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	01/05/2026

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** Based on interview and record review, the facility failed to ensure the Discharge Summary/Post Discharge Plan of Care was provided to the receiving Skilled Nursing Facility (SNF) for one of three sampled residents (Resident 1) when Resident 1 was transferred and/or discharged on 12/11/2025.This deficient practice resulted in the receiving facility obtaining incomplete medical records for Resident 1 and had the potential for Resident 1's discharge care instructions to be overlooked, which could delay the continuity of care at the receiving facility.Findings:During a review of Resident 1's admission Record (Face sheet), the Face sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease ([ESRD] irreversible kidney failure), diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), schizophrenia (a mental illness that is characterized by disturbances in thought), depression (a mood disorder causing persistent sadness and loss of interest in daily life), and anxiety disorder (a disorder of overwhelming feelings of fear, dread or unease that interferes with daily life).During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 11/28/2025, the MDS indicated Resident 1 was unable to make decisions that were reasonable and consistent.During a review of Resident 1's History and Physical (H&P) dated 12/9/2025, the H&P indicated Resident1 did not have a capacity to understand and make medical decisions.During a review of Resident 1's Situation, Background, Assessment, Recommendation ([SBAR] a communication tool used by healthcare workers when there is a change of condition among the residents) Communication dated 11/28/2025 and timed at 3:41p.m., the SBAR indicated Resident 1 was banging her hands on the wall and attempting to grab the private parts of facility staff members. The SBAR indicated Resident 1 was unable to be redirected and reoriented by the facility staff and the facility's psychiatrist gave an order for Resident 1 to be transferred on 5150 (California's Welfare and Institutions Code that allows a peace officer or a designated professional to involuntarily confine someone for a 72-hour psychiatric hold if they are a danger to themselves or others) Hold to a General Acute Care Hospital (GACH) for further evaluation and treatment. Resident 1 was readmitted to the facility on [DATE].During a review of Resident 1's Interdisciplinary (IDT) Care Conference Note dated 12/8/2025, the IDT Note indicated Resident 1's plan of care was discussed with the Responsible Party (RP), which included discharge options to a more appropriate SNF who will be able to manage Resident 1's behavioral needs.During a review of Resident 1's Order Summary Report (Physician's Orders) dated 12/11/2025 and timed at 2:42 p.m., the Order Summary Report indicated an order was received to transfer Resident 1 to a SNF with all remaining medications on 12/11/2025 and a representative from the receiving facility would pick up Resident 1's medications, belongings and discharge paperwork.During a review of Nursing Progress Notes dated 12/11/2025 and timed at 2:45 p.m., the Nursing Progress Notes indicated Registered Nurse Supervisor (RNS) 1 could not reach a licensed staff (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
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member at the receiving facility despite multiple telephone calls, but a representative from the receiving facility will pick up Resident 1's medications, cigarettes and belongings.During a review of Resident 1's Discharge Summary/Post Discharge Plan of Care initiated on 12/10/2025 included the following:a. Instructions to follow-up with primary care physician.b. Hemodialysis (treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) facility, treatment schedule and transportation services.c. Resident 1's vital signs (the simple measurements of the body's basic functions such as temperature, pulse, breathing and blood pressure), assessment of overall well-being, one-on-one supervision, safety needs, blood sugar checks, and assistance with activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).d. Latest hemoglobin (the protein in the red blood cells that is responsible in delivering oxygen to the tissues of the body) result of 7 (normal range of 12.3 to 15.3) grams ([gm] unit of measurement)per deciliter ([dL] unit of measurement) which was being treated with Mircera (a prescription medication used to treat anemia [low red blood cell count]) 175 micrograms ([mcg] a unit of measurement) twice a month provided by the hemodialysis center.During a telephone interview on 12/30/2025 at 9:21 a.m., RP 1 stated the facility discharged Resident 1 to a SNF on 12/11/2025 and when she (RP 1) went to the receiving SNF to check on Resident 1, the receiving facility could not provide her with discharge instructions from the sending facility. RP1 stated she was concerned about the incomplete information of Resident 1's care from the previous facility.During a telephone interview on 1/2/2025 at 12:37 p.m., RNS 1 stated Resident 1's primary physician gave an order for Resident 1 to be transferred to another facility after her hemodialysis appointment on 12/11/2025. RNS 1 stated the representative of the receiving facility came to pick up Resident 1's belongings and he (RNS 1) gave the representative a copy of Resident 1's Face Sheet with the Transfer Discharge Report and/or Transfer Medication List, Resident 1's belongings and medications. RNS1 stated he did not print a copy of Resident 1's Discharge Summary Instructions and did not provide a copy of it to the representative of the receiving facility because he thought the facility's Discharge Planner (DP) had sent a copy to the receiving facility beforehand. RNS 1 stated he was told by the DP to send Resident 1's Transfer Medication List, medications and belongings with the representative of the receiving facility. RNS 1 stated he should have included Resident 1's Discharge Summary with the rest of her paperwork that was sent to the facility to ensure Resident 1's care and other follow-up information necessary for her care is complete.During an interview on 1/5/2025 at 3:02 p.m., the Director of Nursing (DON) stated RNS 1 should have provided the receiving facility of Resident 1's complete discharge summary and instructions. The DON stated the licensed nurses discharging a resident to another facility are expected to provide complete discharge paperwork with the transfer report and/or medication list and discharge summary instructions to the receiving facility to prevent gaps of information that can delay continuity of their care.During a review of the facility's policy and procedure (P&P) titled, Transfer or Discharge Documentation, revised 12/2016, the P&P indicated the facility shall transfer a resident or discharge a resident to another healthcare facility or provider with details of the transfer and discharge and appropriate and/or necessary information such as a copy of the residents' discharge summary and any other documentation, as applicable will be communicated to the receiving health care facility or provider.During a review of the facility's P&P titled, Discharging the Resident, revised 12/2016, the P&P indicated the facility shall complete a transfer summary and a telephone report is called to the receiving facility.