

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Alamitos West Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, medical record review, and facility P&P review, the facility failed to ensure the residents' needs were accommodated in a timely manner for four of 27 final sampled residents (Residents 8, 14, 141, and 146) and one nonsampled resident (Resident 37). * The facility failed to ensure the call lights were promptly answered for Residents 8, 14, 37, 141, and 146 when the residents called for assistance from the staff. This failure placed the residents at risk for not receiving the assistance from staff to meet their needs and potentially compromise their safety and dignity. Findings: Review of the facility's P&P titled Call Light/Bell revised 5/2023 showed the facility staff should answer the light/bell within a reasonable time and respond to the resident's request. If the item is not available or you are unable to assist, explain to the resident and notify the-charge nurse for further instructions. 1. Medical record review for Resident 146 was initiated on 9/23/25. Resident 146 was admitted to the facility on [DATE]. Review of Resident 146's care plan dated 9/21/25, showed Resident 146 had bowel and bladder incontinence related to generalized weakness. The intervention included incontinent: Check as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. On 9/23/25 at 1000 hours, an observation and concurrent interview was conducted with Resident 146. Resident 146 was observed lying in bed, awake, alert, and verbally responsive. Resident 146 stated she had a bowel movement and had been waiting approximately 20 minutes for a diaper change. Resident 146 mentioned a staff member entered the room and turned off the call light, but she did not know who the staff member was. Resident 146 was watching the clock to track how long she had been waiting and expressed feeling upset about the delay. Resident 146 also stated at times she has waited more than 45 minutes to receive assistance for diaper changes or other needs. Resident 146 turned the call light on again. On 09/23/25 at 1015 hours, an interview was conducted with LVN 4. LVN 4 stated CNA 5 who was assigned to the patient, was still busy assisting another resident with a shower. The CNA also reported having a headache and requested a break. LVN 4 stated they would look for another staff member to help. On 09/23/2025 at 1025 hours, CNA 5 went to the room of Resident 146 and provided assistance to Resident 146. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/2025 at 1300 hours, Resident 146 stated that she had been waiting for almost 40 minutes for assistance with a diaper change. On 9/23/2025 at 1440 hours, an interview was conducted with CNA 5. CNA 5 stated that she was busy and had to give a shower to another resident. One resident's shower might take 30 to 45 minutes, including dressing and bathing. CNA 5 stated after she finished showering the other resident, she returned to assist Resident 146 with a diaper change. Resident 146 required assistance with a diaper change. 2. On 9/23/25 at 0933 hours, during the initial tour of the facility, Resident 8 was observed awake in her room. Resident 8 stated she had to wait for more than an hour for the call light to be answered whenever she called for repositioning or to fix the bed sheets. Resident 8 further stated she knew how long she waited because she pressed the call light at the same time as her roommates, Residents 14 and 37. Medical record review for Resident 8 was initiated on 9/23/25. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 8/14/25, showed Resident 8 had the capacity to understand and make decisions. Review of Resident 8's MDS assessment dated [DATE], showed Resident 8 was dependent from the staff for ADL care and mobility. On 9/26/25 at 1345 hours, an observation and concurrent interview was conducted with Resident 8. Resident 8 was observed awake and sitting in the wheelchair. Resident 8 stated the facility staff put her on the wrong incontinence pad, the bed was placed wrong, and the sheet was sliding down. Resident 8 stated she pressed the call light because she wanted to be readjusted since she had a wound on her buttock. Resident 8 stated her bed moved because she had a LAL (Low Air Loss-mattress designed to prevent and treat pressure injuries) mattress, she got over the pad, and the sheet was already down to her feet. Resident 8 stated she felt terrible because the facility staff took at least an hour and a half to answer the call light. Resident 8 further stated she called at the same time as her roommate and that was how she knew how long before the facility staff answered their call lights. 3. On 9/26/25 at 1345 hours, an observation and concurrent interview was conducted with Resident 14. Resident 14 was observed awake in her room. Resident 14 stated last night, she and her roommates, Residents 8 and 37, hit the call light button at the same time but no one was coming so they started yelling one at a time. Resident 14 stated she needed her pain medication at 1900 hours. Resident 14 stated she knew it was 1900 hours because she was watching TV, and all her roommates also pressed the call light button at the same time as hers. Resident 14 stated she felt like she was not worth any attention and angry about the call light waiting time. Resident 14 further stated the facility staff told them they had a lot of residents. Medical record review for Resident 14 was initiated on 9/23/25. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's H&P examination dated 9/18/25, showed Resident 14 was alert and oriented times four (person, place, time, and situation). (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 14's MDS assessment dated [DATE], showed Resident 14 needed substantial/maximal assistance from the staff with ADL care and mobility. 4. On 9/26/25 at 1345 hours, an observation and concurrent interview was conducted with Resident 37. Resident 37 was observed awake in her room. Resident 37 stated last night she waited for over an hour for the call light to be answered at 1900 hours. Resident 37 stated she even called the front desk. Resident 37 stated she was looking at the clock in her room for the time. Resident 37 further stated she did not feel good about waiting so long. Medical record review for Resident 37 was initiated on 9/23/25. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's H&P examination dated 9/16/25, showed Resident 37 had the capacity to make medical decisions. Review of Resident 37's MDS assessment dated [DATE], showed Resident 37 needed substantial/maximal assistance from the staff with ADL care and mobility. 5. On 9/23/25 at 0933 hours, during the initial tour of the facility, Resident 141 was observed awake in her room. Resident 141 stated she used the call light and the last time was over the weekend, on Saturday night when she asked to be changed at 2230 hours. Resident 141 stated she did not get changed until the following morning at 0600 hours. Resident 141 stated she used the clock to check the time. Resident 141 stated she started crying because she felt nasty, useless, and not worth anything. Resident 141 further stated she had complained about the call light not being answered right away all the time to the facility staff. Medical record review for Resident 141 was initiated on 9/23/25. Resident 141 was admitted to the facility on [DATE]. Review of Resident 141's H&P examination dated 7/13/25, showed Resident 141 had the capacity to understand and make medical decisions. Review of Resident 141's MDS assessment dated [DATE], showed Resident 141 needed partial/moderate assistance from the staff with ADL care and substantial/maximal assistance with mobility. On 11/19/25 at 1530 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **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 two of five sampled residents (Residents 13 and 41) reviewed for unnecessary medications were free from unnecessary psychotropic medications. * The facility failed to ensure Resident 13's orthostatic (a sudden drop in blood pressure when standing up, causing symptoms like dizziness, lightheadedness, and fainting) blood pressure was accurately monitored as ordered by the physician for the use of the risperidone (antipsychotic) medication. * The facility failed to ensure Resident 41's orthostatic blood pressure was accurately monitored as ordered by the physician for the use of the Seroquel (antipsychotic) medication; in addition, the facility failed to ensure the accurate monitoring of Resident 41's behavior was done for the use of the Seroquel medication. These failures had the potential for adverse effects from the psychotropic medications use and the potential for not providing the correct data to the prescriber to adjust the dosage of psychotropic medications. Findings: Review of the facility's P&P titled Chemical Restraints and Psychotropic Medication Management revised 4/2024 showed psychotropic medications shall not be administered for the purpose of discipline or convenience. Based on a comprehensive assessment, the facility will ensure that residents who use psychotropic drugs receive gradual dose reductions (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. The IDT will review to ensure: a. The psychotropic medication was prescribed to treat a specific diagnosed condition, as documented in the clinical record; b. Not in excessive dosage; c. Behavior is not related to delirium or other reversible conditions; d. Monitoring for adverse consequences and effectiveness of medications are in place; e. PRN medications are within guidelines; f. Informed consent was obtained prior to medication use; g. Review of plan of care shows individualized, person-centered care approaches to manage behavior with non-pharmacological interventions. New physician's orders for psychotropic medications will be communicated to the Social Services department for review with the IDT and appropriate care planning will be done to ensure updated information in the resident's psychosocial care plan. 1. Medical record review for Resident 13 was initiated on 9/23/25. Resident 13 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 13's H&P examination dated 6/16/25, showed Resident 13 had no capacity to understand and make decisions. Review of Resident 13's MDS assessment dated [DATE], showed Resident 13 had moderately impaired cognition. Review of Resident 13's Order Summary Report dated 9/24/25, showed the following physician's orders:- dated 6/18/25, to administer risperidone (antipsychotic medication) 0.25 mg one tablet by mouth two times a day for psychosis (a mental state where a person loses contact with reality, characterized by symptoms like hallucinations (seeing or hearing things that aren't there) and delusions (false, fixed beliefs)) manifested by suspicious of her roommate harming her, - dated 7/7/25, for the use of the antipsychotic medication, to obtain Resident 13's orthostatic blood pressure in the sitting position, every Sunday during the day shift, - dated 7/7/25, to obtain Resident 13's orthostatic blood pressure in the standing position, every Sunday during the day shift, and- dated 7/7/25, to obtain Resident 13's orthostatic blood pressure in the lying position, every Sunday during the day shift. Review of Resident 13's MAR for August and September 2025 showed the following documented orthostatic BP readings:- on 8/10/25, the BP reading was documented as 132/78 mmHg for the sitting, lying, and standing position.- on 9/14/25, the BP reading was documented as 128/74 mmHg for the sitting and standing position.- on 9/21/25, the BP reading was documented as 115/80 mmHg for the sitting, lying, and standing position. On 9/24/25 at 1527 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 1. RN 1 stated for the residents on the antipsychotic medications were monitored for orthostatic hypotension by obtaining the resident's BP in the lying, sitting, and standing (if applicable) positions and (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comparing the BP readings. RN 1 reviewed Resident 13's medical record and verified the above findings. 2. Medical record review for Resident 41 was initiated on 9/23/25. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's H&P examination dated 8/20/25, showed Resident 41 had fluctuating capacity to understand and make decisions. Review of Resident 41's MDS assessment dated [DATE], showed Resident 41 had severely impaired cognition. Review of Resident 13's Orders Summary Report dated 9/25/25, showed the following physician's orders:- dated 8/18/25, for the use of the Seroquel (antipsychotic) medication, to monitor the episodes of antipsychotic behavior manifested by sudden anger outburst, every shift. To document the non-pharmacological interventions using the following codes: 1= Redirect with activities of interest, 2= Reduce or remove possible stressors, 3= Model appropriate interactions, 4= Remind and set boundaries, 5= Offer support, 6= Remove resident from environment, or 7= Return to room, - dated 9/2/25, to administer Seroquel 12.5 mg one tablet by mouth two times a day for psychosis (a mental state where a person loses contact with reality, characterized by symptoms like hallucinations (seeing or hearing things that aren't there) and delusions (false, fixed beliefs)) manifested by visual hallucinations,- dated 9/5/25, for the use of the psychotropic medication, to obtain Resident 41's orthostatic blood pressure in the lying position, every Sunday during the day shift, - dated 9/5/25, for the use of the psychotropic medication, to obtain Resident 41's orthostatic blood pressure in the sitting position, every Sunday during the day shift, and- dated 9/5/25, for the use of the psychotropic medication, to obtain Resident 41's orthostatic blood pressure in the standing position, every Sunday during the day shift. a. Review of Resident 41's MAR for September 2025 showed the following documented orthostatic BP readings:- on 9/2/25, the BP reading was documented as 121/61 mmHg for the lying and standing positions.- on 9/7/25, the BP reading was documented as 117/70 mmHg for the lying, sitting, and standing positions.- on 9/14/25, the BP reading was documented as 120/72 mmHg for the lying and sitting positions.- on 9/21/25, the BP reading was documented as 110/71 mmHg for the lying position, and NA (not applicable) was documented for the sitting and standing positions. b. Review of Resident 41's MAR for September 2025 showed the licensed nurses were monitoring Resident 41 for the episodes of sudden anger outbursts, every shift from 9/1 to 9/25/25. The MAR showed the licensed nurses' documentation of the nonpharmacologic interventions implemented and it's effectiveness for Resident 41's episodes of sudden anger outbursts, however the number of episodes observed were documented as 0 zero. For example:- on 9/1/25, zero episode was documented during the day and night shifts; however, the licensed nurses documented 2- Reduce or remove possible stressors, for the nonpharmacological interventions attempted.- on 9/2/25, zero episode was documented during the day, night, and NOC shifts; however, the licensed nurses documented 5-offer support, for the nonpharmacological interventions attempted. Further review of the MAR for September 2025 failed to show any monitoring of Resident 41 for the episodes of visual hallucinations, for the use of the Seroquel medication. On 9/26/25 at 0949 hours, an interview and concurrent medical record review for Resident 41 was conducted with RN 1. RN 1 stated for the residents taking the antipsychotic medications, the residents would be monitored every shift by the licensed nurses for the manifested behaviors and the potential side effects related to the use of the antipsychotic medication. RN 1 stated if the monitored behaviors were observed, the licensed nurses should implement the nonpharmacological interventions and document the number of episodes observed during the shift, the non-pharmacological interventions implemented and the effectiveness of the interventions. RN 1 reviewed Resident 41's medical record and verified the above findings. On 11/19/25 at 1015 hours, an interview was conducted with the DON. The DON stated for the residents prescribed with psychotropic medications, the residents were monitored for the potential side effects such as orthostatic hypotension. The DON stated the monitoring for the orthostatic hypotension was done once every week, and the residents' BP readings were obtained when they were in the lying, sitting, and standing positions. The DON stated the BP readings obtained for the different positions should not be the same and should not be marked N/A. The DON stated the monitoring of the specific (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors related to the use of the psychotropic medications were also done every shift by the licensed nurses. The DON stated if the monitored behavior was observed, the licensed nurses were expected to document the number of episodes during the shift and the non-pharmacological interventions implemented and its effectiveness in the MAR. On 11/19/25 at 1430 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.		

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 services to attain or maintain the highest practicable well-being for two of 27 final sampled residents (Residents 29 and 141). * The facility failed to ensure the right arm sling was applied as ordered by the physician for Resident 29. * The facility failed to ensure Resident 141's physician was notified timely of the UA (urine analysis) results and the resident's signs and symptoms of UTI (urinary tract infection). These failures had the potential for not providing the necessary care and services to the residents to meet their needs and delay in treatment. Findings: Review of the facility's P&P titled Sling, Arm revised 11/2007 showed it is the policy of this facility to: 1. Elevate and support the arm. 2. Reduce edema. 3. Relieve stress on the shoulder or elbow. 4. Immobilize a strained or sprained muscle. 5. Immobilize a fracture. 6. Facilitate return circulation from the extremities. Medical record review for Resident 29 was initiated on 9/23/25. Resident 29 was admitted to the facility on [DATE], with the diagnosis of fracture of unspecified part of the right clavicle. Review of Resident 29's H&P examination dated 9/2/25, showed Resident 29 was hospitalized due to a mechanical fall resulting in a right clavicular fracture. Further review of the H&P showed Resident 29 had no capacity to make decisions. Review of Resident 29's Plan of Care showed a care plan problem dated 9/2/25, addressing Residents 29's ADL self-care performance deficit. The interventions included non-weight bearing to the right upper extremity and to apply the right arm sling at all times, may be removed during shower and ADL care. Review of Resident 29's Order Summary Report dated 9/25/25, showed a physician's order dated 9/2/25, for Resident 29 to wear the right arm sling at all times; may remove the sling during shower and ADL care and for non-weight bearing to the right upper extremity, every shift. On 9/23/25 at 1235 hours, an observation for Resident 29 was conducted. Resident 29 was observed lying on bed while CNA 2 was observed repositioning Resident 29 in the bed. Resident 29 was not observed wearing a sling on the right arm. On 9/24/25 at 1055 and 1553 hours, Resident 29 was observed lying in bed. Resident 29 was not observed wearing a right arm sling. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/25 at 0732 and 1210 hours, Resident 29 was observed lying in bed. A staff was not observed in the room providing care to Resident 29 and the resident was not observed wearing a sling on the right arm. On 9/25/25 at 1450 hours, an interview and concurrent observation for Resident 29 was conducted with CNA 3. When asked about Resident 29's use of the sling, CNA 3 stated she was not informed Resident 29 needed to wear a sling. CNA 3 stated Resident 29 had not been wearing a sling during CNA 3's shift that day, during the 0700 to 1500 shift. CNA 3 further stated there was a sling in Resident 29's restroom, however CNA 3 stated she was not informed the sling was for Resident 29. A concurrent observation was conducted of Resident 29 with CNA 3. Resident 29 was observed lying on the bed, and CNA 3 verified Resident 29 was not wearing a sling on her right arm. On 9/25/25 at 1457 hours, an interview and concurrent observation and record review for Resident 29 was conducted with LVN 3. LVN 3 stated Resident 29 had a cervical fracture on the right side. LVN 3 reviewed Resident 29's medical record and stated there was a physician's order for Resident 29 to wear a sling on the right arm. A concurrent observation of Resident 29 was conducted with LVN 3. LVN 3 verified Resident 29 was not wearing a sling on the right arm. LVN 3 stated Resident 29 should be wearing a sling at all times except for showers. LVN 3 further stated Resident 29 had received a shower today, however the CNA did not ask LVN 3 to assist to apply the sling. On 11/18/25 at 1015 hours, an interview was conducted with the DON. The DON stated for the residents with a physician's order to wear the sling, the sling should be applied as per the physician's order. The DON further stated the licensed nurses were responsible for checking the residents to ensure the slings were worn as ordered. On 11/19/25 at 1430 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Physician Order, Transcribing and Notification revised 5/2021 showed laboratory orders are transferred to the laboratory request and physician's order sheet. The laboratory services is notified of the diagnostic procedure ordered. All laboratory orders will be verified, and physician will be notified of results of the laboratory work up. On 9/23/25 at 0933 hours, during the initial tour of the facility, Resident 141 was observed awake in her room. Resident 141 stated she had UTI and the facility had not done anything about her UTI. Resident 141 stated it burned when she urinated, and her urine smelled bad. Resident 141 stated she had a urine sample test done last week and had been begging the facility to find out the results. Resident 141 further stated her son asked the facility staff yesterday and he was told the facility was still waiting for the physician to call about the results. Medical record review for Resident 141 was initiated on 9/23/25. Resident 141 was admitted to the facility on [DATE]. Review of Resident 141's H&P examination dated 7/13/25, showed Resident 141 had the capacity to understand and make decisions. Review of Resident 141's SBAR Communication Form dated 9/11/25 at 1230 hours, showed Resident 141 verbalized she had dysuria, increased in urination, and burning sensation when voiding. Physician (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 was notified and recommended to test the resident's urine for UA with culture and sensitivity. Review of Resident 141's Laboratory Results Report showed: - collected on 9/12/25 at 1350 hours, and reported on 9/13/25 at 1821 hours, Resident 141's urinalysis with culture reflex resulted with multiple organisms present in the urine with possible contamination; and - collected on 9/18/25 at 1300 hours, and reported on 9/20/25 at 1101 hours, Resident 141's urinalysis with culture reflex resulted with positive Escherichia coli (E. coli). Review of Resident 141's Progress Notes showed the following: - dated 9/16/25 at 1644 hours, Physician 1 was reformed regarding Resident 141's urinalysis with culture and sensitivity laboratory result which showed multiple organisms present in the urine and possible contamination, awaiting response from Physician 1. The note also showed Resident 141 was still complaining of burning sensations and dysuria and increased in frequency urination; and - dated 9/18/25 at 1209 hours, Physician 1 saw Resident 1 in the facility, saw the result of the urine test which was done on 9/12/25, and ordered to recollect urine for UA with culture and sensitivity test. Physician 1 also ordered to change Resident 141's cranberry supplement to twice daily. - dated 9/25/25 at 1406 hours, Physician 2 was informed of the result of the UA with culture and sensitivity test but no response; - dated 9/25/25 at 1459 hours, Physician 2 was reformed of the result of the UA with culture and sensitivity test but no response; - dated 9/26/25 at 1512 hours, Resident 141 was still verbalizing bladder discomfort and frequency/urgency in urination. Physician 2 was informed and awaiting for response. Further review of Resident 141's medical record did not show documented evidence the physician was notified of the result of the urinalysis with culture reflex reported to the facility on 9/20/25. In addition, the medical record failed to show documented evidence of continued monitoring/assessment for Resident 141 by the licensed nurses when the resident had a change of condition related to signs and symptoms of the UTI. On 9/26/25 at 1404 hours, an interview and concurrent medical record review for Resident 141 was conducted with LVN 6. LVN 6 stated she was familiar with Resident 141. LVN 6 stated Resident 141 had complained of issues with urination like burning sensation and feeling of increased urgency to urinate. LVN 6 stated Resident 141 had these issues since 9/11/25. LVN 6 stated the charge nurse was responsible to follow up with the physician regarding the laboratory results. LVN stated if there was no response, they would endorse to the next shift's charge nurse and would call the following day. LVN 6 stated if three days had passed and the physician still had not responded, they would ask for help from the DON. LVN 6 further stated they would contact the Medical Director if the physician did not respond for five days. LVN 6 verified no one informed Resident 141's physician after the laboratory reported to the facility the result of the urine test on 9/20/25. On 9/26/25 at 1430 hours, an interview and concurrent medical record review for Resident 141 was (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with the IP. The IP stated Resident 141 did not have any current documented signs and symptoms of infection. The IP stated she was not aware Resident 141 had any signs and symptoms of urinary infection. The IP stated Resident 141's last change of condition was on 9/11/25, and the urinary test showed it was contaminated at that time. The IP stated she was not aware of Resident 141's contaminated urinary result until 9/18/25 and Physician 1 ordered to recollect urine sample to repeat the UA with culture and sensitivity test. The IP stated there was no change or report to her afterwards that Resident 141 still had dysuria. The IP stated for the result on 9/12/25, the nurse reviewed the results on 9/12/25 at 0830 hours. The IP stated the nurse who had reviewed the results was responsible for notifying the physician. The IP acknowledged the physician was not attempted to be notified until 9/15/25. The IP stated they should have followed up with the physician as soon as possible and notified the physician as soon as they got the laboratory result. The IP stated each nurse on every shift should follow up. The IP stated another urine sample was sent out in the laboratory on 9/18/25. The IP stated the results came back on 9/22/25, and the results were reviewed by an RN. The IP verified there was no documented evidence the physician was notified on 9/22/25, of the result of the urine test and it was only not until 9/25/25, when the nurses attempted to notify the physician. The IP verified she was not monitoring Resident 141 and the resident was not on her infection surveillance record. The IP stated the follow up to the physician regarding the result of the urine test ordered was a delay of care. The IP further stated the nurses should attempt to notify the resident's attending physician three times of the laboratory results or any changes in the resident's condition, and if there was no response then the medical director should be notified. On 11/19/25 at 1530 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the findings.		

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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. **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 ensure the necessary care and services were provided to prevent the development of new pressure ulcers (areas of damaged skin caused by staying in one position for a long time which reduces blood flow to the area and causes the skin to die and develop a sore) and promote healing of existing pressure ulcer for three of six final sampled residents (Residents 8, 9, and 29) reviewed for pressure ulcers. * The facility failed to ensure the wound treatment was administered as per the physician's order for Resident 8. * The facility failed to conduct the Weekly Skin Evaluations and IDT Skin Review for Resident 9's coccyx to right buttock wound, as per the facility's P&P and care plan. * The facility failed to ensure the LAL mattress setting was appropriate for Resident 29's weight. These failures posed the potential risks for complications and delayed wound healing for Residents 8, 9, and 29. Findings: Review of the facility's P&P titled Skin and Wound Monitoring and Management revised 4/2025 showed it is the policy of this facility that a resident having pressure injury(s) receives the necessary treatment and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing. For the ongoing skin and wound assessments, a licensed nurse would assess/evaluate a resident's skin at least weekly. Areas of breakdown, excoriation, or discoloration, or other unusual findings (either initially identified at the time of admission or as new findings) must be documented in the nursing notes or on the appropriate weekly assessment form (Skin Pressure Ulcer Weekly, Skin Ulcer Non-Pressure Weekly, or Skin Evaluation-PRN/Weekly). A licensed nurse would assess/evaluate at least weekly each area of alteration/injury, whether present on admission or developed after admission, which exists on the resident. This assessment evaluation should include but not limited to: 1) Measuring the skin injury, 2) Staging the skin injury (when the cause is pressure), 3) Describing the nature of the injury (e.g. pressure, stasis, surgical incision), 4) Describing the location of the skin alteration, 5) Describing the characteristics of the skin alteration, 6) Describing the progress with healing, and any barriers to healing which may exists, and 7) Identifying any possible complications or signs/symptoms consistent with the possibility of infection. Once an area of an alteration in skin integrity has been identified, assessed, and documented, the nursing staff shall administer the treatment to each affected area as per the physician's order. Treatments per the physician's order should be documented in the resident's clinical record at the time they are administered. Further review of the facility's P&P showed in order to prevent the development of skin breakdown or prevent existing pressure injuries from worsening, the nursing staff shall implement the following approaches as appropriate and consistent with the resident's care plan: use pressure relieving/reducing and redistributing devices (including but not limited to low air (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	loss mattresses, wedges, pillows, etc.). If the clinical assessment/evaluation for the Pressure Ulcer, Non-pressure Ulcer, and PRN/Weekly Skin Assessment/Evaluation indicated a change in condition or decline in the wound, the assessing/evaluating nurse would notify the physician and create a narrative note documenting the notification. Under the section Monitoring showed monitoring would be conducted weekly via the Skin Weekly Committee. The facility would prepare and maintain Skin Committee Review Notes and recommendations in the resident's clinical record. Review of the manual titled Supra Air Low Air Loss Alternating Pressure Mattress and Pump (undated) under the section Operating Instructions, showed Step 6- to determine the resident's weight and set the control knob to that weight on the control unit. 1. Medial record review for Resident 9 was initiated on 9/23/25. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's H&P examination dated 10/20/25, showed Resident 9 had the capacity to understand and make decisions. Review of Resident 9's Order Summary Report showed the following physician's orders: - dated 9/16/25, to re-evaluate the coccyx (a small triangular bone at the base of the spinal column in humans) extending to the right buttock pressure injury every day shift, for one day. - dated 9/17/25, to re-evaluate the coccyx extending to the right buttock open area, every day shift, for one day. - dated 9/17/25, for the coccyx extending to the right buttock open area, to cleanse with normal saline, pat dry, apply Calmoseptine cream (topical ointment used to protect and heal skin irritations by creating a moisture barrier and providing a soothing effect), cover with foam dressing every day for 14 days, then re-evaluate. Review of Resident 9's Progress Note dated 11/19/25, showed a nursing entry on 9/16/25 at 0741 hours. The licensed nurse documented the CNA informed the licensed nurse of Resident 9's open skin to the buttock. The resident was assessed and noted with a small open skin to the coccyx extending to the right buttock, approximately 0.3 mm in size. The resident stated she was getting changed yesterday and the CNA kind of accidentally put pressure while cleaning. The treatment was initiated per the facility protocol and Resident 9's physician was informed of the new change of condition and approved of the wound treatment. Review of Resident 9's LN- Skin Evaluation-PRN/Weekly dated 9/16/25, showed the licensed nurse's documentation of Resident 9's 0.3 mm by 0.3 mm pressure injury to the coccyx extending the right buttock. Review of Resident 9's Post-Event IDT Review dated 9/16/25, showed the documentation Resident 9 had a skin alteration on a fragile body area during care. The resident sustained a superficial 0.3 mm size open skin to the coccyx area. The interventions showed caregiver education was provided to ensure post incontinent care, and treatment as ordered. Review of Resident 9's Plan of Care showed a care plan problem dated 9/16/25, addressing Resident 9's open area sustained during care to the lower back area. The interventions included administering (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the treatments as ordered, to monitor for effectiveness, and to assess/record/monitor the wound healing; to measure the length, width, and depth where possible, to assess and document the status of the wound perimeter, wound bed, and healing progress. To report improvements and declines to the physician. Review of Resident 9's TAR for September 2025 showed the documentation of the treatment order for the coccyx extending to the right buttock open area, to cleanse with normal saline, pat dry, apply Calmoseptine cream, and cover with foam. Review of Resident 9's TAR for October 2025 failed to show the documented evidence the above dressing every day for 14 days, then re-evaluate, was administered from 9/17 to 9/30/25. wound care was provided to Resident 9 from 10/1 to 10/7/25 (up to the time when Resident 9 was transferred to the acute care hospital). Further review of Resident 9's medical record failed to show the documentation Resident 9's coccyx extending to the right buttocks wound was monitored and evaluated weekly as per the P&P and care plan, re-evaluated after 14 days of treatment as per the physician's orders, and failed to show the documentation the IDT Skin Review was conducted weekly for Resident 9. On 11/19/25 at 0936 hours, an interview and concurrent medical record review for Resident 9 was conducted with LVN 2. LVN 2 stated upon notification of a new skin impairment, the licensed nurse or treatment nurse would assess the resident's wound, initiate a change of condition, complete the initial skin assessment, and notify the physician for the treatment orders. When asked about classification of the wound and differentiating between pressure and non-pressure wounds, LVN 2 stated if the wound was over a bony prominence, like the coccyx area, then that wound would be classified as a pressure injury. LVN 2 stated for the pressure and non-pressure wounds, the treatment nurse was responsible for assessing and evaluating the wounds weekly to monitor the wound status, to determine if the treatment was effective, or if the wound was deteriorating or getting better. LVN 2 stated following the weekly skin assessments, IDT Skin Review would be conducted weekly to discuss the residents with skin problems. LVN 2 reviewed Resident 9's medical record and verified the above findings. On 11/19/25 at 1015 hours, an interview and concurrent medical record review for Resident 9 was conducted with the DON. The DON stated when a new skin impairment was reported, the licensed nurse was responsible for assessing the resident and completing the initial LN- Skin Evaluation- PRN. The DON stated following the assessment, a weekly skin assessment should be conducted to monitor the wound and the effectiveness of the treatment. The DON stated an IDT Skin Review would be conducted weekly to discuss the resident's skin impairment. The DON stated if the location of the wound was over a bony prominence, the wound should be classified as a pressure injury. The DON reviewed Resident 9's medical record and verified the above findings. The DON stated there should have been the weekly skin assessment/evaluation to monitor the status of the wound and if the wound resolved, then there should have been some documentation in the resident's medical record. 2. On 9/23/25 at 1000 hours, during the initial tour of the facility, Resident 29 was observed lying in bed. The Low Air Loss (LAL) mattress device was observed on and the weight setting was set at 125 pounds. Medical record review for Resident 29 was initiated on 9/23/25. Resident 29 was admitted to the facility on [DATE]. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 29's MDS assessment dated [DATE], showed Resident 29 had severely impaired cognition, was at risk for developing pressure ulcers/injuries, and required partial/moderate assistance (where the helper does less than half the effort) for rolling left and right, and substantial/maximal assistance (where the helper does more than half the effort) for sit to lying, and lying to sitting on the side of the bed for bed mobility. Review of Resident 29's Order Summary Report for September 2025 showed a physician's order dated 9/17/25, for the LAL mattress for skin maintenance and wound care. Review of Resident 29's Plan of Care showed a care plan problem initiated on 9/3/25, addressing Resident 29's potential for pressure injury development. The interventions included the LAL mattress for wound care and skin maintenance. Review of Resident 29's Weights and Vitals Summary dated 9/25/25, showed on 9/14/25, Resident 29 weighed 80 pounds; and on 9/21/25, Resident 29 weighed 81 pounds. On 9/24/25 at 1000, 1055, and 1553 hours, Resident 29 was observed lying on her back on the LAL mattress. The LAL mattress unit was observed turned on and set at 125 pounds. The staff was not observed in Resident 29's room providing care to the resident. On 9/24/25 at 1603 hours, an interview and concurrent observation and medical record review for Resident 29 was conducted with LVN 2. LVN 2 stated Resident 29 could assist with turning in bed but was at risk for developing pressure injuries. LVN 2 stated Resident 29 had a LAL mattress for pressure relief and the setting should be set based on Resident 29's current weight. LVN 2 stated the LAL mattress settings were checked every morning by the treatment nurses to ensure the settings were correct for each resident. LVN 2 reviewed Resident 29's medical record and stated Resident 29's most recent weight was obtained on 9/21/25, and she weighed 81 pounds. An observation was conducted at Resident 29's bedside and LVN 2 verified the LAL mattress setting was set at 125 pounds. LVN 2 stated the LAL mattress weight setting should be set at Resident 29's current weight. On 11/19/25 at 1015 hours, an interview was conducted with the DON. The DON stated for the residents on the LAL mattress, the LAL mattress setting should be set based on the resident's current weight or their comfort level. The DON stated if the LAL setting was not set per the resident's weight and there could be the potential risk of the resident developing pressure injuries. The DON stated if the LAL mattress setting was set per the resident's comfort level and not their weight, then there should be a care plan to address the weight setting discrepancy on the LAL mattress unit. On 11/19/25 at 1430 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. 3. On 9/23/25 at 1120 hours, during the initial tour of the facility, Resident 8 was observed awake and sitting in the wheelchair inside the room. Resident 8 stated she had a wound on her bottom and was being treated by the nurse. Medical record review for Resident 8 was initiated on 9/30/25. Resident 8 was readmitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 8/14/25, showed Resident 8 had the capacity to (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understand and make decisions. Review of Resident 8's Order Summary Report showed a physician's order dated 9/22/25, to cleanse left ischium (a thick, irregularly shaped bone in the pelvis that serves multiple functions. It is also known as a sit bone) pressure injury with NS, pat dry, apply Medihoney (wound treatment that creates a moist healing environment, cleanses wounds, and helps remove dead tissue), apply alginate (used for the management of moderate to heavily exuding wounds to promote healing by maintaining a moist environment) dressing, and cover with dry dressing every day shift for 30 days. Review of Resident 8's Wound assessment dated [DATE] at 1916 hours, showed a surgical debridement of the left buttock wound was performed by the wound physician. The wound physician documented on the plan interventions for the left buttock pressure injury to treat with collagen powder, Medihoney, and cover with dry dressing. The record showed due to Resident 8's medical comorbidities, wound healing prolonged and difficult despite optimal nursing care in place. On 9/30/25 at 1515 hours, an interview and concurrent medical record review for Resident 8 was conducted with LVN 2. LVN 2 stated the wound consultant/physician came to the facility every Thursday of the week. LVN 2 verified Resident 8 had a pressure injury in the left buttock since 9/20/25. LVN 2 stated the current treatment he was providing Resident 8 was Medihoney with alginate dressing. LVN 2 stated he assisted the wound physician and the physician would tell the treatment nurses the new treatment orders on the same day and it would also be recorded in the physician's wound assessment note. LVN 2 stated the wound physician would tell him about changes to the wound treatment orders. LVN 2 stated the wound physician reclassified the wound in Resident 8's left buttock and there was a new order for Medihoney and collagen powder on 9/25/25. LVN 2 verified he did not update the treatment orders per the wound physician's orders. LVN 2 further stated he was aware of the new treatment orders for Resident 8's left buttock wound since 9/25/25. On 11/19/25 at 1530 hours, an interview was conducted with the Administrator, DON, and Nursing Consultant. The Administrator, DON, and Nursing Consultant were informed and acknowledged the above findings for Resident 8.		

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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, medical record review, and facility P&P review, the facility failed to ensure one of two final sampled residents (Resident 3) reviewed for falls were provided the necessary services after a fall. * The facility failed to ensure Resident 3's fall risk evaluation was completed after Resident 3 had a fall on 8/9/25, and failed to ensure Resident 3's Fall Risk Evaluations were completed accurately. These failures had the potential risk of inaccurate fall risk score and the failure to implement the appropriate fall risk interventions for Resident 3. Findings: Review of the facility's P&P titled Fall Management System revised 4/2025 showed it was the policy of the facility to provide each resident with the appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurred. On admission, the Fall Risk Evaluation would be completed to determine the resident's risk for sustaining a fall. When a resident sustained a fall, a physical assessment would be completed by a licensed nurse, with the results documented in the medical record. The Fall Risk Evaluation would be completed post fall incident. Medical record review for Resident 3 was initiated on 9/23/25. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's H&P examination dated 6/26/25, showed Resident 3 had no capacity to make decisions and the diagnosis of dysphagia (difficulty or pain when swallowing) as a late effect of a cerebrovascular accident (a stroke that occurs when blood flow to the brain is interrupted, either by a blockage or a ruptured blood vessel, causing brain cells to die). Review of Resident 3's MDS assessment dated [DATE], showed Resident 3 had severely impaired cognitive skills for daily decision making. Review of Resident 3's Plan of Care showed a care plan problem dated 7/26/25, addressing Resident 3's risk for falls. The care plan showed Resident 3 was found on the floor on 7/21, 8/9, 9/1, 9/10, and 9/14/25. Review of Resident 3's Fall Risk Evaluations showed the following licensed nurses' documentation: - dated 7/25/25, Resident 3 had no falls in the past three months (however, Resident 3 had a fall on 7/21/25), - dated 9/10/25, Resident 3 had one to two falls in the past three months and had no predisposing diseases or conditions (however, Resident 3 had more than two falls in the last three months and had the diagnosis of a cerebrovascular accident), - dated 9/14/25, Resident 3 had one to two falls in the past three months (however, Resident 3 had more than two falls in the last three months). Further review of Resident 3's medical records failed to show a Fall Risk Evaluation was completed for Resident 3's fall on 8/9/25. On 9/30/25 at 1526 hours, an interview and concurrent medical record review for Resident 3 was conducted with the ADON. The ADON stated upon admission to the facility, a Fall Risk Assessment was completed to identify the residents that were at risk for falls. The ADON stated the fall risk interventions were implemented based on the resident's fall risk scores, therefore the assessment should be accurate. The ADON further stated after the resident sustained a fall at the facility, the fall risk reevaluation should be completed. The ADON reviewed Resident 3's medical record and verified the above findings. On 11/19/25 at 1015 hours, an interview was conducted with the DON. The DON stated after a resident had a fall at the facility, the licensed nurse should complete the Fall Risk Evaluation. The DON stated the Fall Risk Reevaluation should be accurate because the fall interventions for the residents were implemented based on the resident's fall risk scores. On 11/19/25 at 1430 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to one of one final sampled resident (Resident 4) reviewed for dialysis. * The facility failed to ensure Resident 4's dialysis communication forms were accurately completed. * The facility failed to ensure Resident 4 had a clamp scissors (a device for dialysis residents that control bleeding or secure tubing) available in the emergency kit at bedside. * The facility failed to ensure Resident 4's 1000 ml fluid restriction in a 24-hour period was maintained. These failures had the potential of not identifying possible negative outcomes related to the dialysis treatment for the resident. Findings: Review of the facility's P&P titled Dialysis (Renal), Pre- and Post-Care revised 1/2022 showed the care of the resident receiving dialysis services will reflect ongoing communication, coordination and collaboration between the nursing home and dialysis staff. Staff will immediately contact and communicate with the attending physician and/or practitioner, resident/resident representative, and designated dialysis staff such as the nephrologist (a medical doctor who specializes in diagnosing and treating kidney disease) or registered nurse regarding any significant changes in the resident's status related to clinical complications or emergent situations that may impact the dialysis portion of the care plan. The P&P further showed documentation related to pre- and post-dialysis care will be placed in the clinical record and include: - Resident assessments, interventions, and any provided education. - Assessment of renal dialysis access site, to include presence or absence and quality of a bruit (the sound of blood flowing through an artery) and thrill (a vibration felt by blood flowing through the fistula) for residents with an arteriovenous fistula (the connection the artery and vein for dialysis access). - Communication between facility and dialysis staff or medical provider. 1. Medical record review for Resident 4 was initiated on 9/23/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's H&P examination dated 9/3/25, showed Resident 4 had the capacity to understand and make decisions. a. Review of Resident 4's Order Summary Report for September 2025 showed the following physician's orders:- dated 8/30/25, for hemodialysis (a medical procedure that uses a machine to filter and clean a person's blood when their kidneys have failed) days on Monday, Wednesday, and Fridays. - dated 9/17/25, to access dialysis site left chest permacath (a long-term, tunneled central venous catheter used for hemodialysis, inserted into a large vein, typically in the neck, and threaded to the right side of the heart) every 30 minutes for four hours post dialysis treatment. Assess for s/s (signs and symptoms) of bleeding, infections, or any issues. Document in the nurses notes if any issues are present and notify MD (Doctor of Medicine). Review of Resident 4's Nurses Dialysis Communication Record under the section for Pre-Dialysis showed the following:- No documentation of the number of lumen (the cavity or channel within a hollow, tubular organ or vessel, such as a blood vessel or the intestine) on 9/19, 9/22, and 9/24/25. Review of Resident 4's Dialysis Communication Record under the section for Dialysis Center showed the following:- Access site marked to the right upper chest.- No documentation of the number of lumen on 9/19, 9/22, and 9/24/25. Review of Resident 4's Dialysis Communication Record under the section for Post-Dialysis showed the following:- A documentation to show the resident has a bruit and thrill on 9/17/25.- No documentation of the number of lumen on 9/17/25.- No documentation of the access site on 9/24/25. - No documentation of redness, swelling, pain, drainage, or bleeding on 9/24/25. On 9/26/25 at 0922 hours, an interview and concurrent medical record review for Resident 4 was conducted with the ADON. The ADON verified the above findings. The ADON stated the dialysis communication forms were completed for pre-dialysis, at dialysis, and post-dialysis. The ADON further stated the charge nurse assigned to the resident were to complete the form prior to the dialysis, upon return, and also follow up with the dialysis center if information on the dialysis communication forms were incomplete or inaccurate. b. Review of Resident 4's Order Summary Report for September 2025 showed the (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following physician's orders:- dated 8/30/25, for hemodialysis days on Monday, Wednesday, and Fridays. - dated 9/17/25, to access dialysis site left chest Permacath every 30 minutes for four hours post dialysis treatment. Assess for signs and symptoms of bleeding, infections, or any issues. Document in the nurses notes if any issues are present and notify the MD. On 9/26/25 at 0922 hours, an observation and concurrent interview for Resident 4 was conducted with the ADON in Resident 4's room. The ADON verified the emergency dialysis kit at Resident 4's bedside did not have the clamp scissors available in the emergency dialysis kit. The ADON verified the emergency dialysis kit had a tourniquet (a device for stopping the flow of blood through a vein or artery, typically by compressing a limb with a cord or tight bandage), gauze, sterile gloves, and tape. The ADON stated clamp scissors should be at the resident's bedside to be used for bleeding. c. Review of Resident 4's Order Summary Report for September 2025 showed the following physician's orders:- dated 8/30/25, for hemodialysis days on Monday, Wednesday, and Fridays. - dated 8/30/25, for 1000 ml per day fluid restriction. Review of Resident 4's medical record titled Fluid Intake dated 10/21 to 11/19/25, showed Resident 4 received over 1000 ml fluid restriction in a day on the following:- dated 10/21/25, 1600 ml;- dated 10/22, 10/25, and 11/6/25, 1200 ml;- dated 11/4/25, 1320 ml; and- dated 11/5/25, 1440 ml. On 11/19/25 at 1008 hours, an interview and concurrent medical record review for Resident 4 was conducted with the IP. The IP verified Resident 4 received over 1000 ml of fluids on multiple dates noted above. The IP also verified Resident 4 was on hemodialysis and had a physician's order for fluid restriction of 1000 ml per day. The IP stated the 1000 ml fluid restriction should be maintained to ensure Resident 4 did not go into fluid overload. On 11/19/25 at 1510 hours, an interview was conducted with the Administrator, DON, Nurse Consultant, and Certified Dietary Manager. The Administrator, DON, Nurse Consultant, and Certified Dietary Manager acknowledged the above findings.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **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 pharmaceutical services for two of 27 final sampled residents (Residents 29 and 85) and one nonsampled resident (Resident 18) to meet the needs of each resident. * The facility failed to verify with the physician the medication route for Resident 18's medication ordered. * The facility failed to ensure the metoprolol (medication to treat high blood pressure) was administered as ordered by the physician for Resident 29. * The facility failed to ensure the amlodipine (medication to treat high blood pressure) was administered as ordered by the physician for Resident 85. These failures posed the risk for negative health outcomes to the residents. Findings: Review of the facility's P&P titled Medication Administration revised 2/2022 showed it is the policy of this facility that medications shall be administered as prescribed by the attending physician. Medications must be administered in accordance with the written orders of the attending physician. If a dose seems excessive considering the resident's age and condition, or a drug order seems to be unrelated to the resident's current diagnosis or condition, the nurse should contact the physician. 1. On 9/25/25 at 0847 hours, medication administration observation for Resident 18 was conducted with LVN 6. LVN 6 was observed administering the multiple vitamins-minerals one tablet via GT (Gastrostomy tube, a tube inserted through the belly that brings nutrition directly to the stomach) to Resident 18. Medical record review for Resident 18 was initiated on 9/25/25. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's H&P examination dated 4/24/25, showed Resident 18 had fluctuating capacity to understand and make decisions. Review of Resident 18's Order Summary Report showed a physician's order dated 8/18/25, to administer multiple vitamins-minerals one tablet by mouth one time a day for supplement. On 9/25/25 at 1430 hours, an interview and concurrent medical record review for Resident 18 was conducted with LVN 6. LVN 6 stated Resident 18 was currently NPO (nothing by mouth) because of dysphagia (difficulty or pain when swallowing). LVN 6 stated Resident 18 was not able to take any medications or food by mouth. LVN 6 further stated all the medications for Resident 18 had been given via GT. LVN 6 verified the multiple vitamins-minerals tablet was administered via GT during medication administration observation conducted earlier. LVN 6 verified the route for medication was incorrect for the multiple vitamins-minerals. LVN 6 stated the charge nurse was responsible in clarifying the order with the physician as well as informing the physician if the medication order was not appropriate for the condition of the resident. On 11/19/25 at 1530 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. 2. Medical record review for Resident 29 was initiated on 9/23/25. Resident 29 was admitted to the facility on [DATE]. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 29's MDS assessment dated [DATE], showed Resident 29 had severely impaired cognition and had the diagnosis of hypertension (high blood pressure). Review of Resident 29's Plan of Care showed a care plan problem dated 9/2/25, addressing Resident 29's altered cardiovascular status related to hypertension. The interventions included to administer the medications as ordered. Review of Resident 29's Order Summary Report for September 2025 showed a physician's order dated 9/2/25, to administer metoprolol (high blood pressure medication) 25 mg one tablet two times a day for hypertension; to hold the medication if the systolic blood pressure (SBP) was below 100 mmHg or the heart rate was below 60 beats per minute. Review of Resident 29's MAR for September 2025 showed the following licensed nurses' documentation for the administration of the metoprolol 25 mg one tablet two times a day, to hold if the SBP was less than 100 mmHg or the heart rate was less than 60 beats per minute: - on 9/3/25 at 1700 hours, the licensed nurse documented the BP was 108/69 mmHg and the heart rate was 93 beats per minute. The licensed nurse documented 12, - on 9/6/25 at 1700 hours, the licensed nurse documented the BP was 108/79 mmHg and the heart rate was 86 beats per minute. The licensed nurse documented 12, - on 9/12/25 at 0900 hours, the licensed nurse documented the BP was 108/76 mmHg and the heart rate was 78 beats per minute. The licensed nurse documented 12, - on 9/17/25 at 0900 hours, the licensed nurse documented the BP was 105/68 mmHg and the heart rate was 75 beats per minute. The licensed nurse documented 12, and - on 9/24/25 at 1700 hours, the licensed nurse documented the BP was 102/55 mmHg and the heart rate was 68 beats per minute. The licensed nurse documented 12. Further review of the MAR for September 2025 under Chart Codes showed 12= the BP below the set parameters. On 9/25/25 at 1152 hours, an interview and concurrent medical record review for Resident 29 was conducted with LVN 3. LVN 3 stated for the administration of the blood pressure medications, the resident's BP reading and heart rate were obtained and the medication administered to the resident if the BP reading and heart rate were within the ordered parameters. LVN 3 stated if the BP reading or heart rate were not within the ordered parameters, the BP medication would be held and documented in the MAR. LVN 3 reviewed Resident 29's medical record and verified the above findings. LVN 3 stated the blood pressure medications should have been administered to Resident 29 for the above dates and times. 3. Medical record review for Resident 85 was initiated on 9/23/25. Resident 85 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 85's MDS assessment dated [DATE], showed Resident 85 had severely impaired cognition. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 85's Order Summary Report dated 9/29/25, showed a physician's order dated 9/1/25, to administer amlodipine (medication to treat high blood pressure) 2.5 mg one tablet by mouth two times a day for hypertension (high blood pressure); to hold if the blood pressure was less than 135 mmHg, per Resident 85's family member's request for concern of low BP. Review of Resident 85's MAR for September and October 2025 showed documentation the amlodipine medication 2.5 mg one tablet two times a day was administered to Resident 85 when the BP reading was outside of the ordered parameters: - on 9/13/25 at 0900 hours, the BP was 131/67 mmHg, - on 9/20/25 at 0900 hours, the BP was 131/89 mmHg, - on 10/11/25 at 0900 hours, the BP was 123/74 mmHg, - on 10/12/25 at 0900 hours, the BP was 130/70 mmHg, - on 10/13/25 at 0900 hours, the BP was 128/74 mmHg, - on 10/19/25 at 0900 hours, the BP was 106/64 mmHg, - on 10/20/25 at 0900 hours, the BP was 134/70 mmHg, - on 10/22/25 at 0900 hours, the BP was 126/78 mmHg, - on 10/25/25 at 0900 hours, the BP was 134/74 mmHg, - on 10/26/25 at 0900 hours, the BP was 128/74 mmHg, and - on 10/27/25 at 0900 hours, the BP was 127/74 mmHg. On 11/18/25 at 1357 hours, an interview and concurrent medical record review for Resident 85 was conducted with LVN 1. LVN 1 stated for the administration of the blood pressure medications, the licensed nurse should check the resident's BP prior to the administration of the BP medication. LVN 1 stated if the BP reading was within the ordered parameters, then the BP medication would be administered. LVN 1 further stated, if the BP reading was not within the ordered parameters, then the medication would be held. LVN 1 stated after the administration of the medication, the licensed nurses documented in the MAR and a check mark would show the medication was administered. LVN 1 reviewed Resident 85's medical record and verified the above findings. On 11/19/25 at 1015 hours, an interview was conducted with the DON. The DON stated the licensed nurses were responsible for the preparation and administration of the resident's medications as per the physician's orders. On 11/19/25 at 1430 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and P&P review, the facility failed to ensure the pharmacy recommendations for one of five final sampled residents (Resident 11) reviewed for unnecessary medications were followed through. * The facility failed to ensure Resident 11's physician was notified of the pharmacy recommendations to notify the physician of the resident's risk for bleeding on allopurinol (medication to lower excess uric acid levels in the blood) and aspirin (medication to treat pain, fever, and inflammation). This failure had the potential to cause negative outcomes for Resident 11. Findings: Review of the facility's P&P titled Medication (Drug) Regimen Review (MRR) revised 4/2025 showed the drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist. The MRR is a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The report will be sent to the attending physician, the facility's medical director, and the DON to be acted upon. The P&P further showed communication and physician response will be documented in the clinical record, along with any new orders or changes to medication regimen. Medical record review for Resident 11 was initiated on 9/23/25. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 11 was discharged from the facility on 9/30/25. Review of Resident 11's Order Summary Report for showed a physician's orders dated 5/5/25, for allopurinol 100 mg to give two tablets by mouth one time a day for gout (a type of arthritis that causes severe joint pain) and for aspirin EC (enteric coated) 81 mg give one tablet by mouth one time a day for CVA PPX (cerebrovascular accident prophylaxis). Further review of Resident 11's Order Summary Report for September 2025 failed to show documented evidence for monitoring of bleeding and bruising. Review of Resident 11's H&P examination dated 5/7/25, showed Resident 11 had no capacity to understand and make decisions. Review of Resident 11's facility document titled Consultant Pharmacist's MRR dated 8/21/25, showed Resident 11 had very low platelets (tiny, disc-shaped blood cells essential for blood clotting to stop bleeding) while on medications aspirin and allopurinol. Please ensure MD is aware of this level. Thrombocytopenia (medical condition characterized by low platelet count) side effects: Fever, chills, lightheadedness, N/V (nausea/vomiting). Please caution for bleeding and bruising as well. On 9/30/25 at 1345 hours, an interview and concurrent medical record review for Resident 11 was conducted with RN 1. RN 1 verified the above findings. RN 1 verified Resident 11's orders for the allopurinol and aspirin were still active orders. RN 1 stated she reviewed the pharmacy recommendations on 8/21/25, for Resident 11; however, she stated she did not document the resident's primary physician or hospice physician were notified of the pharmacy's recommendation. RN 1 also stated she should have received orders from the MD to monitor for bleeding and bruising as per Consultant Pharmacist's MRR recommendations. On 11/19/25 at 1510 hours, an interview was conducted with the Administrator, DON, Nurse Consultant, and Certified Dietary Manager. The Administrator, DON, Nurse Consultant, and Certified Dietary Manager acknowledged findings.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 6.67%. * LVN 5 failed to apply pressure to the right tear duct or wipe the tear from the eye area right away after the administration of eye drop to Resident 107. * LVN 4 failed to administer metformin (medication to treat high blood sugar) to Resident 117 with food as ordered by the physician. These failures posed the risk for adverse health outcomes. Findings: 1. According to the National Eye Institute information titled How to put eye drops dated 12/5/24, squeeze the prescribed number of eye drops into the pocket. For at least one minute, close your eye and press your finger lightly on your tear duct (small hole in the inner corner of your eye) this keeps the eye drop from draining into your nose. Medical record review for Resident 107 was initiated on 9/25/25. Resident 107 was admitted to the facility on [DATE]. Review of Resident 107's Order Summary Report dated 9/1/25, showed a physician's order dated 9/21/25, to administer Refresh Tears Plus Ophthalmic Solution (eye drops used for the temporary relief of burning, irritation, and discomfort due to dryness of the eye or exposure to wind or sun), one drop in the right eye, four times a day, for redness in the right eye. On 9/25/25 at 0845 hours, a medication pass observation for Resident 107 was conducted with LVN 5. LVN 5 was observed squeezing one drop of Refresh Tears Plus Ophthalmic Solution into Resident 107's right eye. The resident immediately closed the eyes, and the drop was seen coming out of the eye. LVN 5 did not apply pressure to the right tear duct or wipe the tear from the eye area right away. On 9/25/25 at 0900 hours, LVN 5 was informed of the observation. LVN 5 acknowledged and verified the findings. 2. According to the National Library of Medicine information titled Metformin dated 2/15/24, metformin comes as a tablet, an extended-release (long-acting) tablet, and a solution (liquid) to take by mouth. The regular tablet is usually taken with meals two or three times a day. Medical record for Resident 117 was initiated on 9/25/25. Resident 117 was admitted to the facility on [DATE]. Review of Resident 117's Order Summary Report dated 9/25/25, showed a physician's order dated 9/11/25, to administer metformin HCl (hydrochloride) oral tablet 850 mg, one tablet by mouth twice a day for diabetes mellitus (DM). Review of Resident 117's medication bubble pack showed: metformin HCl Oral Tablet 850 mg, one tablet by mouth twice a day with meals for DM. On 9/25/25 at 0940 hours, a medication pass observation for Resident 117 was conducted with LVN 4. LVN 4 was observed administering metformin HCl to Resident 117 without any food. On 9/25/25 at 0950 hours, an interview was conducted with Resident 117. Resident 117 was asked when she last ate. Resident 117 stated she had finished her meal at around 0800 hours. On 9/25/25 at 1100 hours, an interview and concurrent medical record review for Resident 117 was conducted with LVN 4. LVN 4 stated the metformin should be given with a meal or within 30 minutes of eating. LVN 4 acknowledged Resident 17 had not received a snack after breakfast and verified the findings.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure proper medication storage, timely disposal of expired medications, and accurate reconciliation of controlled substances were followed. * The facility failed to reconcile controlled substances for Resident 152. * The facility failed to ensure proper storage of the medications in one of two medication rooms (Station A) inspected. * The facility failed to discard the expired medications from two of five medication carts (Medication Carts C and D) inspected. These failures had the potential to negatively impact the residents' well-being. Findings: 1. Medical record review of Resident 152 was initiated on 9/25/25. Resident 152 was admitted to the facility on [DATE]. Review of Order Summary Report dated 9/29/25, showed a physician's order dated 9/22/25, to administer hydromorphone hydrochloride (a potent opioid analgesic used to manage moderate to severe pain when other treatments are inadequate) tablet 2 mg, Give one tablet by mouth every four hours as needed for moderate (4-6, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst) to severe (7-10) pain. Review of Resident 152's Administration Record Controlled Drugs for the hydromorphone hydrochloride 2 mg one tablet by mouth every four hours as needed for moderate to severe pain showed:- On 9/28/25 at 0328 hours, hydromorphone HCL 2mg one tablet was signed off.- On 9/29/25 at 1120 hours, Hydromorphone HCL 2mg one tablet was signed off. Review of Resident 152's MAR of September 2025 showed:- On 9/28/25 at 0432 hours, hydromorphone HCL 2mg one tablet was administered;- On 9/28/25 at 2118 hours, hydromorphone HCL 2mg one tablet was administered;- On 9/29/25 at 0127 hours, hydromorphone HCL 2mg one tablet was administered; and- On 9/29/25 at 0759 hours, hydromorphone HCL 2mg one tablet was administered. Review of Resident 152's Controlled Drug Record showed hydromorphone HCL 2mg was signed off on 9/28/25 at 0328 hours and on 9/29/25 at 1120 hours. However, Resident 152's MAR did not show corresponding documentation. On 9/30/25 at 0850 hours, an interview and concurrent medical record review for Resident 152 was conducted with the DON. The DON was asked about the physician's orders for the hydromorphone HCL 2 mg tablets administered on 9/28 and 9/29/25. The DON stated there was a discrepancy between the Controlled Drug record and MAR. The DON verified Resident 152's MAR was missing the documentation for 9/28/25 at 0328 hours and 1120 hours. Additionally, the entry for 9/29/25 at 1120 hours, in the controlled drug record was inaccurate. According to the DON, the licensed nurse confirmed the medication was actually administered on 9/28/25. The DON explained the process was after a licensed nurse signed off the controlled drug record and administered the medication to the resident, they were required to document in the MAR. Even if the resident refused the medication, it must still be recorded in the MAR. The DON verified the findings. 2. On 9/26/25 at 0839 hours, an inspection of Station A medication room and concurrent interview was conducted with RN 1. During the inspection, the medication room was observed with two bottles of house supply of milk of magnesia (medication to relieve constipation) which were stored together with two boxes of hemorrhoidal suppositories, five boxes of bisacodyl (laxative) suppositories, and six boxes of enemas (liquid inserted into the rectum to cleanse the bowel, relieve constipation, or as a preparation for a medical procedure). RN 1 verified the findings. 3. On 9/26/25 at 0850 hours, an inspection of Medication Cart D and concurrent interview was conducted with RN 1. RN 1 stated the RN Supervisor was responsible for checking the cart. Medication Cart D was observed to contain two boxes containing multi-function sterile red caps and showed an expiration date of 9/2025. However, the pharmacy labels showed different discard dates: one box was labeled 'Discard after 5/20/25, and the other box showed a label 'Discard after 4/14/25.' RN 1 verified the findings. 4. On 09/26/2025 at 1048 hours, an inspection of Medication Cart C and concurrent interview was conducted with LVN 1. LVN 1 stated the LVNs, supervisors, and (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other licensed nurses were responsible for checking the medication carts. LVN 1 was unable to state how often the medication carts were checked for expired items. LVN 1 stated sometimes the pharmacy technicians or corporate staff came to the facility to check. The following items were found in Medication Cart C:- Trelegy Ellipta (inhaled medication used for long-term maintenance treatment of COPD and asthma-for Resident 74) was stored together with a box of unlabeled bisacodyl suppositories.- An opened bottle of acidophilus (used to treat vaginal inflammation and digestive disorders) capsules, dated 9/25/25, labeled refrigerate after opening, was stored unrefrigerated.- fluticasone propionate (medication to treat allergic and non-allergic nasal symptoms) nasal spray 50 mcg (for Resident 60) was not labeled with an open date. LVN 1 verified the above findings.		

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NAME OF PROVIDER OR SUPPLIER Alamitos West Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3902 Katella Avenue Los Alamitos, CA 90720	
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure 17 of 17 residents who received pureed food from the kitchen received the proper diets when the facility's puree recipes and menu were not followed. * The facility failed to ensure the puree recipe for herb mash potatoes was followed. This failure had the potential for the residents on special diets to not receive the adequate nutritional and caloric intake as recommended on the recipes. Findings: Review of the facility's census on 9/23/25, and Order Listing Report dated 9/23/25, of residents on GT feeding showed 131 of 137 resident received food prepared from the kitchen. Review of the facility's P&P titled Food Preparation dated 2023 showed food shall be prepared by methods that conserve nutritive value, flavor, and appearance. Recipes are specific as to portion yield, method of preparation, quantities of ingredients, and time and temperature guidelines. Review the facility's document titled Recipe: Herb Mashed Potatoes dated 2025 showed the directions were to begin preparing mashed potatoes as per package directions, with the following exceptions: When heating the water, milk, margarine, and salt, add the dried oregano to the water. Simmer a few minutes before mixing with the potato flakes to allow the flavors to combine. Add sour cream and mix well. On 9/25/25 at 1047 hours, an observation of [NAME] 1 was conducted during the puree preparation for the pureed herb mashed potatoes with RD 1 present. [NAME] 1 was observed mixing mash potato powder, margarine, and sour cream in hot water. [NAME] 1 was not observed simmering the herb mashed potatoes and did not add milk, salt, or dried oregano. On 9/25/25 at 1115 hours, an interview was conducted with [NAME] 1. [NAME] 1 verified the herb mash potatoes were not simmered and was mixed with hot water. [NAME] 1 also verified he did not add milk, salt, or dried oregano as per the recipe for herb mashed potatoes and stated he should have followed the recipe. On 9/25/25 at 1135 hours, an interview was conducted with RD 1. RD 1 verified the findings and stated the recipes should be followed to ensure the residents were receiving the proper nutrition. On 11/19/25 at 1510 hours, an interview was conducted with the Administrator, DON, Nurse Consultant, Certified Dietary Manager, and Dietary Aide 1. The Administrator, DON, Nurse Consultant, Certified Dietary Manager, and Dietary Aide 1 acknowledged all the above findings.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility P&P review, and facility document review, the facility failed to ensure the food safety and sanitary requirements were met in the kitchen. * The facility failed to ensure the two-compartment preparation sink had an air gap. * The facility failed to ensure food preparation utensils and equipment were in good, sanitary, and cleanable working conditions. * The facility failed to ensure that food items were dated and labeled. * The facility failed to ensure food items were discarded by the best by date. * The facility failed to ensure the kitchen staff wore hair restraint. * The facility failed to ensure fruits with tough rinds or peels like cantaloupes were washed with a brush. These failures had the potential to cause foodborne illnesses to the medically vulnerable resident population who consumed food prepared in the kitchen. Findings: 1. According to the USDA Food Code 2022, Section 5-402.11 Backflow Prevention showed improper plumbing installation or maintenance may result in potential health hazards such as cross connections, back siphonage or backflow. These conditions may result in contamination of food, utensils, equipment, or other food-contact surfaces. It may also adversely affect the operation of equipment such as ware washing machines. According to the USDA Food Code 2022, Section 5-402.11 Backflow Prevention, Air Gap showed an air gap between the water supply inlet and the flood level rim of the plumbing, fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than one inch. Review of the Facility's P&P titled Backflow Prevention/Air Gaps revised 5/2007 showed an air gap is the most reliable backflow prevention device. It is the physical separation of the potable and non-potable water supply systems by an air space. All steam tables, ice machines and bins, food preparation sinks, display cases soda fountains, espresso machines and other equipment that discharge liquid waste of condensate shall be drained through an air gap into an open floor sink. On 9/23/25 at 0857 hours, an observation and concurrent interview with the DSS was conducted during the initial tour of the kitchen. The two-compartment food preparation sink was observed with no air gap. The DSS verified findings. The DSS stated air gaps were used to prevent backflow of water. 2. According to the USDA Food Code 2022, Section 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022 4-501.12, Cutting Surfaces, cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces. Review of the facility's P&P titled Sanitation dated 2023 showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. Review of the facility's P&P titled Can Opener and Base dated 2023 showed proper sanitation and maintenance of the can opener and base is important to sanitary food preparation. Metal shavings and shredding can result from dull cutting blade or worn out cogwheel. The can opener must be thoroughly cleaned each work shift and when necessary, more frequently. On 9/23/25 at 0853 hours, an observation of the kitchen and concurrent interview was conducted with the DSS. The following were observed: a. one sauce pot with dried food particles;b. one sauce pot with dark discoloration;c. one pan with brown and black discoloration;d. one scooper with gray handle with dried food particles;e. one scooper with ivory handle with dried food particles;f. two green cutting boards heavily marred with white discoloration;g. the container storing the scoopers with dried food particles; andh. the can opener observed with white and brown particles The DSS verified the above findings and stated the items should be replaced to ensure particles will not (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	go into the food. 3. Review of the facility's P&P titled Labeling and Dating of Foods dated 2023 showed all food items in the storeroom, refrigerator, and freezer need to be labeled and dated. Newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines within this section specifically the Dry Goods Storage, Refrigerated Storage Guidelines, Produce Storage guidelines, and Freezer Storage Guidelines. All prepared foods need to be covered, labeled, and dated. On 9/23/25 at 0906 hours, during the initial tour of the kitchen with the DSS, the following were observed: a. eight containers of sherbet undated;b. one case of frozen hash browns undated; andc. one bag of opened cereal undated. The DSS verified the above findings and stated the items should be labeled and dated to ensure food items were fresh and safe to serve to the residents. 4. On 9/23/25 at 0910 hours. during the initial tour of the kitchen with the DSS, one bag of frozen English muffins was observed with a best by date of 9/6. The DSS verified the findings and stated the food items should be consumed within the best by date to ensure freshness and food items were safe to serve the residents. 5. According to the USDA Food Code 2022, Section 2-402.11, Hair Restraints - Effectiveness showed consumers are particularly sensitive to food contaminated by hair. Hair can be both a direct and indirect vehicle of contamination. Food employees may contaminate their hands when they touch their hair. A hair restraint keeps dislodged hair from ending up in the food and may deter employees from touching their hair. The USDA Food Code 2022 further showed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep hear from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.Review of the facility's P&P titled Dress Code dated 2023 showed personal hygiene and appropriate dress are a very important part of the total appearance of the Food and Nutrition Services Department. Proper Dress included hair net for hair, if hair is long (over the ears or longer). If applicable, beards and mustaches (any facial hair) must wear beard restraint. On 9/23/25 at 0930 hours, an observation and concurrent interview with Dishwasher 1 was conducted. An observation of Dishwasher 1 showed he had facial hair and wearing a surgical mask with parts of his facial hair exposed. When asked if he should wear a beard restraint, Dishwasher 1 stated he should have to ensure facial hair did not go on the food. 6. According to the USDA Food Code 2022, Section 3-302.15 Washing Fruits and Vegetables showed pathogenic microorganisms, such as Salmonella spp. (bacteria spread through contaminated food or water affecting the intestinal tract), and chemicals such as pesticides, may be present on the exterior surfaces of raw fruits and vegetables. The USDA Food Code further showed scrubbing with a clean brush is only recommended for produce with a tough rind or peel, such as carrots, cucumbers or citrus fruits that will not be bruised easily or penetrated by brush bristles. Scrubbing firm produce with a clean produce brush and drying with a clean cloth towel or fresh disposable towel can further reduce bacteria that may be present. Review of the facility's P&P, untitled, with a subtitle Preparation of Fruits dated 2023 showed to wash fresh fruits through under running water and scrub with a brush, if needed, to remove soil or other contaminants before being cut, peeled, combined with other ingredients, cooked, or served. Failure to wash fruit before cutting it may result in contamination of the fruit's interior. On 9/23/25 at 0940 hours, an observation and concurrent interview with Dietary Aide 2 was conducted. A container of cantaloupes were observed in the kitchen. Dietary Aide 2 verified the finding. When asked if there was a brush to scrub the cantaloupes with, Dietary Aide 2 denied using a brush and stated she washed the cantaloupes with gloved hands. Dietary Aide 2 further stated they did not have a brush for fruits with tough rinds or peels like cantaloupes. On 9/23/25 at 0948 hours, an interview with Dietary Aide 3 was conducted. Dietary Aide 3 stated when handling cantaloupes, she washed the fruit in a basin using gloved hands and rinse. Dietary Aide 3 denied using a brush to wash the cantaloupes. Dietary Aide 3 stated a brush should be used to clean off the dirt. On 11/19/25 at 1510 hours, an interview was conducted with the Administrator and the DON with the Nurse Consultant, Certified Dietary Manager, and Dietary Aide 1 present. The Administrator, DON, Nurse Consultant, Certified Dietary Manager, and Dietary Aide 1 acknowledged all the above findings.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the facility's P&P about the Food Brought by Family or Visitor was implemented. * The facility failed to ensure the visitors and staff were educated on safe food handling practices of food brought from outside of the facility. This failure had the potential to cause foodborne illnesses to the 131 medically vulnerable resident population who received food prepared by the facility and may potentially receive foods prepared from the outside sources. Findings: Review of the facility's P&P titled Foods Brought by Family or Visitor revised 9/2025 showed all the food brought into the facility by the family members or visitors must be checked by a representative of the food and nutrition department or a nurse to assure that the food is not in conflict with the resident's prescribed diet plan as it relates to therapeutic and texture and/or fluid modifications as ordered. The resident and/or resident representative will be informed of the policy and provide safe food handling guidance in the form Foods from Home - Tips for Family Members. Review of the facility's document titled Food from Home - Tips for Family Members (undated) showed preparing food at home included hand wash for at least 20 seconds, thaw raw meats under refrigeration or under cold running water, wash hands when leaving and returning to prep areas to prevent cross-contamination, and cook foods to a safe internal temperature with fish and whole meats at 145 degrees Fahrenheit and all other foods to 165 degrees Fahrenheit. Storing includes refrigerating the food item within an hour of arrival and all food items not consumed within 72 hours must be thrown out. Review of the CMS S&C-09-39 dated 5/29/09, showed the residents have the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices. The CMS guideline further showed the facility had the responsibility under the food safety regulation to help the visitors to understand safe food handling practices such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees Fahrenheit. Furthermore, the facility's responsibility to ensure that if they are assisting the visitors with reheating or other preparation activities, that facility staff use safe food handling practices and encourage visitors and residents who are contributing to food preparation in the facility to use these safe practices as well. On 9/26/25 at 1412 hours, an interview was conducted with RD 2. When asked if the families and visitors were educated on the safe food handling and storage of foods brought from outside sources, RD 2 stated We can't control what the families do with the food prior to bringing it in. RD 2 stated the residents' refrigerator was in a designated area in the walk-in refrigerator in the kitchen. On 9/26/25 at 1426 hours, an interview was conducted with the DON. The DON stated the families and visitors were informed food from the outside sources was for a one-time consumption and the facility informed them there were no refrigerators available to store foods brought from the outside sources. When asked about the designated area in the walk-in refrigerator where food was stored for the residents, the DON stated it has not been implemented. On 9/26/25 at 1442 hours, an interview was conducted with LVN 4. LVN 4 stated the families and visitors may bring food to the residents; however, since the facility did not have a refrigerator to store resident's food, the facility was unable to keep left over food and would have to discard. LVN 4 denied educating the families on the safe food handling and storage of the foods brought from the outside sources. LVN 4 was unable to state the safe handling temperatures of the foods. On 9/26/25 at 1534 hours, an interview was conducted with RN 2. RN 2 stated the family and visitors were advised the facility did not have a resident refrigerator for storing leftover foods. RN 2 denied discussing safe food handling and safe temperatures of foods to families and visitors. RN 2 stated it was important to educate the families and visitors of the safe food storage and handling to minimize the risk of food poisoning. On 11/18/25 at 1430 hours, an interview was conducted with the DSD. When asked if she provided a staff in-services on safe food handling and food brought from outside sources, the DSD stated she has not provided an in-service regarding safe food handling and storage from foods brought from the outside sources since she been a DSD at the facility. When asked if she has communicated (continued on next page)		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the residents' family and visitors on the safe food handling and storage of the foods brought from the outside sources, she stated she has not and stated she would inform them not to have the foods too hot. On 11/18/25 at 1525 hours, an observation and concurrent interview was conducted with Resident 48 and Family Member 1 in the hallway across from Room A. Family Member 1 stated she brought Resident 48 a hamburger and chocolate shake from the outside; however, did not check in the food with the staff. When asked if the facility had educated her about the safe food handling and storage of the foods brought from outside sources, Family Member 1 stated she was not. Family Member 1 further denied being informed of the temperature of the foods brought from the outside sources. On 11/19/25 at 1510 hours, an interview was conducted with the Administrator and DON, Nurse Consultant, Certified Dietary Manager, and Dietary Aide 1. The Administrator acknowledged the facility's document titled Foods from Home - Tips for Family Members were provided to the resident and/or responsible party; however, was not provided to the visitors. The Administrator, DON, Nurse Consultant, Certified Dietary Manager, and Dietary Aide 1 acknowledged all the above findings.		

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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 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 ensure the staff performed proper doffing in a COVID-19 positive isolation room as per the facility's COVID-19 Mitigation Plan. * The facility failed to ensure the ice scooper attached to the ice bucket in Hallway A was not exposed. * The facility failed to ensure the staff wore the proper PPE while emptying Resident 77's indwelling urinary catheter bag. * The facility failed to ensure CNA 2 donned the gown when repositioning Resident 29. Resident 29 was on EBP due to her wound. In addition, CNA 2 failed to perform hand hygiene after the removal of the gloves and before touching the lunch tray. * The facility failed to include Resident 141 in the infection surveillance when the resident was having active signs and symptoms of UTI infection which started on 9/11/25. These failures placed the residents at risk for increased risk of infection and transmissions of diseases. Findings: 1. Review of the facility's COVID-19 Mitigation Plan titled Additional Information revised 4/12/23, showed Red Zone (COVID Unit) are for residents who tested positive for COVID-19 will be placed on a designated area that are separated from the rest of the facility by distance or demarcated by some visual indicator privacy stand or other barrier to prevent entry of residents and non-red unit staff. For Red Zone (COVID Unit): COVID-19 Confirmed Cases have trash can/s placed inside the room and in hallways of the unit for staff to discard PPE if moving out of designated area. On 9/24/25 at 1140 hours, an observation and concurrent interview was conducted with CNA 9 across from Room B. An observation of Room B showed a Red Zone and a Novel Respiratory Precaution signages posted outside of the room. CNA 9 was observed coming outside from Room B without a N95 mask. CNA 9 verified Room B was on isolation for COVID-19 positive. CNA 9 stated the PPEs required for Room B included gown, gloves, N95 mask, and face shield. CNA 9 verified she was not wearing an N95 mask while exiting from Room B. CNA 9 stated she had removed her N95 mask inside the room. CNA 9 further stated she should not have removed the N95 mask since she was still inside the COVID-19 positive isolation room. On 9/24/25 at 1151 hours, an observation and concurrent interview was conducted with LVN 8 across from Room B. An observation of LVN 8 was observed coming outside of Room B without a N95 mask. LVN 8 stated the PPE for COVID-19 positive isolation room included gown, gloves, N95 mask, and a face shield. LVN 8 verified she removed her N95 mask inside the room and did not have on a N95 mask coming outside from the COVID-19 positive isolation room. On 9/24/25 at 1205 hours, an interview was conducted with the IP. When asked what the staff expectations were for removing the N95 mask in a COVID-19 positive isolation room, the IP stated for the staff's protection, they should remove the N95 mask outside the COVID-19 positive isolation room. The IP acknowledged removing the N95 mask while still inside the COVID-19 positive isolation room increased the risk for the staff to COVID-19 exposure. 2. On 9/24/25 at 1140 hours, an observation and concurrent interview was conducted with CNA 8 in Hallway A. The ice scooper attached to the ice bucket was observed not covered with the top and bottom of the ice scooper exposed. CNA 8 verified the findings and stated the ice scooper should be (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	covered to maintain infection control and minimize the exposure to bacteria. During the interview with CNA 8, multiple observations of the staff and residents were observed walking past the exposed ice scooper. 3. Review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions revised 4/2025 showed examples of high-contact resident care activities requiring gown and glove use for EBP include device care or use indwelling urinary catheter, feeding tube, and hemodialysis catheters. Medical record review for Resident 77 was initiated on 9/23/25. Resident 77 was admitted to the facility on [DATE]. Review of Resident 77's H&P examination dated 10/2/24, showed Resident 77 had fluctuating capacity to understand and make decisions. Review of Resident 77's Order Summary Report for September 2025 showed the following physician's orders: - dated 2/15/23, for Foley catheter Fr 16/10 ml to drainage bag for obstructive uropathy (medical condition where the flow of urine is blocked). - dated 4/2/24, for Enhanced Barrier Precautions due to presence of the indwelling device Foley catheter. On 9/23/25 at 1110 hours, an observation and concurrent interview was conducted with CNA 10 in Resident 77's room. An observation of outside Resident 77's room showed an EBP signage posted by the door and an isolation cart with disposable gowns and gloves, and sanitizer with the purple top outside the resident's room. Inside Resident 77's room, CNA 10 was observed emptying Resident 77's indwelling urinary catheter bag without wearing an isolation gown. CNA 10 verified the findings and stated she should have worn an isolation gown while emptying out Resident 77's indwelling urinary catheter bag to maintain infection control. On 11/19/25 at 1510 hours, an interview was conducted with the Administrator, DON, Nurse Consultant, and Certified Dietary Manager present. The Administrator, DON, Nurse Consultant, and Certified Dietary Manager acknowledged findings. 4. Review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions revised 4/2025 showed Enhanced Barrier Protection (EBP): to expand the use of PPE and refer to 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 when indirectly transferred to residents or from resident- to-resident. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: i. Dressing ii. Bathing/showering iii. Transferring iv. Providing hygiene (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	v. Changing linens vi. Changing briefs or assisting with toileting vii. Device care or use: central vascular line, indwelling urinary catheter, feeding tube, tracheostomy/ventilator viii. Wound Care: any skin opening requiring a dressing. Review of the facility's P&P titled Hand Hygiene revised 4/2025 showed to use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; m. After removing gloves; n. Before and after entering isolation precaution settings; o. Before and after eating or handling food; p. Before and after assisting a resident with meals. Medical record review for Resident 29 was initiated on 9/23/25. Resident 29 was admitted to the facility on [DATE]. Review of Resident 29's Order Summary Report dated 9/25/25, showed a physician's order dated 9/2/25, to wear the following PPE: clean, non-sterile gown and gloves, for Enhanced Barrier Precautions during direct cares due to Resident 29's wound. On 9/23/25 at 1235 hours, during the dining observation, CNA 2 was observed inside Resident 29's room. CNA 2 was observed uncovering Resident 29's blanket from her upper body, and while standing on Resident 29's right side, CNA 2 was observed reaching over Resident 29 to pull Resident 29's draw sheet from under the resident's left side. CNA 2 was not observed wearing a gown and CNA 2's clothes were observed coming in contact with Resident 29. CNA 2 was then observed repositioning Resident 29's lower legs and repositioned both legs over a pillow. On 9/23/25 at 1239 hours, an observation and concurrent interview was conducted with CNA 2. CNA 2 was observed removing her gloves, exiting Resident 29's room, and grabbing a lunch tray from the cart in the hallway. CNA 2 was not observed performing hand hygiene after the removal of the gloves, after exiting Resident 29's room, and before touching another resident's lunch tray. CNA 2 was interviewed and stated Resident 29 was on EBP due to her sacral wound. CNA 2 stated the EBP sign outside of Resident 29's room notified the staff of when EBP should be followed. CNA 2 stated for a resident on EBP, the gown and gloves should be worn when making contact with the resident and when repositioning or touching the resident's body. CNA 2 verified the above findings and stated she should have worn a gown and performed hand hygiene upon removal of her gloves. On 10/1/25 at 0955 hours, an interview was conducted with he IP. The IP stated for the residents on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EBP, the staff was expected to don the proper PPE- which consisted of the gown and gloves when in the residents room to reposition the resident or for any direct contact with the resident. The IP stated after providing the care to the resident and upon leaving the resident's room, staff were expected to remove the PPEs and perform hand hygiene with soap and water or antibacterial hand gel. On 11/19/25 at 1430 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. 5. Review of the facility's P&P titled Infection Control revised 10/2022 showed it is the policy of this facility to maintain an ongoing system of surveillance designed to identify possible communicable diseases or infections to ensure that measures are taken to prevent any potential outbreak. The Procedure section showed the following: - Assessment and Identification of actual/potential infection/communicable disease: a. During the initial assessment, the physician or provider will help identify individuals who have had a recent infection or who are at risk of developing an infection; and b. Infection may be suspected based on clinical signs and symptoms, and may include, but are not limited to: if culture obtained for any reason and positive culture report. - Infection Control Surveillance Log is maintained by IP. The charge nurses will be responsible for recording the requested information of all residents displaying any of the above symptoms on the log. On 9/23/25 at 0933 hours, during the initial tour of the facility, Resident 141 was observed awake in her room. Resident 141 stated she had UTI (urinary tract infection) and the facility had not done anything about her UTI. Resident 141 stated it burned when she urinated and her urine smelled bad. Resident 141 stated she had a urine sample test last week and had been begging the facility to find out the results. Resident 141 further stated the resident's family member asked the facility staff yesterday and he was told the facility was still waiting for the physician to call about the results. Medical record review for Resident 141 was initiated on 9/23/25. Resident 141 was admitted to the facility on [DATE]. Review of Resident 141's H&P examination dated 7/13/25, showed Resident 141 had the capacity to understand and make decisions. Review of Resident 141's SBAR Communication Form dated 9/11/25 at 1230 hours, showed Resident 141 verbalized she had dysuria, increased in urination, and burning sensation when voiding. Physician 1 was notified and recommended to test the resident's urine for UA with culture and sensitivity. Review of the Progress Notes showed the following: - dated 9/16/25 at 1644 hours, Physician 1 was reformed regarding Resident 141's urinalysis with culture and sensitivity laboratory result which showed multiple organisms present in the urine and possible contamination, awaiting response from Physician 1. The note also showed Resident 141 was still complaining of burning sensations and dysuria and increased in frequency urination; and (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Alamitos West Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3902 Katella Avenue Los Alamitos, CA 90720	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 9/18/25 at 1209 hours, Physician 1 saw Resident 1 in the facility, saw the result of the urine test which was done on 9/12/25, and ordered to recollect urine for UA with culture and sensitivity test. Physician 1 also ordered to change Resident 141's cranberry supplement to twice daily. On 9/26/25 at 1404 hours, an interview and concurrent medical record review for Resident 141 was conducted with LVN 6. LVN 6 stated she was familiar with Resident 141. LVN 6 verified Resident 141 had complained of burning sensation and feeling of urgency to urinate which started on 9/11/25. On 9/26/25 at 1430 hours, an interview and concurrent medical record review for Resident 141 was conducted with the IP. The IP stated Resident 141 did not have any current documented signs and symptoms of infection. The IP stated she was not aware Resident 141 had any signs and symptoms of urinary infection. The IP stated Resident 141's last change of condition was on 9/11/25, and the urinary test showed it was contaminated at that time. The IP stated she was not aware of Resident 141's contaminated urinary result until 9/18/25, and Physician 1 ordered to recollect urine sample to repeat the UA with culture and sensitivity test. The IP stated there was no change or report to her afterwards that Resident 141 still had dysuria. The IP verified she was not monitoring Resident 141, and the resident was not on her infection surveillance record. On 11/19/25 at 1530 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.		

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F 0557 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **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 ensure one of three final sampled residents (Resident 85) reviewed for urinary catheter care received the necessary care and services. The facility failed to provide a dignity bag to cover Resident 85's urinary catheter drainage bag. This failure had the potential to compromise Resident 85's rights to be treated with respect and dignity. Findings: Review of the facility's P&P titled Catheter Care, Indwelling (undated) showed it is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and PRN for soiling. Review of the procedures for catheter care showed to keep the tubing below the level of the bladder and cover the drainage bag with the privacy bag. Medical record review for Resident 85 was initiated on 9/23/25. Resident 85 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 85's H&P examination dated 10/4/24, showed Resident 85 had fluctuating capacity to understand and make decisions. Review of Resident 85's MDS assessment dated [DATE], showed Resident 85 had severely impaired cognition and was coded for the diagnosis of neurogenic bladder (a condition of nerve damage to the brain, spinal cord, or peripheral nerves, resulting in a loss of bladder control) and the use of the indwelling urinary catheter (a thin, hollow tube inserted into the bladder to continuously drain urine into a collection bag). Review of Resident 85's Order Summary Report dated 11/18/25, showed a physician's order dated 9/12/25, for the Foley catheter size 16 Fr/10 ml to bedside drainage bag due to neurogenic bladder. On 9/25/25 at 0859 hours, an observation was conducted inside of Resident 85's room. CNA 1 was observed exiting the room with Resident 85's breakfast tray. Resident 85 was observed in bed and Resident 85's urinary drainage bag was observed with cloudy yellow drainage and hanging on the right side of Resident 85's bed. The urinary drainage bag was not observed inside a privacy bag. On 9/25/25 at 0913 hours, CNA 1 was observed reentering Resident 85's room with toast, butter, and jelly for Resident 85. CNA 1 was observed assisting Resident 85 with her meal set up. On 9/25/25 at 0921 hours, an interview and concurrent observation of Resident 85 was conducted with CNA 1. CNA 1 stated Resident 85 had a urinary catheter and the urinary collection bag should be placed inside of a special bag to provide the resident with privacy and dignity. CNA 1 verified the above findings. On 9/25/25 at 1116 hours, an observation was conducted of Resident 85. Resident 85 was observed lying in bed with a facility staff at Resident 85's bedside providing nail care to Resident 85. Resident 85's urinary drainage bag was observed hanging on the right side of Resident 85's bed and the urinary drainage bag was not observed inside of the privacy bag. On 9/25/25 at 1117 hours, an interview and concurrent observation was conducted with the Case Manager. The Case Manager verified the above findings and stated the urinary drainage bag should be covered to provide the residents with privacy and dignity. The Case Manager was observed entering Resident 85's room and placing the urinary collection bag inside the privacy bag. On 11/19/25 at 1430 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.		

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F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **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 P&P were followed for one of eight final sampled residents (Resident 41) reviewed for advance directives. * The facility failed to obtain and maintain copies of the advance directive in the medical records for Resident 41. This failure had the potential to not provide the care and life sustaining measures in accordance with the resident's treatment wishes. Findings: Review of the facility's P&P titled Advance Directives and Associated Documentation revised 4/2025 showed to obtain a copy of the Advance Directive and conservatorship/guardianship documents and place in the resident's health record. Medical record review for Resident 41 was initiated on 9/23/25. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's H&P examination dated 8/20/25, showed Resident 41 had fluctuating capacity to understand and make decisions. Review of Resident 41's MDS assessment dated [DATE], showed Resident 41 had severely impaired cognition. Review of section S of the MDS assessment showed do not attempt resuscitation (DNR) was selected on Resident 41's POLST. Further review of the MDS showed Resident 41 was coded for no Advanced Directive. Review of Resident 41's Advance Directive Acknowledgement form signed and dated on 8/22/25, showed Resident 41's responsible party selected I/We have Advanced Healthcare Directives, I/we understand that the terms of any Advanced Directive that I have executed will be followed by the health care facility and my care givers or the extent permitted by law. The section for the Advance Directive type and date the Advance Directive was received was left blank. Review of Resident 41's Social Services Assessment/Evaluation dated 8/25/25, showed the documentation the facility selected No Advance Directives for Resident 41. Further review of the assessment showed under additional information, the facility documented POLST was DNR, selective treatment, no tube feeding, no AHCD. Resident not interested in formulating one. Trust at home, daughter will review to make sure POLST matches. Review of Resident 41's medical record failed to show a copy of Resident 41's Advance Directive and failed to show the documentation the facility attempted to obtain a copy of Resident 41's Advance Directive. On 9/26/25 at 0814 hours, an interview and concurrent medical record review for Resident 41 was conducted with the Social Services Director. The Social Services Director stated upon admission to the facility, the Advanced Directive Acknowledgement form would be completed by the Social Service staff to identify whether the resident had an Advance Directive. The Social Service Director stated if the resident had an Advance Directive, the Social Service Staff would attempt to obtain a copy and document the attempts and follow-ups in the resident's progress notes. The Social Service Director reviewed Resident 41's medical record and verified the above findings. Review of Resident 41's Progress Notes showed a Social Service Note dated 9/26/25 at 0844 hours, showed the documentation the Social Service was requesting a copy of the living will/trust from Resident 41's family member. The note documented Resident 41's responsible party has not provided a copy yet since admission. On 11/19/25 at 1015 hours, an interview was conducted with the DON. The DON stated upon admission to the facility, every resident would be asked if they have an Advance Directive. The DON stated if they had an Advance Directive, the Social Services staff would follow up to obtain a copy of the Advance Directive and would document the attempts to obtain the copy. The DON stated a copy of the resident's Advance Directive should be obtained as soon as possible so that in the event of an emergency and the resident no longer had the capacity, the facility would ensure the residents' wishes were being honored. On 11/19/25 at 1430 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.		

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the MDS assessment was completed accurately for one of 27 final sampled residents (Resident 3). * The facility failed to accurately code Resident 3's history of fall in the MDS assessment dated [DATE], when Resident 3 had a fall on 7/21/25. This failure posed the risk of Resident 3 not receiving the individualized plan of care based on the resident's specific needs. Findings: Medical record review for Resident 3 was initiated on 9/23/25. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's H&P examination dated 6/26/25, showed Resident 3 had no capacity to make decisions. Review of Resident 3's Post-Event IDT Review dated 7/22/25, showed a documentation on 7/21/25, Resident 3 was found on the floor in her room, on her stomach and left side. Resident 3 was taken to the emergency room shortly thereafter. Review of Resident 3's MDS assessment dated [DATE], for Resident 3's re-entry from the short-term acute care hospital on 7/25/25, showed the facility coded Resident 3 for no falls in the last month prior to the admission/entry or re-entry (readmitted) to the facility. On 10/1/25 at 0850 hours, an interview and concurrent medical record review for Resident 3 was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings and stated Resident 3 should have been coded for a fall in the last month prior to her re-entry to the facility. On 11/19/25 at 1015 hours, an interview was conducted with the DON. The DON stated the MDS assessments provided guidance to the facility for the specific care to provide to each resident and should be accurately coded. On 11/19/25 at 1430 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.		

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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 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **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 PASRR (Preadmission Screening and Resident Review) screening was accurately completed and updated for one of two final sampled residents (Resident 4) reviewed for PASRR. * Resident 4's PASRR Level 1 screening completed by the acute care hospital prior to the admission to the facility showing inaccurate information was not updated to include serious mental illness diagnosis and the use of psychotropic (drugs that affect the mind, emotions, and behavior, used to treat various mental health conditions). This failure had the potential of not providing the resident to be screened for mental illness or intellectual disabilities with additional resources if needed. Findings: Review of the facility's P&P titled Resident Assessment - PASRR revised 7/2022 showed a PASRR shall be completed on every resident upon admission. Upon admission of a resident to the facility, Admissions or licensed nursing personnel will complete the Level 1 PASRR. Based upon the assessment, the facility will ensure proper referral to appropriate state agencies for the provision of specialized services to residents with ID/RC (Intellectual Disability or Related Condition) or SMI (Serious Mental Illness). Medical record review for Resident 4 was initiated on 9/23/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's Preadmission Screening and Resident Review (PASRR) Level I Screening dated 5/27/25, showed Section III - Serious Mental Illness if the resident was on psychotropic medications, suspected of mental illness, or diagnosed with a serious mental illness such as psychosis (a mental state characterized by a loss of contact with reality) and mood disturbance was marked No. Review of Resident 4's Order Summary Report for June 2025 showed a physician's order dated 6/8/25, for Seroquel (antipsychotic medication) 50 mg by mouth every six hours as needed for psychosis. Review of Resident 4's H&P examination dated 9/3/25, showed Resident 4 had the capacity to understand and make decisions. Review of Resident 4's Facesheet - Diagnosis Information dated 9/30/25, showed Resident 4 had a diagnosis of unspecified psychosis with the onset date of 5/31/25. On 9/26/25 at 0953 hours, an interview and concurrent medical record review for Resident 4 was conducted with the ADON. The ADON verified the above findings. The ADON stated the acute care hospital completed the PASARR; however, if there were discrepancies in the information, then the facility would update and complete the PASRR for the resident upon admission. The ADON stated Section III of Resident 4's PASRR Level I Screening dated 5/27/25, should have been marked, Yes. The ADON further stated the facility should have done a reassessment and submitted another PASRR with accurate and updated information. On 11/19/25 at 1510 hours, an interview was conducted with the Administrator, DON, Nurse Consultant and Certified Dietary Manager. The Administrator, DON, Nurse Consultant, and Certified Dietary Manager acknowledged the findings.		

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F 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and P&P review, the facility failed to provide the necessary care and services for one of one final sampled resident (Resident 148) reviewed for oxygen and nebulizer (a machine which turns liquid medication into a fine, inhalable mist that is delivered directly to the lungs, which provides fast relief for respiratory symptoms like wheezing, shortness of breath, and coughing) use. * The facility failed to ensure the the oxygen tubing and nebulizer equipment were dated for Resident 148. This failure placed the resident at risk for the untimely replacement of the respiratory equipment which may lead to increased risk for infection or compromised respiratory care. Findings: 1. Medical record review for Resident 148 was initiated on 9/25/25. Resident 148 was admitted to the facility on [DATE]. Review of the Facility's P&P titled Respiratory Policy and Procedure dated 5/2021 showed the oxygen cannula or mask will be changed at least every 7 days, as well as the disposable humidifier. Tubing, masks, humidifiers and other disposables used for oxygen administration will be dated in an identifiable fashion. Review of Resident 148's Order Summary dated 9/30/25, showed a physician's order dated 9/17/25 to:Administer continuous oxygen at 2 liters per minute via nasal cannula to maintain oxygen saturation above 90%, every shift; andAdminister Ipratropium-Albuterol Solution (medication to treat and prevent symptoms caused by ongoing lung disease, such as wheezing and shortness of breath) 0.5-2.5 (3)mg/3 ml, 3 ml to be inhaled orally every 6 hours for bilateral pleural effusion (a buildup of excess fluid in between the lungs and the chest cavity). On 9/23/25 at 0800 hours, an observation for Resident 148 was conducted. Resident 148 was observed receiving oxygen at 2 liters per minute via nasal cannula. The oxygen tubing and nebulizer were not dated or labeled. On 9/23/25 at 1000 hours, an interview and concurrent observation for Resident 148 was conducted with the Central Supply staff. The Central Supply staff confirmed the oxygen tubing and nebulizer were not dated or labeled. The Central Supply staff stated the tubing and nebulizer were typically changed and labeled weekly. The Central Supply staff acknowledged and verified the findings.		

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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 for one of 27 final sampled residents (Resident 60) was accurate. * CNA 4 failed to ensure Resident 60's turning/repositioning record was documented accurately. This failure had the potential for the resident's care needs not being met as their medical information was inaccurate. Findings: Review of the facility's P&P titled Nursing Clinical Section: Documentation revised 5/2007 showed the resident's clinical record is a concise and accurate account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. It is also necessary to include data needed for identification and communication with family and friends. Complete history of resident and present illness is required under current law and regulations at the time of admission. Medical record review for Resident 60 was initiated on 9/29/25. Resident 60 was admitted to the facility on [DATE]. Review of Resident 60's H&P examination dated 8/20/25, showed Resident 60 had the capacity to understand and make decisions. Review of Resident 60's CNA column for the tasks for turning/repositioning showed the N/A was marked on the following dates and times:- 9/18/25 at 1429 hours;- 9/22/25 at 1254 hours;- 9/24/25 at 1242 hours;- 9/27/25 at 1058 hours; and- 9/28/25 at 1411 hours. On 9/29/25 at 1431 hours, an interview and concurrent medical record review was conducted with CNA 4. When asked about the process of documenting in the residents' records and when the N/A column would be appropriate to mark for the turning and repositioning, CNA 4 stated she used the N/A column if Resident 60 refused care, or if he did not feel like being turned or repositioned at that time. CNA 4 stated she also used the N/A column when Resident 60 verbalized to CNA 4 he preferred the 2nd shift (3pm-11pm) nurses to reposition him to his right side. On 9/30/25 at 1425 hours, an interview was conducted with the DON. The DON stated the N/A column in the CNA tasks for turning/repositioning should be used if the resident was not in their room, bed, or if the resident was out of the facility and was at an appointment. The DON stated if there was a column for resident refused that was where the nurses should document about the resident's refusal for the care. The DON further stated the CNA should also make the charge nurse aware of the refusal. The DON verified the above findings.		

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility document review, the facility failed to ensure the Arbitration Agreement was explained in a form, manner, and language the residents or their representative understood for two of three residents (one final sampled resident (Resident 11) and one nonsampled resident (Resident 122) reviewed for the Arbitration Agreements. * The facility allowed Residents 11 and 122 who had no capacity to understand and make medical decisions, to enter and sign the Arbitration Agreement. This failure posed the risk for the residents to not have a clear understanding of the arbitration process they signed. Findings: 1. Medical record review for Resident 11 was initiated on 9/24/25. Resident 11 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 11's H&P examination dated 2/17/25, showed the resident had no capacity to understand and make decisions. Review of Resident 11's Arbitration Agreement dated 6/4/25, showed the form was signed by Resident 11. The agreement showed by signing the agreement, the resident was giving up the right to dispute allegations of medical malpractice in the court of law, and must use arbitration (where disputing parties used a third party to make a final decision about their dispute). The agreement also showed it was binding for all the parties including the resident, their heirs, representative, executors, family members, successors, and administrators. Review of Resident 11's MDS assessment dated [DATE], showed Resident 11 had a BIMS score of 99, which meant the resident was unable to complete the interview. On 9/26/25 at 1425 hours, an interview and concurrent medical record review for Resident 11 was conducted with the Admissions Coordinator. When asked about the arbitration process for the residents who had fluctuating or no capacity to understand and make decisions, the Admissions Coordinator stated they communicated with the resident's Power of Attorney (POA) if they had one. The Admissions Coordinator stated if there was no POA, they will then have communicated with the resident's Responsible Party. The Admissions Coordinator further stated once they determined who was responsible for the resident, they asked the Responsible Party if they wanted to enter into the Arbitration Agreement. The Admissions Coordinator stated the residents who did not have the capacity to understand or make decisions should not be able to sign, since they did had no capacity. The Admissions Coordinator reviewed the Arbitration Agreement signed by Resident 11 and verified the resident should not have been able to sign the Arbitration Agreement. 2. Medical record review for Resident 122 was initiated on 9/26/25. Resident 122 was admitted to the facility on [DATE]. Review of Resident 122's Arbitration Agreement dated 5/14/25, showed the form was signed by Resident 122. The agreement showed by signing the agreement, the resident was giving up the right to dispute allegations of medical malpractice in the court of law, and must use arbitration (where disputing parties use a third party to make a final decision about their dispute). The agreement also showed it was binding for all the parties including the resident, their heirs, representative, executors, family members, successors, and administrators. Review of Resident 122's H&P examination dated 5/16/25, showed the resident had no capacity to make decisions. On 9/26/25 at 1425 hours, an interview and concurrent medical record review for Resident 122 was conducted with the Admissions Coordinator. When asked about the arbitration process for the residents who had fluctuating or no capacity to understand and make decisions, the Admissions Coordinator stated they communicated with the resident's Power of Attorney (POA) if they had one. The Admissions Coordinator stated if there was no POA, they will then have communicated with the resident's Responsible Party. The Admissions Coordinator further stated, once they determined who was responsible for the resident, they asked the Responsible Party if they wanted to enter into the Arbitration Agreement. The Admissions Coordinator stated the residents who did not have the capacity to understand or make decisions should not be able to sign, since they did not have capacity. The Admissions Coordinator reviewed the Arbitration Agreement (continued on next page)		

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056169	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Alamitos West Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0847 Level of Harm - Potential for minimal harm Residents Affected - Some	signed by Resident 122 and verified the resident should not have been able to sign the Arbitration Agreement.		