

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/08/2025
NAME OF PROVIDER OR SUPPLIER Marlora Post Acute Rehab Hosp		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the California Department of Public Health (CDPH) was notified within 24-hours when the facility had a Covid (a highly contagious disease caused by the coronavirus SARS-Cov-2 spread by droplets from coughing, sneezing or talking) outbreak on 10/16/2025 for two of two sampled residents (Residents 3 and 10) and one facility staff. This deficient practice resulted in an increase of Covid positive residents and staff without CDPH knowledge and oversight and had the potential for the Covid to continue spreading amongst residents, staff and visitors due to possible ineffective infection control practice. Findings: a. During a record review of Resident 3's admission Record (Face sheet), the Face sheet indicated Resident 3 was admitted to the facility on [DATE] with diagnosis including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movements) and failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition and inactivity). During a review of Resident 3's Minimum Data Set ([MDS] a resident assessment tool) dated 9/17/2025, the MDS indicated Resident 3 was able to make decisions that were reasonable and consistent. During a record review of Resident 3's SBAR (Situation, Background, Assessment and Recommendation- a communication tool used by healthcare workers when there is a [NAME] in condition among the residents) dated 10/15/2025, the SBAR indicated Resident 3 was dizzy, had a sore throat and runny nose and was positive for Covid. b. During a record review of Resident 10's admission Record (Face sheet), the Face sheet indicated Resident 10 was admitted to the facility on [DATE] with a diagnosis of hypothyroidism (a condition when the thyroid gland does not make or release enough hormone into the bloodstream causing slow functions of the body such as tiredness and weight gain). During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10 was able to make decisions that were reasonable and consistent. During a record review of Resident 10's SBAR dated 10/15/2025, the SBAR indicated Resident 10 had no symptoms of a respiratory infection but was positive Covid. During a review of an email from the Public Health Nurse (PHN) to the facility's Infection Preventionist Nurse (IPN) and the facility's Administrator (ADM) dated 10/16/2026 and timed at 2:35 p.m., the email indicated the facility met the criteria for a Covid outbreak because of two or more Covid cases amongst the residents and staff. The email indicated the facility should report the Covid outbreak to CDPH. During an interview on 10/23/2025 at 12:59 p.m., the IPN stated on 10/15/2025, Resident 3 and Resident 10 tested positive for Covid along with the facility's receptionist was tested positive for Covid on 10/16/2025. The IPN stated as of 10/23/2025, there were 18 residents and 15 staff who were positive for Covid. The IPN stated the PHN gave the facility guidance to report the Covid outbreak to the State Agency (CDPH) but she did report the incidence to CDPH until 10/22/2025 because she thought the other government entities would be notified including CDPH, once she reported the Covid outbreak to the local public health office. The IPN stated she should have reported the Covid outbreak to CDPH on 10/16/2025 (within 24 hours) of the facility's initial Covid outbreak so CDPH could monitor the facility's infection control procedures and/or practices and their compliance with the PHN's guidance. During an interview on 10/23/2025 at 1:30 p.m., the Director of Nursing (DON) stated the IPN should have followed the guidance of the PHN regarding reporting the Covid outbreak to CDPH because the State agency could investigate the infection control procedure and policies of the facility to determine how effective the facility's monitoring process and efforts of preventing further spread of Covid amongst residents, staff and visitors. During an interview on 10/23/2025 at 1:51 p.m., the ADM stated he and the IPN were aware of the guidance from the PHN on 10/16/2025 regarding the facility's Covid outbreak. The ADM stated the current Covid outbreak was considered an unusual occurrence and the IPN and he should have reported it to CDPH within 24 hours based on the facility's policy and procedure. During a review of the facility's undated Policy and Procedure (P/P), titled, Unusual Occurrence Reporting the P/P indicated the facility is required by the Federal or State regulations, to report any unusual occurrence or reportable events that can threaten the welfare, safety or health of the residents, employees or visitors, such as an outbreak of a communicable disease to the appropriate agencies within 24 hours.</p>		