STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555292	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alhambra Post Acute	331 Ilene Street Martinez, CA 94553

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 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, and record review, the facility failed to ensure the pacemaker defibrillator monitor (a remote monitor that automatically collects device data and sends it to the healthcare team) for one of four residents (Resident 1) was adequately monitored at the nurse's station when Resident 1's pacemaker defibrillator monitor was unable to be located.This failure had the potential to increase Resident 1's risk of cardiovascular accidents and decline in health condition.During record review of admission record, printed on 6/2/26, Resident 1 was admitted on [DATE].During record review of Resident 1's Minimum Data Set (MDS, an assessment tool used to guide care), dated 4/14/26, indicated Resident 1's Brief Interview for Mental Status (BIMS, an assessment tool used to assess mental status) score was 15 out of 15, which indicated Resident 1's cognition was intact. During an interview on 6/2/26, at 11:47 a.m., with Resident 1, Resident 1 stated their pacemaker defibrillator monitor was serviced by a technician due to poor signal, interfering with remote physician monitoring and accurate readings from device. Resident 1 stated days after technician came to service pacemaker defibrillator monitor, they were unable to find the device, even though Resident 1 was instructed to remain close to the device once a day for a few minutes to allow readings to transfer to physician. Resident 1 stated they called the Ombudsman (OMB) because monitor was not being monitored by staff and they could not find it at the nurse's station. Resident 1 stated the technician placed the device to the right of the closet in a specific area that had a good signal and staff moved it stating the signal was not good in that area. Resident 1 stated the monitor was found under papers, on the floor of nurse's station and out of nurses' view at times, and Resident 1 felt ignored when they expressed concerns regarding the pacemaker defibrillator monitor device. During a phone interview on 6/2/26, at 12:51 p.m., with OMB, OMB stated on 5/7/26, Resident 1 informed OMB of recent pacemaker technician visit due to pacemaker not functioning properly for several months and expressed pacemaker defibrillator monitor was not being properly monitored by nursing staff. OMB stated on 5/7/26 during an onsite visit she found the pacemaker defibrillator monitor to be missing from the nurse's station. OMB stated the Director of Nursing (DON) could not find the pacemaker defibrillator monitor and believed it had gone missing the night before OMB's visit but DON was unsure. OMB stated after twenty minutes of searching the skilled nursing unit the pacemaker defibrillator monitor was found in a supply closet near the nurse's station, not plugged in or in nurse's view for monitoring. During a concurrent observation and interview on 6/2/26, at 3:26 p.m., with the DON, the DON stated Resident 1's pacemaker defibrillator monitor was at the nurses' station within the nurse's view for monitoring. DON stated Resident 1 checked nurses' station daily to ensure device was in place and functioning properly, indicating a green light. DON stated Resident 1's pacemaker defibrillator monitor was found in the supply room near the nurses' station unplugged and out of nurses' view after the nurses' station was cleaned. DON stated they were unsure how long the device was in the supply closet, but likely it was moved from the nurses' station the day before it went missing when night shift was cleaning. DON stated it was important the pacemaker defibrillator monitor was visible at the nurses' station to ensure staff were monitoring the device appropriately and were able to intervene when necessary. During an interview on 6/3/26, at 11:00 a.m., with (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Staff Development (DSD), DSD stated they were in the facility when OMB visited and found Resident 1's pacemaker defibrillator monitor was missing from the nurses' station and later found by a staff member in the supply closet near the nurses' station. DSD stated they were unsure of how the pacemaker defibrillator monitor ended up in the supply closet but it could have been due to a nursing student cleaning the nurses' station as the monitor looked like a router. DSD stated it was important that nurses monitor Resident 1's pacemaker defibrillator monitor as the monitor would alert staff of a cardiac emergency. During record review of Resident 1's Cardiac Device Interrogation Report Progress Note, dated 4/21/26, the Cardiac Device Interrogation Report progress note indicated Resident 1 had a Cardiac Resynchronization Therapy Defibrillator (CRT-D; an implantable device that combines a pacemaker and a defibrillator. It is primarily used for heart failure patients whose lower heart chambers pump out of sync, and who are also at high risk for sudden cardiac arrest) that was last checked on 12/9/24 and programmed to normal function on the service date. During record review of Resident 1's Order Audit Report, order date 6/2/26, the order audit report indicated, monitor pacemaker status and report abnormalities or signs of malfunction to [the medical doctor] MD, every shift for pacemaker use.During a review of the facility's undated policy and procedure (P&P) titled, Neglect, the P&P indicated, Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide them and this has resulted in (or may result in) physical harm, pain mental anguish or emotional distress .Goods and services that the resident needs are identified and addressed though the following: The facility assessment to determine what resources are necessary to care for residents competently; The provision of sufficient numbers of qualified, trained staff based upon the facility assessment and as needed to meet resident needs; An effective orientation, training, and evaluation program; Oversight and monitoring of staff performance; Oversight and monitoring of contracted services or services provided under arrangement; The provision and implementation of a resident-specific care plan including the ongoing evaluation and revision of the care plan as necessary; and Ongoing monitoring and supervision of staff to assure the implementation of the care plan as written.Examples of failures to provide care and services to the resident that result in neglect include: Failure to provide sufficient, qualified, competent staff, to meet resident's needs; Failure to provide orientation and/or training to staff; Failure to provide training on new equipment or new procedures or medications required for the care of a specified resident or required due to changes in acceptable standards of practice.