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	11/23/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident, who had diagnoses of congestive heart failure ([CHF] a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic obstructive pulmonary disease with acute exacerbation ([COPD] a chronic lung disease causing difficulty in breathing), chronic respiratory failure (a long-term condition where the lungs cannot supply enough oxygen to the blood or remove enough carbon dioxide) and dependence on supplemental oxygen (O2) was not administered a narcotic (a substance used to treat moderate to severe pain by binding to opioid receptors in the central nervous system)-analgesic (a drug or agent used to relieve pain, acting as a painkiller); Hydrocodone-Acetaminophen ([Norco] used for pain relief) concurrently with benzodiazepines (a class of prescription drugs that slow down the central nervous system ([CNS] a complex of nerve tissues that controls the activities of the body) used for anxiety [a feeling of fear, dread, and uneasiness]), a sedative medication Diazepam, an antipsychotic medication Olanzapine (used to treat mental health condition including schizophrenia [a disorder characterized by disruptions in thought processes, perceptions, and emotional responsiveness] and bipolar disorder [a disorder characterized by extreme mood swings]), and an anti-anxiety medication Buspirone Hydrochloride (used to treat anxiety) for one of four sampled residents (Resident 2) who became unresponsive and stopped breathing. The facility failed to: 1. Ensure licensed nurses recognized the increased effect of CNS depressants (drugs that slow down brain activity, reducing arousal and stimulation leading to relaxation, drowsiness and slowed reflexes), Diazepam, Olanzapine, Buspirone Hydrochloride, in combination with Norco, causing Resident 2's oversedation (a condition resulting in a decreased level of consciousness that interferes with a patient's proper assessment, recovery, and essential bodily functions like breathing) and affecting Resident 2's ability to breathe. On 11/1/2025 after concurrent administration of Norco, Diazepam, Olanzapine and Buspirone Hydrochloride, Resident 1 became unresponsive, was without a pulse and stopped breathing. 2. Ensure licensed nurses monitored the black box warning for Buspirone HCL as ordered by the physician on 10/31/2025 to avoid concomitant (occurring at the same time) administration of benzodiazepines and narcotics which could result in Resident 2's profound sedation, respiratory depression, coma, and death. 3. Ensure the Director of Staff Development (DSD) provided training to licensed vocational nurses, who administered medications in the facility, on black box warnings and use of narcotics-analgesics concurrently with psychotropic medications. 4. Ensure licensed nurses followed the facility's Policy and Procedure (P&P) titled, Administering Medications dated 1/2024, which indicated If .a medication has been identified as having potential adverse consequences (a negative or harmful result) for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medications will contact the prescriber, attending physical, or facility medical director to discuss concerns. These deficient practices resulted in Resident 2 experiencing a cardiac arrest (when the heart suddenly and unexpectedly stops beating) on 11/1/2025, transfer to a General Acute Care Hospital (GACH) 2 where Resident 2 was intubated (having a breathing tube inserted (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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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 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9:48 a.m., the psychiatric Nurse Practitioner (NP) stated Diazepam 7.5 mg was a large dose and he was not aware that Resident 2 was prescribed Diazepam or Olanzapine. The NP stated Resident 2 received Buspirone and Norco together without issues in the past because his tolerance of the medications was high. The NP stated the combination of Olanzapine, narcotic-analgesic, and Diazepam could have a sedative effect, and the narcotic pain medication and benzodiazepine should be spaced out at least one hour from each other and not given concurrently. The NP stated if he would have known Resident 2 was prescribed Olanzapine, he would have adjusted the dose because 10 mg twice a day and 15 mg at night was a lot. The NP stated, he would have clarified the indication for Olanzapine's use because Resident 2 did not have a diagnosis to support the prescription of that medication. The NP stated he would have also adjusted the dose of the Diazepam to be lower, because Norco and Diazepam were both CNS depressants. During a review of the National Library of Medicine's drug information on hydrocodone bitartrate and acetaminophen usage warning, revised on 10/6/2025, the National Library of Medicine's drug information indicated concomitant use of narcotics with benzodiazepines or other central nervous system depressants such as antipsychotics may result in profound sedation, respiratory depression, coma, and death. The National Library of Medicine's drug information warning indicated serious, life-threatening, or fatal respiratory depression has been reported with the use of narcotics, even when used as recommended and that respiratory depression, if not immediately recognized and treated, may lead to respiratory arrest and death. The National Library of Medicine's drug information indicated management of respiratory depression may include close observation, supportive measures, and use of narcotics antagonists (a substance which interferes with or inhibits the physiological action of another substance), depending on the patient's clinical status. The National Library of Medicine's drug information indicated narcotics can cause sleep-related breathing disorders including central sleep apnea (CSA, a sleep disorder where the brain temporarily fails to send signals to the muscles that control breathing, causing repeated pauses in breathing during sleep) and sleep-related hypoxemia. https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl. During review of facility's P/P titled Administering Medications dated 1/2024, the P/P indicated If a dosage is believed to be inappropriate for a resident, or a medication has been identified as having potential adverse consequences (a negative or harmful result) for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medications will contact the prescriber, attending physical, or facility medical director to discuss concerns.