

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555850	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Alhambra Hospital Med Ctr Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 100 S Raymond Ave Alhambra, CA 91801	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to provide privacy and confidentiality (safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the resident and/or the individual's surrogate or representative) of the resident's medical records for four (4) of 4 sampled residents (Residents 6, 10, 14, and 21) observed for medication administration by not locking the screen prior to walking away from the computer. This deficient practice had the potential to expose Residents 6, 10, 14, and 21's medical records to others and violated the residents' right for privacy and confidentiality. Findings: 1. During a review of Resident 6's admission Record, the admission Record indicated the resident was admitted on [DATE] with the following diagnosis of chronic respiratory failure (occurs when the respiratory system cannot supply enough oxygen to the blood or remove enough carbon dioxide from it), and tracheostomy (a surgically created hole in the front of the neck that opens directly into the windpipe) status. During a review of Resident 6's History and Physical (H&P), dated 12/24/2025, the H&P indicated the following but not limited to diagnoses of dysphagia (difficulty swallowing), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) disorder and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 6's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 6/25/2026, the MDS indicated the resident is persistent vegetative state (a condition where a patient is completely unaware of themselves or their surroundings, yet retains basic physiological functions like breathing, heart rate, and sleep-wake cycles)/ no discernible consciousness (a person shows no observable or measurable signs of awareness of themselves or their surroundings). The MDS also indicated that the resident is dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/ taking off footwear, and personal hygiene. During a medication administration observation in the hallway on 7/16/2026 at 8 AM, Licensed (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Vocational Nurse 1 (LVN 1) was observed preparing medications for Resident 6. LVN 1 was then observed walking away from the computer and leaving the monitor on. The computer monitor was observed with Resident 6's medical records. During an interview on 7/16/2026 at 9 AM, LVN 1 stated he left the monitor on/ open when it was not in use, and he should have closed or locked the screen so that Resident 6's medical information is not exposed and to maintain privacy and confidentiality. During an interview on 7/16/2026 at 9:10 AM, the Director of Nursing (DON) stated the monitor, or screen should be off when it is not in use to protect the resident's information. The DON also stated it is a Health Insurance Portability and Accountability Act (HIPAA - standards protecting sensitive health information from disclosure without patient's consent) violation and a confidentiality issue if it was left open by LVN 1 and other resident or visitors who pass by can see Resident 6's medical information from the monitor left open and unattended by the facility staff. 2. a. 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 Diagnosis, not dated, the Diagnosis record indicated Resident 21 with the diagnoses including but not limited to acute and chronic respiratory failure with hypoxia (lack of oxygen in the tissues to sustain bodily function), tracheostomy status, and dependence (when resident is unable to wean off a ventilator [a piece of medical technology that provides mechanical ventilation by moving breathable air into and out of the lungs] and breathe independently) on respirator [ventilator] status. During a record review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21 was comatose (in a state of deep unconsciousness for a prolonged period as a result of a severe injury or illness) and in a persistent vegetative state/no discernible consciousness. The MDS indicated Resident 21 was dependent on toileting hygiene, shower/bathe self, and personal hygiene. During an observation on 7/16/2026 at 8:04 AM during medication administration with LVN 2, LVN 2 walked away from the computer after preparing Resident 21's medications and into Resident 21's room. The computer screen displayed resident's name, age, date of birth , room number, medical record number (a unique identifier assigned to a patient by a healthcare facility to link all their medical records within that system), height, weight, drug allergies, and medications displayed on the screen. LVN 2 did not log off (to disconnect or stop using a computer system or program so no other individual can access) from her account and did not turn off the computer screen before walking away from the computer. 2. b. During a review of Resident 10's admission Record, the admission record indicated Resident 10 was admitted to the facility on [DATE]. During a review of Resident 10's Diagnosis, not dated, the diagnosis indicated Resident 10 with the diagnoses including but not limited to chronic respiratory failure, persistent vegetative state, and tracheostomy status. (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lock screen before walking away from the computer to maintain patient privacy and confidentiality. During a record review of the facility's policy and procedure (P&P) titled, Medication Administration, reviewed 3/2023, the P&P indicated computerized work stations must be locked and logged off when unattended. During a record review of the facility's P&P titled, Privacy and Confidentiality of Patients & General Guidelines, reviewed 7/2023, the P&P indicated all personnel are also obligated to protect the confidentiality of any Protected Health Information (PHI). The facility must maintain the confidentiality and security of PHI in any form & electronic, on paper or oral.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) receive the necessary services to maintain good personal and oral hygiene for two (2) of 2 sampled residents (Residents 7 and 12) reviewed for ADLs to ensure: Resident 7's oral hygiene was maintained when resident's tongue was observed dry with white coating and red spots on the tongue bed. Resident 12 did not have dry nasal mucus outside the left nostril (outer opening of the nose). This deficient practice had the potential to result in a decrease in quality of life, oral health, and higher risk of oral infections for Resident 7 and had the potential to result in a negative impact on Resident 12's self-esteem. Findings: 1. During a review of Resident 7's admission Record, the admission record indicated Resident 7 was admitted to the facility on [DATE]. During a review of Resident 7's Diagnosis, not dated, the diagnosis indicated Resident 7 with the diagnoses including but not limited to chronic respiratory failure (a long-term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body), persistent vegetative state (condition where resident has woken from a coma but still lacks awareness), and candidal stomatitis (also known as oral candidiasis or oral thrush, is a fungal infection of the mouth caused by overgrowth of Candida species). During a record review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 6/10/2026, the MDS indicated Resident 7 was comatose (in a state of deep unconsciousness for a prolonged period as a result of a severe injury or illness) and in a persistent vegetative state/no discernible consciousness. The MDS indicated Resident 7 was dependent (helper does all of the effort, resident does none of the effort to complete the activity or, the assistance of two or more helpers is required for the resident to complete the activity) for oral hygiene, toileting hygiene, and personal hygiene. During a record review of Resident 7's Care Plan, dated 6/10/2026, the Care Plan indicated Resident 7 needs assistance with oral care and intervention was to ensure good oral hygiene and monitor dental condition and refer to dentist if indicated. During an observation on 7/14/2026 at 3:44 PM in Resident 7's room, Resident 7 was lying in the bed with his mouth open. Resident 7's tongue was observed dried, with whitish discoloration or coating on top of the tongue bed and the tongue tip was noted with redness. During an observation on 7/16/2026 at 11:08 AM in Resident 7's room, Resident 7 was lying in bed with his mouth open. Resident 7's tongue was observed dried. During a concurrent observation and interview on 7/16/2026 at 11:13 AM in Resident 7's room with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 7 always has his mouth open. CNA 1 (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated Resident 7's tongue is a little dirty and dried. CNA 1 stated we needed to do oral care as needed and Resident 7 needs oral care right now. CNA 1 stated Resident 7 is unable to perform oral care for himself. During a concurrent interview, and record review on 7/16/2026 at 2:24 PM, with Minimum Data Set Nurse (MDSN), photos of Resident 7's mouth taken during observation on 7/14/2026 at 3:44 PM and 7/16/2026 at 11:13 AM were reviewed. MDSN stated basing off the photo of Resident 7's mouth and tongue taken on 7/14/2026 and 7/16/2026, Resident 7 had white spots, darkish red spots, and the resident's tip portion of tongue looked dry. MDSN stated Resident 7 had a history of candida stomatitis. MDSN stated mouth care for Resident 7 needed to be provided very consistent and routine daily and/ or as needed oral care to prevent another occurrence of candida stomatitis or other mouth diseases. MDSN stated oral hygiene was also important for Resident 7 since Resident 7 had a tracheostomy (a surgical procedure to create an opening through the neck into the windpipe to provide direct airway, bypassing the mouth and nose) since anything in his mouth could go down and affect the resident. MDSN stated Resident 7 was dependent on staff for oral care. During an interview on 7/17/2026 at 9:44 AM with the Director of Nursing (DON), the DON stated oral hygiene was a basic standard of care. The DON stated Resident 7 was unable to perform oral hygiene by himself. The DON stated good oral hygiene was needed to prevent any abnormalities from not cleaning or maintaining oral care of the resident. The DON stated poor oral hygiene could result in Resident 7's candida stomatitis coming back. 2. During a review of Resident 12's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnosis of respiratory failure (occurs when the respiratory system cannot supply enough oxygen to the blood or remove enough carbon dioxide from it) with vent dependent (an individual's body requires a mechanical device to breathe or sustain adequate oxygen levels). During a review of Resident 12's History and Physical (H&P), dated 12/18/2025, the H&P indicated the resident has the following but not limited to diagnoses of dysphagia (difficulty swallowing), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury) and status epilepticus (any single continuous seizure lasting more than 5 minutes, or two or more seizures occurring without the person fully regaining consciousness in between). During a review of Resident 12's Care Plan with focus self-care deficit, revised 5/2026, the Care Plan indicated the resident is unable to do self-daily hygiene and grooming. The Care Plan also indicated the residents daily personal care needs will be met during the facility stay. During a review of Resident 12's Care Plan with focus impaired communication, revised 5/2026, the Care Plan indicated to ask simple yes or no questions and resident is able to mouth words. During a review of Resident 12's MDS, dated [DATE], the MDS indicated the resident is independent in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated, the resident is dependent with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/14/2026 at 9:44 AM in Resident 12's room, Resident 12's observed with a dry nasal mucus outside the left nostril. Resident mouth words stating it makes him uncomfortable. During an observation and interview on 7/15/2026 at 3:53PM, the DON stated Resident 12 should have been cleaned and the dry nasal mucus should not have been on Resident 12's nose. DON also stated it is a dignity issue and can affect the resident's self-esteem. It is not in the policy but should be in the policy. During an interview on 7/16/2026 at 10:19AM, the facility's undated Policy and Procedure (P&P) titled Residents Rights, was reviewed. The DON stated the P&P indicated the facility must promote care for the residents that enhances their dignity which includes cleaning the residents face of any mucus or secretions. During a review of the facility's undated P&P titled Residents rights, the P&P indicated the facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary respiratory care services for four (4) or eight (8) sampled residents (Residents 1, 3, 8, and 14) reviewed under respiratory in accordance with the facility policy by: Failing to ensure Resident 1 [NAME] Suction Catheter (t-piece- used to deliver oxygen therapy and suction in an intubated resident) was changed when there were dry blood and mucus- build up on 7/14/2026. Failing to ensure Resident 3 t- piece was connected to the cool aerosol to administer oxygen to the resident per physician's (MD) order. Failing to ensure Resident 8's did not have mucus flowing out of the t-piece onto a towel. Failing to ensure Resident 14's Yankauer (a rigid, curved suction tool used to clear fluids, secretions and debris from the mouth and throat) was placed in a storage bag and another used Yankauer was left on Resident 14's bed. These deficient practices have the potential for Resident 1, 3, 8 and 14 to develop a respiratory infection, cause complications, associated with oxygen therapy, and result in the spread of diseases and infection. Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnoses hypoxia (a condition where your body's tissues and organs do not receive enough oxygen to function properly), chronic respiratory failure (occurs when the respiratory system cannot supply enough oxygen to the blood or remove enough carbon dioxide from it), and ventilator dependent (an individual's body requires a mechanical device to breathe or sustain adequate oxygen levels). During a review of Resident 1's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 5/19/2026, the MDS indicated the resident is independent in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene and upper body dressing but requires substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathe self and is dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with lower body dressing and putting on/ taking off footwear. The MDS indicated the resident is receiving tracheostomy (a surgically created opening [stoma] in the windpipe [trachea] through the front of the neck) care and is on an invasive mechanical ventilator (life-saving medical treatment that delivers oxygenated air directly into the lungs using a machine called a ventilator). During an observation on 7/14/2026 at 9:52 AM, Resident 1 was observed with dry blood and mucus build up in the resident's t-piece. During an observation on 7/14/2026 at 3:34 PM, Resident 1 was observed with dry blood and mucus build up in the t-piece. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/14/2026 at 3:45 PM, Resident 1's t-piece was observed with dry blood and mucus build up. The Director of Nursing (DON) stated the dry blood and mucus in the resident's t- piece and it can obstruct the flow of air or get dislodge and block the resident's airway. During an interview on 7/16/2026 at 10:36A M, Respiratory Therapist 1 (RT 1) stated the t- piece should be changed twice weekly and as needed per policy. RT 1 also stated as needed, meaning if there is blood or mucus built up then the t- piece would need to be changed. During a record review on 7/15/2026 at 3:55PM, the facility's Policy and Procedure (P&P) titled Subacute Respiratory Equipment Changing Timetable and Responsibilities, revised 7/2020, the P&P indicated the [NAME] Suction Catheter should be changed twice weekly and as needed. The P&P also indicated all resident equipment will be changed to decrease the risk of infection. 2. During a review of Resident 3's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnoses of respiratory failure and ventilatory support (attaching a breathing machine to the tracheostomy tube [a curved plastic or metal tube placed into a surgically made hole in the neck to keep the airway open and help a person breathe]) tracheostomy. During a review of Resident 3's MDS, dated [DATE], the MDS indicated the resident comatose (in a state of deep unconsciousness for a prolonged period as a result of a severe injury or illness) persistent vegetative state (occurs when a patient emerges from a coma but lacks cognitive function and awareness, while retaining sleep-wake cycles and basic bodily functions)/no discernible consciousness (there is no observable or measurable evidence that an individual is aware of themselves or their environment). The MDS also indicated that the resident is dependent on oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting off footwear, and personal hygiene. The MDS indicated the resident is on tracheostomy care and on an invasive mechanical ventilator. During a review of Resident 3's Physician Orders, dated 5/12/2026, the Physician orders indicated aerosol (a fine mist of liquid droplets suspended in a gas used for medical respiratory therapy) ongoing at 35% Fraction of Inspired Oxygen (FIO2) t-piece cool aerosol, keep peripheral oxygen saturation (SPO2 &ndash; a percentage that measures how much oxygen your red blood cells are carrying) greater than (>) 92%. During an observation on 7/14/2026 at 9:18 AM, Resident 3 was observed with t- piece not connected to the cool aerosol. During an interview on 7/15/2026 at 3:56 PM, the DON stated the t-piece should be always connected to the cool aerosol because the resident can go into respiratory distress if it is not connected. The DON also stated the staff are not following the MD order for the respiratory therapy if the t- piece was not connected to the cool aerosol or to the oxygen. During a review of the facility's P&P titled Nursing Scope of Practice, reviewed 2/2017, the P&P (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated the scope of nursing is direct and indirect patient care services such as administration of medications and therapeutic agents, necessary to implement a treatment, ordered by and within a scope of licensure of a physician. During a review of the facility's P&P titled Sub-Acute Unit Respiratory Service, review date 10/2018, the P&P indicated to provide and maintain adequate oxygenation and ventilation for residents with respiratory insufficiency and/or acute respiratory distress. 3. During a review of Resident 8's admission Record, the admission record indicated Resident 8 was admitted to the facility on [DATE]. During a review of Resident 8's Diagnosis, not dated, the Diagnosis record indicated Resident 8 with the diagnoses including but not limited to acute and chronic respiratory (sudden onset with short duration and a long-term condition in which the respiratory system is unable to adequately exchange oxygen and carbon dioxide in the body) failure with hypoxia, gastrostomy (a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or drainage), and tracheostomy status. During a record review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 was comatose and in a persistent vegetative state/no discernible consciousness. The MDS indicated Resident 8 was dependent on toileting hygiene, shower/bathe self, and personal hygiene. During a record review of Resident 8's Care Plan, reviewed 4/2026, the Care Plan indicated Resident 8 had potential for infection related to tracheostomy tube. It indicated, the nursing staff interventions were to provide tracheostomy care every shift and suction every two (2) hours and as needed. During a record review of Resident 8's Subacute Monthly Orders, dated 6/23/2026, the order indicated tracheal suction every 2 hours and as needed. During an observation on 7/14/2026 at 11:39 AM in Resident 8's room, Resident 8 was lying in bed, and mucus was noted in the inner t-piece and overflowing out from the t-piece down Resident 8's body and onto the towel on the bed and on the call light (a visible and audible alarm activated by a call button). During a concurrent observation and interview on 7/17/2026 at 8:08 AM with Minimum Data Set Nurse (MDSN), MDSN stated the t-piece needed to be changed and the mucus needed to be suctioned. MDSN stated Resident 8 should be suctioned every 2 hours and suctioned as needed and Resident 8 needed to be suctioned. MDSN stated the mucus flowing out from the t-piece was an infection control issue and hygiene issue since the clothing was soiled. During an interview on 7/17/2026 at 9:36 AM with the DON, the DON stated Resident 8 needed to be suctioned every 2 hours and suctioned as needed since having excessive mucus was an aspiration (inhaling small particles of food or drops of liquid into the lungs) precaution. The DON stated Resident 8 was at high risk for aspiration due to the resident's diagnosis and being in the subacute unit (a specialized healthcare setting that provides subacute care which is a level of medical care that is (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	less intensive than acute care but more specialized than typical skilled nursing care). The DON stated Resident 8's excessive mucus was not the standard of practice at the facility. 4. During a review of Resident 14's admission Record, the admission record indicated Resident 14 was admitted to the facility on [DATE]. During a review of Resident 14's Diagnosis, not dated, the diagnosis record indicated Resident 14 with the diagnoses including but not limited to acute and chronic respiratory failure, tracheostomy status, and gastrostomy status. During a record review of Resident 14's MDS, dated [DATE], the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 14 was dependent on toileting hygiene and showering/bathing self. During a record review of Resident 14's Care Plan, dated 5/26/2026, the Care Plan indicated Resident 14 had the potential for infection related to tracheostomy tube. It indicated, the nursing staff interventions were to provide tracheostomy care every shift and suction every 2 hours and as needed. During an observation on 7/14/2026 at 8:17 AM in Resident 14's room, Resident 14 was lying in bed. The Yankauer was left uncovered attached to the suction tube and another used Yankauer with dried mucus was left on Resident 14's bed. During a concurrent observation and interview on 7/14/2026 at 8:35 AM with Registered Nurse 1 (RN 1), RN 1 stated the Yankauers on the resident's bed were dirty and the attached Yankauer was supposed to be kept in a bag. RN 1 stated the used Yankauer should be discarded in the appropriate trash bin and not left on Resident 14's bed. RN 1 stated both Yankauers placed Resident 14 at risk for infection. During an interview on 7/17/2026 at 9:40 AM with the DON, the DON stated the Yankauer was supposed to be placed in a bag to avoid cross contamination since it was going inside the resident's mouth. The DON stated the detached used Yankauer was supposed to be disposed of and not left on Resident 14's bed. The DON stated disposal of the used Yankauer could prevent staff from reusing the detached Yankauer since there was no date labeled and it was already opened. During a review of the facility's policy and procedure (P&P) titled, Suctioning: Tracheostomy and Endotracheal, reviewed 3/2023, the P&P indicated assess need for further suctioning at least every 2 hours, or more frequently if secretions are copious (an abnormally large or excessive production of bodily fluids). During a review of the facility's P&P titled, Sub-Acute Infection Control Policies, revised 6/2026, 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.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident 1) reviewed for unnecessary medications (medication prescribed or consumed without a valid clinical indication for an excessive duration, at too high a dose, or when potential risks outweigh the benefits) was free from unnecessary medication use by failing to monitor signs and symptoms of bleeding, notify the physician and hold Resident 1's Xarelto (a prescription blood thinner used to treat and prevent dangerous blood clots) on 7/14/2026 and 7/15/2026 due to the presence of tracheostomy bleeding, as indicated on the resident's care plan and facility's policy and procedures (P&P). This deficient practice had the potential to increase Resident 1's risk of experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to anticoagulant medication (medications that delay or prevent the body from forming dangerous blood clots) which can lead to complications, harm, and hospitalization. Findings: During a review of Resident 1's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the diagnoses of hypoxia (a condition where the body's tissues and organs do not receive enough oxygen to function properly), chronic respiratory failure (occurs when the respiratory system cannot supply enough oxygen to the blood or remove enough carbon dioxide from it), and ventilator dependent (an individual's body requires a mechanical device to breathe or sustain adequate oxygen levels). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/19/2026, the MDS indicated the resident was independent in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 1 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene and upper body dressing and required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathe self. The MDS also indicated Resident 1 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with lower body dressing and putting on/ taking off footwear. The MDS indicated Resident 1 was receiving tracheostomy (a surgically created opening [stoma] in the windpipe [trachea] through the front of the neck) care and was on an invasive mechanical ventilator (life-saving medical treatment that delivers oxygenated air directly into the lungs using a machine called a ventilator). During a review of Resident 1's Care Plan, dated 5/19/2026, the Care Plan indicated the resident is at risk for bleeding, bruising, and complications of anticoagulant therapy. The care plan also indicated Resident 1's risk factors included use of Xarelto. The care plan interventions included were to assess and monitor signs and symptoms of bleeding closely and report to Medical Doctor (MD) any abnormal signs and symptoms. During a review of Resident 1's Care Plan, dated 5/19/2026, the Care Plan indicated the resident is at risk for tracheal bleeding associated with routine tracheostomy tube change and use of anticoagulant. The care plan interventions included were to assess for signs of/ presence of tracheal bleeding closely and notify MD. During an observation on 7/14/2026 at 9:52 AM, Resident 1 was observed with dried blood and mucus buildup in the [NAME] suction catheter (t-piece directly attached to the tracheostomy tube used to deliver oxygen therapy and suction an intubated resident). During an observation on 7/14/2026 at 3:34 PM, Resident 1 was observed with dried blood and mucus buildup in the t-piece. During a concurrent observation and interview on 7/14/2026 at 3:45 PM, Resident 1's t-piece was observed with dried (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood and mucus build up. The Director of Nursing (DON) stated that there were dried blood and mucus in Resident 1's t-piece. During a review of Resident 1's Physician's Order/Active Orders, the Physician's Order/Active Orders indicated Rivaroxaban (Xarelto) 10 milligrams (mg - unit of measure) via feeding tube every afternoon (PM). During a review of Resident 1's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 7/15/2026 at 5:04 PM, the MAR indicated Xarelto 10 mg was administered to the resident. During a review of Resident 1's Physician's Order/Active Orders, the Physician's Order/Active Orders indicated Rivaroxaban (Xarelto) 10 mg via feeding tube every afternoon (PM). During a concurrent review and interview on 7/16/2026 at 11:53 AM, Resident 1's Long Term Care (LTC) Progress Notes, dated 7/14/2026, and MAR, dated 7/14/2026 and 7/15/2026 at 5:04 PM, were reviewed. Registered Nurse 1 (RN 1) stated the progress notes indicated to hold Xarelto as needed for tracheostomy bleeding. RN 1 also stated that Resident 1 was experiencing tracheostomy bleeding on 7/13/2026, so the physician should have been notified and Xarelto should have been placed on hold. RN 1 further stated that the anticoagulant should have been held on 7/14/2026 and 7/15/2026, but it was administered when it should not have been. During an interview on 7/17/2026 at 9:15 AM, the Director of Nursing (DON) stated Resident 1's Xarelto should have been on hold on 7/14/2026 and 7/15/2026 and should not have been administered to Resident 1. During a review of the facility's P&P titled, Pharmacy Monitoring of Physician Dosing of Anticoagulants, revised 9/2020, the P&P indicated to monitor patients for signs and symptoms of bleeding or bruising. If present, the physician shall be notified.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of 1 sampled resident (Resident 18) reviewed for nutrition was provided with a therapeutic diet (a diet ordered by a physician as part of treatment for a disease or clinical condition, or to eliminate or decrease specific nutrients in the diet or to increase specific nutrients in the diet, or to provide food the resident is able to eat such as mechanically altered diet [diet where the texture of the food is changed so it is easier and safer to chew and swallow for people with swallowing or chewing difficulties]) as indicated on the physician's order and facility's policy and procedure (P&P). This deficient practice had the potential to cause a choking hazard, result in inadequate food intake, which could compromise nutrition and hydration, and place Resident 18 at risk for aspiration pneumonia (a lung infection that happens when the resident inhales [aspirates] material like food, liquid, saliva, stomach contents, or bacteria into the lungs instead of swallowing it). Findings: During a review of Resident 18's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure (a long-term condition where the respiratory system cannot properly oxygenate the blood or remove carbon dioxide), tracheostomy (a surgically created hole, known as a stoma, in the front of the neck and directly into your windpipe) status, and dependence on ventilator (a medical machine that helps or takes over the breathing process for someone who cannot breathe effectively on their own). During a review of Resident 18's Physician Orders, dated 9/3/2025, the Physician Orders indicated pureed diet (a type of soft diet where all foods are blended into a smooth, pudding-like texture so they require no chewing and are easy to swallow) with honey thick liquids (pourable but move significantly slower than thin liquids, resembling the flow of honey). During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool), dated 4/30/2026, the MDS indicated the resident was moderately impaired with cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 18 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bath self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS also indicated Resident 18 required tracheostomy care, had difficulty swallowing, and was on a therapeutic diet. During a review of Resident 18's Care Plan, dated 4/30/2026, the Care Plan indicated the resident had a potential or actual alteration of nutrition related to swallowing problem. The care plan interventions included were to provide diet as ordered by physician and assess the diet texture and tolerance of food. During a concurrent observation and interview on 7/14/2026 at 12:45 PM in Resident 18's room, Resident 18's meal tray was observed containing pureed chicken with crusted edges, pureed broccoli, and honey thick milk. Registered Nurse 1 (RN 1) stated the crusted edges on the pureed chicken were hard and could pose a choking hazard for Resident 18. During an interview on 7/15/2026 at 11:45 AM, Lead [NAME] (LC) stated Resident 18 was not supposed to have crusted edges on his pureed food because this presents a choking hazard. During an interview on 7/15/2026 at 12PM, the Director of Food and Nutrition (DFN) stated it was not acceptable for Resident 18 to have crusted edges of pureed diet because this presents a choking hazard for the resident. During an interview on 7/17/2026 at 8:46 AM, the Director of Nursing (DON) stated it was not acceptable for Resident 18 to have crusted edges of pureed diet because this presents a choking hazard for the resident. During a review (continued on next page)		

Department of Health & Human Services
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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the facility's P&P titled, Diet Order Guideline, revised 6/2024, the P&P indicated all diet order should compose of:Therapeutic Nutritional NeedsTexture andLiquid ConsistencySuch as Pureed Diet: pureed foods are easy to swallow, smooth, lump free, not firm, and not sticky, all foods remain intact and hold their shape on a plate, liquids do not separate form solid and foods.		

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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 ensure proper food handling practices in accordance with the facility's policy and procedure (P&P) by failing to ensure: Cook wore a beard net when preparing vegetables on 7/14/2026. Dry food items were labeled with use-by date. Fruits and vegetables in the refrigerator had a use-by date. Opened bags of cilantro and beansprouts had a use-by date. The interior of the ice machine was free of brown smudges and black particles. These deficient practices have 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 a concurrent observation and interview on 7/14/2026 at 7:45 AM, the [NAME] was observed preparing vegetables. The [NAME] was also observed with a beard and was not wearing a beard net. Lead [NAME] (LC) stated that the [NAME] has a long beard and should be wearing a beard net but was not. The LC further stated that hair from the beard could fall into the food and contaminate it. During a concurrent observation and interview on 7/14/2026 at 7:48 AM in the dry storage area, the LC stated that the pure white sugar, low-sodium brown gravy mix, plain gelatin, sugar-free lemon gelatin dessert mix, strawberry gelatin mix, and raisins were not labeled with a use-by date. The LC further stated when food items are not labeled with a use-by date, the food items may be used past their safe period, which can lead to foodborne illness. The LC also stated all food items should be labeled with a use-by date before storage. During a concurrent observation and interview on 7/14/2026 at 8 AM in the refrigerator, the refrigerator was observed with jalapeno, green tomatoes, green bell peppers, red potatoes, yam, apples, pineapples, daikon radish, and tomatoes without use-by dates. Open bags of bean sprouts and cilantro were also observed without use-by dates. The LC stated that all items should have a use-by date before being placed into storage. During a concurrent observation and interview on 7/14/2026 at 8:18 AM in the kitchen, the interior of the ice machine was observed to have brown smudges and black particles. The LC stated that the ice machine should not have any brown smudges or black particles because it is required to be clean. The LC further stated this is an infection control concern and can lead to foodborne illness. During a concurrent review and interview on 7/15/2026 at 2PM, the facility's P&P titled, Food Receiving, Storage and Discard, revised 4/2021, was reviewed. The Director of Food and Nutrition (DFN) stated all food should be wrapped, labeled, and dated with a use-by date before placing into the storage. The DFN further stated the dry food items should have a use-by date because the absence of proper labeling can lead to foodborne illness. During a concurrent review and interview on 7/15/2026 at 2:10 PM, the facility's P&P titled, Storage and Handling of Ice, revised 3/2020, was reviewed. The DFN stated that the ice machine should be cleaned weekly and stated not knowing when it was last cleaned. The DFN also stated the facility does not have a cleaning log for the ice machine. The DFN further stated the brown smudges and black particles observed inside the ice machine could contaminate the ice used for residents. In addition, the DFN stated a cleaning log should be maintained to ensure the ice machine is cleaned weekly. During a review of the facility's P&P titled, Storage and Handling of Ice, revised 3/2020, the P&P indicated the ice machine will be maintained routinely to ensure that ice is clean and free from microorganisms. The P&P also indicated a designated employee cleans and drains areas on each ice machine and disinfects weekly. During a review of the facility's P&P titled, General Rules - Food and Nutrition Services, revised 9/2020, the P&P indicated beards, moustaches and sideburns must be (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neatly trimmed. The P&P also indicated hair net for these types of hairs should also be worn during food preparation. During a review of the facility's P&P titled, Food Receiving, Storage and Discard, revision 4/2021, the P&P indicated all food should be wrapped, labeled, and dated before placed in storage. The P&P also stated check expiration date for food items in its original packaging, if it is not visible; rewrite the expiration date on its outer box.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed for five (5) of 14 sampled residents (Residents 2, 6, 10, 14, and 21) reviewed for infection control as indicated on the facility policy by failing to ensure: 1. Licensed Vocational Nurse 1 (LVN 1) used a clean medication cup to administer Resident 6's morning medications on 7/16/2026. LVN 1 also did not use a gastrostomy tube (G-Tube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) de-clogger (typically a small syringe-like device or a flexible plastic tool used to clear blockage in a G-Tube) that was placed on top of a contaminated medication cup, to flush Resident 6's G-Tube. 2. Resident 2's G-Tube port was free from residue buildup. Certified Nursing Assistant 1 (CNA1) also failed to remove gloves and perform hand hygiene after providing incontinent care to Resident 2 before proceeding to reposition the resident and touching the clean bed linens. 3. to 5. Staff wore personal protective equipment (PPE - protective clothing, helmets, gloves, face shields, goggles, face masks and/or respirators or other equipment designed to protect the wearer from injury or the spread of infection or illness) while providing care for Residents 10, 14, and 21 who were on enhanced barrier precautions (EBP - an approach of targeted gown and glove use during high contact resident care activities designed to reduce transmission). These deficient practices have the potential for cross contamination and increased risk for the spread of bacteria, viruses and pathogens (harmful microorganisms) to the residents, visitors, and staff. Findings: 1. During a review of Resident 6's admission Record, the admission Record indicated the resident was admitted on [DATE] with diagnoses of chronic respiratory failure (occurs when the respiratory system cannot supply enough oxygen to the blood or remove enough carbon dioxide from it) and tracheostomy (a surgically created hole in the windpipe that provides an alternative airway for breathing) status. During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 6/25/2026, the MDS indicated the resident was in persistent vegetative state no discernible consciousness (a condition where a resident is completely unaware of him/herself or its surroundings, yet retains basic physiological functions like breathing, heart rate, and sleep-wake cycles). The MDS also indicated that Resident 6 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/ taking off footwear, and personal hygiene. The MDS also indicated Resident 6's was on a feeding tube. During a medication administration observation and interview on 7/16/2026 at 8:34AM, LVN 1 was observed dropping a medication cup on the floor. LVN 1 was then observed picking up the medication cup and placing it on the workstation on wheels (WOW - computer on wheels that allows access to electronic medical record and dispense medications). LVN 1 was later observed putting the G-Tube declogger on top of the contaminated medication cup. LVN 1 was observed preparing Resident 6's medications on a bedside table. LVN 1 grabbed the contaminated medication cup and was about to (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	put one of Resident 6's medications in it until Surveyor 1 intervened and stopped LVN~1 from placing the medications into the contaminated cup. LVN 1 stated he should have discarded the contaminated medication cup that fell on the floor and should have retrieved a new cup for Resident 6's medication administration instead. During the same medication administration observation and interview at 7/16/2026 at 8:55 AM, LVN 1 was observed giving medications to Resident 6. During the medication administration, LVN 1 was observed using the declogger, to flush the GTube, that was placed on the contaminated medication cup. LVN 1 stated the declogger was already contaminated when it was placed on top of the contaminated medication cup. LVN 1 also stated the declogger should have been discarded and a new one should have been used to prevent infection to the resident. During an interview on 7/17/2026 at 8:56AM, the Director of Nursing (DON) stated the contaminated medication cup and declogger should have been discarded and not used on Resident 6 for infection control reasons. 2. During a review of Resident 2's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses respiratory failure, tracheostomy and g-tube feeding. During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident was in a persistent vegetative state/no discernible consciousness. The MDS also indicated the resident was dependent on oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/ taking off footwear and personal hygiene. The MDS indicated the resident was on a feeding tube. During an observation on 7/14/2026 at 9:08 AM, Resident 2 G-Tube port was observed with buildup and residue. During a concurrent observation and interview on 7/15/2026 at 3:55PM, the DON stated Resident 2 G-Tube port has residue buildup. DON stated that it was not acceptable that the G-Tube port had residue buildup. The DON stated these can harbor bacteria which may be flushed through the G-Tube and could lead to Resident 2 getting sick. During an observation on 7/16/2026 at 2:08 PM, CNA 1 was observed providing incontinence care and changing Resident 2's brief. CNA 1 was then observed with the same gloves, after wiping Resident 2 peri-area, and touched Resident 2's clean bed sheets and repositioned the resident. During an interview on 7/16/2026 at 4:01 PM, CNA 1 stated he did not change gloves and performed hand hygiene after providing incontinence care to Resident 2. CNA 1 also stated he should have changed gloves and performed hand hygiene before continuing care for infection control. During an interview on 7/17/2026 at 9:10 AM, the G-Tube port manufactures instructions titled Dale ACE Connector with Legacy Connections, dated 2024, was reviewed. The instructions indicated to change as needed. The DON stated change as needed means change when the G-Tube port is dirty or (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555850	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Alhambra Hospital Med Ctr Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 100 S Raymond Ave Alhambra, CA 91801	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	has buildup. During an interview on 7/17/2026 at 10:11AM, the Infection Control Supervisor (ICS) stated after incontinence care, the gloves should be removed, and the CNA should have performed hand hygiene and replaced gloves before continuing with care for infection control. During a review of the facility's Policy and Procedure (P&P) titled, Nursing Standards of Care, revised 5/2019, the P&P indicated all nursing staff shall be competent in complying with infection control policies and procedures that minimize and/or prevent cross contamination, and knowledgeable of the principles of Universal Precautions. During a review of the facility's P&P titled, Hand Hygiene & Hospital Wide, revised 11/2022, the P&P indicated gloves should be used for hand-contaminating activities. Gloves should be removed and hands washed or sanitized when such activity is completed. The P&P also stated gloves may need to be changed during the care of a single patient such as moving from one procedure to another. During a review of the facility's P&P titled Infection Prevention and Control Plan, revised 2/2026, the P&P indicated to provide patients with an environment that is free, as much as possible from infection-causing exposure. The P&P also indicated to assure a safe environment for patients by following policies dealing with contaminated equipment assuring they are appropriately handled to minimize risk of infection to patients. During a review of the facility's P&P titled Sub-Acute Infection Control Policies, revised 6/2026, the P&P indicated each staff member assigned in the unit is responsible for ensuring that infection prevention and control procedures are performed. 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 Diagnosis List form, not dated, the Diagnosis List form indicated Resident 21 with the diagnoses including but not limited to acute and chronic respiratory failure with hypoxia (lack of oxygen in the tissues to sustain bodily function), tracheostomy status, and dependence (when resident is unable to wean off a ventilator [a piece of medical technology that provides mechanical ventilation by moving breathable air into and out of the lungs] and breathe independently) on respirator (ventilator) status. During a record review of Resident 21's Minimum Data Set (MDS, a resident assessment tool), dated 5/2/2026, the MDS indicated Resident 21 was comatose (in a state of deep unconsciousness for a prolonged period as a result of a severe injury or illness) and in a persistent vegetative state/no discernible consciousness. The MDS indicated Resident 21 was dependent on toileting hygiene, shower/bathe self, and personal hygiene. During a record review of Resident 21's Care Plan, reviewed 6/2026, the Care Plan indicated Resident 21 needs enhanced barrier precautions due to tracheostomy and gastrostomy (a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or drainage). The (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Alhambra Hospital Med Ctr Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Few	nursing staff interventions were to perform hand hygiene and use PPE per protocol. During an observation on 7/16/2026 at 8:04 AM during medication administration with LVN 2, LVN 2 walked into Resident 21's room wearing a mask and a glove to administer Resident 21's medication through his gastrostomy tube. LVN 2 did not wear an isolation gown during Resident 21's medication administration via the G-tube. 4. During a review of Resident 10's admission Record, the admission record indicated Resident 10 was admitted to the facility on [DATE]. During a review of Resident 10's Diagnosis List form, not dated, the Diagnosis List form indicated Resident 10 with the diagnoses including but not limited to chronic respiratory failure, persistent vegetative state, and tracheostomy status. During a record review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 was comatose and in a persistent vegetative state/no discernible consciousness. The MDS indicated Resident 10 was dependent on toileting hygiene, shower/bathe self, and personal hygiene. During a record review of Resident 10's Care Plan, dated 5/4/2026, the Care Plan indicated Resident 10 needs enhanced barrier precautions due to tracheostomy and gastrostomy. The nursing staff interventions were to perform hand hygiene and use PPE per protocol. During an observation on 7/16/2026 at 8:32 AM during medication administration with LVN 2, LVN 2 walked into Resident 10's room wearing a mask and a glove to administer Resident 10's medication through the gastrostomy tube. LVN 2 did not wear an isolation gown during Resident's medication administration via the G-tube. 5. During a review of Resident 14's admission Record, the admission record indicated Resident 14 was admitted to the facility on [DATE]. During a review of Resident 14's Diagnosis List form, not dated, the Diagnosis List form indicated Resident 14 with the diagnoses including but not limited to acute and chronic respiratory failure, tracheostomy status, and gastrostomy status. During a record review of Resident 14's MDS, dated [DATE], the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 14 was dependent on toileting hygiene and showering/bathing self. During a record review of Resident 14's Care Plan, dated 5/26/2026, the Care Plan indicated Resident 14 needs enhanced barrier precautions due to tracheostomy and gastrostomy. The nursing staff interventions were to perform hand hygiene and PPE per protocol. During an observation on 7/16/2026 at 8:51 AM during medication administration with LVN 2, LVN 2 walked into Resident 14's room wearing a mask and a glove to administer Resident 14's medication (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Alhambra Hospital Med Ctr Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Few	through the gastrostomy tube. LVN 2 did not wear an isolation gown during Resident 14's medication administration via the G-tube. During an interview on 7/16/2026 at 9:22 AM with LVN 2, LVN 2 stated she did not wear and was supposed to wear an isolation gown during administering medications for Residents 21, 10, and 14. LVN 2 stated an isolation gown, gloves, and masks were supposed to be worn during medication pass with residents who had G-tubes in order to not contaminate the residents and the staff. During an interview on 7/17/2026 at 9:45 AM with the DON, the DON stated that when administering medications via a G-tube, staff needed to wear PPE such as gloves, gown, and a mask. The DON stated it was a high contact activity with resident care and staff needed to protect themselves and the residents from any contamination. During a record review of the facility's P&P titled, Sub-Acute Infection Control Policies, revised 6/2026, the P&P indicated enhanced barrier precautions 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. For relatively health residents follow enhanced barrier precautions making sure that gloves and gowns are used for contact with uncontrolled secretions, pressure ulcers, draining wounds, stool incontinence and ostomy tubes/bags.		