STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlora Post Acute Rehab Hosp	3801 E Anaheim St Long Beach, CA 90804

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review the facility failed to ensure two of three sampled residents (Resident 2 and Resident 3) resident rights were upheld and protected when the Administrator (ADM) failed to speak to Resident 2 and Resident 3 in a respectful manner that maintained the resident's dignity, privacy, and individuality. This deficient practice resulted in Resident 2 and Resident 3 feeling anxious, powerless, frustrated, humiliated, angry and distrustful toward the facility. Findings: a. During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including generalized anxiety disorder (excessive and persistent feelings of fear, worry and dread), major depressive disorder ([MDD] a serious condition that affects how a person feels, thinks, acts), and hemiplegia (a slight paralysis or weakness on one side of the body) and hemiparesis (paralysis of the arm, leg, and trunk on the same side of the body) affecting the right side of Resident 2's body. During a review of Resident 2's History and Physical (H&P , dated 5/24/2024, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 8/24/2024, the MDS indicated Resident 2 could always express ideas and wants and could always understand others. During a review of Resident 2's Social Services Progress note , dated 9/9/2024, the Social Services Progress note indicated Resident 2 expressed being very upset following a visit from the Administrator (ADM) and the Business Office Manager (BOM), and the way they requested his past due payment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlora Post Acute Rehab Hosp	3801 E Anaheim St Long Beach, CA 90804

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/11/2024, at 8:30 a.m., Resident 2 stated he had an outstanding balance that he owed the facility, but because he had a delay in the receipt of his bank card, he had been unable to make a payment. Resident 2 stated on 9/6/2024 the ADM and BOM came to his room without permission and demanded he (Resident2) pay his share of cost (SOC). Resident 2 stated the ADM stood over him and spoke to him in a tone that was insulting and demeaning, asking him how he was able to buy items from Walmart but could not pay what he owed to the facility, and it made him feel increasingly anxious during their interaction. Resident 2 stated, the ADM violated his privacy by being in his room, invaded his personal space, and made him feel disrespected. Resident 2 stated he felt intimidated by the ADM and still felt anxious thinking about having future interactions with her. During an interview on 9/11/2024, at 8:45 a.m., Resident 2's roommate (Resident 4) stated on 9/6/2024, he was in his room behind the privacy curtain when he heard someone talking to Resident 2. Resident 4 stated he could not see who it was but heard the conversation. Resident 4 stated a woman asked Resident 2 to pay his bill and asked how he could buy items from Walmart but not pay the facility. Resident 4 stated I could hear their conversation because it was not kept private, and the tone of the person's voice was very disrespectful and insulting to Resident 2. Resident 4 stated no one should talk to a person in the way that woman spoke to Resident 2 especially because it was in Resident 2's room where he lives. During an interview on 9/11/2024, at 9:37 a.m., the BOM stated a few days ago (9/6/2024), she entered Resident 2's room with the ADM to discuss Resident 2's outstanding SOC. The BOM stated she did not know if Resident 2 had given permission for them to discuss his financial affairs in his room and she did not know if other residents were present in the room when they spoke to Resident 2. The BOM stated the ADM asked Resident 2 why he could not pay the facility but could purchase personal items from Walmart. The BOM stated residents have the right to privacy when speaking about their personal and financial matters and residents have the right to be spoken to in a dignified way. The BOM stated Resident 2 was not respected when the ADM asked him how he spends his money. During an interview on 9/12/2024, at 12:38 p.m., the Social Services Director (SSD) stated on 9/9/2024, Resident 2 asked that she come to his room and reported to her that he was very upset at the way the ADM discussed his outstanding balance. The SSD stated Resident 2 had a diagnosis of anxiety and depression and Resident 2's interaction with the ADM had the potential to cause Resident 2 to anxious which could affect his overall health and wellness. During an interview on 9/13/2023, at 10 a.m., the ADM stated Resident 2 had an outstanding balance that was owed to the facility and she and the BOM entered Resident 2's room to discuss his debt to the facility. The ADM stated she asked Resident 2 how he was able to pay for his personal items and not pay the facility. The ADM stated she did not have permission from Resident 2 to discuss his financial business in his room and admitted during the meeting, she left the door to Resident 2's room open and stood at the foot of Resident 2's bed during their discussion. The ADM stated during the meeting Resident 2 did appear to be upset. b. During a review of Resident 3's the Admission Record (Face Sheet), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including anxiety disorder, MDD, and schizophrenia (a serious mental illness that affects a person's thoughts, feelings, behaviors). During a review of Resident 3's H&P, dated 8/30/2024, the H&P indicated Resident 3 had the capacity to understand and make decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlora Post Acute Rehab Hosp	3801 E Anaheim St Long Beach, CA 90804

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 could express ideas and wants and could always understand others. During a review of Resident 3's Notification of Room Change, dated 8/28/2024, the Notice of Room Change indicated Resident 3 would be moved on 8/31/2024 to another room. The Notice of Room Change indicated Resident 3 did not agree to the room change. During a review of Resident 3's Grievance/Concern form, dated 8/28/2024, the Grievance/Concern form indicated Resident 3 was not agreeable to a room change due to the location of the room. During an interview on 9/11/2023, at 2 p.m., Resident 3 stated at the end of 8/2024, she was moved into her current room against her wishes. Resident 3 stated the ADM informed her she would be moved to another room, despite her disagreement with the room change. Resident 3 stated she did not want to move to another room because moving and the room change would cause her anxiety because she did not like moving. Resident 3 stated she called the Ombudsman (an advocate and representative that assist residents understand their rights) because she felt the ADM violated her rights, and disrespected her wishes, which was demeaning and humiliating. Resident 3 stated she did not feel like she had any rights because the ADM moved her against her will despite her opposition to the move. During an interview on 9/11/2023, at 3:23 p.m., the Ombudsman stated Resident 3 called her on 8/28/2024 to report that she (Resident 3) was required to move to another room. The OMB stated when she called the ADM, the ADM stated she would move Resident 3 regardless of Resident 3's wishes to remain in her room. The OMB stated, I reminded the ADM of the resident's rights and the ADM stated, I am aware of residents rights but Resident 3 will be moved anyway. During an interview on 9/12/2023, at 12:38 p.m., the SSD stated prior to moving a resident to another room, the resident will be given notice of the proposed room change, which they can refuse. The SSD stated she met with Resident 3 who refused to be moved to another room but was moved to another room against her wishes. The SSD stated the ADM wanted to move Resident 3 to another room so newly admitted residents could be close to the nurse's station. The SSD stated she filed a grievance concern form on Resident 3's behalf, per Resident 3's request. During an interview on 9/13/2023, at 10:10 a.m., the ADM stated she spoke with the OMB regarding Resident 3's refusal to move to another room but decided to move Resident 3 to another room because Resident 3 did not like who was then her current roommate and she (ADM) wanted Resident 3's room open to place newly admitted residents near the nurse's station. The ADM stated Resident 3 was moved to another room despite Resident 3's refusal and she (ADM) did not feel like Resident 3's rights were violated. During a review of the facility's policy, and procedure (P/P) titled, Room Change/ Roommate Assignment, revised 3/2021, the P/P indicated changes in room or roommate assignments are made when the facility deems it necessary or when a resident requests a room change. The P&P indicated resident preferences are taken into account when such changes are considered, residents have the right to refuse to move to another room in the facility if the purpose of the move is to relocate the resident from a skilled facility unit within the facility to one that is not a skilled nursing unit, to relocate the resident from a nursing unit within a facility to one that is a skilled nursing unit or solely for the convenience of the staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlora Post Acute Rehab Hosp	3801 E Anaheim St Long Beach, CA 90804

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P/P titled, Resident Rights, revised 12/2020, the P/P indicated employees shall treat all residents with kindness and respect and dignity. During a review of the facility's P/P titled, Quality of Life, revised 8/2009, the P/P indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Residents will be treated with dignity and respect at all times, treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth, residents' private space and property shall be respected at all times, staff will knock and request permission before entering residents' rooms, staff shall speak respectfully to all residents at all times, staff shall promote, maintain and protect resident privacy, demeaning practices and standards of care that compromise dignity are prohibited, staff shall promote dignity and assist residents as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlora Post Acute Rehab Hosp	3801 E Anaheim St Long Beach, CA 90804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on observation, interview, and record review, the facility failed to ensure facility staff called 911 immediately to activate Emergency Medical Services ([EMS] a system that responds to emergencies in need of highly skilled pre-hospital clinicians), delegate staff to retrieve the facility's crash cart (a mobile cabinet that contains equipment and medications used to treat patients in a medical emergency) and obtain a non-rebreather mask (a device that delivers a large amount of O2, between 10 to 15 liters per minute [LPM]) to deliver an effective amount of oxygen (O2), when one of three sample residents (Resident 1), was observed choking while eating and required emergency assistance. As a result of this deficient practice, there was a 14 minute delay in calling 911 after Resident 1 was found choking, when RN 1 and LVN 1 went to check Resident 1's code status (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop) while at the same time calling the Director of Staff Development (DSD) to inquire if they should call 911. This deficient practice resulted in Resident 1, whose oxygen saturation ([O2sat] the percentage of oxygen [O2] in person's blood: normal level is 95% to 100% without the use of supplemental [extra] oxygen]) rate, during his choking episode, fluctuated between 52% and 82% was administered O2 at five liters per minute (LPM) via a nasal cannula ([NC] a medical device that delivers low amounts of O2, usually between one to six LPM), instead of a higher rate of O2 via a non-rebreather mask (a medical device that delivers high higher amounts of O2, usually between 10 and 15 LPM) to more effectively ventilate (air exchange in and out of the lungs) Resident 1 until EMS could arrive. This deficient practice had the potential to result in Resident 1's death. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing), and encephalopathy (a disease affecting brain and its function). During a review of Resident 1's History and Physical (H&P), dated [DATE], the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Sheet ([MDS] a standardized assessment and care screening tool) dated [DATE], the MDS indicated Resident 1 had severely impaired cognitive skills (ability to learn, understand, and make decisions) for daily decision making and was dependent on staff for eating. The MDS indicated Resident 1 had difficulty or pain with swallowing and was prescribed a mechanically altered diet. During a review of Resident 1's Situation Background Assessment Recommendation ([SBAR] a form of communication between members of a health care team) dated [DATE] and timed at 5:55 p.m., the SBAR indicated Resident 1 had decreased consciousness (state of being aware and responsive to one's surroundings, shortness of breath (SOB) and a low O2sat while eating. The SBAR indicated LVN 1 notified Registered Nurse 1 (RN 1), who after assessing Resident 1, called 911. The SBAR indicated Resident 1 was transferred to a General Acute Care Hospital (GACH) for further evaluation and treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlora Post Acute Rehab Hosp	3801 E Anaheim St Long Beach, CA 90804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Nursing Progress Note dated [DATE] and timed at 5:56 p.m., the Nursing Progress Note indicated at 5:15 p.m., Resident 1 was slumped over in bed choking, RN 2 performed a mouth sweep (when a finger is placed in a person's mouth to remove any objects) and noticed Resident 1's lips were blue (a life threatening sign indicating a lack of oxygen in body). The Nursing Progress Note indicated RN 1 administered two LPM of O2 to Resident 1 via a NC. The Nursing Progress Note indicated Resident 1's O2sat was 82%. The Nursing Progress Note indicated RN 1 increased the administration of O2 to Resident 1 to 5 LPM and requested a non-rebreather mask. The Nursing Progress Note indicated Resident 1's lips were no longer blue but Resident 1 was observed with agonal breathing (irregular or gasping breaths, a sign of a severe medical emergency that occurs when the brain is not getting enough O2, and a person is near death). The Nursing Progress Note indicated the Director of Staff Development (DSD) and 911 were called, and when the paramedics arrived, Resident 1's O2sat was 52% while on O2 at five LPM via a NC. On [DATE], at 1:30 p.m., the facility's video surveillance was viewed with the DSD present. The video surveillance reflected the following events were observed to occur on [DATE]: 5:28 p.m. - LVN 1 entered Resident 1's room. 5:30 p.m. - RN 1 entered Resident 1's room. 5:33 p.m. - RN 2 entered Resident 1's room. 5:35 p.m. - RN 1 and LVN 1 exited Resident 1's room, walked to the nurse's station, that was located near Resident 1's room, sat in front of a computer and engaged in a discussion about what was viewed on the computer.(RN 1 and LVN 1 were observed pointing at the computer screen). 5:38 p.m. - RN 1, who was still at the nursing station, picked up a telephone and made a call. 5:41 p.m. - CNA 1 took an O2 tank into Resident 1's room, then she was observed exiting Resident 1's room. 5:42 p.m. - CNA 1 took a physiological monitor (a device that measures and displays a person's vital signs [v/s]) into Resident 1's room. At the same time RN 1 was observed making a telephone call. 5:48 p.m. - Paramedics arrived at Resident's 1 room. 5:55 p.m. - Resident 1 was transferred from his room on a gurney while being ventilated by a paramedic using a bag-valve mask ([BVM] a handheld device used to provide O2 and ventilation to people who are in respiratory distress or not breathing adequately). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlora Post Acute Rehab Hosp	3801 E Anaheim St Long Beach, CA 90804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Rescue and Emergency Medical Service Incident report dated [DATE], the Rescue and Emergency Medical Service Incident report indicated EMS was dispatched to the facility on [DATE] at 5:42 p.m., and arrived at the facility at 5:47 p.m. The Rescue and Emergency Medical Service Incident report indicated Resident 1 was found seated in bed, his Glasgow Coma Scale ([GCS] a tool medical professional's use to objectively evaluate the degree to which a person is conscious or comatose. It operates on a scale of 3 to 15. A score of 15 means you are fully awake, responsive and have no problems with thinking ability or memory. A score of eight or fewer generally means you are in a coma. The lower the score the deeper the coma) was six. The Rescue and Emergency Medical Service Incident report indicated Resident 1 had an altered level of consciousness ([ALOC] a change in a person's state of awareness and alertness) that occurred after eating. The Rescue and Emergency Medical Service Incident report indicated Resident 1 presented with diminished lung sounds, labored breathing, pale skin, and was immediately transported to the GACH for an uncontrolled airway. The Rescue and Emergency Medical Service Incident report indicated Resident 1 was ventilated via a BVM and small portions of a foreign body were removed from Resident 1's throat using [NAME] forceps (a medical instrument used for procedures in the throat and mouth such as foreign object removal) while enroute to the GACH. During a review of the GACH's Face Sheet, the Face Sheet indicated Resident 1 was admitted to GACH on [DATE]. During a review of the GACH's emergency room (ER) Consultation report dated [DATE], the ED Consultation report indicated Resident 1 was admitted to the GACH after choking on spaghetti noodles requiring intubation (a medical procedure where a tube is inserted into a person's airway to help with breathing through a machine) on arrival to the GACH. The ER Consultation report indicated during intubation, the ER physician noted large amounts of spaghetti present before and after Resident 1's vocal cords. During a review of the GACH's Operative and Procedure report, dated [DATE], the Operative and Procedure report indicated Resident 1 underwent a bronchoscopy (a procedure that examines the inside of the lungs and airways using a thin, flexible tube called a bronchoscope) to remove food material that was consistent with spaghetti. During an interview on [DATE] at 1:40 p.m., CNA 1 stated on [DATE] she was feeding Resident 1 dinner which consisted of noodles when she observed Resident 1 coughing nonstop. CNA 1 stated she stayed with Resident 1 while CNA 2 went to get help. CNA 1 stated LVN 1 and RN 1 came to Resident 1's room and LVN 1 performed the Heimlich Maneuver (first aid technique to help someone who is choking), that's when she left Resident 1's to attend to her other assigned residents. CNA 1 stated she was not instructed by LVN 1 or RN 1 to call 911 or to get the crash cart. During an interview on [DATE] at 3:30 p.m., CNA 2 stated she was passing out dinner trays in the hallway when she heard CNA 1 call for help, she (CNA 2) went to Resident 1's room and observed Resident 1 sitting up in bed, making gurgling noises and having a hard time breathing. CNA 2 stated, CNA 1 asked her to get assistance and she (CNA 2) called LVN 1 to the room. CNA 2 stated she was not instructed by licensed nurses to call 911 or to get the crash cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlora Post Acute Rehab Hosp	3801 E Anaheim St Long Beach, CA 90804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:45 p.m., LVN 1 stated CNA 2 called him to go to Resident 1's room, and when he arrived in Resident 1's room, CNA 1 told him that Resident 1 began to choke while she was feeding him spaghetti noodles for dinner. LVN 1 stated he observed Resident 1 drooling and he (Resident 1) appeared to be choking. LVN 1 stated he performed the Heimlich maneuver on Resident 1 and saw food particles expel from Resident 1's mouth. LVN 1 stated when RN 1 and RN 2 entered Resident 1's room, he left the room to validate Resident 1's code status to determine if 911 should be called. LVN 1 stated he did not inform RN 1 that he had performed the Heimlich maneuver on Resident 1, and he did not remember giving a report to the RNs before he left Resident 1's room. LVN 1 stated he did not return to the room, and he did not call 911 right away because he was looking for Resident 1's code status. During an interview on [DATE] at 4:20 p.m., RN 2 stated a CNA (CNA 2) called her to Resident 1's room, and when she arrived, she observed Resident 1 with what appeared to be noodles in his mouth. RN 2 stated she was able to sweep the food from Resident 1's mouth but his lips were blue. RN 2 stated she asked staff members for a suction device, oxygen and a nonrebreather mask, and CNA 1 brought her an O2 tank and a NC. RN 2 stated she applied the NC and administered O2 to the Resident 1 before asking staff to bring her a v/s machine. RN 2 stated Resident 1's O2sat was 82% on 5 LPM of O2 via a NC. RN 2 stated she then asked staff for a non-rebreather mask, but no one brought her the supplies she asked for. RN 2 stated staff should have brought the crash cart to Resident 1's room once the emergency was identified and 911 should have been called immediately to ensure Resident 1 did not have a delay in care. During an interview on [DATE] at 12:25 p.m., RN 1 stated CNA 2 called her to Resident 1's room, and when she arrived, she observed CNA 1, CNA 2 and LVN 1 at Resident 1's bedside, LVN 1 was performing the Heimlich maneuver on Resident 1 which resulted in some food particles (noodles) being expelled from Resident 1's mouth. RN 1 stated Resident 1's mouth was blue, and RN 2 gave Resident 1 O2 via a NC, checked Resident 1's O2sat, which was 82%. RN 1 stated she left the room to assist LVN 1 to look for Resident 1's code status to determine if 911 needed to be called. RN 1 stated she called the DSD who instructed her to call 911 immediately. RN 1 stated she should have called or instructed staff to call 911 immediately instead of searching the chart for Resident 1's code status. RN 1 stated the delay in calling 911 put Resident 1 at risk of further injury and death. During an interview on [DATE] at 1:20 p.m., the DSD stated on [DATE] at approximately 5:30 p.m., RN 1 called her at home. The DSD stated RN 1 informed her that Resident 1 choked while he was eating and asked her about calling 911 and locating Resident 1's code status. The DSD instructed RN 1 to call 911 right away and to retrieve Resident 1's code status after calling 911. The DSD stated the facility staff should have called 911 once the Resident 1 was observed choking because time was critical. The DSD stated the facility delayed care to Resident 1 by not calling 911 immediately and stated the licensed nurses should have remained with Resident 1 and instructed the non-licensed staff to call 911 and retrieve the crash cart and any other needed supplies. During an interview on [DATE] at 4:30 p.m., the DON stated 911 must be initiated once an emergency such as choking has been identified. The DON stated, while the licensed nurses provided care to Resident 1, other staff should have been instructed to call 911 and bring the crash cart to Resident 1's room. The DON stated Resident 1 experienced a delay in care that could have led to serious injury and death. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlora Post Acute Rehab Hosp	3801 E Anaheim St Long Beach, CA 90804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE], at 1:30 p.m., after viewing the facility's video surveillance, the DSD stated it appeared as if RN 1 made a call to her at 5:38 p.m., (10 minutes after LVN 1 was observed entering resident 1's room) and called 911 at 5:42 p.m., (14 minutes after LVN 1 was observed entering Resident 1's room). The DSD stated there was a delay in Resident 1's care when 911 was not called immediately after Resident 1 was identified as choking and by not bringing the emergency cart to Resident 1's room. During a review of the facility's policies and Procedures (P&P), titled Crash Cart Policy, revised [DATE], the P&P indicated the emergency crash cart is to be used for residents' requiring immediate interventions such as CPR, suctioning, oxygen, etc. During a review of the facility's P&P, titled Emergency Procedure Choking, revised ,d+[DATE], the P&P indicated trained staff will assist a resident who is choking by attempting to expel foreign body from the airway, if unable to clear the foreign body from obstructing the airway, arrange emergency transport of the resident to the nearest GACH. During a review of an online article titled, Adult Basic Life Support, the article indicated, the actions taken during the first few minutes of an emergency are critical to the victim's survival. Basic Life Support ([BLS] set of life saving procedures performed in the early stages of an emergency) includes recognition of foreign body airway obstruction ([FBAO] a medical emergency that occurs when a foreign object such as food blocks the airway and prevents breathing). Early access requires prompt recognition of emergencies that require time critical BLS interventions, such as heart attack, stroke, FBAO, respiratory and cardiac arrest. Early access of the EMS system quickly alerts EMS providers who can respond with a defibrillator. Foreign bodies may cause either partial or complete airway obstruction, with partial airway obstruction the victim may be capable of either good air exchange or poor air exchange. If partial airway obstruction persists, activate EMS system. Signs of poor air exchange include weak ineffective cough, high pitched noise while inhaling, respiratory difficulty, and possible cyanosis. https://www.ahajournals.org/doi/10.1161/circ.102.suppl_1.I-22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlora Post Acute Rehab Hosp	3801 E Anaheim St Long Beach, CA 90804

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to document the care provided to one of three sampled residents (Resident 1), who was observed choking while being fed at dinner time, and who required a licensed nurse (LVN 1) to perform the Heimlich maneuver (a first aid and lifesaving technique used to help someone who is choking) on him. This deficient practice resulted in Resident 1's medical record having no documentation to show Resident 1's condition following a choking episode and the care provided to him. This deficient practice had the potential for non-continuity of care to Resident 1. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing), and encephalopathy (a disease affecting brain and its function). During a review of Resident 1's History and Physical (H&P), dated 3/22/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Sheet ([MDS] a standardized assessment and care screening tool) dated 6/18/2024, the MDS indicated Resident 1 had severely impaired cognitive skills (ability to learn, understand, and make decisions) for daily decision making and was dependent on staff for eating. The MDS indicated Resident 1 had difficulty or pain with swallowing and was prescribed a mechanically altered diet. During a review of Resident 1's Situation Background Assessment Recommendation ([SBAR] a form of communication between members of a health care team) dated 9/8/2024 and timed at 5:55 p.m., the SBAR indicated Resident 1 had decreased consciousness (state of being aware and responsive to one's surroundings, shortness of breath (SOB) and a low O2sat while eating. The SBAR indicated LVN 1 notified Registered Nurse 1 (RN 1), who after assessing Resident 1, called 911. The SBAR indicated Resident 1 was transferred to a General Acute Care Hospital (GACH) for further evaluation and treatment. During an interview on 9/10/2024 at 1:40 p.m., CNA 1 stated on 9/8/2024 she was feeding Resident 1 dinner which consisted of noodles when she observed Resident 1 coughing nonstop. CNA 1 stated she stayed with Resident 1 while CNA 2 went to get help. CNA 1 stated LVN 1 and RN 1 came to Resident 1's room and LVN 1 performed the Heimlich Maneuver (first aid technique to help someone who is choking). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marlora Post Acute Rehab Hosp	3801 E Anaheim St Long Beach, CA 90804

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/10/2024 at 3:45 p.m., LVN 1 stated CNA 2 called him to go to Resident 1's room, and when he arrived in Resident 1's room, CNA 1 told him that Resident 1 began to choke while she was feeding him spaghetti noodles for dinner. LVN 1 stated he observed Resident 1 drooling and he (Resident 1) appeared to be choking. LVN 1 stated he performed the Heimlich maneuver on Resident 1 and saw food particles expel from Resident 1's mouth. LVN 1 stated he did not document in Resident 1's clinical record, Resident 1's condition after he found him (Resident 1) choking or that he (LVN 1) performed the Heimlich maneuver on Resident 1 because he got busy and failed to document. LVN 1 stated not documenting Resident 1's condition and the care Resident 1 received after he was found choking resulted in an inaccurate reflection of what lead to Resident 1's transfer to the GACH. During an interview on 9/12/2024 at 1:20 p.m., the Director of Staff Development ([DSD] licensed nurse who plans, directs, and coordinates training) stated it was important for licensed nurses to accurately document the care provided to residents in order to ensure quality of care and proper communication between health care providers. The DSD stated LVN 1 should have created a progress note, even as a late entry written at the end of his shift, to document Resident 1's condition and the care that was provided to him. During an interview on 9/12/2024 at 4:10 p.m., the Director of Nursing (DON) stated licensed nurses should documentation the care provided to the residents and LVN 1's failure to document the details of Resident 1's choking episode and the care provided to him prevented accurate communication between other health care professionals. The DON stated accurate documentation provides important information that the facility can use to monitor how the facility delivers care to residents. The DON stated the facility was unable to review and thoroughly investigate the nature of Resident 1's choking incident due to missing documentation. During a review of the facility's policy and procedure (P/P), titled Emergency Procedure Choking, revised 8/2018, the P&P indicated trained staff will assist a resident who is choking by attempting to expel foreign body from the airway. The person performing this procedure should record the following information in the resident's medical record: the date and time the procedure was performed, the name and title of the individual who performed the procedure, the exact time the choking began, all assessment data obtained during procedure, the time the procedure was started and stopped, the resident's response to the procedure, the signature and title of the person recording the data. During a review of the facility's P/P, titled Charting and Documentation, revised 4/2022, the P&P indicated all services provided to the resident, or any changes in the resident's medical record or mental condition shall be documented in the resident's medical record.