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	04/23/2026

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

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, the facility failed to ensure that it was free of medication error rate of five percent (5%) or greater, as evidenced by the identification of five medication errors out of 27 opportunities, to yield a facility error rate of 18.5 % as evidenced by:1.For Resident 1, Registered Nurse (RN) 1 crushed four different medications, mixed them together in one cup, and administered them in a single administration via resident's gastrostomy tube (also called G-tube, is a tube surgically inserted through the abdomen into the stomach to administer nutrition and medications).2.RN 2 did not administer Cholecalciferol (Cholecalciferol is Vitamin D3, a supplement essential for bone health) as ordered by the physician, to Resident 8.These failures had the potential to compromise the residents' medical health.Findings:Review of Resident 1's physician order dated April 2026 indicated the following medication orders to be given via G-tube:Apixaban oral tablet 5 milligrams, give one tablet two times a day (apixaban is a medication that thins the blood and prevents stroke; milligrams or mg. is a form of measurement).Ascorbic acid liquid 500 mg. per 5 ml., give 5 ml. one time a day (ascorbic acid is vitamin C, a supplement; milliliters or ml. is a form of measurement).Atorvastatin calcium oral tablet 40 mg. give one tablet one time a day (atorvastatin is a medication that lowers cholesterol).Spironolactone oral tablet 25 mg., give one tablet one time a day (spironolactone is a medication that lowers blood pressure and decreases body swelling).During a medication pass observation on 4/21/26 at 8:43 a.m., RN 1 placed Apixaban 5 mg one tablet, Ascorbic acid 500 mg one tablet, Atorvastatin calcium 40 mg one tablet and Spironolactone 25 mg one tablet in an individual plastic pouch and crushed each medication into powder and mixed all four medications in one small medication cup. At Resident 1's bedside, RN 1 added a small amount of water about 10 ml. to the medication cup and dissolved the four medications. RN 1 attached a syringe to Resident 1's G-tube and flushed it with about 30 ml. of water. RN 1 then poured the contents of the medication cup to the G-Tube. After administering the medications, RN 1 flushed the Resident 1's G tube with 30 ml. water.During a review of Resident 1's physician's order printed on 4/22/26, the record indicated an order with a start date of 3/26/26 of .Prior to medication administration, flush tubing with 15-30 ml of water. Before medication administration, flush tube with 5-10 ml between each medication. Flush with 15-30 ml of water after medication administration.During an interview on 4/21/2026 at 3:35 p.m., with Director of Staff Development (DSD), DSD stated that medications should have been given separately administered to Resident 1's G-tube and not mixed together in one medication cup, to prevent the G tube from clogging and to avoid drug interactions.During a concurrent interview and record review on 4/22/2026 10:55 a.m., with RN 1, Resident 1's physician order was reviewed, RN 1 stated she should have followed the physician's order of giving liquid Vitamin C instead of giving the tablet form via Resident 1's G tube.During a review of the facility's policy and procedure (P&P) titled, General Guidelines for Administering Medication via Enteral Tube, dated May 2022, the P&P indicated, .Procedures.D. Enteral tubes are flushed with at least 15-30 ml. (or prescribed amount) of room temperature or warm tap water before administering medications, and 10-15 ml. (or prescribed amount) between each medication .(an enteral tube or feeding tube is a soft, flexible plastic tube used to deliver liquid nutrition, fluids and medications directly into the stomach or small intestine. G-tube is (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	considered an enteral tube).2. Review of Resident 8's Facesheet (information containing contact details, brief medical history at a glance) indicated, Resident 8 was admitted to the facility on [DATE], with diagnoses that included right shoulder osteoarthritis (a common wear and tear disease where the cushion at the ends of bones gradually breaks down, leading to joint pain, stiffness, and reduced movement).Review of Resident 8?s physician order, indicated an order of Cholecalciferol tablet, give 1000 units one time a day.During a medication pass observation on 4/21/26 at 9:39 a.m., RN 2 was observed giving Vitamin D 400 IU one tablet orally to Resident 8 (IU means international units or units). During a concurrent interview and record review on 4/22/2026 at 10:52 a.m., Resident 8?s physician orders were reviewed. RN 2 acknowledged that he gave the wrong form and dosing to Resident 8. RN 2 stated he should have followed the physician's cholecalciferol's order for the resident. RN 2 further stated that the risk of not giving the correct form and dosage of cholecalciferol was for the resident not receiving the proper amount of nutrients.During an interview on 4/22/2026, at11:08 a.m., with the Director of Nursing (DON), DON stated the nurse should have followed the physician's order for cholecalciferol or vitamin D3. DON stated the risk of not giving the correct form and dose was for the resident to be underdosed. During an interview on 4/23/26, at 10:15 a.m., with Pharmacist Consultant (PC), stated not giving the correct dosage of cholecalciferol was a medication error because the resident was underdosed and was given less cholecalciferol to the resident's bones.During a review of the facility's P&P titled, Administering medications, dated 2001, the P&P indicated, .Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders.10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, the facility failed to ensure:1.Expired medications for one of 14 sampled residents (Resident 6) were properly disposed.2. An opened, full box of expired one ml. needles (ml. or milliliters is a form of measurement) was not stored in the facility medication storage room.3. An opened, multidose PPD vial (PPD is purified protein derivative. PPD vial is used for PPD test, a skin test used to check if you have been infected with the bacteria that causes tuberculosis- an infectious lung disease; multidose vial is a small bottle of medicine designed to be punctured multiple times, allowing healthcare professionals to draw out several doses over a period of time) in the medication storage room refrigerator, had no date opened label. These failures had the potential of exposing residents to drugs and biologicals with questionable potency and efficacy.Findings:1.A review of Resident 6's admission Record (AR), dated 4/22/26, indicated Resident 6 was admitted on [DATE] with diagnoses that included dementia (dementia is a decline in mental ability severe enough to interfere in daily life, such as memory loss, confusion, and personality changes) mood disturbance and anxiety. A review of Resident 6's Minimum Data Set, (MDS, a standardized resident assessment and care screening tool) dated 1/23/26, indicated the resident had severe cognitive impairment.During a concurrent observation and interview on 4/20/2026 at 2:33 p.m., with the Director of Staff Development (DSD), during an inspection of the south medication cart, expired medications for Resident 6 were found. The following expired medications were: One bottle that contained 12 Haldol 1 mg. tablets, expired on 4/4/26.One bottle that contained 14 Olanzapine 2.5 mg. tablets, expired on 4/4/26.One bottle that contained 14 Amlodipine 5 mg. tablets, expired on 4/4/26.One bottle that contained six Hyoscyamine 0.125 mg. tablets- expired on 4/3/26One bottle that contained six Ondansetron 4 mg. tablets- expired on 4/3/26.The DSD stated that Resident 6's expired medications should have been disposed to eliminate the risk of administering less effective medication. (Haldol and Olanzapine are strong medications used to treat serious mental health conditions, Amlodipine is a medication for high blood pressure, Hyoscyamine is a medication that calms stomach muscles and Ondansetron is a medication to prevent nausea and vomiting; mg. or milligrams is a form of measurement). 2. During an observation and interview on 4/20/2026 at 11:28 a.m., with the Director of Nursing (DON), in the medication storage room, a full box of opened 1 ml syringes were found with an expiry date of 3/3/26. The DON stated that the box of expired syringes should have been disposed and should not be in the medication storage room.3. During an observation and interview on 4/20/2026 at 11:35 a.m., an opened PPD vial was found stored in the medication storage room refrigerator with no open date label. The DON stated the PPD vial should have been labeled with the open date label to know when the expiry date was.During an interview on 4/23/26, at 10:15 a.m., with the Pharmacist Consultant (PC), PC stated the PPD vial should have been labeled with the open date when first opened and used the first time and the vial was only good for 30 days from the date it was opened.A review of facility's policy and procedure (P&P), titled Medication Labeling and Storage, dated 2001, the P&P indicated, . 3. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. 5.Multi dose vials that have been opened or accessed (e.g. needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. (e.g. is an abbreviation for the Latin phrase exempli gratia, which translates to for example).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe food handling and storage practices when three bottles of [NAME] Designer Dessert Sauce were found past their use-by dates at the dry food storage area. This failure had the potential to cause foodborne illnesses when consumed by residents.Findings:During the initial tour of the kitchen on 4/20/26 at 9:13 a.m., one opened bottle of [NAME] Designer Dessert Sauce, Kiwi Lime flavor, with a use-by date of 4/4/26, was observed in the dry food storage area. Additionally, one unopened bottle of [NAME] Designer Dessert Sauce, Mango flavor, with a use-by date of 3/14/26, and one unopened bottle of [NAME] Designer Dessert Sauce, [NAME] Chocolate flavor, with a use-by date of 4/2/26 were observed.During a follow-up tour of the kitchen on 4/21/26 at 9:26 a.m., the Dietary Manager (DM) stated they check the dry food shelves every day to ensure expired and past use-by date food items are removed; however, staff missed checking the three past use-by date dessert sauces. The DM was unable to provide evidence or logs demonstrating that daily checks in the dry food shelves were performed.During a concurrent interview and record review on 4/22/26 at 9:39 a.m., the Registered Dietitian (RD) stated that they inspect the kitchen monthly and submit Nutrition Therapy Essentials (inspection report) to the Administrator (ADM), Director of Nursing (DON), and DM. The March 2026 inspection report indicated there were Multiple foods passed use by date.During an interview on 4/22/26 at 1:50 p.m., the DM stated that dessert sauces past their use-by dates should not be kept in the storage area because they could be mistakenly consumed by residents and potentially cause foodborne illnesses.During an interview on 4/23/26 at 8:09 a.m., the ADM stated that it is the DM's responsibility to ensure that there are no expired or past use-by date food items in the kitchen.During a review of facility's Policy and Procedure (P&P), titled, Food Receiving and Storage, revised [DATE], the P&P indicated, Foods shall be received and stored in a manner that complies with safe food handling practices.During an interview on 4/23/26 at 10:30 a.m., the ADM stated that the facility did not have a P&P for specifically addressing monitoring of food expiration dates.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to ensure a safe and sanitary method for storing residents' food brought from outside for one of six sampled residents (Resident 42) when a jar of jam and fruit preserve and fruit cups were stored in a rectangular plastic container with ice and ice water.This failure has the potential to place the resident at risk for foodborne illnesses.Findings:During a review of Resident 42's admission Record (AR) printed on 4/22/26, the AR indicated, Resident 42 was admitted to the facility in March 2026.During an observation on 4/20/26 at 10:55 a.m., in Resident 42's room, one unopened jar of Smucker's Blueberry Preserves, one opened jar of Sunny Select Grape Jam, and two sealed fruit cups were observed stored in a rectangular plastic container filled with ice chips.During an interview on 4/20/26 at 11:00 a.m., Resident 42 stated that she uses the jams for her peanut butter crackers and had requested that the jam be placed in a refrigerator. Resident 42 stated she was informed that there was no refrigerator for residents to store their food.During an interview on 4/21/26 at 1:50 p.m., with the Director of Staff Development (DSD), DSD stated that due to space limitations, the facility does not provide a refrigerator for residents to store their food including leftovers or food brought from outside. DSD stated the facility educates residents to either consume food brought from outside within two hours or throw it away after two hours.During a concurrent observation and interview on 4/22/26 at 10:06 a.m., with the Director of Nursing (DON), in Resident 42's room, two jars of jam were observed stored in a plastic rectangular container containing melted ice water, and one fruit cup was observed submerged under the water. DON asked staff to move the container away.During an interview on 04/22/2026 at 10:08 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated that Resident 42 always asks for ice to keep the jam cold. CNA 1 further stated that they did not pay attention to or notice when the ice had melted into water.During an interview on 04/22/26 at 1:07 p.m., Resident 42 stated that she was upset that the facility did not provide a refrigerator for residents to keep their food and that staff had removed her ice container, leaving her unsure of what to do.During an interview on 04/23/26 at 9:37 a.m., with Registered Nurse (RN) 2, RN 2 stated that there was no system or log in place to monitor the temperature or ensure that ice is consistently maintained in the container. RN 2 further stated that, in practice, they check to ensure there is still ice in the container whenever they enter the resident's room. A review of facility's policy and procedure (P&P) titled, Food Brought by Family/Visitors, revised in March 2022, the P&P indicated, food brought to the facility by visitors and family is permitted. 5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food. a. Non-perishable foods are stored in re-sealable containers with tight-fitting lids. Intact fresh fruit may be stored without a lid. b. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 14 sampled residents (Resident 51) dignity was maintained when staff referred to the resident as a feeder in the lunchroom. This failure had the potential to result in Resident 51 feeling disrespected, demeaned, embarrassed, or devalued, thereby negatively affecting the resident's sense of self^worth and well^being.Findings:During a record review of Resident 51's admission Record (AR) printed on 4/22/26, the AR indicated, Resident 51 was admitted to the facility on [DATE].During a record review of Resident 51's Brief Interview for Mental Status (BIMS, an assessment for mental status) assessment dated [DATE], Resident 51's BIMS score was nine (9) out of 15, indicating moderate impaired cognition (mental status).During a record review of Resident 51's Care Plan Report Special Instruction (CPRSI) dated 4/10/26, CPRSI indicated, Resident 51 required 1:1 feeding (requires one staff member to stay with resident the whole time they are eating and help them with every bite and sips) and Aspiration Precautions (steps staff take to help keep food or drinks from going into the resident's airway).During an observation on 4/20/26, at 12:38 p.m., in the lunchroom, Resident 51 was sitting at the dining table. Activity Coordinator (AC 1) was heard referring to Resident 51 as a feeder when describing the resident during the meal service.During an interview on 4/20/26 at 12:50p.m., AC 1 stated the wording came out wrong. AC 1 stated that the appropriate way to refer to the resident is simply to indicate whether the resident needed assistance with meals.During an interview on 4/20/26 at 1:15p.m., with the Director of Staff Development (DSD), DSD stated the term feeders should not be used when referring to residents. DSD stated that staff are expected to address individuals as residents, clients, or patients. DSD stated the term feeder was not an appropriate term, and using it would be insulting and demeaning for the residents.During a record review of the facility's policy and procedure (P&P), titled, Dignity, dated February 2021, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well^being, level of satisfaction with life, and feelings of self^worth and self^esteem. The P&P further indicated, that staff must speak respectfully to residents at all times, including addressing residents by their name of choice and not labeling them by referring to the resident by their room number, diagnosis, or care needs.

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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 observation, interview and record review, the facility failed to ensure that one of 14 sampled residents (Resident 6) had adequate indications for the use of Haloperidol (or Haldol, is a strong antipsychotic. An antipsychotic is a medication that is used for the mind to manage delusions, hallucinations, and disordered thoughts. Antipsychotic medications can cause severe side effects).This failure had the potential for increased risks associated with the use of psychotropic (psychotropic medications are prescription drugs that affect how the brain works, changing a person's mood thoughts, feelings or behavior. Antipsychotic medication like Haldol is a psychotropic medication) medications that could negatively affect the residents' physical, mental and psychosocial well-being.Findings:During a review of the facility's policy and procedure (P&P) titled, Antipsychotic Medication Use, dated 2001, the P&P indicated, Policy statement: Residents will not receive medications that are not clinically indicated to treat a specific condition.7. Antipsychotic medications should generally be used for the following conditions /diagnoses .: a. Schizophrenia .f. psychosis in the absence of dementia . 8. Diagnosis alone do not warrant the use of antipsychotic medication. In addition to the above criteria, anti-psychotic medications will generally only be considered if the following conditions are also met: a. The behavioral symptoms present a danger to the resident or others. (schizophrenia is a brain disorder that causes people to lose touch with reality; dementia is loss of memory, language, problem-solving and other thinking abilities).During an observation on 4/20/26, Resident 6 was awake, quiet, and lying in bed. During another observation, on 4/21/2026 at 10:00 a.m., Resident 6 was sleeping in her bed. A review of Resident 6's admission record indicated, the resident was admitted on [DATE], with diagnoses that included, dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (psychotic disturbance or psychosis means a person has temporarily lost touch with reality. It is a collection of symptoms where the brain has trouble distinguishing between what is real and what is not.) The resident's diagnosis indicated the resident had dementia without psychotic disturbance.A review of Resident 6's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 1/23/26, indicated, the resident had severe cognitive impairment.A review of Physician's orders dated 4/23/26, indicated, an order with a start date of 1/16/26 of Haloperidol 1 mg tablet by mouth every morning and at bedtime for agitation, and Haloperidol 1 mg tablet give 2 mg. by mouth in the afternoon for agitation before lunch.During an interview on 4/22/26 10:14 a.m., with Certified Nursing Assistant (CNA) 2, stated Resident 6 had no behavior of being a danger to herself or to others. CNA 2 stated that the resident's behavior was yelling at times but stated the resident would eventually calm down when the staff talked to her.A review of the Consultant Pharmacist's (CP) Medication Review Recommendation, for Haldol, dated 1/29/26, indicated the CP was asking the facility for an approved indication for the Haldol use for Resident 6.A review of another CP Medication Review Recommendation, for Haldol, dated 3/26/26, indicated the CP was asking the facility again for an approved indication for the Haldol use for Resident 6.During a concurrent interview and record review on 4/23/2026 at 9:20 a.m., with Director of Nursing (DON), Resident 6's Antipsychotic Medication care plan dated 4/22/26 was reviewed. The care plan indicated that the resident had a diagnosis of schizophrenia. DON stated that the resident did not have a diagnosis of schizophrenia and was just probably a mistake in documentation. DON further stated that agitation was not an appropriate indication for Haldol. DON also stated that Haldol should be given to the resident with the correct diagnosis and indication. Resident 6's Medication Administration Record (MAR) for April 2026 was also reviewed. On 4/1/26- 4/22/26, the MAR indicated a behavior monitoring of increased anxiety and paranoid behavior for the Haldol use. The MAR did not indicate that the behaviors were observed.During an interview on 4/23/2026 at 10:15 a.m., with the CP, CP stated that agitation was not an appropriate indication to give Haldol to Resident 6.

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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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and record review, for one of three sampled residents (Resident 36) the facility failed to ensure that an arbitration agreement (Arbitration is a method of settling disputes between individuals, the two parties choose some disinterested and qualified person or people-the arbitrator-to judge the matter) was explained to the resident or resident representative in a manner that they understood.This failure had the potential for Resident 36's rights to be compromised by preventing the resident and the resident's representative from making fully informed choices about matters affecting the resident's care and wellˆbeing.Findings:During a record review of Resident 36's admission Record printed on 4/21/26, the record indicated Resident 36 was admitted to the facility on [DATE].During a record review of Resident 36's History and Physical, dated 3/24/26, the record indicated Resident 36's Durable Power of Attorney (DPOA, A legal document that gives one person the authority to make medical, legal, or financial decisions for another person.) was listed as Resident Representative (RR 1).During a record review of Resident 36's Minimum Data Sheet (MDS, a standardized assessment tool used to evaluate a resident's functional capabilities, health needs, and clinical status) dated 4/1/26, the MDS indicated a Brief Interview for Mental Status (BIMS, an assessment for mental status) score was seven (7) out of 15, indicating that Resident 36 had severe cognitive impairment.During an interview and record review on 4/22/26 at 10:06 a.m. with the Infection Preventionist (IP), Resident 36's physician order summary in electronic health record was reviewed. The physician order dated 3/28/26, indicated, that the IP documented a telephone order (obtained from the doctor via phone) that Resident 36 did have the capacity to sign documents. IP stated he had entered the order based on the nursing admission assessment dated 3/28/26, which indicated Resident 36 was alert and oriented to time, place and person. IP stated, however, the physician should be the one to determine a resident's capacity.During an interview on 4/21/26 at 8:50 a.m. Resident 36 was lying in bed in her room. Resident 36 stated Resident Representative (RR 1) signed all documents upon her admission to the facility.During a phone interview on 4/21/26 at 9:10 a.m., RR 1 stated she did not remember being explained the arbitration process and/or signing an arbitration agreement for Resident 36 upon her admission to the facility on 3/28/26.During an interview and record review on 4/21/26 at 10:20 a.m., with the Marketing Director 1 (MD 1), Resident 36's arbitration agreement dated 3/30/26 was reviewed. MD 1 stated he and facility's admission Director (AD 1) were responsible for explaining the arbitration process and getting the agreements signed from residents or their responsible representatives. MD 1 stated Resident 36's arbitration agreement indicated facility's AD 1 and Resident 36 signed the agreement on 3/30/26.AD 1 remained unavailable for an interview throughout the survey.During an interview and record review on 4/21/26 at 12:55 PM, with the Director of Nursing (DON), Resident 36's physician progress note dated 3/31/26 were reviewed. The notes indicated that Resident 36's doctor noted, patient does not have the capacity to make medical decisions. The DON stated based on doctor's note and Resident 36's impaired mental status, Resident 36 should not have signed her arbitration agreement. The DON stated residents could feel misled if they were signing something that they didn't understand.During a record review of the facility's policy and procedure (P&P) titled, Binding Arbitration Agreements, dated 2001, the P&P indicated, The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a way that ensures his or her understanding of the agreement.The record also indicates, The terms and conditions of a binding arbitration agreement are explained to the resident (or representative) in a form and manner that he or she understands.

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	04/23/2026

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility had sixteen resident rooms (Rooms 1, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17 and 18) with multiple beds that provided less than 80 square foot (sq. ft) per resident who occupied these rooms. This deficient practice had the potential to result in inadequate space for the delivery of care to each of the residents in each room or for storage of residents' belongings. Findings:During an observation on 4/22/26 at 1:31 p.m., the following rooms and corresponding sq. ft per bed were identified: room [ROOM NUMBER] was observed with three beds. The room measured a total of 200 square feet. This size only provided 66 square feet per resident space. room [ROOM NUMBER] was observed with three beds. The room measured a total of 200 square feet. This size only provided 66 square feet per resident space. room [ROOM NUMBER] was observed with two beds. The room measured a total of 140 square feet. This size only provided 70 square feet per resident space. room [ROOM NUMBER] was observed with three beds. The room measured a total of 200 square feet. This size only provided 66 square feet per resident space. room [ROOM NUMBER] was observed with two beds. The room measured a total of 140 square feet. This size only provided 70 square feet per resident space. room [ROOM NUMBER] was observed with three beds. The room measured a total of 200 square feet. This size only provided 66 square feet per resident space.room [ROOM NUMBER] was observed with two beds. The room measured a total of 140 square feet. This size only provided 70 square feet per resident space. room [ROOM NUMBER] was observed with two beds. The room measured a total of 140 square feet. This size only provided 70 square feet per resident space. room [ROOM NUMBER] was observed with three beds. The room measured a total of 200 square feet. This size only provided 66 square feet per resident space. room [ROOM NUMBER] was observed with two beds. The room measured a total of 140 square feet. This size only provided 70 square feet per resident space. room [ROOM NUMBER] was observed with three beds. The room measured a total of 200 square feet. This size only provided 66 square feet per resident space. room [ROOM NUMBER] was observed with three beds. The room measured a total of 200 square feet. This size only provided 66 square feet per resident space.room [ROOM NUMBER] was observed with two beds. The room measured a total of 140 square feet. This size only provided 70 square feet per resident space. room [ROOM NUMBER] was observed with three beds. The room measured a total of 200 square feet. This size only provided 66 square feet per resident space. room [ROOM NUMBER] was observed with two beds. The room measured a total of 140 square feet. This size only provided 70 square feet per resident space.room [ROOM NUMBER] was observed with three beds. The room measured a total of 200 square feet. This size only provided 66 square feet per resident space. During random observations of care and services from 04/20/26 to 04/23/26, there were sufficient space for the provision of care for the residents in the rooms. There was no heavy equipment in the room that might interfere with residents' care and each resident had adequate personal space and privacy. There were no complaints from the residents regarding insufficient space for their belongings. There were no negative consequences attributed to the decreased space and/or safety concerns in the 16 rooms. Granting of room size waiver recommended.