

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055760	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Alhambra Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a bed rail (side rails - metal or plastic bars attached to the sides of a bed to help prevent falls, provide support and assist patients with moving or getting out of bed) assessment was completed to assess for risk for entrapment (an event in which a resident is caught, trapped, or entangled in the space in or about) for three (3) of 3 sampled Residents (Residents 7, 59 and 104) reviewed for accidents as indicated on the facility policy and procedure (P&P). This failure had the potential to result in the inappropriate use of bed rails for Residents 7, 59 and 104, which could pose a safety risk and result in injury or harm. Findings: 1. During a review of Resident 7's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of unspecified sequelae (the aftereffects, complications or secondary conditions that follow a prior disease, injury or trauma) of cerebral infarction (also known as ischemic stroke &ndash; brain tissue damage and death caused by a sudden loss of blood supply and oxygen) and generalized muscle weakness (widespread loss of physical strength affecting the entire body, making everyday tasks such as standing, lifting, or moving require extra effort). During a review of Resident 7'S Minimum Data Set (MDS &ndash; a resident assessment tool), dated 5/12/2026, the MDS indicated the resident had severe impairment (difficulty with or unable to make decisions, learn, remember things) with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 7 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for resident to complete the activity) with tub/shower transfers (the ability to get in and out of a tub/shower), putting on/taking off footwear and lower body dressing (the ability to dress and undress below the waist). MDS indicated Resident 7 needed substantial/maximal assistance (helper does more than half the effort) with chair/bed-to-chair transfers, rolling left and right in bed, going from lying down to sitting on the side of the bed, upper body dressing (the ability to dress and undress above the waist) and personal hygiene. The MDS also indicated Resident 7 needed partial/moderate assistance (helper does less than half the effort) with eating. During a review of Resident 7's Care Plan, dated 6/11/2026, the Care Plan indicated Resident 7 had a potential for injury (e.g. [for example] bruises, skin tears, entrapment) related to the use of bilateral 1/3 bed rails used as an enabler when in bed to assist with ADLs (activities of daily living &ndash; the fundamental self-care tasks required for basic survival and independent functioning, including bathing, dressing and eating), (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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON stated because every resident is unique, if the resident needs to use a bed rail, they need to identify the resident's mobility, cognitive status and medical condition and explain the risks and benefits since the use of a bed rail has a risk for entrapment. The DON also stated if no bed rail assessment is done, the risk for entrapment could lead to major injury or fracture in the case the resident gets trapped in the bed rail if they are agitated or moving abruptly. The DON further stated it is important to have a care plan for the use of bed rails because they need to make sure it is individualized and resident centered so that they can promote safety and provide quality care for the residents according to their individualized needs. 3. During a review of Resident 59's admission Record, the admission Record indicated Resident 59 was admitted to the facility on [DATE] with history of falling and bone density disorder (the bones are losing their strength and minerals, making them thin, fragile, and easily breaks). During a review of Resident 59's MDS, dated [DATE], the MDS indicated Resident 59 had moderate impairment in cognitive skills for daily decision making. The MDS also indicated Resident 59 required setup assistance (helper sets up; resident completes activity) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 59 was independent (resident completes the activity by themselves with no assistance from helper) with eating, upper body dressing, oral and personal hygiene. During an observation on 7/22/2026 at 9:10 AM, Resident 59 was in bed sleeping with both 1/3 padded bed rails up. During a concurrent interview and record review on 7/22/2026 at 3:51 PM with the MDS Nurse, Resident 59's Medical Records were reviewed. The MDSN stated Resident 59 had a physician's order for the 1/3 bed rail on 7/7/2026 readmission but did not have a nursing bed rail evaluation prior to installing the bed rail. During a concurrent interview and record review on 7/23/2026 at 2:55 PM with RN 1, Resident 59's nursing bed rail evaluation was reviewed. RN 1 stated Resident 59 did not have nursing bed rail evaluation completed upon the 7/7/2026 readmission and, therefore, was not evaluated for risk for entrapment upon readmission. RN 1 stated a nursing bed rail evaluation was necessary to ensure the bed rails were appropriate for Resident 59 and to assess the resident's risk of entrapment. RN 1 further stated the admitting nurses should conduct bedrail screening and evaluation during admission and each readmission. During an interview on 7/23/2026 at 3:33 PM, the Maintenance Services Director (MSD) stated a resident should have a bedrail evaluation completed by the nurses before he is informed to install a bed rail, to ensure the bed rail is appropriate for the resident. The MSD also stated the nursing bedrail evaluation was done to prevent injuries such as bed entrapment. During a review of the facility's Policy and Procedure (P&P) titled, Bed Rail Screening and Implementation, dated 4/22/2026, the P&P indicated that the facility was to evaluate risks, benefits, and the need for bed rail use prior to installation. The P&P also indicated that the bed rail evaluation will be completed by the licensed nurse in collaboration with the Inter Disciplinary Team (IDT, (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprised of team members from different disciplines working together, with a common purpose, to set goals, make decisions, and share resources and responsibilities), prior to the use and/or installation of any bed rail upon: 1. Admission 2. Readmission 3. Change in bed or mattress, or 4. Following any significant change of condition, including mobility, cognition behavior, and medical status.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with the facility's policy and procedure titled Food Storage and Handling by failing to ensure:1. The chopped lettuce salad in a small styrofoam container was prepared fresh on the same day and labeled with the resident's name.2. Dietary staff washed her hands prior to touching clean food containers and plate covers after touching the floor. 3. A tray with three (3) small cups of watermelon and 3 cups of Jell-O pudding with strawberry sauce inside walk-in refrigerator was labeled with its preparation date. These deficient practices have the potential to result in foodborne illness (illness that comes from eating contaminated food) in a population of 79 residents who consume the food prepared by the facility every day. Findings:During a kitchen tour on 7/21/2026 at 7:47 AM with the Assistant Dietary Services Supervisor (ADSS) a small styrofoam container with chopped lettuce salad inside dated 7/20/2026 was observed inside the walk-in refrigerator. ADSS stated it could have been for 1 of the residents but was not labeled with the resident's name. During another interview with the ADSS on 7/21/2026 at 8:44 AM, the ADSS stated vegetable salads should be prepared fresh on same day to ensure they are still crisp and palatable for the resident. During dinnerware sanitization and storage observation on 7/23/2026 at 9:04 AM, the Dietary Aid (DA) stooped down and touched the floor with the rubber mats to check the low temperature dishwasher gauge, took a fresh chlorine test strip (a small piece of chemical paper used to measure the amount of chlorine bleach in the water during a commercial low-temperature wash cycle), opened the dishwasher cover and removed the clean food covers to check the Parts Per Million (PPM, concentration of chemical sanitizer) then touched the clear plastic food container sitting on the clean cart to dry without washing her (DA) hands. During an interview on 7/23/2026 at 9:10 AM the ADSS stated she should have washed her hands after touching the floor and before touching clean food covers and the plastic food container to prevent potential spread of infection because staff walk all over the floor and there could be all kinds of bacteria on them. During an interview on 7/23/2026 at 9:16 AM, Dietary Service Supervisor (DSS) stated the clear plastic containers are used to store cut vegetables. DSS also stated the DA should have washed her (DA) hands after she touched the floor and before touching anything that has been washed to prevent contaminating the clean food containers. During another kitchen observation with the DSS on 7/23/2026 at 12:19 PM, a tray with three (3) small cups of chopped pieces of watermelon covered with a plastic wrap and 3 covered cups of Jell-O pudding with strawberry sauce inside the walk-in refrigerator was not labeled with a preparation date. DSS stated the tray with 3 small cups of watermelon and 3 cups of Jell-O pudding with strawberry sauce inside the walk-in refrigerator should be labeled with the date when they were prepared so the kitchen staff would know when they were made and when to toss them away before they go bad to prevent food borne illness to the residents. During a review of the facility's Policy and Procedure (P&P) titled, Food Storage and Handling, revised 2/29/2024, the P&P indicated, food items will be stored, thawed, and prepared in accordance with standard sanitary practices and that all items will be correctly labeled and dated including fresh fruits and vegetables to avoid foodborne illnesses. During a review of the facility's P&P titled, Infection Control, revised 2/29/2024, the P&P indicated that dietary employees would follow infection control policies and procedures as established and approved by the facility's infection control committee. The P&P also indicated its purpose was to ensure that the dietary department is maintained in a sanitary condition to prevent food contamination and the growth of disease producing organism and toxins (natural or man-made harmful substances that could make someone sick).		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light (a cord with a button next to the bed which turns on a light or makes a sound when pushed to alert staff) was within resident's arm's reach for two (2) of (2) sampled residents (Residents 11 and 59) reviewed for environment in accordance with the facility's policy. This deficient practice had the potential for Resident 11 and 59 not to be able to call the facility staff for help or assistance, especially during an emergency. Findings: 1. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), generalized muscle weakness and history of falling. During a review of Resident 11's Minimum Data Set (MDS, resident assessment tool), dated 4/21/2026, the MDS indicated Resident 11 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 11 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear and required partial/moderate assistance (helper does less than half the effort) with upper body dressing. The MDS further indicated Resident 11 required supervision (helper provides cues) with oral and personal hygiene and required setup assistance (helper sets up; resident completes activity) with eating. During a review of Resident 11's Care Plan, revised on 5/8/2026, the Care Plan indicated the resident has an Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily) self-care performance deficit due to weakness and Parkinson's disease and included an intervention to ensure the resident's call light is within reach and functioning properly. During a review of Resident 11's Care Plan, revised on 5/8/2026 Resident 11's Care Plan also indicated the resident was at risk for fall related to poor balance, unsteady gait and history of falls and included an intervention to ensure the resident's call light is within reach. During an observation on 7/21/2026 at 4:37 PM, Resident 11 was lying in bed with the resident's call light seen on the floor on the right side of the resident's bed. 2. During a review of Resident 59's admission Record, the admission Record indicated Resident 59 was admitted to the facility on [DATE] with history of falling, and bone density disorder (the bones are losing their strength and minerals, making them thin, fragile, and easily breaks). During a review of Resident 59's MDS dated [DATE], the MDS indicated Resident 59 had moderate impairment in cognitive skills for daily decision making. The MDS also indicated Resident 59 required setup assistance (helper sets up; resident completes activity) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 59 was independent (resident completes the activity by themselves with no assistance from helper) with eating, upper body dressing, oral and personal hygiene. During a review of Resident 59's Care Plan, revised on 6/3/2026, the Care Plan indicated the resident was at risk for injury related to use of side rail (a long or short protective bars attached to the side of the bed to prevent falls, or assist with movement) as an enabler to assist with ADL and included an intervention to ensure the resident's call light is within reach. During an observation on 7/21/2026 at 8:53 AM, Resident 59 was sitting in her wheelchair on the left side of the resident's bed with the resident's call light hanging on the wall hooked on the head part of the resident's bed. During an interview on 7/22/2026 at 2:28 PM, Certified Nursing Assistant 3 (CNA 3) stated the resident's call light should be within the residents' reach to ensure the resident can call if there is an emergency and whenever they needed something. CNA 3 (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	also stated the call light would not be within the resident's reach if the call light is left hanging on the wall or if it is on the floor. During an interview on 7/22/2026 at 2:39 PM, Licensed Vocational Nurse 3 (LVN 3) stated call lights should be placed by the side of the bed where residents could reach the call light to call for the staff when assistance is needed and during emergencies. LVN 3 also stated Resident 11 and 59 would not be able to reach the call light if the resident's call light is on the floor or hanging on the wall by the head of the bed. During a review of the facility's Policy and Procedure (P&P) titled, Communication- Call System, revised 8/29/2024, the P&P indicated the facility will maintain a communication system to allow residents to call for staff assistance from their rooms. The P&P also indicated the call alert device will be placed within the resident's reach.		

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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, interview, and record review, the facility failed to ensure the wheelchair was at the right height to ensure the resident's feet were resting on the foot pedals (the flat platform at the front of a wheelchair where a user places their feet) for one (1) of two (2) sampled residents (Residents 72) reviewed for positioning according to the facility policy. This deficient practice placed Resident 72 at risk for poor posture and poor body alignment and potential for fall due to unsafe weight shifts during transfers. Findings: During a review of Resident 72's admission Record, the admission Record indicated Resident 72 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with generalized muscle weakness and history of falling. During a review of Resident 72's Minimum Data Set (MDS, resident assessment tool), dated 7/3/2026, the MDS indicated Resident 72 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 72 was dependent (helper does all the effort) with eating, oral, toileting and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear. During an observation on 7/21/2026 at 8:50 AM, Resident 72 was seated on the wheelchair with the resident's feet dangling and not resting on the wheelchairs foot pedals while the resident was outside the resident's restroom. Certified Nursing Assistant 2 (CNA 2) later transported Resident 72 to the activity room using the same wheelchair and the resident's feet dangling and not resting on the wheelchair's foot pedals. During an interview on 07/22/2026 at 2:50 PM, Registered Nurse 2 (RN 2) stated Resident 72 could develop footdrop (inability to lift the front part of the foot due to nerve damage or muscle weakness) if the resident's feet were not resting on the wheelchair's foot pedals. RN 2 also stated Resident 72 should be re-evaluated for proper wheelchair use by the Physical Therapist (PT, a trained health expert who helps residents recover strength, manage pain and improve movement). During an interview on 7/22/2026 at 2:57 PM, Director of Rehab (DOR) stated Resident 72's feet should be resting on the wheelchair's foot pedals to support the resident's feet when the resident is sitting on the wheelchair so the resident's feet would not be dangling. DOR also stated Resident 72's feet should be resting on the wheelchair's foot pedals for proper sitting positioning to prevent the resident from sliding. During an interview on 7/23/2026 at 2:06 PM, the Director of Nursing (DON) stated wheelchairs should be properly fitted for Resident 72 because the resident could slip off the wheelchair if the wheelchair was too high for the resident and the resident's feet were not touching the foot pedals. During a review of the facility's Policy and Procedure (P&P) titled, Positioning in Chair, revised 1/1/2012, the P&P indicated that the residents are positioned to maintain correct body alignment when seated. The P&P also indicated footrests are adjusted so that the resident's thighs are parallel with supporting surfaces and feet are flat on the foot pedals with the backs of the heels against the heel loops and the toes pointed straight ahead while on the wheelchair		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop an individualized resident-centered care plan (CP, a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) for one (1) of two (2) sampled residents (Resident 19) reviewed for pain, as indicated on the facility policy by failing to have a care plan for Resident 19's use of pain medication, tramadol hydrochloride (Hcl, a drug used to treat moderate to severe pain in adults). This deficient practice had the potential to result in medication misuse, or failure to achieve optimal pain relief for Resident 19. Findings: During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was initially admitted to the facility on [DATE]. Resident 19's diagnoses included malignant neoplasm of unspecified part of unspecified bronchus or lung (lung cancer happens when harmful cells in your lungs grow unchecked) and secondary malignant neoplasm of bone (a cancer that has started in another part of the body and has spread to the bone via the bloodstream or lymph nodes). During a review of Resident 19's Minimum Data Set (MDS, resident assessment tool), dated 5/19/2026, the MDS indicated Resident 19 had moderately impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 19 needed partial or moderate assistance, (helper does less than half the effort) with toilet hygiene, shower/bathe self, upper and lower body dressing and putting on/taking off footwear. Resident 19 needed supervision or touching assistance, (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) for oral and personal hygiene. Resident 19 needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for eating. The MDS also indicated Resident 19 received scheduled pain medication regimen. During a review of Resident 19's Physician Orders, dated 7/6/2026, the Physician's Order indicated tramadol Hcl tablet 50 milligrams (mg, a unit of measurement for weight) give 1 table by mouth every eight (8) hours for pain management (a multidisciplinary medical approach to diagnosing, treating, and alleviating acute or chronic discomfort) for 30 days. During a concurrent interview and record review on 7/24/2026 at 1:04 PM with the Registered Nurse Supervisor 1 (RNS1), Resident 19's pain management plan of care (a structured, individualized document that outlines the medical and supportive services a patient needs to address their specific health conditions and goals) was reviewed. RNS 1 stated Resident 1 was prescribed with tramadol Hcl, but it was not and should have been included in the resident's pain management plan of care. RNS 1 stated it is important to include tramadol in Resident 1's pain management plan of care to ensure resident was provided effective pain treatments. During an interview on 7/24/2026 at 1:23 PM with the Director of Nursing (DON), the DON stated it is very important to include Resident 1's pain medication, tramadol, in the care plan so that staff can ensure the medication is working properly to control Resident 19's pain. During a review of the facility's Policy and Procedure (P&P) titled, Pain Management, effective 5/26/2023, the P&P indicated: A pain assessment will be completed for each resident upon admission, quarterly, when there is a new onset of pain, exacerbation of pain, or when there is a significant change in status. The IDT will review the residents' Pain Management and make changes to the care plan as needed. Documentation, the Licensed Nurse will update the Care Plan for pain management with any change in treatment and/or medication.		

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 11) reviewed for Activities of Daily Living (ADL - activities such as bathing, dressing and toileting a person performs daily) was provided care and services to maintain good grooming and personal hygiene by failing to ensure Resident 11's long and jagged fingernails (rough and uneven nails) were cleaned and trimmed. This deficient practice resulted in multiple scattered scratch marks on Resident 11's left lower flank area, across right outer arm and upper right side of the resident's body. Findings: During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with dementia (a progressive state of decline in mental abilities) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) During a review of Resident 11's Minimum Data Set (MDS, resident assessment tool), dated 4/21/2026, the MDS indicated Resident 11 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 11 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear and required partial/moderate assistance (helper does less than half the effort) with upper body dressing. The MDS further indicated Resident 11 required supervision (helper provides cues) with oral and personal hygiene and required setup assistance (helper sets up; resident completes activity) with eating. During a review of Resident 11's Care Plan revised on 4/28/2026, the Care Plan indicated a goal to keep the resident's skin intact with a proposed plan to keep the resident's fingernails short and clean. During an observation on 7/21/2026 at 4:37 PM, Resident 11 was lying in bed with jagged and untrimmed fingernails on both hands. In addition, there was yellowish-brown discoloration on top of the nailbeds and dark brown dirt built up under the fingernails. During an observation on 7/22/2026 at 8:20 AM, Registered Nurse 2 (RN 2) was doing skin checks on Resident 11 while the resident was lying in bed and observed scratch marks on the resident's left lower flank (the side of the body between the top hip bone and the lower ribs, closer to the lower back) area, across right outer arm and upper right side. Resident 11 was also observed scratching the right side of his body while RN 2 was doing skin checks on the resident. During an interview on 7/22/2026 at 1:50 PM, Certified Nursing Assistant 3 (CNA 3) stated the residents' fingernails should be cleaned and trimmed when the resident's fingernails look outgrown and dirty to prevent the residents' from hurting themselves and others. CNA 3 also stated the residents' nails should be filed after cutting them to prevent any jagged or sharp edges. During an interview on 7/22/2026 at 2:42 PM, Licensed Vocational Nurse 3 (LVN 3) stated CNAs should report any fingernail trimming that needed to be done for diabetic (a disorder characterized by difficulty in blood sugar control and poor wound healing) residents to the licensed staff but for all other residents that are not diabetic, any of the CNAs could do the nail trimming. LVN 3 also stated scratching the skin with dirty and untrimmed nails could break or scratch the resident's skin and could cause an infection to the broken skin. During an interview on 7/24/2026 at 12:30 PM, the Director of Nursing (DON) stated it is important to maintain good grooming and hygiene to the residents to prevent contaminating their food when eating with their hands during meals. The DON further stated long, dirty, and untrimmed fingernails could cause skin injuries to the residents if the resident scratches themselves and if the same area of the skin gets scratched it could break and could lead to complications such as skin infection or bleeding. During a review of the facility's Policy (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Procedure (P&P) titled, Grooming Care of the Fingernails and Toenails, revised 10/21/2021, the P&P indicated nail care is given to clean the nail bed and keep the nails trimmed. The P&P also indicated procedures to include gently removing the dirt from around and under each nail, trim fingernails into an oval shape and smooth the nails with a nail file or emery board.		

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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, and record review, the facility failed to ensure the low air loss mattress (LAL mattress, a specialized medical bed mattress designed to prevent and treat pressure ulcers [localized damage to the skin and/or underlying tissue usually over a bony prominence] by constantly blowing a tiny amount of air through) for one (1) of three (3) sampled residents (Residents 97) reviewed for pressure ulcers was set according to the residents' current weight as indicated on the Physician's order and facility policy. This deficient practice placed Resident 97 at risk for development of new pressure ulcer and progression of moisture associated skin damage (MASD, caused from prolonged exposure to moisture) to Sacro-coccyx (pertains to both large triangular shaped bone in the lower spine that forms part of the pelvis and the tailbone) area. Findings: During a review of Resident 97's admission Record, the admission Record indicated Resident 97 was admitted to the facility on [DATE] with type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 97's Minimum Data Set (MDS, resident assessment tool), dated 4/29/2026, the MDS indicated Resident 97 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 97 was dependent (helper does all the effort) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with eating, upper body dressing, oral and personal hygiene. During a review of Resident 97's Physician's Order, dated 7/1/2026 at 1:11 PM, the Physician's Order indicated LAL mattress for skin management. The Physician's Order also indicated LAL setting according to Resident 97's current weight. During a review of Resident 97's Braden Scale (used for predicting pressure ulcer risk) with an effective date of 7/10/2026, the Braden Scale indicated Resident 97 was high risk for developing pressure ulcer. During a review of the residents 97's Weight Record, the Weight Record indicated Resident 97's weight on 7/13/2026 was 150.8 pounds (lbs). During a review of Resident 97's Wound Assessment and Plan Record dated 7/14/2026, the Wound Assessment and Plan Record indicated Resident 97 had an MASD on the Sacro-coccyx area extending to the right/left buttocks and posterior thighs. During an observation on 7/21/2026 at 11:51 AM, Resident 97 was lying in bed with the LAL set at 200 lbs. During a concurrent observation and interview on 7/22/2026 at 3:04 PM, Registered Nurse 1 (RN 1) stated Resident 97's LAL mattress was set at 200 lbs. RN 1 also stated Resident 97's LAL mattress should be set based on the resident's current weight and according to the Physician's order. RN 1 further stated LAL mattress is used for skin maintenance to help redistribute pressure and promote wound healing. During an interview on 7/24/2026 at 9:09 AM, the Assistant Director of Nursing (ADON) stated LAL should be set correctly based on the resident's weight so the mattress can inflate properly to relieve pressure and used as preventive measures to prevent further skin breakdown to the resident. During a review of the facility's Policy and Procedure (P&P) titled, Mattresses, revised 6/27/2024, the P&P indicated that the facility provides a mattress appropriate to the residents' needs. The P&P also indicated that the facility provides pressure reduction mattress to residents at risk for skin breakdown and help to distribute body weight relieving areas of pressure. P&P also indicated an air mattress is used under the direction of an attending physician's order or when the resident's clinical condition warrants pressure reducing devices. During a review of the P&P titled, Pressure Injury Prevention, revised 6/27/2024, the P&P indicated its purpose was to prevent the development of pressure injury in residents identified at risk. The P&P also indicated that the facility (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would implement interventions identified in the plan of care which ay include but are not limited to pressure redistributing devices for the bed.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer gastrostomy tube (G-tube, a tube inserted through the abdomen to deliver nutrition directly to the stomach) feeding for one (1) of two (2) sampled residents (Resident 5) reviewed for tube feeding in accordance with the physician's order and facility's policy. This failure had the potential to result in Residents 5 experiencing fluid overload (when the body has too much water which can raise the blood pressure, force the heart to work harder and make it hard to breathe) which could then also lead to aspiration (when food, liquid or other material enters a person's airway and eventually the lungs by accident which can happen as a person swallows or when food comes back up from the stomach). Findings: During a review of Resident 5's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of protein-calorie malnutrition (refers to various degrees of nutritional disorders caused by inadequate quantities of protein and energy in the diet) and dysphagia (difficulty swallowing). During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 5/13/2026, the MDS indicated the resident was moderately impaired with cognitive (ability to think, remember, and reason) skills for daily decision making. MDS indicated Resident 5 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with chair/bed-to-chair transfers, rolling left and right in bed, upper and lower body dressing (the ability to dress and undress above and below the waist), and putting on/taking off footwear. MDS also indicated Resident 5 needed substantial/ maximal assistance (helper does more than half the effort) with personal hygiene and had a feeding tube. During a review of Resident 5's Order Summary Report, dated 7/23/2026, Resident 5's Order Summary Report indicated a physician's order, dated 5/18/2026 for Jevity 1.5 (type of feeding formula) at 60 cubic centimeters (cc equal to 1 milliliter [ml]; a measure of fluid volume)/hour (hr) using Kangaroo pump (a medical device used to deliver liquid food, nutrients, or water directly into a person's stomach or small intestine through a feeding tube) via (by) G-tube for 20 hours to provide 1200 ml or 1800 kilocalorie (kcal, a unit of energy). On at 2 PM and off at 10 AM or until complete volume is infused. During a concurrent observation on 7/21/2026 at 10:09 AM with Registered Nurse 1 (RN^1) inside Resident^5's room, Resident^5 was observed sitting up in his wheelchair at bedside with his G^tube connected to a Kangaroo pump. The pump displayed a rate of 60^mL/hr, with 144 minutes remaining, 143^mL of formula left, and a total of 2,165^ml delivered. RN^1 stated Resident^5 should have only received 1,200^ml and the feeding exceeded the amount ordered by 965^ml. RN^1 further stated receiving more than the ordered amount places Resident^5 at risk for aspiration and upset stomach due to overfeeding. RN^1 further stated when starting a new feeding, the Kangaroo pump settings should be cleared and correctly programmed according to the physician's order to ensure the displayed volume accurately reflected what the resident received. During a concurrent observation and interview on 7/21/2026 at 10:09 AM with the Director of Nursing (DON) inside Resident 5's room, Resident 5 was observed sitting up in his wheelchair at bedside with his G-tube connected to a Kangaroo pump. The pump displayed a rate of 60^mL/hr, with 144 minutes remaining, 143^mL of formula left, and a total of 2,165^ml delivered. The DON stated the Kangaroo pump's display showed the residents had received more volume than ordered, indicating the resident was overfed. The DON stated staff must follow the procedure of resetting the Kangaroo pump before starting a new feeding so the volume the resident receives (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accurately follows the order. The DON further stated that if a resident receives too much feeding, it could potentially lead to fluid overload, and for a resident who already has a condition such as edema (swelling caused by excess fluid trapped in the body's tissues), overfeeding can negatively affect the resident. During a review of the facility's policy and procedure (P&P) titled, Enteral Feedings, revised 8/24/2023, the P&P indicated:Review order for the enteral feeding.Administer enteral feeding formula per physician order.Set pump settings according to the physician order.Set dose limit on machine and start, if applicable.		

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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, and record review, the facility failed to monitor the fluid restriction (a dietary change that limits the amount of liquid a person can consume in a day) for one (1) of three (3) sampled residents (Resident 10), reviewed and receiving dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney/s have failed) as indicated on the physician order and facility's policy. This deficient practice had the potential for Resident 10 to have fluid overload (harmful amount of fluid in the body) which could cause complications such as swelling, high blood pressure, shortness of breath, and pulmonary edema (an accumulation of fluid in the lungs) or fluid deficit (condition where fluid output exceeds the fluid intake) which could cause complications such as low blood pressure, electrolyte imbalances (occurs when levels of essential minerals in the body are too high or too low disrupting normal bodily functions), reduced dialysis efficiency, or cardiac arrest (sudden and unexpected cessation of heart function causing the heart to stop pumping blood to the brain and other vital organs). Findings: During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 10's diagnoses included end stage renal disease (ESRD - the final, irreversible stage of kidney [vital for filtering waste, excess fluid, and toxins from the blood to produce urine] failure where kidney function declines to below 15% of normal), dependence on renal dialysis (a person's kidneys have failed, requiring a machine or medical process to clean waste and extra fluid from their blood to stay alive), and pleural effusion (an abnormal buildup of excess fluid in the space between the lungs and the chest cavity). During a review of Resident 10's Minimum Data Set (MDS, resident assessment tool), dated 6/26/2026, the MDS indicated Resident 10 had moderate cognitive impairment with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 10 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, shower/bath self, upper and lower body dressing, putting on/taking off footwear, personal hygiene, sit to stand and toilet transfer. Resident 10 needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for eating and oral hygiene. During a review of Resident 10's Physician Orders, dated 7/10/2026, the Physician's Order indicated fluid restriction of 1200 milliliters (ml-unit of measure) per day. During a concurrent interview and record review on 7/23/2026 at 10:51 AM with Licensed Vocational Nurse (LVN 2), Resident 10's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 7/23/2026, was reviewed with LVN2. MAR did not indicate Resident 10's oral intake to ensure fluid restriction of 1200 ml per day. During a concurrent review of Resident 10's medical records and interview on 7/23/2026 at 11:04 AM with the Registered Nurse Supervisor 1 (RNS1), RNS 1 stated she cannot find any documentation of oral intake monitoring for Resident 10. RNS1 also stated Resident 10 did not have a care plan indicating the resident's fluid restriction of 1200 ml as indicated on the physician order, dated 7/10/2026 either. During an interview on 7/23/2026 at 12:56 PM with the Director of Nursing (DON), the DON stated it was important for licensed nurses to monitor and document the oral intake of a resident receiving dialysis in order to prevent fluid overload, protect heart health, and ensure effective dialysis treatments. During a review of the facility's Policy and Procedure (P&P) titled, Fluid Restriction, effective 5/26/2026, the P&P indicated Residents on fluid restrictions will be monitored for intake and output and will receive appropriate interventions to alleviate discomfort from the fluid restrictions for the duration of the (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Providers' order. Residents on fluid restrictions must have a provider order and a plan of care for the restriction which indicates the amount of fluid allowed within a 24-hour timeframe. The Licensed Nurse will: complete intake and output documentation. During a review of the facility's P&P titled, Dialysis Management, effective 3/27/2026, the P&P indicated the facility should assure that each resident receives care and services consistent with professional standards of practice. Diet and fluid restrictions will be followed as ordered. All documentation concerning dialysis services and care of the dialysis resident will be maintained in the resident's medical record.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a container of 18 ounces (oz, unit of measurement used to describe weight or volume) perishable (spoils quickly) raw organic kraut (uncooked, naturally fermented cabbage grown without chemical compound used to control pests) stored in the residents' refrigerator was properly labeled with the storage and expiration dates. This deficient practice had the potential to result in food borne illnesses (any illness resulting from eating contaminated/spoiled foods) to Resident 83 if the food was consumed. Findings: During a review of Resident 83's admission Record, the admission Record indicated Resident 83 was admitted to the facility on [DATE] with unspecified protein calorie malnutrition (a condition that occurs when a person's body does not get the right amount of nutrients it needs to function properly). During a review of Resident 83's Minimum Data Set (MDS, resident assessment tool), dated 6/2/2026, the MDS indicated Resident 83 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 83 was dependent (helper does all the effort) on toileting hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 83 required partial/moderate assistance (helper does less than half the effort) with oral hygiene and upper body dressing and required supervision (helper provides cues) with eating. During a concurrent observation and interview on 7/21/2026 at 1:54 PM with Licensed Vocational Nurse 3 (LVN 3) in the employee lounge where the residents' refrigerator was located, inside the residents' refrigerator was a thermal bag with boxed food items labeled with Resident 83's name. Inside Resident 83's thermal bag was an 18 oz dented plastic container of perishable raw organic kraut without an expiration date. There was also an approximately 1/4 left of light-yellow liquid in a container inside the thermal bag without a storage date. LVN 3 stated the food stored inside the residents' refrigerator should all be labeled with storage and expiration dates because the unlabeled food can spoil and pose a risk of foodborne illness to Resident 83 if consumed. During an interview on 7/23/2026 at 12:09 PM, the Dietary Services Supervisor (DSS) stated nurses should label food items stored in residents' refrigerators with the resident's name and the date the food was stored to ensure food safety. The DSS stated the proper labeling allows staff to determine when the food was stored and when it should be discarded to prevent foodborne illness. During a concurrent observation and interview on 7/24/2026 at 8:42 AM with Resident 83, the resident was observed lying in bed and stated his family brought him food and often buys his own food. Resident 83 also stated he has a thermal bag where the staff puts his food and places it in the residents' refrigerator. Resident 83 further stated the facility has a policy where they throw the food away in two to three days if not consumed. During a review of the facility's Policy and Procedure (P&P) titled, Food Brought in by Visitors, revised 4/24/2025, the P&P indicated that the facility would store food by placing the food in a food container that is clearly labeled with the resident's name and date received and stored in the refrigerator designated for this purpose. The P&P also indicated that refrigerated perishable food will be labeled, dated and discarded after 48 hours if not consumed.		

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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, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed for one (1) of seven (7) sampled residents (Resident 52) reviewed for infection control in accordance with the facility's policy and procedure (P&P) when: The facility failed to ensure trash bag was not placed on top of Resident 52's bed, next to Resident 52's right leg while Licensed Vocational Nurse (LVN) 1 was providing the resident's wound dressing change. 2. Housekeeping (HK) 1 used her feet with a small towel to clean a large puddle of liquid leaks coming out of the broken trash bag inside Rooms A and B. These deficient practices have the potential to contaminate clean items and can place Resident 52 and other residents at risk of infection. Findings: 1. During a review of Resident 52's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and muscle weakness. During a review of Resident 52's Minimum Data Set (MDS- a resident assessment tool) dated 7/10/2026, the MDS indicated Resident 1 had moderately impaired cognitive (ability to think and process information) ability. The MDS indicated Resident 52 required partial assistance (helper does less than half the effort) for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 52 required supervision for eating, oral hygiene, upper body dressing and personal hygiene. During a review of Resident 52's Order Summary Report (list of doctor's orders) dated 7/16/2026, the Order Summary Report indicated Resident 52 had an order for dressing changes to a right forearm skin tear. During an observation on 7/23/2026 at 9:37 AM in Resident 52's room, LVN 1 was observed placing a trash bag on top of Resident 52's bed, next to the resident's right leg. LVN 1 was observed removing Resident 52's right arm dressing and throwing into the trash bag that was placed on Resident 52's bed. LVN 1 was observed cleaning the wound with gauze and throwing the gauze into the same trash bag. During a concurrent observation and interview on 7/23/2026 at 9:42 AM with LVN 1, a trash bag containing soiled gauze from wound care was observed on top of Resident 52's bed next to Resident 52's right leg. LVN 1 stated the trash bag with gauze that has bodily fluids should not be on the resident's bed next to the resident's right leg because the resident's leg can touch the dirty contents and the resident's bed should be maintained clean and to prevent spread of infection. During a concurrent interview and record review on 7/24/2026 at 10:14 AM with Infection Prevention Nurse (IPN), the facility's P&P titled, Infection Prevention and Control Program Description, dated (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055760	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Alhambra Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/8/2024 was reviewed. The P&P indicated: The Infection Prevention and Control Program (IPCP) is a set of comprehensive processes that address the prevention and control of infections. Infection Prevention and Control Risk areas will be assessed. The spread of infections will be prevented. IPN stated the trash bag should not be placed on the resident's bed next to the resident because the trash from a wound dressing change is contaminated by infectious bodily fluids and can spread infection if the resident touches it or if it touches the resident's bed. IPN stated that the policy indicated that the facility would prevent the spread of infections and identify risks for infections. During an interview on 7/24/2026 at 11:11 AM with the Director of Nursing (DON), the DON stated that trash bags should not be placed on top of a resident's bed because the trash may contaminate clean areas and touch the resident which may spread infection. 2. During an observation on 7/22/2026 at 9:33 AM, HK 1 was observed inside the residents' room remove a large clear plastic trash bag from the black trash bin located between Rooms A and B. A large puddle of liquid spilled on the floor was observed coming from the large clear plastic trash bag. HK 1 discarded the trash outside the room in the trash container, wiped the puddle of liquid spilled on the floor with a small towel using her (HK 1) feet then came out and grabbed the mop to clean remaining liquid. HK 1 was then seen enter Room C afterwards. During an interview on 07/22/2026 at 1:55 PM, HK 1 stated she was supposed to use the mop and not used her feet and a small towel to clean the liquids spilled from the trash bag between Room A and Room B to prevent getting germs on her shoes and spreading them to other rooms. During an interview on 7/22/2026 at 2:09 PM, the Maintenance Assistant (MA) stated HK 1 should be using the floor mop when cleaning out spills from the clear plastic trash bag and not use a small towel and wipe the floor with her feet. MA also stated we do not know what type of germs are in that liquid spilled on the floor from the trash bag and HK 1 could spread the germs on the floor including the rest of the rooms. During an interview on 7/22/2026 at 2:20 PM, IPN stated HK 1 should have used the mop right away to clean the liquid spills from the clear plastic trash bag instead of using HK 1 feet to wipe the liquid spills from the trash bag to prevent contaminating HK 1's shoes with potential germs and bacteria's and spread them everywhere and in other residents' rooms. During an interview on 7/24/2026 at 8:55 AM, the Assistant Director of Nursing (ADON) stated HK 1 should have mopped and sanitized the floor because the staff would not know what kind of bacteria's (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Alhambra Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 415 South Garfield Alhambra, CA 91801	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that was mixed in the liquids that spilled from the trash, and if you use your shoes to wipe the spills those bacteria's could get to your shoes and the staff could spread those bacteria's as she walks around. ADON also stated residents could potentially pick up those germs if they do not wash their hands after picking up items on the floor. During a review of the facility's P&P titled, Housekeeping &ndash; General, revised 1/1/2012, the P&P indicated to ensure that the facility is clean, sanitary at all times so as to promote the health and safety of residents, staff and visitors. The P&P also indicated that the housekeeping department uses safe and proper methods for cleaning, disinfecting, and sterilizing all areas, surfaces, and equipment as required by law. During a review of the facility's P&P titled, Infection Control &ndash; P&P, revised 1/1/2012, the P&P indicated the facility infection control P&P are intended to facilitate maintaining a safe, sanitary environment and to help prevent and manage transmission of diseases and infections.		