aware and acknowledged the above findings.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **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 necessary dental services was coordinated for one of six sampled residents (Resident 2). * The facility failed to ensure a follow up dental appointment was scheduled for Resident 2 as per resident's request and per the facility's dental progress notes. This failure had the potential for the resident to not receive the necessary dental care. Findings: Review of the facility's P&P titled Dental Services revised 4/2025 showed it is the policy of this facility to ensure that its residents who require dental services on a routine or emergency basis have access to such services without barrier. The facility will provide or obtain from an outside resource, routine, and emergency dental services for each resident. The facility will assist the resident as necessary or requested to make appointments for dental services or arrange for transportation to and from dental services locations. Review of the facility's P&P titled Resident Appointment and Transportation revised 8/2023 showed it is the policy of the facility to assist residents in arranging appointments and transportation to and/or from when necessary. The facility social services and/or designee will assist residents or responsible representatives in scheduling for appointments including, but not limited to diagnostic procedures outside the facility. Medical record review for Resident 2 was initiated on 6/4/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 10/28/25, showed Resident 2 had the capacity to understand and make decisions. Review of Resident 2's Dental Progress Note dated 3/5/26, showed dental consult was due to Resident 2's report of pain on tooth #5 (the upper right first premolar). The note showed Resident 2 was informed of possible retreatment and/or new crown. Resident 2 refused the test. Further review of the dental progress notes showed will arrange appointment with outside dentist to save the tooth. On 6/4/26 at 1303 hours, an interview was conducted with Resident 2. Resident 2 stated although she had seen the facility dentist, she still wanted to see her primary dentist for dental work which the facility dentist could not do. Resident 2 stated she has been waiting for an appointment for four to five months. On 6/10/26 at 0941 hours, an interview and concurrent medical record review for Resident 2 was conducted with the SSD. The SSD verified the Dental Progress Notes showed Resident 2 refused test and will arrange appointment with outside dentist to save the tooth. The SSD stated the nursing staff and social services should follow up on the dental progress notes to ensure any recommendations made by the dentist were followed up and appointments were scheduled. On 6/10/26 at 1330 hours, a follow-up interview was conducted with Resident 2. Resident 2 stated she did not have dental pain; however, stated she had sensitivity. Resident 2 further stated she wanted to be seen by her primary dentist for a second opinion on recommendations made by the facility dentist. On 6/10/26 at 1655 hours, an interview with the Administrator, DON, and MDS Resource was conducted. The Administrator, DON, and MDS Resource were made aware and acknowledged the above findings.