STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055760	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alhambra Healthcare & Wellness Centre, LP	415 South Garfield Alhambra, CA 91801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152 Based on interview and record review, the facility failed to notify the doctor for one of one sampled resident (Resident 1), of Resident 1's change in condition of a decreased oxygen saturation (the amount of oxygen carried by red blood cells) of 78% (a normal level is between 95% and 100%) once identified as indicated in facility's policy and procedure. This failure had the potential to result in delayed treatment and provision of services for Resident 1, negatively affecting the resident's health and well-being. Findings: A review of Resident 1's Admission Record, indicated Resident 1 was initially admitted at the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that include pneumonia (PNA- inflammation of the lungs due to a bacterial or viral infection, acute respiratory failure(a sudden condition in which not enough oxygen passes from the lungs into the blood), moderate persistent asthma (a respiratory disorder characterized by inflamed airways and difficulty breathing), and congestive heart failure (CHF - a chronic condition in which a weakness of the heart leads to a buildup of fluid in the lungs). A review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment care screening tool) dated [DATE], indicated Resident 1 with a moderately impaired ability to think, remember, and reason. The MDs also indicated Resident 1 needs supervision or touching assistance (assistance of verbal cues or touching/steadying) with eating, oral hygiene, and moderate assistance (staff does less than half of the effort) with toileting and showering. A review of Resident 1's PNA, Respiratory Failure care plan (a document that outlines the facility's plan to provide personalized care to a resident) dated [DATE], indicated staff are to monitor vital signs every shift and notify doctor of significant abnormalities. A review of Resident 1's Incentive Spirometer (a handheld medical device used to help improve lung function by training patients to take slow and deep breaths) care plan dated [DATE], indicated staff are to notify doctor of significant changes in condition. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:23 AM with Licensed Vocational Nurse (LVN), LVN stated on [DATE] around 9:30 AM, she went to check on Resident 1 and Resident 1's was short of breath with uneven breathing and her oxygen saturation was ,d+[DATE]%. During an interview on [DATE] at 12:45 PM with the Director of Nursing (DON), the DON stated, on [DATE] around 9:50 AM, LVN informed the DON regarding Resident 1's low oxygen saturation around 9:50 AM. The DON stated they went to check Resident 1 and the resident was awake, on oxygen therapy (helps people with lung diseases or breathing problems get the oxygen their bodies need to function) at the time before suddenly passing out. During a concurrent interview and record review on [DATE] at 2:39 PM with LVN, Resident 1's documented vital sign (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions) dated [DATE] were reviewed. The vital signs indicated at 9:53 AM Resident 1's O2 saturation was 78%. LVN stated the vital signs were taken around 9:30 AM, but she was unable to enter them into Resident 1's chart until 9:53 AM and she did not notify the doctor regarding Resident 1's oxygen saturation level at 78%. During a concurrent interview and record review on [DATE] at 5:52 PM with the DON, Resident 1's medical chart dated [DATE] was reviewed. The medical chart did not indicate any communication and notification to the doctor regarding Resident 1's O2 saturation of 78%, with the only doctor notification documented at 10:41 AM by the DON. The DON stated he reported to Resident 1's doctor's after when Resident 1 was found unresponsive and expired in the facility. During an interview with on [DATE] at 10:34 AM with Medical Doctor (MD), MD stated the DON called him and informed him that Resident 1 was coughing, then went into cardiac arrest (when the heart stops beating suddenly), where cardiopulmonary resuscitation (CPR, involves giving strong, rapid pushes to the chest to keep blood moving through the body. Usually, it also involves blowing air into the person's mouth to help with breathing and send oxygen to the lungs) was started and then Resident 1 expired. MD stated no staff informed him that Resident 1 had any respiratory distress or had a decreased O2 saturation of 78% and was only informed of her condition after the resident died . MD also stated, facility staff should have called him when Resident 1 had change of condition and/ or respiratory distress so he can order the appropriate treatment for the resident. During a review of the facility's policy and procedure (P&P) titled, Change of Condition Notification revised [DATE], the P&P indicated facility is to ensure physicians are informed of changes in the resident's condition in a timely manner and facility will promptly inform the resident's Attending Physician when the resident endures a significant change in their condition. The P&P also indicates a change of condition related to attending Physician notification is defined as when the attending physician must be notified when any sudden and marked adverse change in the resident's condition which is manifested by signs and symptoms different than usual denote a new problem, complication or permanent change in status and require a medical assessment, coordination and consultation with the attending physician and a change in the treatment plan. Lastly the P&P indicates facility will notify the attending physician STAT in emergency situations (including shortness of breath).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48152 Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 1), had an active doctor's order for oxygen (O2) therapy (helps people with lung diseases or breathing problems get the oxygen their bodies need to function) administration and an indication (the condition that leads to the requirement of a treatment) for oxygen use, before and during oxygen administration. This failure placed resident at risk for inadequate oxygen with the potential to negatively impact Resident 1's health and well-being. Findings: A review of Resident 1's Admission Record, indicated Resident 1 was initially admitted at the facility on 1/14/2024 and readmitted to the facility on [DATE] with diagnoses that include pneumonia (PNA- inflammation of the lungs due to a bacterial or viral infection, acute respiratory failure(a sudden condition in which not enough oxygen passes from the lungs into the blood), moderate persistent asthma (a respiratory disorder characterized by inflamed airways and difficulty breathing), and congestive heart failure (CHF - a chronic condition in which a weakness of the heart leads to a buildup of fluid in the lungs). A review of Resident 1's Minimum Data Set (MDS - a standardized resident assessment care screening tool) dated 4/2/2024, indicated Resident 1 with a moderately impaired ability to think, remember, and reason. The MDs also indicated Resident 1 needs supervision or touching assistance (assistance of verbal cues or touching/steadying) with eating, oral hygiene and moderate assistance (staff does less than half of the effort) with toileting and showering. A review of Resident 1's Medication Administration Records for the month of March 2023 and April 2023, indicated oxygen 2 liters per minute (LPM) was given to Resident 1 on 3/26/2024, 3/27/2024 and 3/29/2024 through 4/3/2024. A review of Resident 1's Order Summary dated 4/4/2024, it did not indicate an active physician's order for oxygen administration of 2 LPM from 3/26/2024 until 4/4/2023. A review of Resident 1's PNA, Respiratory Failure care plan (a document that outlines the facility's plan to provide personalized care to a resident) dated 3/26/2024, indicated licensed staff are to administer oxygen as ordered. During an interview on 4/5/2024 at 12:18 PM with Certified Nurse Assistant (CNA), CNA stated she was regularly assigned to Resident 1 and was familiar with the resident's care. CNA stated Resident 1 was on oxygen all the time through nasal cannula (NC- a device that delivers extra oxygen through a tube and into your nose). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/5/2024 at 2:39 PM with Licensed Vocational Nurse (LVN), Resident 1's electronic medical chart dated 4/3/2024 to 4/4/2024 was reviewed. The chart indicated under oxygen (O2) saturation trends, LVN charted Resident 1 receiving oxygen via NC on 4/3/2024 and 4/4/2024. LVN stated when she administered and charted oxygen via NC to Resident 1, she assumed there was an active physician's order after observing Resident 1 receiving oxygen. LVN stated it is important to inform the doctor and have a physician order for the oxygen therapy, because that is the facility protocol, and the doctor will know what is best for the resident. LVN also stated if oxygen is given to the resident without an order, it can be given incorrectly and resident can have difficulty breathing, shortness of breath or altered level of consciousness. During a concurrent interview and record review on 4/5/2024 at 5:52 PM with the Director of Nursing (DON), Resident 1's electronic medical chart dated from 3/26/2024 to 4/4/2024 was reviewed. The electronic medical chart indicated under the O2 saturation trends, oxygen therapy was given via NC to Resident 1 on 3/26/2024, 3/27/2024 and 3/29/2024 through 4/4/2024 during various times of the day. The DON stated giving Resident 1 oxygen, without the physician's order is a main problem because there is no doctor's order that nurses can follow to ensure consistent oxygen administration. The DON also stated it can cause harm of respiratory distress (difficulty breathing) and lead up to death for Resident 1. During an interview on 4/8/2024 at 10:34 AM with Medical Doctor (MD), MD stated he was Resident 1's primary doctor and did not order oxygen administration for Resident 1, nor was he aware Resident 1 was receiving any oxygen therapy, including the amount being given at 2 LPM. MD stated staff cannot give oxygen without his knowledge or physician's order. The MD also stated if the staff continuously give oxygen to Resident 1 without a physician's order nor notifying the MD about changed in resident's condition such as respiratory distress, the resident is at risk for getting inappropriate oxygen therapy and may lead to worsening of the resident's condition. A review of the facility's policy and procedure (P&P) titled Oxygen Therapy revised 11/2017, indicated oxygen is administered under safe conditions, licensed nursing staff will administer oxygen as prescribed by the doctor.