STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555850	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alhambra Hospital Med Ctr Dp/Snf	100 S Raymond Ave Alhambra, CA 91801

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain a safe, clean, comfortable sanitary and home-like environment by failing to ensure one (1) of 12 sampled residents (Resident 19) had a sink in the resident's room with a Formica (hard durable plastic laminate used for countertops, cupboard doors, and other surfaces) that was stripped off and with an exposed rough wood. This deficient practice caused an unsanitary environment and had potential for resident and staff to be placed at risk of injury. Findings: During a record review of Resident 19's admission Record, the admission record indicated Resident 19 was admitted on [DATE]. During a record review of Resident 19's History and Physical (H&P), dated 4/29/2025 indicated Resident 19 with diagnosis of acute chronic hypoxic respiratory failure (a person's lungs are unable to provide enough oxygen), hypertension (high blood pressure), and seizure (involuntary muscle movement). During a record review of Resident 19's Minimum Data Set (MDS, a resident assessment tool), dated 6/10/2025, the MDS indicated resident was severely impaired with cognitive skills for daily decision making and was dependent on shower/bathe self, upper body dressing, lower body dressing, personal hygiene. During an observation on 6/30/2025 at 10:21 AM in Resident 19's room, the resident room's sink had a Formica that was stripped off and had an exposed rough wood. During concurrent observation and interview on 7/1/2025 at 12: 43 PM in Resident 19's room, the Director of Nursing (DON) stated Resident 19's room sink was stripped off its protective barrier and chipped rough wood was exposed. The DON stated this can grow molds or any unwanted growth, that can possibly cause infection control to residents or harm to staff like scrape themselves. During concurrent observation and interview on 7/1/2025 at 4:31 PM in Resident 19's room with the Maintenance Assistant (MA 1), MA 1 stated Resident 19's room sink Formica was stripped. MA stated the wood was chipped possibly caused by water damage. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/2/2025 at 1:56 PM with the License Vocational Nurse (LVN 2), LVN 2 stated exposed rough wood in resident's room sink was not acceptable. LVN 2 stated this can build moisture possible for molds. LVN 2 also stated residents can inhale and possibly cause infection or any sickness to vulnerable residents. During a concurrent interview and record review on 7/3/2025 at 2:44 PM with the DON of the facility's Policy and Procedure (P&P) titled, Management of Environment of Care, dated 1/2023, the DON stated P&P indicated the intent of these program is to enhance the quality of patient's stay. By ensuring that the environment is safe and secure, comfortable, and appropriately furnished . The P&P also indicated to provide a quality patient care in a safe environment that is sensitive to patient's physical, social, spiritual and cultural needs. The DON stated the facility did not meet the standard according to P&P.

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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. Based on observation, interview, and record review the facility failed to follow its Policy and Procedure on pressure ulcer (localized damage to the skin and underlying soft tissue caused by prolonged pressure) prevention and wound management for one (1) of two (2) sample residents (Resident 13) by failing to ensure the Low Air Loss mattress (LAL mattress, designed to prevent and treat pressure ulcer) was set at the correct setting in accordance with the resident's weight. This deficient practice had the potential for Resident 13's pressure ulcer to worsen and develop complications which will negatively affect the resident's overall wellbeing. Findings: During a record review of Resident 13's admission Record, the admission Record indicated the facility originally admitted Resident 12 on 12/22/2023. During a record review of Resident 13's History and Physical (H&P) dated, 12/22/2023, the H&P indicated Resident 13 with diagnosis of tracheostomy (tracheostomy- a surgically created opening (stoma) in the trachea (windpipe) to allow for breathing and airway management), dependence (the condition where an individual relies on a tracheostomy tube to breathe), sacral ulcer stage four (the most severe stage of a pressure ulcer, characterized by full-thickness skin and tissue loss that extends into muscle, bone, tendon, or other supporting structures), and hypertension (high blood pressure). During a record review of Resident 13's Minimum Data Set (MDS, a resident assessment tool), dated 6/25/2025, the MDS indicated resident was dependent on shower/bathe self, upper body dressing, lower body dressing, personal hygiene. The MDS also indicated the resident was at risk for developing pressure ulcer/ injuries. The MDS also indicated skin and ulcer/ injury treatment included pressure reducing device for bed and turning/ repositioning program. During a record review of Resident 13's Active Orders, dated 6/30/2025, the Active Orders indicated ongoing air loss mattress for pressure injury management / healing. During a record review of Resident 13's Skin Progress Notes, dated 6/29/2025, the Skin Progress Notes indicated: Site: Coccyx (small bone at the bottom of the spine) Skin Issue: Stage 4 pressure injury. Length: 1.8 centimeters (cm; a unit of length in the metric system), Width: 1.2 cm, Dept: 2.2 cm. During a record review of Resident 13's Care Plan, dated 6/19/2025, the Care Plan indicated Pressure injury stage 4 Sacro coccyx (bones at the base of the spine). The intervention included air mattress for healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 13's Care Plan, dated12/28/2024, the Care Plan indicated potential impaired skin integrity related to skin mobility, altered nutrition status, and chronic disease process. The interventions included were to use resident's own low air loss mattress per family preference for prevention of pressure injury and educate all nursing staff to follow manufacturer's guidelines recommendation of level of firmness based on patients' weight/comfort. During observation on 6/30/2025 at 9:49 AM in Resident 13's room, Resident 13 was observed lying in bed with the LAL mattress setting at four (4), 175 pounds (lbs., when it refers to weight). During an interview on 7/1/2025 at 4:20 AM with Registered Nurse (RN 2), RN 2 stated Resident 13's weight was 123 lbs. The LAL mattress setting should have been set at 2 to 3 (105-140 lbs.) RN2 stated it defeats the purpose of the LAL mattress if it is not on the right setting. RNS 2 stated it is not comfortable for the resident and the wound will take longer to heal. During a concurrent interview and record review of Resident 1's care plan on 7/2/2025 at 1:21 PM with RN 3, RN3 stated the LAL mattress is used to decrease the pressure and to prevent pressure injury. The set up depends on the weight of the resident. RN3 also stated Resident 13's care plan indicated to educate all nursing staff to follow manufacturers guidelines recommendation of level firmness based on patients' weight/ comfort. RN3 stated Med One user guide indicated to use the weight scale to match the resident's weight to the closest weight number in the scale (top lbs. - bottom is kilo) and using the 0-9 setting on the top of the scale set LED (green light). During an interview on 7/3/2025 at 2:38 PM with the Director of Nursing (DON), the DON stated the facility did not follow Resident 13's care plan and manufacturer's guideline. The DON stated the mattress could be too firm that it could possibly worsen the pressure injury or prevent it from healing. During a review of the facility's Policy and Procedure (P&P) titled, Low air loss Therapy, dated 9/2022 indicated: Purpose: To reduce the mechanical forces of pressure, shear friction and moisture which contribute to tissue breakdown. To reduce the healing time of existing tissue breakdown. During a review of the facility's P&P titled, Care Plan, Patient Interdisciplinary, dated 6/2024 indicated To provide quality patient care based on the unique needs and diagnosis of patients. The P&P also indicated the plan of care will be based on the patient's unique needs, problems related to the triggered care area from the MDS assessment and diagnosis of the patient and will include patient problems, expected outcomes/realistic goals and interventions.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 cap the purple cone tip of the gastronomy tube feeding (g-tube; a tube inserted through the belly that brings nutrition directly to the stomach) when not connected to resident for two (2) of 2 sampled residents (Resident 17 and 22). This deficient practice had the potential to result in complications including infections and stomach discomfort. Findings: 1.During a record review of Resident 17's admission record indicated the facility originally admitted Resident 17 on 5/6/2025. During a record review of Resident 17's history and physical (H&P) dated 5/7/2025 indicated Resident 17 with diagnosis of respiratory failure ventilator dependent (a person's lungs are unable to provide enough oxygen), dementia (a decline in mental abilities, including memory, thinking, and reasoning, severe enough to interfere with daily life), and hypertension (high blood pressure). During a record review of Resident 17's Minimum Data Set (MDS, a resident assessment tool), dated 5/13/2025, the MDS indicated resident was dependent on shower/bathe self, upper body dressing, lower body dressing, personal hygiene. The MDS also indicated nutritional approaches feeding tube (g-tube) on admission. During a record review of Resident 17's Active Orders indicated order date 6/16/2025 g-tube feeding diet, Vital 1.5 calories (a type of feeding formula) continuous at 65 milliliter per hour (ml/hr., measurements of volume) for 20 hours. During a record review of Resident 17's care plan titled Sub Acute Care Plan date initiated 5/6/2025 indicated expected outcome no signs and symptoms of tube feeding related infection. During observation on 6/30/2025 at 11:23 AM in Resident 17's room observed the purple cone tip of g- tube feeding of Resident 17 was uncapped/ uncovered. 2. During a record review of Resident 22's admission record indicated the facility originally admitted Resident 22 on 8/20/2024. During a record review of Resident 22's H&P dated 8/22/2024 indicated Resident 22 with dysphagia (difficulty swallowing), hypertension, and dementia. During a record review of Resident 22's MDS, dated [DATE], the MDS indicated residents were dependent on shower/bathe self, upper body dressing, lower body dressing, personal hygiene. The MDS also indicated nutritional approaches feeding tube while a resident. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 22's Active Orders indicated order date 9/24/2024 tube feeding diet: Tube feeding route of administration G-tube. Tube feeding formula type: Jevity 1.2 calories (type of feeding) continuous at 45ml/hr. for 20 hours. During a record review of Resident 22's care plan titled Sub Acute Care Plan date initiated 8/20/2024 indicated expected outcome: no signs and symptoms of tube feeding related infection. During observation on 6/30/2025 at 11:35 AM in Resident 22's room observed the purple cone tip of Resident 22's g- tube feeding was not covered/ uncapped. During a concurrent interview and record review on 7/2/2025at 10:27 AM with the Director of Nursing (DON), the manufacturer's guidelines titled Midline Safety Spike Pump Set Up with Brand 1 undated was reviewed. The guideline indicated under directions of use, replace connector cap. The DON stated the g-tube purple cone tip should be capped when not connected to residents, to prevent it from touching unnecessary surface that can transmit unwanted bacteria, virus that can cause sickness. The DON stated no specific policy and procedure (P&P) regarding the purple cone tip of the G-tube should be covered but it was indicated in the manufacturer's guidelines titled Midline Safety Spike Pump Set Up with Brand 1. The DON stated under directions for use indicated replace connector cap. During an interview on 7/2/2025 at 4:05 PM with License Vocational Nurse (LVN 2), LVN 2 stated the G-tube purple cone tip was supposed to be covered with a cap when not used to prevent cross contamination that can possibly cause sickness like diarrhea and stomach flu to residents. During an interview on 7/3/2025 at 2:31PM with the DON the DON stated all G-tube purple cone tip should be covered when not in use, and it was not in the P&P, but it was in the manufacturer's guideline. The DON also stated it should be indicated the P&P.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview and record review the facility failed to ensure the midline catheter (a specific type of intravenous [IV] catheter designed for administering fluids, medications, and sometimes for drawing blood over an extended period) with 2 lumen injection ports had a swab cap (a disinfecting cap, often used in healthcare settings, designed to cover and disinfect needleless connectors on IV lines) when not in use for one (1) of 12 sampled residents (Resident 9) in accordance to the facility policy. This deficient practice had the potential to result in Resident 9 developing IV complications which can lead to infection and possible hospitalization. Findings: During a record review of Resident 9's admission Record, the admission Record indicated the facility originally admitted Resident 9 on 6/22/2025. During a record review of Resident 9's History and Physical (H&P), dated 6/23/2025, the H&P indicated Resident 9 with a diagnosis of anemia (levels of healthy red blood cells to carry oxygen throughout your body), seizure (a sudden, uncontrolled electrical disturbance in the brain that can)cause changes in awareness, behavior, muscle control, and sensations), and quadriplegia (a medical condition characterized by the complete or partial loss of motor function in all four limbs (arms and legs). During a record review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 6/25/2025, the MDS indicated the resident had severe impairment with cognitive skills for daily decision making and was dependent on shower/bathe self, upper body dressing, lower body dressing, and personal hygiene. During a record review of Resident 9's Active Orders, dated 6/26/2025, the Active Orders indicated peripherally inserted central catheter (PICC, peripherally inserted central catheter, is a long, thin, flexible tube inserted into a vein in the arm, typically near the bend of the elbow, and threaded into a larger vein near the heart) line care per protocol every Thursday. The intervention text included to change midline dressing including injection ports every Thursday and PRN (as needed) if soiled. During a record review of Resident 9's Care Plan, dated 6/24/2025, the Care Plan indicated potential infection related to midline invasive line right arm. The interventions indicated were to cover injection ports with swab caps, change daily, and PRN after every use. During observation on 6/30/2025 at 11:40 AM in Resident 9's room, resident's right upper arm midline two lumen injection port does not have a swab cap. During a concurrent observation and interview on 7/1/2025 at 4:15 PM with registered nurse 2 (RN 2), RN 2 stated Resident 9's midline two lumen injection port was not and should have been covered. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/2/2025 at 3:45 PM with RN 3, RN 3 stated to prevent infection, the midline injection ports were supposed to be covered with swab cap. RN3 stated facility's policy and procedures (P&P) titled, Midline Catheter Policy dated 10/2021, indicated to reduce the incidence of intravascular catheter related infections following evidence-based guidelines for the use, insertion and management of midline catheter. RN3 also stated P&P also indicated injection cap should be changed when the cap has been removed for any reason. During an interview on 7/3/2025 at 2:35 PM with the Director of nursing (DON), the DON stated the midline catheter was supposed to be capped because it is the facility's practice to prevent infection.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of one (1) of six (6) sampled residents (Resident 24) by failing to ensure two (2) of 6 medications, mixed with water, were completely administered during medication administration. This deficient practice resulted in Resident 24 not being able to take the full amount/dose of the prescribed medications which had the potential to result in harm due to unmet individual medication needs. Findings: During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included respiratory failure (a condition where the lungs are unable to adequately deliver oxygen to the blood or remove carbon dioxide), tracheostomy (a surgical procedure to create an opening in the windpipe through the neck allowing for a tube to be inserted for breathing), and G-tube (gastrostomy tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) feeding. During a review of Resident 24's Minimum Data Set (MDS- a resident assessment tool), dated 5/19/2025, the MDS indicated Resident 24 was assessed having severely impaired (never/rarely made decisions) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 24 was dependent (helper completed the activities for the resident) with oral/toileting hygiene, shower/bathe self, upper/lower body dressing, sit to lying, and chair/bed-to-chair transfer. Resident 24 required substantial/maximal assistance (helper does more than half the effort) with rolling left and right. Resident 24 was on a mechanically altered diet (required change in texture of food or liquids). Resident 24 had an abdominal feeding tube (G-tube). During a review of Resident 24's Active Orders Report, dated 7/3/2025, the Active Orders Report indicated a physician order, with a start date of 12/6/2024, for ascorbic acid (Vitamin C- a vitamin that protects the cells from damage and is essential for the growth and repair of tissues throughout the body) 500 milligrams (mg-unit of measurement) via feeding tube twice daily. Resident 24's Active Orders Report also indicated a physician order, with a start date of 6/24/2025, for glycopyrrolate (a medication used to treat severe drooling caused by certain brain disorders) 1 mg via feeding tube three times a day. During an observation of the medication preparation, on 7/3/2025, at 8:54 AM, Licensed Vocational Nurse 1 (LVN 1) was observed preparing the following medications in individual medication cups: 1. Colace (a medication that softens the stool and relieves occasional constipation) 100 mg /10 milliliter (ml-unit of measurement for volume) solution (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Eliquis (a medication used to treat and prevent blood clots) 2.5 mg 3. Metoprolol (a medication that slows the heart rate and relaxes the blood vessels to improve blood flow and lowers blood pressure) 50 mg 4. Losartan Potassium (a medication that relaxes the blood vessels and lowers blood pressure) 50 mg 5. Glycopyrrolate 1 mg 6. Vitamin C 500 mg LVN 1 also prepared and placed 10 ml of water in several medication cups. During an observation of the medication administration, on 7/3/2025, at 9:08 AM, LVN 1 poured 10 ml of water into the different medication cups containing Resident 24's medications. LVN 1 swirled each medication cup in her hand before administering each medication via Resident 24's G-tube. LVN 1 did not mix the water with the medication with a tongue depressor or stirrer. LVN 1 administered the following medications to Resident 24: 1. Colace 100 mg /10 milliliter (ml-unit of measurement for volume) solution 2. Eliquis 2.5 mg, with 10 ml of water 3. Metoprolol 50 mg, with 10 ml of water 4. Losartan Potassium 50 mg, with 10 ml of water 5. Glycopyrrolate 1 mg, with 10 ml of water (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Vitamin C 500 mg, with 20 ml of water During a concurrent observation of Resident 24's medication cups after medication administration and interview with LVN 1, on 7/3/2025, at 9:15 AM, LVN 1 stated there was a white pasty residual left inside Resident 24's glycopyrrolate and Vitamin C medication cups. LVN 1 stated the white pasty residual in the medication cups were glycopyrrolate and Vitamin C medications that did not completely dissolve in the water. LVN 1 stated she did not stir and make sure the medications were completely dissolved before administering the medications to Resident 24. LVN 1 stated Resident 24 was not administered the complete dose of his glycopyrrolate and Vitamin C medications since there was medication left in Resident 24's glycopyrrolate and Vitamin C medication cups. LVN 1 stated Resident 24's medications will be effective if the prescribed dose was not administered. During an interview with the Director of Nursing (DON), on 7/3/2025, at 2:45 PM, the DON stated crushed medication should be mixed with water and stirred to ensure the medication dissolved in the water solution. The DON stated there should not be any residual medication visible in the cup after medication administration. The DON stated Resident 24 did not receive the entire dose of glycopyrrolate and Vitamin C if traces of the medications were left in the medication cup. The DON stated Resident 24 should have received the whole dose of the glycopyrrolate and Vitamin C. The DON stated it was important for Resident 24 to receive all his medications to target the issues that he was diagnosed with. The DON stated the medication would not be as efficient if the entire dose was not received. The DON stated LVN 1 did not follow the facility's policy and procedure (P&P) for medication administration since Resident 24 did not receive the full dose of his medications. During a review of the facility's P&P titled, Medication Administration, approved on 10/2019, the P&P indicated, Before administering a medication, the licensed independent practitioner or appropriate health care professional administering the medication does the following: verifies the medication is being administered at the proper time, in the prescribed dose, and by the correct route.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). Two (2) medication errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/ manufacturer's specifications / accepted professional standards and principles out of 27 opportunities (observed administered medications) for error, to yield an overall medication error rate of 7.41 percent (%) for one (1) of six (6) sampled residents (Resident 24) observed during medication administration (med pass). Licensed Vocational Nurse 1 (LVN 1) failed to administer the entire dose of glycopyrrolate (a medication used to treat severe drooling caused by certain brain disorders) and ascorbic acid (Vitamin C- a vitamin that protects the cells from damage and is essential for the growth and repair of tissues throughout the body) 500 milligrams (mg-unit of measurement) to Resident 24 as indicated in the Physician's order. This deficient practice resulted in Resident 24 not being able to take the full amount/dose of the prescribed medications which had the potential to result in harm due to unmet individual medication needs. Findings: During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included respiratory failure (a condition where the lungs are unable to adequately deliver oxygen to the blood or remove carbon dioxide), tracheostomy (a surgical procedure to create an opening in the windpipe through the neck allowing for a tube to be inserted for breathing), and G-tube (gastrostomy tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) feeding. During a review of Resident 24's Minimum Data Set (MDS- a resident assessment tool), dated 5/19/2025, the MDS indicated Resident 24 was assessed having severely impaired (never/rarely made decisions) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 24 was dependent (helper completed the activities for the resident) with oral/toileting hygiene, shower/bathe self, upper/lower body dressing, sit to lying, and chair/bed-to-chair transfer. Resident 24 required substantial/maximal assistance (helper does more than half the effort) with rolling left and right. Resident 24 was on a mechanically altered diet (required change in texture of food or liquids). Resident 24 had an abdominal feeding tube (G-tube). During a review of Resident 24's Active Orders Report, dated 7/3/2025, the Active Orders Report indicated a physician order, with a start date of 12/6/2024, for ascorbic acid (Vitamin C- a vitamin that protects the cells from damage and is essential for the growth and repair of tissues throughout the body) 500 mg via feeding tube twice daily. Resident 24's Active Orders Report also indicated a physician order, with a start date of 6/24/2025, for glycopyrrolate (a medication used to treat severe drooling caused by certain brain disorders) 1 mg via feeding tube three times a day. (continued on next page)

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	555850	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alhambra Hospital Med Ctr Dp/Snf	100 S Raymond Ave Alhambra, CA 91801

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of the medication preparation, on 7/3/2025, at 8:54 AM, LVN 1 was observed preparing the following medications in individual medication cups: 1. Colace (a medication that softens the stool and relieves occasional constipation) 100 mg /10 milliliter (ml-unit of measurement for volume) solution 2. Eliquis (a medication used to treat and prevent blood clots) 2.5 mg 3. Metoprolol (a medication that slows the heart rate and relaxes the blood vessels to improve blood flow and lowers blood pressure) 50 mg 4. Losartan Potassium (a medication that relaxes the blood vessels and lowers blood pressure) 50 mg 5. Glycopyrrolate 1 mg 6. Vitamin C 500 mg LVN 1 also prepared and placed 10 ml of water in several medication cups. During an observation of the medication administration, on 7/3/2025, at 9:08 AM, LVN 1 poured 10 ml of water into the different medication cups containing Resident 24's medications. LVN 1 swirled each medication cup in her hand before administering each medication via Resident 24's G-tube. LVN 1 did not mix the water with the medication with a tongue depressor or stirrer. LVN 1 administered the following medications to Resident 24: 1. Colace 100 mg /10 ml solution 2. Eliquis 2.5 mg, with 10 ml of water 3. Metoprolol 50 mg, with 10 ml of water (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Losartan Potassium 50 mg, with 10 ml of water 5. Glycopyrrolate 1 mg, with 10 ml of water 6. Vitamin C 500 mg, with 20 ml of water During a concurrent observation of Resident 24's medication cups after medication administration and interview with LVN 1, on 7/3/2025, at 9:15 AM, LVN 1 stated there was a white pasty residual left inside Resident 24's glycopyrrolate and Vitamin C medication cups. LVN 1 stated the white pasty residual in the medication cups were glycopyrrolate and Vitamin C medications that did not completely dissolve in the water. LVN 1 stated she did not stir and make sure the medications were completely dissolved before administering the medications to Resident 24. LVN 1 stated Resident 24 was not administered the complete dose of his glycopyrrolate and Vitamin C medications since there was medication left in Resident 24's glycopyrrolate and Vitamin C medication cups. LVN 1 stated Resident 24's medications will be effective if the prescribed dose was not administered. During an interview with the Director of Nursing (DON) on 7/3/2025, at 2:45 PM, the DON stated crushed medication should be mixed with water and stirred to ensure the medication dissolved in the water solution. The DON stated there should not be any residual medication visible in the cup after medication administration. The DON stated Resident 24 did not receive the entire dose of glycopyrrolate and Vitamin C if traces of the medications were left in the medication cup. The DON stated Resident 24 should have received the whole dose of the glycopyrrolate and Vitamin C. The DON stated it was important for Resident 24 to receive all his medications to target the issues that he was diagnosed with. The DON stated the medication would not be as efficient if the entire dose was not received. The DON stated LVN 1 did not follow the facility's policy and procedure (P&P) for medication administration since Resident 24 did not receive the full dose of his medications. During a review of the facility's P&P titled, Medication Administration, approved on 10/2019, the P&P indicated, Before administering a medication, the licensed independent practitioner or appropriate health care professional administering the medication does the following: verifies the medication is being administered at the proper time, in the prescribed dose, and by the correct route.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with its policy and procedure by failing to ensure: 1. A box of Kosher salt was not open and unsealed. 2. A container of soy sauce was free of drippings. 3. A container of Japanese curry powder was properly sealed. 4. The can opener was clean, not chipped, and free of rust. These deficient practices had the potential to result in pathogen (germ) exposure to residents, which could place the residents at risk for developing foodborne illness ([food poisoning] with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and can lead to other serious medical complications and hospitalization. Findings: During an observation in the facility's kitchen on 6/30/2025 at 7:57 AM in the kitchen's preparation area, the following were observed: 1. A box of Kosher salt was not open and unsealed. 2. A container of soy sauce was free of drippings. 3. A container of Japanese curry powder was not properly sealed. 4. The can opener was clean, not chipped, and free of rust. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/2/2025 at 8:29 AM with the Registered Dietitian (RD), the RD stated the Kosher salt box was unsealed, soy sauce container with residuals, and the Japanese Curry container was not properly sealed. The RD also stated food containers were supposed to be sealed properly and without drippings on the container to prevent food contamination. RD stated there was a possibility that insects could get in and it could attract rodents which could cause stomach upsets, diarrhea, and food poisoning. During a concurrent observation and interview on 7/2/2025 at 8:30 AM with the RD, RD stated the can opener was chipped and rusted. RD also stated this was not acceptable because it can lead to food contamination or poisoning of residents. During a concurrent interview and record review on 7/3/2025 at 9:30 AM with the Kitchen Supervisor (KS), of the facility's Policy and Procedure (P&P) titled, Food Storage, dated 5/2024, KS stated P&P indicated, Food items will be stored appropriately to ensure product safety and quality. The P&P also indicated, Food and supplies are properly covered and labeled. During the same concurrent interview and record review on 7/3/2025 at 9:30 AM with KS, of the facility's P&P titled, Department of Safety Rules, dated 10/2025, KS stated P&P indicated: 1. All work areas are kept neat, orderly, and properly sanitized. 6. Employees must immediately report the following to their supervisor: a) Report unsafe conditions such as broken chairs, frayed electrical wires, broken electrical outlets and defective equipment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 four (4) of four sampled residents (Residents 5, 11, 21, and 6) in accordance with the facility's policy and procedure (P&P) by failing to: 1. and 2. Sanitize (make clean and hygienic) the pulse oximetry (pulse ox- a non-invasive method used to measure the oxygen saturation [the percentage of hemoglobin in the blood that is carrying oxygen] level in a resident's blood) monitor before and after each resident's use for Resident 5 and Resident 11. 3. Ensure facility staff donned (wear) personal protective equipment (PPE- a barrier precaution which includes use of gloves, gown, mask, face shield, shoe covers, head covers, respirators, etc. when you anticipate contact with blood or body fluids or other communicable toxins or agents) before checking Resident 21's gastrostomy tube (G-tube- a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach) placement and medication administration. 4. a. Change gloves and perform hand hygiene in between tasks during tracheostomy (a surgical procedure to create an opening in the windpipe through the neck allowing for a tube to be inserted for breathing) dressing change to Resident 6. b.Dispose Resident 6's used tracheostomy drain sponge (a dressing used to absorb and manage fluids leaking from tracheostomy tubes) and inner cannula (a tube inserted in the tracheostomy to help with breathing) in the trash after tracheostomy care. c.Sanitize Resident 6's bedside table after Resident 6's used tracheostomy dressings and inner cannula were placed on top by Registered Nurse 2 (RN 2) after providing tracheostomy care. These deficient practices had the potential to result in the spread of and development of infection through possible cross-contamination (passing of bacteria, or other harmful substances indirectly from one resident to another through improper or soiled equipment, procedures, or products.) Findings: 1. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. During a review of Resident 5's History and Physical (H&P), dated 12/3/2024, the H&P indicated Resident 5 had diagnoses which included chronic ventilator-dependent respiratory failure (when a resident is unable to breathe independently and requires mechanical ventilation), tracheostomy, and chronic obstructive pulmonary disease (COPD- a long-term lunch disease causing difficulty breathing). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool), dated 6/11/2025, the MDS indicated Resident 5 was in a persistent vegetative state (a condition where a resident is awake but shows no signs of awareness)/no discernable consciousness. Resident 5 was dependent (helper does all of the effort) with upper/lower body dressing, personal/toileting hygiene, rolling left and right, and chair/bed-to-chair-transfer. Resident 5 required oxygen therapy (to provide supplemental oxygen to residents who have low blood oxygen levels or other breathing difficulties), suctioning (the process of removing secretions or fluids by means of a tube and a device), tracheostomy care, and an invasive mechanical ventilator (a life support intervention that provides respiratory support to residents unable to breath adequately on their own by delivering positive pressure directly into their lungs through an artificial airway). During a review of Resident 5's Active Orders Report, dated 7/2/2025, the Active Orders Report indicated a physician order, with a start date of 4/1/2023 for pulse ox monitoring every day and as needed. During a review of Resident 5's care plan, dated 6/11/2025, the care plan indicated Resident 5 had a potential for infection related to tracheostomy tube and ventilator dependency. The care plan intervention indicated to suction every two hours and as needed. During an observation in Resident 5's room, on 7/2/2025, at 10:14 AM, Respiratory Therapist 1 (RT 1) entered Resident 5's room and informed him that he was going to be suctioned. RT 1 performed hand hygiene, donned (put on) his PPE, placed the pulse ox monitor on top of Resident 5's bed and inserted Resident 5's right index finger (the finger next to the thumb) in the sensor. RT 1 suctioned Resident 5's tracheostomy and mouth and removed Resident 5's finger from the sensor. RT 1 doffed (removed) his PPE, performed hand hygiene, placed the pulse ox monitor inside his right shirt pocket, and exited Resident 5's room. RT 1 did not sanitize the pulse ox monitor and sensor before and after placing the pulse ox monitor on the bed and checking Resident 5's oxygen saturation level. During an interview, on 7/2/2025, at 11:05 AM, with RT 1, RT 1 stated he did not clean the pulse ox monitor before and after checking Resident 5 and Resident 11's oxygen saturation. RT 1 stated it was important to sanitize the pulse ox monitor before and after use to prevent cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). RT 1 stated residents can get sick from getting an infection caused by cross contamination. RT 1 stated the pulse ox monitor and sensor should have been sanitized with alcohol pads and disinfectant wipes. 2. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was initially admitted on [DATE] and readmitted on [DATE]. During a review of Resident 11's H&P, dated 6/23/2025, the H&P indicated Resident 11 had diagnoses which included chronic respiratory failure with hypoxia (a condition where the respiratory system is unable to adequately oxygenate the blood resulting in chronically low blood oxygen levels), dysphagia (difficulty or discomfort in swallowing), and hypertension (HTN- high blood pressure). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11 was assessed having severely impaired (never/rarely made decisions) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. Resident 11 was dependent with upper/lower body dressing, personal/toileting hygiene, roll left and right and chair/bed-to-chair transfer. Resident 11 required oxygen therapy, suctioning, tracheostomy care, and an invasive mechanical ventilator. During a review of Resident 11's Active Orders Report, dated 7/2/2025, the Active Orders Report indicated a physician order, with a start date of 10/14/2024 for suction nasal (nose) or trach every two hours and as needed. During a review of Resident 11's Monthly Orders, dated 6/24/2025, the Monthly Orders indicated a physician order under respiratory care to check pulse oximetry daily and as needed. During a review of Resident 11's care plan, dated 6/17/2025, the care plan indicated Resident 11 had a potential for infection related to tracheostomy tube. The care plan intervention indicated to suction every two hours as needed. During an observation on 7/2/2025, at 10:23 AM, RT 1 entered Resident 11's room after suctioning Resident 5. RT 1 informed Resident 11 that she was going to be suctioned, performed hand hygiene, and donned his PPE. RT 1 took the pulse ox monitor out of his right shirt pocket, placed it on Resident 11's pillow, and inserted Resident 11's left index finger in the sensor. RT 1 suctioned Resident 11's tracheostomy and mouth and removed Resident 11's left index finger from the sensor. RT 1 doffed his PPE, performed hand hygiene, placed the pulse ox monitor inside his right shirt pocket, and exited Resident 11's room. RT 1 did not sanitize the pulse ox monitor and sensor before and after placing it on Resident 11's pillow and before and after checking Resident 11's oxygen saturation level. During an interview, on 7/2/2025, at 11:05 AM, with RT 1, RT 1 stated he did not clean the pulse ox monitor before and after checking Resident 5 and Resident 11's oxygen saturation. RT 1 stated it was important to sanitize the pulse ox monitor before and after use to prevent cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another). RT 1 stated residents can get sick from getting an infection caused by cross contamination. RT 1 stated the pulse ox monitor and sensor should have been sanitized with alcohol pads and disinfectant wipes. During an interview, on 7/2/2025, at 4:04 PM, with the Infection Prevention Director (IPD), the IPD stated facility staff should store the pulse ox monitors in their computer carts and not in the shirt pockets because the shirt pockets can be contaminated. The IPD stated the pulse ox monitor and sensor should be sanitized with an alcohol and bleach wipe before and after resident use. The IPD stated it was important to sanitize the pulse ox monitor and sensor to prevent the risk of transmitting infection from one resident to another. The IPD stated residents can get really sick from infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 7/3/2025, at 2:53 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P), titled, Cleaning/Decontamination of Equipment, revised on 1/2008, was reviewed. The DON stated the pulse ox monitor should be sanitized before and after use. The DON stated the pulse ox monitor should be sanitized before placing it inside and after it is removed from the shirt pocket. The DON stated not sanitizing the pulse ox monitors can transmit infectious organisms from one resident to another. The DON stated the P&P for cleaning/decontamination of equipment did not and should include when an equipment needs to be sanitized. During a review of the facility's policy and procedure (P&P), titled, Isolation Precautions, revised on 5/2024, the P&P indicated the following: Indirect contact transmission involves the transfer of an infectious agent through a contaminated intermediate object or person. Examples of opportunities for indirect contact transmission include: Patient care devices (example: electronic thermometers, glucose monitoring devices) may transmit pathogens if devices contaminated with blood or body fluids are shared between patients without cleaning and disinfecting between patients. During a review of the P&P, titled, Sub-Acute Infection Control Policies, revised on 5/2021, the P&P indicated, all used equipment must be considered contaminated and is collected/handled in a safe manner in order to protect other patients, visitors, staff and the hospital environment. 3. During a review of Resident 21's admission Record, the admission Record indicated Resident 21 was admitted to the facility on [DATE]. During a review of Resident 21's H&P, dated 1/27/2025, the H&P indicated Resident 21 had diagnoses which included anoxic brain injury (when the brain is completely deprived of oxygen, leading to cell death and potential severe neurological damage), congestive heart failure (CHF- a serious condition in which the heart does not pump blood as efficiently as it should), and hypertension. During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21 was in a persistent vegetative state. Resident 21 was dependent with oral/toileting hygiene, upper/lower body dressing, personal hygiene, and roll left and right. Resident 21 had an abdominal feeding tube During a review of Resident 21's Active Orders Report, dated 7/2/2025, the Active Orders Report indicated a physician order, dated 8/16/2025 to check G-tube residual every six hours, hold tube feeding for two hours if residual is greater than 100 milliliters (ml- unit of measurement) then resume. During an observation of Resident 21's medication administration on 7/2/2025, at 1:07 PM, inside Resident 21's room, Registered Nurse1 (RN 1) entered Resident 21's room, washed his hands and donned gloves. RN 1 proceeded to unclamp Resident 21's G-tube and inserted a 60 milliliter (ml-unit of measurement) syringe to Resident 21's medication port. RN 1 pulled the plunger back to check for residual and administered the following medications through Resident 21's G-tube: Esomeprazole (medication used to treat conditions involving excessive stomach acid production) 40 mg, with 10 ml of water (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Baclofen (medication used to treat muscle spasms) 10 mg, with 10 ml of water RN 1 flushed Resident 21's G-tube with 30 ml of water and disconnected the syringe. RN 1 doffed his gloves, washed his hands, and exited Resident 21's room. During an interview, on 7/2/2025, at 1:28 PM, with RN 1, RN 1 stated he did not don a gown before entering Resident 21's room. RN 1 stated he was supposed to don a gown prior to checking G-tube placement and administering Resident 21's medications via her G-tube. RN 1 stated it was important to don a gown before providing direct contact care to protect residents from contamination and infection from bodily fluids. RN 1 stated PPEs were worn to prevent the spread of infection which can cause the residents to get very sick. During an interview, on 7/2/2025, at 4:29 PM, with the IPD, the IPD stated the clothing of facility staff can get in contact with the residents while providing G-tube care and can cross contaminate to other residents in the facility. The IPD stated facility staff were required to wear a mask, gloves, and gown if there was possible contact with bodily fluids while providing care for the residents. The IPD stated facility staff were required to wear a mask, gown, gloves, and possibly face shield when handling G-tubes due to the risk of getting in contact with bodily fluids. The IPD stated it was important for facility staff to don PPE to protect and prevent the residents from getting an infection. The IPD stated RN 1 did not follow the facility policy to don a gown before checking Resident 21's G-tube residual and administering medications via Resident 21's G-tube. During a concurrent interview and record review, on 7/3/2025, at 2:51 PM, with the DON, the sub-acute P&P titled, Sub-Acute Infection Control Policies, revised on 5/2021 was reviewed. The DON stated it was not enough for facility staff to wear just a mask and gloves when handling the residents' G-tube. The DON stated facility staff need to wear a gown while handling the G-tube to protect the residents and staff from splash backs and contamination. The DON stated PPEs prevent the transmission of communicable diseases to the residents in the facility. The DON stated the Sub-Acute Infection Control Policies indicated, Enhanced Standard Precautions (EBP - the use of gown and glove use for nursing home residents with wounds and indwelling devices during specific-high contact resident care activities associated with multidrug-resistant organisms [MDRO] transmission) are to be used in providing care to patients. This is to protect personnel from contamination with body substances and to prevent transmission of microorganisms between residents. The DON stated the P&P did not and should indicate the specific procedures that involves EBP. The DON stated the policy did not indicate what PPEs need to be donned when caring for residents on EBP. During the same concurrent interview and record review, on 7/3/2025, at 2:51 PM, with the DON, the hospital-wide P&P titled, Precautions to Prevent Transmission of Infectious Disease, revised on 1/2010, was reviewed. The DON stated the P&P did not and should include Enhanced Based Precautions for consistency of policies between the sub-acute units and the hospital. The DON stated the policy should include the specific PPE that were required to be donned and the specific procedures that involved EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same record review of the P&P, titled, Precautions to Prevent Transmission of Infectious Disease, the P&P indicated, Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. Also, equipment or items in the patient environment likely to have been contaminated with infectious agents (e.g. wear gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment before use on another patient). 4. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE]. During a review of Resident 6's H&P, dated 1/21/2025, the H&P indicated Resident 6 had diagnoses which included acute on chronic respiratory failure/insufficiency (a sudden worsening of respiratory function in a resident who already has a pre-existing chronic respiratory condition), anoxic encephalopathy (a severe brain injury resulting from a complete lack of oxygen to the brain), and quadriplegia (paralysis that affects all four limbs plus the torso). During a review of resident 6's MDS, dated [DATE], the MDS indicated Resident 6 was in a persistent vegetative state. Resident 6 was dependent with oral/toileting hygiene, upper/lower body dressing, personal hygiene, and roll left and right. Resident 6 required tracheostomy care. During a review of Resident 6's Monthly Orders, dated 6/24/2025, the Monthly Orders indicated a physician order for the following: Trach care daily at 9PM and as needed Clean trach site with hydrogen peroxide (H2O2) 3% solution, then cover with drain sponge Change trach tie and inner cannula Resident 6's Monthly Orders further indicated that Resident 6 did not have the capacity to make healthcare decisions. During a review of Resident 6's care plan, dated 12/4/2024, the care plan indicated Resident 6 had a potential for infection related to tracheostomy tube. The care plan intervention indicated to change the inner cannula daily and as needed, perform trach care every day and as needed, and practice good hand hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555850	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alhambra Hospital Med Ctr Dp/Snf	100 S Raymond Ave Alhambra, CA 91801

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a tracheostomy care observation on 7/1/2025, at 2:13 PM, inside Resident 6's room, RN 2 performed hand hygiene, donned gloves and gown and moved Resident 6's bedside table close to where she was standing. RN 2 placed several clean gauzes, a bottle of hydrogen peroxide, trach tie, and a packet of split gauze on the Resident 6's bedside table. RN 2 removed Resident 6's old drain sponge from Resident 6's tracheostomy site and placed it on the bedside table next to the clean tracheostomy care supplies. RN 2 opened the hydrogen peroxide bottle and poured hydrogen peroxide into the clean drain gauze. RN 2 cleaned around Resident 6's tracheostomy tube with the gauze and placed the used gauze on the bedside table. RN 2 removed and replaced Resident 6's old trach tie and placed the old trach tie on the bedside table. RN 2 opened the packet of split gauze and placed the clean split gauze around Resident 6's tracheostomy tube. RN 2 removed Resident 6's inner cannula and replaced it with a new inner cannula. RN 2 placed the old inner cannula on the bedside table. RN 2 picked up all the used tracheostomy care supplies, placed them in the trash can located by Resident 6's door, doffed her PPE and exited Resident 6's room. RN 2 did not change her gloves before placing Resident 6's clean drain sponge around her tracheostomy tube and before inserting Resident 6's new inner cannula. RN 2 did not clean Resident 6's bedside table after throwing the used dressings and old inner cannula in the trash. During an interview, on 7/1/2025, at 2:25 PM with RN 2, RN 2 stated she did not change her gloves after removing Resident 6's old tracheostomy dressing and inner cannula and before placing the clean dressing and new inner cannula. RN 2 stated she was not familiar with the facility's P&P for changing gloves during tracheostomy care. RN 2 stated the used dressing was supposed to be disposed of in the trash but it was too far away from her during tracheostomy care, so she placed it on top of Resident 6's bedside table. RN 2 stated she should have covered the bedside table before placing Resident 6's clean tracheostomy supplies. RN 2 stated she should have sanitized Resident 6's bedside table after she disposed of the used dressings and inner cannula. During an interview, on 7/2/2025, at 4:16 PM, with the IPD, the IPD stated RN 2 should have doffed her gloves after removing Resident 6's used dressings and inner cannula and donned new gloves before placing the new dressing and inner cannula. The IPD stated it was important for facility staff to follow the hand hygiene policy to avoid the risk of contamination and prevent the spread of infections. The IPD stated there could be an active disease or infection on the used dressing and placing it on the bedside table contaminated the bedside table and could get other residents sick. The IPD stated the used dressings and inner cannula should not be placed on the bedside table. The IPD stated the used dressings and inner cannula should have been placed inside a sealed bag and disposed of in the proper container. The IPD stated the bedside table should have been sanitized after the used dressings and inner cannula was disposed in the trash. (continued on next page)

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	555850	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alhambra Hospital Med Ctr Dp/Snf	100 S Raymond Ave Alhambra, CA 91801

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 7/3/2025, at 2:55 PM, with the DON, the DON stated the used tracheostomy dressings should go straight into the regular trash can. The DON stated the facility did not consider used tracheostomy dressings as regulated medical, clinical, or biomedical waste and did not require special handling. The DON stated the used dressing should not be placed on top of the bedside table. The DON stated the facility's P&P, titled, Procedure for Handling Medical Waste, revised on 2/2024, the DON stated the P&P indicated that the purpose of the policy was to, Establish, implement, monitor, and document evidence of an ongoing program for the identification, packaging, storage, and disposal of medical wastes generated the hospital and to ensure that there is minimal risk to patients, personnel, visitors and the community environment of the transmission of communicable diseases. The DON stated the P&P did not clearly indicate were tracheostomy dressing and used tracheostomy supplies like the inner cannula should be disposed. The DON stated it should be included in the P&P to be able to properly handle the used dressing and to make sure the residents, staff, and visitors are safe. The DON stated RN 2 should have sanitized the bedside table with a germicidal wipe after the disposed the used dressings and inner cannula in the trash can. The DON stated RN 2 should have also placed the trash can close to her before starting tracheostomy care. During a review of the hospital-wide P&P, titled, Recommendations, from the Infection Control Manual, revised on 1/2010, the P&P indicated the following: These recommendations are designed to prevent the transmission of infectious agents among patients and healthcare personnel in all settings where healthcare is delivered. As in other CDC/HICPAC guidelines, each recommendation is categorized on the basis of existing scientific data, theoretical rationale, applicability, and when possible, economic impact. The CDC/HIPAC system for categorizing recommendations is as follows: Category IB (strongly recommended for implementation and supported by some experimental, clinical, or epidemiologic studies and a strong theoretical rationale, Category IC (required for implementation, as mandated by federal and/or state regulation or standard). Standard Precautions: Assume that every person is potentially infection or colonized with an organism that could be transmitted in the healthcare setting and apply the following infection control practices during the delivery of health care. PPE- observe the following principles of use: a) Wear PPE when the nature of the anticipated patient interaction indicates that contact with blood or body fluids may occur. b) Wear a gown, that is appropriate to the task, to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated. c) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wear a gown for direct patient contact if the patient has uncontained secretions or excretions.