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 12/06/2024

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on observation, interview and record review, the facility failed to ensure an Interdisciplinary Team ([IDT] team members from different departments working together, to set goals, make decisions that ensure residents receive the best care) Care Conference meeting, involving one of three sampled residents (Resident 86) was initiated after Resident 86 had been to multiple eye doctor appointments and neither staff nor resident were aware of the outcome from the appointments. This deficient practice violated Resident 86's right to be an active participant in the IDT meeting to discuss his plan of care and services with the IDT members and possible delayed discussion of needed care and services. Findings: During a record review of Resident 86's Admission Record, the Admission Record indicated Resident 86 was admitted to the facility on [DATE] with diagnoses of end stage renal disease ([ESRD], also known as kidney failure, an illness that occurs when the kidneys can no longer function properly), diabetes type 2 ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), and hypertension ([HTN]-high blood pressure). During a record review of Resident 86's Minimum Data Set ([MDS], a resident assessment tool), dated 10/2/2024, the MDS indicated Resident 86 had intact cognitive (ability to think, understand, learn, and remember) status. The MDS indicated Resident 86 required setup or clean up assistance (helper sets up or cleans up but resident can complete the activity, helper assists only prior to or following the activity) for self-care abilities such as eating, oral hygiene and required supervision or touching assistance (helper provides verbal cues and/or touch assistance as resident completes activity) for toileting hygiene, shower/bathe, dressing and personal hygiene. The MDS also indicated Resident 86 required supervision for functional abilities such as rolling left and right, sit to lying position, lying to sitting at edge of bed and sit to stand position. During a record review of Resident 86's history and physical dated 7/28/24, Resident 86 had the capacity to understand and make decisions about his care. During a record review of Resident 86's IDT Care Conference Meeting Notes dated 6/27/2024, there was no mention of poor/decline in vision. There was no IDT Care Conference meeting after 6/27/2024. (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: 056234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Marlora Post Acute Rehab Hosp		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/3/2024 at 11:27 a.m., with Resident 86 in his room, Resident 86 was resting in bed with his eyes closed. Resident 86 opened his eyes when surveyor greeted resident. Resident 86 stated he saw the eye doctor two months ago and the eye doctor stated he was going to get surgery but Resident 86 did not know when or where. Resident 86 stated no one has told him anything about arrangements for surgery and his vision was getting worse. During a concurrent interview and record review on 12/6/2024 at 11:16 a.m., with Licensed Vocational Nurse (LVN) 4, the IDT Care Conference Meeting Notes dated 6/27/24 were reviewed. There was no mention of poor/decline in vision. LVN 4 stated the decline in vision did not happen until September 2024. LVN 4 stated there was no IDT meeting in September when Resident 86 verbalized a decline in vision in his eyes. LVN 4 stated she made an appointment for Resident 86 to be seen by a specialist ophthalmologist (a physician that specializes in diagnosing and treating eye disease) because during his recent eye exam last month with the in house eye doctor (contracted eye office conduct vision screenings, eye exams, mobile eye tests, and fit eyewear in the facility), the in house eye doctor stated Resident 86 needed another appointment to be seen by the specialist for diabetic retinopathy (a condition that damages the retina's blood vessels due to diabetes, leading to vision loss and potentially blindness). LVN 4 stated Resident 86 have been going to an outside eye doctor with his children when Resident 86 goes out on pass (someone is temporarily allowed to leave for a specific period, usually with the expectation of returning later) but the facility staff had not received any updates on what happened during those appointments. LVN 4 stated there should have been an IDT meeting in September to discuss Resident 86's blurry vision and what type of interventions Resident 86 may need. During a concurrent interview and record review on 12/6/2024 at 11:57 a.m., with the Social Service Director (SSD), the IDT Care Conference Meeting Notes dated 6/27/2024 were reviewed. There was no mention of poor/decline in vision during that meeting. The SSD stated the IDT team consisted of the physical therapist (a healthcare provider who helps you improve how your body performs physical movements) or occupational therapist (a healthcare provider who helps people improve their ability to do daily tasks such as dressing, cooking, eating), Nursing Team such as Registered Nurse, and Certified Nursing Assistant, Dietary Supervisor (manage and support the preparation and service of regular meals and therapeutic diets, order food and supplies), Activity Director (organization, conduct, and evaluation of planned activities such as arts and crafts, dancing, and music), and the SSD. The SSD stated the importance of the IDT meeting was to update the care plan and to discuss the plan on what else the facility can do for the residents in terms of their care. The SSD stated the last IDT meeting for Resident 86 was on 6/27/2024, and another IDT meeting should have been held in September. The SSD stated she does not remember if the facility had an IDT meeting in September for Resident 86 but stated there should been one. The SSD stated she was not aware of Resident 86's vision getting worse and was not aware of the multiple eye doctor appointments that Resident 86 went to. The SSD stated she did not know what was done during the eye appointments that Resident 86 was going to for his vision as the facility did not have any paperwork after the visits. (continued on next page)

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/6/2024 at 3:39 p.m., with the Assistant Director of Nursing (ADON), the IDT Care Conference Meeting Notes dated 6/27/2024 was reviewed. There was no other IDT Care Conference Meeting Notes after 6/27/24. The ADON stated the importance of having an IDT meeting was to see if the interventions in the care plan are working for the residents. The ADON stated if the interventions do not work, the doctor would be notified to figure out what other care can be provided to the residents. The ADON stated the IDT team members consist of the Director of Nursing, Quality Assurance ([QA], evaluates nursing practices within a department to help maximize efficiency and optimize patient care) nurse, MDS Nurse, PT/OT, Dietary Supervisor, SSD and Activity Director. During an interview on 12/7/2024 at 11:51 a.m., with the MDS Nurse, MDS Nurse stated IDT meetings are held for any significant changes in the resident, every quarterly, annual and when residents get discharged from the facility. MDS Nurse stated the last IDT meeting was on 6/27/2024 for Resident 86. MDS nurse stated there was no IDT meeting in September for significant changes when Resident 86 verbalized changes in his vision and was seen by an eye doctor. MDS Nurse stated there should have been an IDT meeting in September because of the significant changes in the resident and the quarterly IDT meeting was due as well since the last IDT meeting was on 6/27/2024. The MDS Nurse stated the IDT meeting was missed for Resident 86. During a review of the facility's policy and procedure (P/P) titled, Care Plans, Comprehensive Person-Centered, revised December 2016, indicated, the IDT members includes the Attending Physician, a registered nurse who has responsibility for the resident, a nurse aide who has responsibility for the resident, a member of the food and nutrition services staff, the resident and the resident's legal representative; and, other appropriate staff or professionals as determined by the resident's needs or as requested by the resident . the resident will be informed of his or her right to participate in his or her treatment assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .the Interdisciplinary Team must review when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment. During a review of the facility's P/P titled, Care Planning - Interdisciplinary Team, revised September 2013, indicated, interdisciplinary team includes the resident's attending physician, the registered nurse, the dietary manager/dietitian, the social services worker, the activity director/coordinator, therapists, director of nursing, charge nurse, nursing assistants, and others to meet the needs of the resident the resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan .every effort will be made to schedule care plan meetings at the best time of the day for the resident and family .the mechanics of how the interdisciplinary team meets its responsibilities in the development of the interdisciplinary care plan (e.g., face-to-face, teleconference, written communication, etc.) is at the discretion of the care planning committee.

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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 0578

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49573

Based on observation, interview and record review, the facility failed to ensure residents medical records were up to date as per the facility's policy and procedure (P/P) titled, Advance Directives ([AD], a legal document of a resident's wishes regarding medical treatment) for two of six sampled residents (Residents 38 and Resident 86).

This deficient practice violated the residents' rights to be fully informed of the option to formulate an AD and had the potential to cause conflict with the residents' wishes regarding health care in the event residents became incapacitated (unable to participate in a meaningful way in medical decisions) or unable to make medical decisions that would not be identified and/or carried out by the facility staff.

a.During a review of Resident 38's Admission Record, the Admission Record indicated Resident 38 was admitted to the facility on [DATE] with diagnoses of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), depression (sad mood disorder), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and hypertension ([HTN], high blood pressure).

During a review of Resident 38's Minimum Data Set ([MDS], a resident assessment tool) dated 4/23/2024, the MDS indicated Resident 38 was moderately impaired in cognitive skills (thought process) for daily decision-making and needed minimal assistance (helper provides verbal cues and/or touching) with eating, oral hygiene and upper body dressing and was dependent (helper does all of the effort and resident does none of the effort to complete the activity) on toileting hygiene, shower/bathe, lower body dressing.

During a review of Resident 38's history and physical (H/P) dated 11/11/2024, the H/P indicated Resident 38 was alert and oriented to self (a person knows who they are but may not be fully oriented to other aspects like where they are or the current time and date) and unable to make his or her own medical decisions at this time.

During a review of Resident 38's AD Acknowledgment form, the AD Acknowledgement form indicated Resident 38 had not executed an Advance Healthcare Directive (AHCD) but would like to receive more information about AHCD. The AD Acknowledgement form indicated Resident 38 signed and dated the form on 12/5/2024.

During a concurrent observation and interview on 12/5/2024 at 3:20 p.m., with Resident 38 in his room, Resident 38 was resting in bed with eyes closed. Resident 38 opened his eyes when surveyor greeted resident. Resident 38 stated he does not remember if advance directive was discussed with him when he was first admitted to the facility, but the facility staff did have him sign something today.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with record review on 12/620/24 at 3:57 p.m., with the Social Service Director (SSD), AD Acknowledgement form dated 12/5/24 along with H/P dated 11/11/24 was reviewed. The SSD stated Resident 38 was not alert when he was first admitted to the facility, so the AD Acknowledgement form was not discussed with the resident during his admission process. The SSD stated the AD Acknowledgement form should have been done when he was first admitted on [DATE] or 72 hours after admission during care conference meeting (also called Interdisciplinary Team meeting, a gathering where healthcare professionals, a patient, and their family members come together to discuss the patient's current care plan, address any concerns, and collaboratively make decisions regarding their treatment and overall well-being). The SSD stated the AD Acknowledgment form was not valid since the H/P dated 11/11/2024 indicated Resident 38 was not able to make his or her own medical decisions at this time. The SSD stated another AD Acknowledgement form should be discussed with the resident since Resident 38 was more alert now after the doctor reassessed the resident for mental and functional ability. During a concurrent interview and record review on 12/7/2024 at 12:11 p.m., with the Director of Nursing (DON), the AD Acknowledgement form dated 12/5/24 along with H/P dated 11/11/24 was reviewed. The DON stated the importance of having an AD was so the facility would know what to do if something were to happen to the resident when the resident goes to the hospital. The DON stated the Registered Nurse Supervisor (RNS) does the AD Acknowledgment form with the residents during the admission process but if the residents were not alert, the SSD does it during the care conference meeting within 72 hours of admission. The AD Acknowledgment form was not valid since Resident 38 did not have the capacity to make medical decisions and another one should be discussed with Resident 38 after Resident 38 has been reassessed by the doctor for mental and functional ability. b.During a review of Resident 86's Admission Record, the Admission Record indicated Resident 86 was admitted on [DATE] with diagnoses of atrial fibrillation (abnormal heartbeat), hypertension, insomnia (difficulty falling asleep), and anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). During a review of Resident 86's MDS dated [DATE], the MDS indicated Resident 86's cognitive skills for daily decision making were moderately impaired and needed supervision to minimal assistance with self-care needs such as eating, oral hygiene, toileting, shower, and dressing and mobility abilities such as rolling left and right, sitting to lying position and lying to sitting on the side of the bed. During a record review of Resident 86's AD Acknowledgement form, the AD Acknowledgement form indicated Resident 86 had an AHCD, understood that the terms of any AD that had been executed would be followed by the health care facility and caregivers to the extent permitted by law. The AD Acknowledgement form indicated Resident 86 had executed an AHCD and a copy was requested by the facility. The AHCD indicated Resident 86 had signed and dated the form on 12/5/2024. During a concurrent observation and interview on 12/5/2024 at 3:03 p.m., with Resident 86, Resident 86 was sitting in bed watching TV. Resident 86 stated she does not remember if the AD Acknowledgement form was discussed with her. Resident 86 stated she had a discussion with the doctor, stated she talked to her doctor about what she wanted when she goes to the hospital. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 12/6/2024 at 11:46 a.m., with the SSD, the AD Acknowledgement form dated 12/5/24 was reviewed. The SSD stated the facility does not have a copy of Resident 86's AD. The SSD stated if the facility doesn't have a copy of the AD documents, the facility does not know what the resident wishes are. During a concurrent interview and record review on 12/7/2024 at 12:11 p.m., with the DON, the AD Acknowledgement form dated 12/5/2024 was reviewed. The DON stated the AD Acknowledgement form should have been done when Resident 86 was admitted to the facility. The DON stated if the AD Acknowledgement form was done during the admission process, the facility would have a copy of the AD by now. The DON stated if the facility does not have a copy of the AD, the facility would not know what the resident's wishes were and not respecting the resident's wishes when it comes to their care. During a review of the facility's policy and procedure (P/P) titled, Advance Directive, revised December 2016, indicated, upon admission, the resident will be provided with written information concerning the right to formulate an advance directive if he or she chooses to do so if the resident is incapacitated and unable to receive information about his or her right to formulate an AD, the information may be provided to the resident's legal representative if the resident became able to receive and understand this information later, he or she will be provided with the same written material as described above, even if his or her legal representative has already been given the information prior to or upon admission of a resident, the Social Service Director or designee will inquire of the resident, his/her family members and/or legal representative, about the existence of any written advance directives .information about whether or not the resident has executed an advance directives shall be displayed prominently in the medical record.

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on interview and record review the facility failed to notify two of eight sampled resident's (Residents 6 and 26) primary care physician immediately when: a. Resident 6, who had a diagnosis of Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and received insulin (a hormone which lowers the level of glucose [a type of sugar in the blood] had a blood sugar reading of 508 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount)/deciliter (dL- a metric unit of capacity) on 11/17/2024. This deficient practice resulted in Resident 6's physician being unaware of Resident 6's elevated blood sugar (BS) level and had the potential for a delay in treatment interventions to decrease Resident 6's BS level. This deficient practice had the potential for Resident 6 to have diabetic ketoacidosis (DKA- a serious and potentially life-threatening complication of diabetes that occurs when the body doesn't have enough insulin to use blood sugar for energy), hospitalization , coma, and/or death. b. Resident 26's, who received mexiletine (medication for the treatment of life-threatening heart disease including ventricular arrhythmias [an irregular heartbeat], such as sustained ventricular tachycardia [SVT- a rapid, irregular heartbeat], a life-threatening arrhythmia [an irregular heartbeat or irregular heart rhythm]) 150 milligrams (mg) every eight hours, dose was missed on 10/20/2024 and when the dose was administered late on 11/8/2024, 11/26/2024, and on 12/12/2024. These deficient practices resulted in a delay of treatment and a potential for Resident 26 to experience worsening cardiac arrythmia and need for hospitalization . (Cross Reference to F760) Findings: a. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility 6/23/2011 and readmitted [DATE] with diagnoses including DM, supraventricular tachycardia (SVT- a rapid heart rate), and heart failure (a heard disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 6's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 9/25/2024, the MDS indicated Resident 6 had severe cognitive impairment (a condition that makes it difficult for a person to remember things, learn, concentrate, make decisions, or understand the meaning of things). During a review of Resident 6's Order Summary Report (Physician's Orders), the report indicated Resident 6 was to receive insulin Lantus 10 units subcutaneously (SQ-under the skin) at bedtime for diabetes and hold if BS is less than 100 mg/dL. The report indicated to check Resident 6's BS prior to administering Lantus. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's Medication Administration Record (MAR) dated 11/2024, the MAR indicated Resident 6 had a BS level of 508 mg/dL on 11/17/2024 at 9 p.m. The MAR indicated there was no documentation in Resident 6's medical record that the physician was notified of Resident 6's elevated BS. During an interview on 12/6/2024 at 12:49 p.m., Licensed Vocational Nurse (LVN 11) stated it was facility's policy to call the physician if blood sugars were below 70 mg/dL or above 400 mg/dL. LVN 11 stated it was important to call the physician when Resident 6's BS was 508 mg/dL to see if any new orders needed to be placed and/or additional interventions were needed. During a concurrent interview and record review on 12/6/2024 at 1:09 p.m., Resident 6's clinical record was reviewed. There was no documentation indicating Resident 6's physician was notified of Resident 6's BS level of 508 mg/dL. The DSD stated she reviewed Resident 6's clinical record and could not find any documentation indicating Resident 6's physician was notified of the BS level of 508 mg/dL on 11/17/2024. The DSD stated a BS of 508 mg/dL was abnormally high and was considered a change of condition, which required notification to the physician. The DSD stated elevated BS levels can lead to diabetic ketoacidosis and coma (a medical emergency that involves a prolonged state of unconsciousness where a person cannot be awakened and does not respond to external stimuli). b. During a review of Resident 26's Admission Record, the Admission Record indicated Resident 26 was originally admitted to the facility 1/31/2024 and readmitted on [DATE] with diagnoses including ventricular tachycardia (VT- a rapid, irregular heartbeat), cardiac arrythmia (an irregular heart beat or heart rhythm), and presence of a cardiac pacemaker (a small, battery-powered device that regulates the heart's rhythm by sending electrical pulses to the heart's chambers). During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 26 had moderate cognitive impairment. During a review of Resident 26's Order Summary Report (Physician's Orders), the report indicated Resident 26 was to receive mexiletine HCl 150 mg every eight hours scheduled at 12 a.m., 8 a.m., and at 4 p.m., ordered on 9/20/2024. During a review of Resident 26's MAR, dated 10/2024 and 11/2024, the MAR indicated between 10/1/2024 to 10/31/2024, Resident 26 did not receive the 4 p.m. dose of mexiletine HCl 150 mg on 10/20/2024 and the MAR indicated to see progress notes for reason. During a review of Resident 26's MAR Administration Note (Progress Notes) for 10/20/2024 at 3:34 p.m. mexiletine HCl 150 mg, read awaiting delivery. During a review of Resident 26's Medication Admin Audit Report (MAAR- a document indicating the exact time medications were documented as administered dated 11/1/2024 to 12/4/2024, the MAAR indicated mexiletine HCl was administered to Resident 26 as follows: 1. On 11/8/2024 - mexiletine HCl was scheduled to be administered at 12 a.m., however, according to the MAAR, mexiletine HCL was administered to Resident 26 at 5:12 a.m. (5 hours and 12 minutes after the scheduled administration time). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 11/8/2024 - mexiletine HCl was scheduled to be administered at 8 a.m., however, according to the MAAR, mexiletine HCL was administered at 7:45 a.m. (less than 2 hours and 33 minutes between doses that the physician prescribed). 3. On 11/26/2024 - mexiletine HCl the 12 a.m. dose was given at 3:02 a.m., (3 hours and 2 minutes late and 9 hours 38 minutes after the last dose on 11/25/2024 that was given at 5:24 p.m.) and the 8:00 a.m. dose was given at 7:46 a.m. (4 hours and 44 minutes since the last dose). 4. On 12/2/2024 - mexiletine HCl 12 a.m. dose was given at 2:42 a.m., (2 hours and 42 minutes late) and the 8:00 a.m. dose was given at 7:51 a.m. (5 hours and 9 minutes apart). During a review of Resident 26's SBAR (Situation, Background, Assessment, Recommendation) Communication Form dated 12/4/2024, the SBAR indicated Resident 26 informed the facility he received a late dose of mexiletine on 12/2/2024. The SBAR indicated Resident 26's primary care physician (MD 3) was informed on 12/4/2024 at 6:39 p.m. regarding the late dose from 12/2/2024 (2 days later). During a review of Resident 26's clinical record, there was no documentation indicating MD 3 was notified of the missed mexiletine dose on 10/20/2024, nor was informed of the late administration on 11/8/2024, 11/26/2024, and on 12/2/2024. During an interview on 12/5/2024 at 3:04 p.m., Licensed Vocational Nurse (LVN 5) stated a late dose or missed dose of medication was a medication error and needed to be relayed to the resident's physician to see if any new orders need to be placed or if any additional monitoring needed to be done. During an interview on 12/5/2024 at 3:22 p.m., the Director of Nursing (DON) stated missed doses and late doses of medication are considered medication errors. The DON stated the licensed nurses should have done a change of condition and notified Resident 26's physician. The DON stated Resident 26 was supposed to be monitored for three days after each medication error. The DON stated a missed dose or late dose of mexiletine could cause a worsening cardiac arrhythmia. During a review of the facility's policy and procedure (P&P) titled Diabetes-Clinical Protocol, dated 2001, the P&P indicated the physician was to follow up on any acute (sudden) episodes associated with a significant change in blood sugars. During a review of the P&P titled Change in a Resident's Condition or Status, dated 2021, the P&P indicated the facility was to promptly notify the resident's attending physician for any changes in the resident's medical condition. The P&P indicated the nurse was to record in the resident's medical record any information relative to changes in the resident's medical condition. During a review of the facility's P&P titled Adverse Consequences of Medication Errors, dated 2/2023, the P&P indicated a medication error was defined as the preparation or administration of drugs which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards. Examples of medication errors included the medication being given at the wrong time or a drug is ordered but not administered. A significant medication error is determined as one that is life threatening. The physician was to be promptly notified of any significant error and the resident was to be monitored for 24 to 72 hours after a significant medication error. The P&P further indicated the significant medication error was to be communicated to the oncoming shift as needed to alert staff of the need for continued monitoring.

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NAME OF PROVIDER OR SUPPLIER Marlora Post Acute Rehab Hosp		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 45777 AMENDED 1/2/2025 Based on interview and record review the facility did not protect three of three sampled resident (Resident's 62 and 69) from abuse and neglect: The facility failed to: 1a.Report alleged abuse of Resident 69 by Resident 1 b.Ensure Resident 69 was safe from Resident 1 after alleged abuse. c.Monitor Resident 1 and 69 for alleged abuse. 2a. Ensure Resident 146, who was aggressive and combative toward staff on 8/15/2024 was sent out to a general acute care hospital (GACH) on a 5150 (temporary, involuntary psychiatric commitment of residents who present a danger to themselves or others due to signs of mental illness) hold, was not placed in the in front of the nursing station around other residents. b. Ensure Resident 62 was not subjected to Resident 146's aggressive outburst when suddenly Resident 146 grabbed Resident 62's quad cane (adjustable walking cane with 4-pronged base for extra stability) and hit Resident 62. As a result, Resident 146 punched Resident 62 in the chest and arms subjecting Resident 652 to physical abuse. These deficient practices placed Resident 69 and Resident 62 at risk for further abuse and had the potential to cause feelings of intimidation, neglect and not feeling safe in the facility. Findings: 1.During a review of Resident 69's Admission Record, the Admission Record indicated the facility initially admitted Resident 69 on 1/16/2023 and readmitted on [DATE] with diagnoses of end stage renal disease (kidney failure- a condition in which the kidney's lose ability to remove waste and balance fluids in the body), generalized muscle weakness, and hypertension (high blood pressure). During a review of Resident 69's history and physical (H&P), dated 3/20/2024, the H&P indicated Resident 69 did not have the capacity to understand and make decisions. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 69's Minimum Data Set ([MDS] resident assessment tool), dated 8/30/2024, the MDS indicated Resident 69 required substantial/maximal assistance (helper lifts or hold trunk of limbs and provides more than half the effort) with shower and bathing self, lying to sitting on side of bed, and sit to lying. Resident 69 is dependent (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). During a review of Resident 69's census (room locations within the facility) the census indicated Resident 69's room was next to Resident 1's room with a shared bathroom from 1/16/2023 until 3/26/2024 when Resident 1 was moved to another room. During a phone interview on 12/26/2024 at 8:44 a.m., with Resident 69's family member (FM1), FM1 stated Resident 69 was sexually assaulted by Resident 1 in the middle of the night in March 2023. FM1 stated he spotted Resident 1 next door to Resident 69's room in July 2024 and wondered why someone would place Resident 1 next to Resident 69 again. FM1 stated Social Service Director (SSD) was notified of Resident 1 being placed back in the room next to Resident 69. FM1 stated the SSD said she does not know who placed Resident 1 next to Resident 69. FM1 stated Resident 69 said he sometimes sees a shadow of someone going to the restroom and thinks it is Resident 1. During an interview on 11/27/2024 at 2:33 p.m., with Resident 69, Resident 69 became agitated when asked about the incident. Resident 69 stated sometime last year in 2023, he could not recall the exact date he was sexually assaulted by Resident 1. Resident 69 stated he was taking a nap in his bed and Resident 1 came into his room and got on top of him, groped his private area, kissed him, and put his hand over his mouth. Resident 69 stated he tried to scream but no one could hear him. Resident 69 stated his roommate finally heard him say call the police. Resident 69 stated that same day he told the charge nurse (unknown), and they did nothing. Resident 69 stated he had to fill out a complaint and was halfway through it, and he was told he was done. Resident 69 stated the next day the Social Service Director (SSD) told him the facility could not address everything on the report and this made him feel terrible. Resident 69 stated after that the SSD never came back to check on him. During a review of Resident 1's Admission Record , the Admission Record indicated Resident 1 was admitted to facility on 12/12/2022 and readmitted on [DATE] with diagnoses of schizophrenia, unspecified (a mental health condition that affects everything from how you feel and behave), unspecified dementia (a group of symptoms that impact memory, thinking, and social abilities), psychotic disturbance (a severe mental disorder that causes a person to lose touch with reality and have abnormal thoughts , perceptions and behaviors, Mood disturbance (a mental health condition that primarily affects your emotional state), and anxiety (an intense, excessive and persistent worry and fear about everyday situations). During a record review of Resident 1's H&P dated 7/27/2024, the H&P indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 requires supervision or touching assistance (helper provides verbal cues and/ or touching/ steadying and/or contact guard assistance as resident completes activity) in shower bathing self, putting on and taking off footwear, Independent in sit to stand, and sit to lying and wheels 50 feet with two turns. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During record review of the Situation Background Assessment Recommendation Communication Form (SBAR- a structured communication framework used to convey critical information), dated 3/26/2023 at 3:57 p.m., the SBAR indicated CNA 5 reported the alleged incident around 3:15 p.m., that Resident 1 attempted to kiss Resident 69 in Resident 69's room Resident 69 stated that he woke up and Resident 1 was hovering in front of his face and no one saw what happened. The SBAR indicated Resident 69 also reported it to his roommate. The SBAR indicated Charge nurse (unidentified) and Registered Nurse (unidentified) assessed both parties and Resident 1 denied doing anything. The SBAR indicated Resident 1 was transferred to another room immediately. The SBAR indicated Resident 69 stated that he felt uncomfortable. The SBAR indicated the Charge nurse (unidentified) also saw Resident 1 pacing back and forth towards the bathroom like he did not know where to go, this is unusual behavior for Resident 1. During an interview on 11/27/2024 at 11:25 a.m., the SSD stated that she was aware of the alleged incident in 2023 between Resident 1 and Resident 69. The SSD stated she checked on Resident 69 once to see if he was ok. The SSD stated when there is an alleged incident of abuse the two residents need to be separated. The SSD verified on 11/27/2024 Resident 1 was placed 10 rooms from Resident 69. The SSD stated she had no documentation of the alleged incident. The SSD stated it was important to monitor the victim of the alleged abuse for 72 hours to make sure the resident feels safe, and the perpetrator is not a continuous threat to the resident. The SSD stated if the 72-hour monitoring was not documented it wasn't done. During an interview on 11/27/2024 at 1:52 p.m., with Registered Nurse (RN 1), RN 1 stated when there is a suspected resident to resident abuse the two residents are separated the abuse is reported to the abuse coordinator who is the Administrator (ADM). RN 1 stated if there was an allegation of physical abuse, facility staff call the police, the primary doctor, ombudsman (resident advocate) and the family. RN 1 stated the two residents are monitored for 72 hours. RN 1 stated when separating the two residents it was not wise to put Resident 1 down the hallway from Resident 69 because Resident 1 is independently ambulatory and can easily walk to Resident 69's room. During an interview on 12/4/2024 at 10:10 a.m., the Facility Nursing Consultant stated he was the DON at the time the incident occurred in 2023. The Facility Nursing Consultant stated when there is an alleged resident to resident altercation the victim and the aggressor need to be separated immediately to ensure the safety of both residents. The Facility Nursing Consultant stated the victim must be monitored for emotional distress and behavioral support may need to recommend by the SSD. The Facility Nursing Consultant stated the SSD also monitors and documents on both residents. The Facility Nursing Consultant stated there needs to be room a room change to separate the residents because if they are in the same vicinity the victim can be triggered of the incident again. The Facility Nursing Consultant stated the room placement of Resident 1 and Resident 69 was close (the same Hallway). The Facility Nursing Consultant stated if there are no other rooms available to maintain their separation Resident 1 should have been sent out to another facility. During an interview on 12/6/2024 at 10:11 a.m. with the Administrator (ADM), the ADM stated when there is an allegation of abuse the staff must report to myself, the police, the ombudsman, the California department of public health (CDPH), and call the family. The ADM stated it was important that everything is done according to policy and procedure so that the facility does not have another incident like this one. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 62s Admission Record, the Admission Record indicated Resident 62 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), difficulty of walking, and abnormalities of gait and mobility. During a review of Resident 62's Minimum Data Set (MDS), a resident assessment tool, dated 10/24/2024, the MDS indicated Resident 62's cognitive skills (ability to think and reason) for daily decision-making was intact. The MDS indicated Resident 62 required set up assistance when with eating, oral hygiene, dressing, and personal hygiene, and supervision with showering. During a review of Resident 146's Admission Record, the Admission Record indicated Resident 146 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder, PTSD, and acquired absence of left foot, and acquired absence of right leg below the knee. During a review of Resident 146's MDS, dated [DATE], the MDS indicated Resident 146's cognitive skills for daily decision-making was moderately impaired. The MDS indicated Resident 146 required set up assistance when with eating, partial assistance (helper does less than half the effort) with oral hygiene, substantial assistance (helper does more than half the effort) with showering and dressing, and resident was dependent on staff with toileting hygiene. During a record review of Resident 146's Interdisciplinary Team (IDT) Progress Note, 8/16/2024 12:52 p.m., the note indicated on 8/15/2024 the following events transpired: a. At 3:20 p.m. Resident 146 made sexual advances to an unnamed Certified nurse assistant (CNA) while he was being changed in his room. The Charge nurse assessed the resident and Resident 146 started to get confused, agitated, cursing, trying to get out of bed. Resident 146 was transferred to his wheelchair. b. At 4:30 p.m. the physician was notified. c. At 4:40 p.m., Resident 146 started to get more confused, agitated, and cursing people around him, yelling This is my house, get out of my house! I do not want no one in my house!. d. At 5 p.m., a CNA (unidentified) tried to encouraged resident to eat but Resident 146 refused, grabbed the food tray the CNA was trying to serve, and the food fell on the floor and things that Resident 146 can reach were thrown away. e. At 5:10 p.m., Resident 146 was placed in front of the nursing station for close supervision. Resident 146 refused afternoon medication and the physician ordered to send Resident 146 out to the general acute care hospital (GACH). f. At 5:30 p.m., No one could go near him as Resident 146 was starting to be combative. g. At 7:08 p.m. Resident 62 was walking towards the front of nursing station from the lobby when suddenly Resident 146 grabbed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 62's quad cane and eventually hitting Resident 62 in the chest and arms. h. At 7:15 p.m., the police and fire department were notified of the incident. i. At 7:33 p.m., Resident 146 was transferred out to GACH for further evaluation and treatment. During an interview on 12/6/2024 at 3:05 p.m., CNA 1 stated she was changing Resident 146 and as she reached over to turn Resident 146, Resident 146 stated Let me fuck you. CNA 1 stated she stopped and told the charge nurse. CNA1 stated CNA 2 took over care of Resident 146 after the incident and when CNA 2 preceded to offer to render care to Resident 146, Resident 146 became more agitated, instructed CNA 2 to get out and refused CNA 2's assistance. CNA 1 stated all shift Resident 146 was agitated. CNA 1 stated Resident 146 was cussing and was transferred to the wheelchair to try to calm Resident 146 and Resident 146 was placed in the front of the nursing station. During an interview and record review on 12/6/2024 at 3:17 p.m., with the Director of Staff Development (DSD), Resident 146's IDT progress notes, dated 8/16/2024, were reviewed. The DSD stated after reviewing the notes, Resident 146 was placed in the wheelchair in front of the nursing station, agitated. The DSD stated the agitated and combative resident should have been kept away from other residents. The DSD stated because Resident 146 was not separated from other residents, Resident 146 had a physical altercation with Resident 62, thus rendering the event preventable. The DSD stated it was abuse and should have also been reported to the California Department of Public Health (CDPH). During an interview on 12/7/2024 at 12:30 p.m., with the Director of Nursing (DON), the DON stated residents have the right to be free from abuse and neglect. During a review of the facility's Director of Social Worker Job Description, dated 7/1/2024 indicated, The director of Social Services reports to the Administrator. 1.Makes and enforces policies and procedures, ensuring that an ongoing program of assessments of interests and the physical, mental, physical, mental psychosocial wellbeing of each resident, with the advice and consent of the Administrator. 2. Monitor for non-compliant trends and make recommendations. 3. Educates residents, families, and staff on resident's rights in accordance with all Title 22 and federal regulations. 4. Ensure that progress notes updates and care plan are completed in a timely manner. 5. Work with relevant staff to implement resident's care plan. 6. Attend all required in-service training annually. 7. Coordinate room changes, manage bed assignments and provide appropriate contact with the resident, roommates, and responsible party. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Resident Rights, revised 2/2016, the P&P indicated Federal and state laws guarantee certain basic rights to all the residents of the facility and that include the resident's right to be free of abuse and neglect. During a review of the facility's P&P titled, Abuse, Neglect, and Exploitation or Misappropriation- Prevention Program, revised 4/2021, the P&P indicated residents have the right to be free from abuse and neglect. This includes but is not limited to freedom from mental, sexual, or physical abuse. The facility will protect residents from abuse and neglect and develop policies to prevent abuse. The facility will implement measures that may lead to abusive situations and protect residents from any further harm during investigations.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review, the facility failed to report allegations of physical abuse involving two of four sampled residents (Resident 146 and 62), to the California Department of Public Health (CDPH) within the regulated time frame of two hours. This deficient practice resulted in CDPH's inability to investigate the allegation of abuse timely and had the potential for other allegations of abuse to go unreported. Findings: During a review of Resident 62s Admission Record, the Admission Record indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), difficulty of walking, and abnormalities of gait and mobility. During a review of Resident 62's Minimum Data Set (MDS), a resident assessment tool, dated 10/24/2024, the MDS indicated Resident 62's cognitive skills (ability to think and reason) for daily decision-making was intact. The MDS indicated Resident 62 required set up assistance when with eating, oral hygiene, dressing, and personal hygiene, and supervision with showering. During a review of Resident 146's Admission Record, the Admission Record indicated Resident 146 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder, PTSD, and acquired absence of left foot, and acquired absence of right leg below the knee. During a review of Resident 146's MDS, dated [DATE], the MDS indicated Resident 146's cognitive skills for daily decision-making was moderately impaired. The MDS indicated Resident 164 required set up assistance when with eating, partial assistance (helper does less than half the effort) with oral hygiene, substantial assistance (helper does more than half the effort) with showering and dressing, and resident was dependent on staff with toileting hygiene. During a record review of Resident 146's Interdisciplinary Team (IDT) Progress Note, 8/16/2024 12:52 p.m., the note indicated on 8/15/2024 at 7:08 p.m.- Resident 62 was walking towards the front of nursing station from the lobby when suddenly Resident 146 grabbed Resident 62's quad cane and eventually hitting Resident 62 in the chest and arms. During an interview and record review on 12/6/2024 at 3:17 p.m. with the Director of Staff Development (DSD), Resident 146's IDT progress notes, dated 8/16/2024, were reviewed. The DSD stated Resident 146 had a physical altercation with Resident 62. The DSD stated it was physical abuse and should have also been reported to California Department of Public Health (CDPH). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/7/2024 at 12:30 p.m., with the Director of Nursing (DON), the DON stated the altercation that occurred between Resident 146 and Resident 62 was reported to the local police department and to the ombudsman but not to CDPH. During a review of the facility's P&P titled, Abuse Investigation and Reporting revised 4/2017, the P&P indicated: 1) All reports of resident abuse and neglect shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. 2) An alleged violation of abuse, neglect, will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review, the facility failed to report allegations of physical abuse and submit the investigation report involving two of four sampled residents (Resident 146 and 62), to the California Department of Public Health (CDPH), within 5 days of the incident. This deficient practice resulted in CDPH's inability to investigate the allegation of abuse timely and had the potential for other allegations of abuse to go unreported. Findings: During a review of Resident 62s Admission Record, the Admission Record indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event), difficulty of walking, and abnormalities of gait and mobility. During a review of Resident 62's Minimum Data Set (MDS), a resident assessment tool, dated 10/24/2024, the MDS indicated Resident 62's cognitive skills (ability to think and reason) for daily decision-making was intact. The MDS indicated Resident 62 required set up assistance when with eating, oral hygiene, dressing, and personal hygiene, and supervision with showering. During a review of Resident 146's Admission Record, the Admission Record indicated Resident 146 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder, PTSD, and acquired absence of left foot, and acquired absence of right leg below the knee. During a review of Resident 146's MDS, dated [DATE], the MDS indicated Resident 146's cognitive skills for daily decision-making was moderately impaired. The MDS indicated Resident 164 required set up assistance when with eating, partial assistance (helper does less than half the effort) with oral hygiene, substantial assistance (helper does more than half the effort) with showering and dressing, and resident was dependent on staff with toileting hygiene. During a record review of Resident 146's Interdisciplinary Team (IDT) Progress Note, 8/16/2024 12:52 p.m., the note indicated on 8/15/2024 at 7:08 p.m.- Resident 62 was walking towards the front of nursing station from the lobby when suddenly Resident 146 grabbed Resident 62's quad cane and eventually hitting Resident 62 in the chest and arms. During an interview on 12/7/2024 at 12:30 p.m., with the Director of Nursing (DON), the DON stated the altercation that occurred between Resident 146 and Resident 62 was reported to the local police department and to the ombudsman but not to CDPH and no investigative report was sent to CDPH. During a review of the facility's P&P titled, Abuse Investigation and Reporting revised 4/2017, the P&P indicated the Administrator, or designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on observation, interview and record review, the facility failed to implement a care plan for poor/decline in vision for one of three sampled residents (Resident 86). This deficient practice had the potential to negatively affect the quality of life and wellbeing for Resident 86 and to prevent him from achieving his highest practicable well-being. Findings: During a review of Resident 86's Admission Record, the Admission Record indicated Resident 86 was admitted to the facility on [DATE] with diagnoses of end stage renal disease ([ESRD], also known as kidney failure, is a terminal illness that occurs when the kidneys can no longer function properly), diabetes type 2 ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), and hypertension ([HTN]-high blood pressure). During a review of Resident 86's Minimum Data Set ([MDS], a resident assessment tool), dated 10/2/2024, the MDS indicated Resident 86 had intact cognitive (ability to think, understand, learn, and remember) status. The MDS indicated Resident 86 required setup or clean up assistance (helper sets up or cleans up but resident can complete the activity, helper assists only prior to or following the activity) for self-care abilities such as eating, oral hygiene and required supervision or touching assistance (helper provides verbal cues and/or touch assistance as resident completes activity) for toileting hygiene, shower/bathe, dressing and personal hygiene. The MDS also indicated Resident 86 required supervision for functional abilities such as rolling left and right, sit to lying position, lying to sitting at edge of bed and sit to stand position. During a review of Resident 86's history and physical dated 7/28/2024, Resident 86 had the capacity to understand and make decisions about his care. During a review of Resident 86's comprehensive care plans, the comprehensive care plans did not indicate a care plan addressing Resident 86's poor/decline in vision for his eyes. During a concurrent observation and interview on 12/3/2024 at 11:27 a.m., with Resident 86 in his room, Resident 86 was resting in bed with his eyes closed. Resident 86 opened his eyes when surveyor greeted resident. Resident 86 stated he was supposed to have surgery for his eyes but there were no updates on when and where it would be. Resident 86 stated it was surgery because his vision was getting worse. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview with record review on 12/6/2024 at 11:16 a.m., with Licensed Vocational Nurse (LVN) 4, the comprehensive care plan was reviewed. There was no comprehensive care plan for poor/decline in vision for Resident 86. LVN 4 stated for a decrease in vision, the facility should have implemented a care plan for poor/decline in vision. LVN 4 stated Resident 86 had issues with his vision just recently in September, his vision was blurry, and he couldn't see well. LVN 4 stated Resident 86 had been going to see the eye doctor during his out on pass (someone is temporarily allowed to leave for a specific period, usually with the expectation of returning later) with his son and daughter to his eye appointment at an outside facility. LVN 4 stated there should have been a care plan for Resident 86's poor vision so that everyone in the healthcare team was aware and to make sure the interventions being done was working and if it was not, the interventions needed to be reassessed and revised. During a concurrent interview with record review on 12/6/2024 at 4:20 p.m., with the MDS Nurse, Resident 86's comprehensive care plans were reviewed. The MDS Nurse stated Resident 86 did not have a comprehensive care plan for poor/decline in vision. The MDS Nurse stated Resident 86 should have had a care plan for decline in vision when Resident 86 first verbalized his concerns about his vision back in September. The MDS Nurse stated Resident 86 had been seeing an eye doctor since September and there was no comprehensive care plan implemented for Resident 86 to monitor and update the interventions. During a concurrent interview with record review on 12/7/2024 at 12:18 p.m. with the Director of Nursing (DON), the comprehensive care plan was reviewed. The comprehensive care plan did not address poor/decline in vision. The DON stated the importance of a comprehensive care plan was to make staff aware of what to do in terms of care to the residents with the interventions. The DON stated there needs to be a comprehensive care plan to make sure the interventions are working and if the interventions were not working, the facility can revise the care plan as needed. The DON stated the comprehensive care plan should be person-centered and tailored to the resident to make sure the care was provided to the residents correctly. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised December 2016, indicated, a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident the comprehensive, person-centered care plan will include measurable objectives and timeframes; and describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .aid in preventing or reducing decline in the resident's functional status and/or functional levels .areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan .the comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS) and assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. During a review of the facility' policy and procedure titled, Care Planning-Interdisciplinary Team, revised September 2013, indicated, the facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident the care plan is based on the resident's comprehensive assessment and is developed by a care planning/interdisciplinary team.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to ensure one of one resident's (Resident 70) diclofenac sodium external gel (medication for pain) order indicated the dose. This deficient practice resulted to Resident 70's diclofenac was administered from 11/17/2024 to 12/3/2024 without a documented dose which had the potential for overdosing or underdosing. Findings: During a review of Resident 70's Admission Record, the Admission Record indicated Resident 70 was readmitted to the facility on [DATE] with diagnoses including ventricular fibrillation (life threatening irregular heart beat), paroxysmal atrial fibrillation (type of irregular heart beat that usually end on their own within a week), and hypertensive heart disease (group of heart conditions caused by long-term high blood pressure - force of the blood pushing against the artery walls is consistently too high)with heart failure (serious condition that occurs when the heart is unable to pump enough blood and oxygen to the body's organs). During a review of Resident 70's Minimum Data set (MDS), A resident assessment tool, dated 11/23/2024, the MDS indicated Resident 70's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making was severely impaired. During a review of Resident70's Order, 11/17/2024 the order indicated Diclofenac sodium external gel (medicine to treat pain) 1 percent apply to left shoulder topically two times a day for pain. During a review of Resident 70's Medication Administration record (MAR) for11/2024 and 12/2024, Resident 70 received Diclofenac sodium external gel 1 percent applied to the left shoulder without a specified dose from 11/17/2024 to 12/3/1024 During an interview and record review on 12/4/2024 at 9:28 a.m. with Licensed Vocational Nurse (LVN) 7 the MAR for 12/2024 was reviewed and the MAR indicated the Diclofenac gel did not specify a dose but it had been administered and ordered since 11/17/2024. LVN 7 stated the staff need to clarify the order to indicate how much topical gel we need to apply to Resident 70's shoulders. During an interview on 12/7/2024 at 12:30 p.m., with the Director of Nursing (DON) the DON stated medications orders need to indicate the dose to be able to administer the medication correctly. During a review of the facility's policy and procedure (P&P) titled, Administering Medication, undated, the P&P indicated medications were administered in a safe manner as prescribed. The P&P indicated the individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method of administration before giving the medication.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on observation, interview and record review, the facility failed to ensure a resident was provided a foley catheter (a thin, flexible tube that drains urine from the bladder into a bag outside the body, also called urinary catheter or indwelling urethral catheter) care to prevent recurrent urinary tract infections ([UTI], a bacterial infection that affects the urinary tract, which includes the bladder, ureters, and kidneys) for one of two sampled resident (Resident 25). This deficient practice had the potential to result in Resident 25 acquiring recurrent UTIs when foley catheter care was not provided according to the doctor's order. Findings: During a record review of Resident 25's Admission Records, the Admission Records indicated Resident 25 was admitted to the facility on [DATE] with a readmitted on 5/120/24 with diagnoses of obstructive and reflux uropathy (a blockage in the urinary tract that prevents urine from draining which can cause urine to build up in the kidneys, which can lead to kidney damage), hypertension ([HTN, high blood pressure), benign prostatic hyperplasia ([BPH], prostate enlargement, a noncancerous condition that occurs when the prostate gland in the male reproductive system grows larger than normal) with lower urinary tract symptoms, and mechanical complication of indwelling urethral catheter (a thin, hollow tube that is inserted into the bladder through the urethra to collect and drain urine). During a record review of Resident 25's Minimum Data Set ([MDS], a resident assessment tool) dated 9/17/2024, the MDS indicated Resident 25 had intact cognitive (ability to think, understand, learn, and remember) status. The MDS indicated Resident 25 required setup or clean up assistance (helper sets up or cleans up but resident can complete the activity, helper assists only prior to or following the activity) for self-care abilities such as eating, and oral hygiene and required maximal assistance (helper does more than half of the effort, Helper lifts or holds trunk or limbs and provides more than half the effort) for toileting hygiene, shower/bathe, dressing and personal hygiene. The MDS also indicated Resident 86 required moderate to maximal assistance for functional abilities such as rolling left and right, sit to lying position, lying to sitting at edge of bed and sit to stand position. During a record review of Resident 25's history and physical dated 5/2/2024, Resident 25 had the capacity to understand and make decisions about his care. During a record review of Resident 25's Order Summary Report, the Order Summary Report indicated a suprapubic catheter (a tube that drains urine from the bladder by creating a surgical connection between the bladder and the skin in the lower abdomen) orders: foley catheter care every shift three times a day ordered on 5/2/24, suprapubic catheter orders: monitor for foul odor in urine every shift. (+) if yes, (-) if no. notify doctor if present three times a day ordered on 5/2/2024, suprapubic catheter orders: monitor for hematuria (blood in the urine) every shift. (+) if yes, (-) if no. notify doctor if present three times a day, suprapubic catheter orders: monitor for sediments in urine every shift. (+) if yes, (-) if no. notify doctor if present three times a day ordered on 5/2/2024. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 25's Treatment Administration Record (TAR) for November 2024, the TAR indicated suprapubic catheter orders: foley catheter care every shift three times a day for Day, Evening and Night. There was missing documentation on Day for 11/2/2024, Night on 11/4/2024, Evening on 11/12/2024, Evening on 11/15/2024, Night on 11/19/2024, 11/20/2024, 11/25/2024, and 11/26/2024. The TAR indicated suprapubic catheter orders: monitor for foul odor in urine every shift. (+) if yes, (-) if no. notify doctor if present three times a day for Day, Evening and Night. There was missing documentation on Day for 11/2/2024, Night on 11/4/2024, Evening on 11/12/2024, Evening on 11/15/2024, Night on 11/19/2024, 11/20/2024, 11/25/2024, and 11/26/2024. The TAR indicated suprapubic catheter orders: monitor for hematuria every shift. (+) if yes, (-) if no. notify doctor if present three times a day. There was missing documentation on Day for 11/2/2024, Night on 11/4/2024, Evening on 11/12/2024, Evening on 11/15/2024, Night on 11/19/2024, 11/20/2024, 11/25/2024, and 11/26/2024. The TAR indicated suprapubic catheter orders: monitor for sediments in urine every shift. (+) if yes, (-) if no. notify doctor if present three times a day. There was missing documentation on Day for 11/2/2024, Night on 11/4/2024, Evening on 11/12/2024, Evening on 11/15/2024, Night on 11/19/2024, 11/20/2024, 11/25/2024, and 11/26/2024. During a concurrent observation and interview on 12/3/2024 at 2:03 p.m., with Resident 25 in his room, Resident 25 was in bed watching television. Resident 25 had foley catheter bag with a privacy cover hanging on the bed off of the floor. Resident 25 stated he has had the foley catheter in for a while now. Resident 25 stated he got UTIs a lot but currently does not have one now. During a concurrent interview with record review on 12/6/2024 at 10:40 a.m., with LVN 8, the TAR for November 2024 was reviewed. LVN 8 stated when providing foley catheter care, she would cleanse the area with normal saline, pat dry and cover site with a dressing and tape using clean technique. LVN 8 stated during foley catheter care, staff should check to see if the foley catheter was draining properly and if it was not, staff should flush the foley catheter as needed. LVN 8 stated the signs and symptoms (s/s) of UTI was confusion, sedimentation in urine, fever, urgency, burning, and frequency of urination. LVN 8 stated foley catheter care should be provided daily for Resident 25 and if it was not documented in the TAR, then the care was not provided. During an interview on 12/7/2024 at 12:25 p.m., with the Director of Nursing (DON), the DON stated if there was no documentation that foley catheter care was provided in the TAR, the care was not provided. The DON stated staff should make sure care was provided to the residents and they are documenting that the care was provided. The DON stated there should be no gap in foley catheter care because residents can get recurrent UTIs. The DON stated the importance of foley catheter care and monitoring was so if staff see sediments, or hematuria in the urine, the staff should let the doctor know of the change in condition. The DON stated if foley catheter care was not provided to the residents as ordered, the residents can get UTIs. The s/s of UTIs are foul odor, fever, and suprapubic pain. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P/P), titled Catheter Care, Urinary, revised September 2014, indicated purpose of this procedure is to prevent catheter-associated urinary tract infections maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag, routine hygiene (e.g., cleansing of the meatal surface during daily bathing or showering) is appropriate, be sure the catheter tubing and drainage bag are kept off the floor, empty the drainage bag regularly using a separate, clean collection container for each resident, avoid splashing, empty the collection bag at least every eight (8) hours .observe the resident for complications associated with urinary catheters, if the resident indicates that his or her bladder is full or that he or she needs to void (urinate), notify the physician or supervisor, check the urine for unusual appearance (i.e., color, blood, etc.), notify the physician or supervisor in the event of bleeding, or if the catheter is accidently removed, report any complaints the resident may have of burning, tenderness, or pain in the urethral area, observe for other signs and symptoms of urinary tract infection or urinary retention, report findings to the physician or supervisor immediately .the following information should be recorded in the resident's medical record, the date and time that catheter care was given, the name and title of the individual(s) giving the catheter care, all assessment data obtained when giving catheter care, character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor, any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview, and record review the facility failed to ensure one of one resident (Resident 45) was receiving the correct concentration of oxygen. This failure has the potential to result in too much oxygen which can cause serious health problems. Findings: During a review of Resident 45's Admission Record, the Admission Record indicated Resident 45 was readmitted to the facility on [DATE] with diagnoses including interstitial pulmonary disease (chronic condition that refers to a group of disorders that cause scarring in the lungs), pulmonary fibrosis (chronic lung disease that causes scarring and thickening of the lung tissue, making it difficult to breathe), acute respiratory failure (life-threatening condition that occurs when the lungs and blood are unable to exchange gases properly), and dependence on supplemental oxygen. During a review of Resident 45's Minimum Data set (MDS), A resident assessment tool, dated 11/22/2024, the MDS indicated Resident 45's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making was intact. The MDS indicated Resident 45 required set up assistance with eating, partial assistance (helper does less than half the effort) with oral hygiene, and resident was dependent on staff with toileting hygiene, showering, and personal hygiene. During a review of Resident45's Order Summary Report as of 12/5/2024, the report indicated oxygen 2 liters per minute as needed to maintain oxygen saturation (a measurement of how much oxygen the blood is carrying as a percentage) above 92 percent every 24 hours as needed. During an observation and interview on 12/3/2024 at 9:13 a.m., in Resident 45's room, Resident 45's oxygen was observed, and the Assistant Director of Nursing (ADON) confirmed the oxygen at 2.5 liters per minute. During an interview on 12/6/2024 at 7:46 a.m. the ADON stated Resident 45's oxygen was ordered at 2 liters per minute and not 2.5 liters per minute. The ADON stated it was important to make sure the oxygen was at the prescribed order to maintain air in the lungs. During an interview on 12/7/2024 at 12:30 p.m., with the Director of Nursing (DON) the DON stated the staff need to follow physician orders and administer the correct oxygen as prescribed for the resident's safety. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, revised 10/2010, the P&P indicated to review and verify the physician's order for this procedure for safe oxygen administration.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review, the facility failed to ensure two of two residents (Resident 62 and 146), who was diagnosed with post-traumatic stress disorder (PTSD - mental health condition that can develop after someone experiences or witnesses a traumatic even), received trauma informed care (a model that aims to provide effective mental health services by considering a person's past experiences with trauma). This deficient practice had the potential to result in resident re-traumatization and can be detrimental for the resident's psychosocial status. Findings: During a review of Resident 62s Admission Record, the Admission Record indicated Resident 40 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and PTSD. During a review of Resident 62's Minimum Data Set (MDS), a resident assessment tool, dated 10/24/2024, the MDS indicated Resident 62's cognitive skills (ability to think and reason) for daily decision-making was intact. The MDS indicated Resident 62 required set up assistance when with eating, oral hygiene, dressing, and personal hygiene, and supervision with showering. During a review of Resident 62's Brief Trauma Questionnaire, dated 1/18/2024, the questionnaire indicated Resident 62 has experienced the following trauma in the past: a. The resident served in a war or non-combat job that exposed the resident to war related casualties. b. The resident experienced a natural disaster, tornado, fire earthquake, hurricane, or chemical spill. c. The resident has been in other situations in which the resident was injured or situation in which you feared you might be seriously injured or killed. d. The resident has witnessed a situation in which someone was seriously injured or killed. During a review of Resident 146's Admission Record, the Admission Record indicated Resident 146 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder and PTSD. During a review of Resident 146's MDS, dated [DATE], the MDS indicated Resident 146's cognitive skills for daily decision-making was moderately impaired. The MDS indicated Resident 164 required set up assistance when with eating, partial assistance (helper does less than half the effort) with oral hygiene, substantial assistance (helper does more than half the effort) with showering and dressing, and resident was dependent on staff with toileting hygiene. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 146's Brief Trauma Questionnaire, dated 8/6/2024, the questionnaire indicated Resident 146 has experienced the following trauma in the past: a. The resident served in a war or non-combat job that exposed the resident to war related casualties. b. The resident experienced a natural disaster, tornado, fire earthquake, hurricane, or chemical spill. c. The resident has had a life-threatening illness, cancer, or heart attack. d. The resident has been in other situations in which the resident was injured or situation in which you feared you might be seriously injured or killed. e. The resident has witnessed a situation in which someone was seriously injured or killed. During an interview and record review on 12/6/2024 at 10:34 a.m. with the Director of Staff Development (DSD), The DSD stated both residents had PTSD. The DSD stated Resident 62 and 146's triggers (a stimulus that causes a reaction, often an intense or unexpected emotional response to trauma) were not assessed and a trauma informed cared plan was not developed and implemented addressing the residents' triggers to prevent re-traumatization. During an interview with the Director of Nursing (DON) on 12/7/2024 at 12:30 p.m., the DON stated the nurses need to develop individualized trauma informed person-center care plans for residents who suffered PTSD, address the triggers and to prevent re-traumatization. During a review of the facility's policy and procedure (P&P) titled, Trauma Informed Care and Culturally Competent Care, revised 8/2022 the P&P indicated staff will be providing trauma-informed care in accordance with professional standards. The facility will address the needs of trauma survivors by minimizing triggers and/or re-traumatization. The P&P indicated for trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. The P&P indicated triggers were highly individualized and need to be addressed.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on interview and record review, the facility failed to ensure the licensed nurses were competent during medication administration for four out of eight sampled residents (Resident 6, 26, 29, and Resident 30). These deficient practices resulted in Resident 6, 26, 29, and Resident 30 having significant medication errors and had the potential for all residents in the facility to experience medication errors. (Cross Reference to F760 and F865) Findings: a. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility 6/23/2011 and readmitted on [DATE] with diagnoses including type 2 Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), supraventricular tachycardia (SVT- a rapid heart rate), and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 6's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 9/25/2024, the MDS indicated Resident 6 had severe cognitive impairment (a condition that makes it difficult for a person to remember things, learn, concentrate, make decisions, or understand the meaning of things). During a review of Resident 6's untitled Care Plan, initiated 5/2/2019 and revised 11/15/2022, the Care Plan indicated Resident 6 had heart disease and was at risk of SVT. The Care Plan goal indicated for Resident 6 to not have any chest pain. Under this Care Plan, the interventions included Resident 6 to receive amiodarone hydrochloride (HCl- medication used to treat irregular heart rate) tablet as ordered. During a review of Resident 6's Order Listing Report (Physician's Orders), the report indicated Resident 6 was to receive amiodarone HCl 200 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) one tablet by mouth once a day and hold if pulse is less than 60 beats per minute (BPM), ordered on 10/5/2022. During a review of Resident 6's Medication Administration Record (MAR), dated 10/2024 and 11/2024 was reviewed. The MAR indicated for amiodarone HCl, NA (not applicable) was documented on the [DATE] times from 10/1/2024 to 10/31/2024 and 13 times on the MAR from 11/1/2024 to 11/30/2024 in place of the pulse reading for the administration of amiodarone HCl tablet, one tablet by mouth once daily, hold if pulse is less than 60 BPM and the medication was marked as given. (continued on next page)

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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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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 26's Admission Record, the Admission Record indicated Resident 26 was originally admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including ventricular tachycardia (VT- a rapid, irregular heartbeat), cardiac arrythmia (an irregular heart beat or heart rhythm), and presence of a cardiac pacemaker (a small, battery-powered device that regulates the heart's rhythm by sending electrical pulses to the heart's chambers). During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 had moderate cognitive impairment. During a review of Resident 26's Order Summary Report (Physician's Orders), the report indicated Resident 26 was to receive the following medications: 1. Amiodarone 200 mg, one tablet by mouth twice a day for arrhythmia, hold for heart rate less than 60 BPM, ordered on 9/20/2024. 2. Mexiletine HCl Oral Capsule 150 mg, one capsule by mouth every eight hours to be administered at 12 a. m., 8 a.m., and at 4 p.m., for arrhythmia, ordered on 9/20/2024. During a review of Resident 26's untitled Care Plan initiated 9/21/2024, the Care Plan indicated there was a Black Box Warning (the most serious warning that the U.S. Food and Drug Administration (FDA) for a drug, indicating that it has the potential for serious adverse reactions that could result in death, hospitalization , or permanent damage) for the use of mexiletine. The Care Plan goal indicated Resident 26 will not experience side effects or interactions with the use of mexiletine. The Care Plan indicated there was a Black Box Warning that indicated there was a risk of acute liver injury with the use of mexiletine. During a review of Resident 26's untitled Care Plan initiated 9/22/2024, the Care Plan indicated Resident 26 had altered cardiovascular status related to arrhythmia. The Care Plan goal indicated Resident 26 will be free from complications of cardiac problems. Under this Care Plan, the interventions included monitoring Resident 26's vital signs (measurements of the body's basic functions, such as temperature, breathing rate, blood pressure, and pulse rate) and notifying the physician of any significant abnormalities. During a review of Resident 26's MAR dated 10/2024 and 11/2024, the MAR indicated Resident 26 did not receive his 4 p.m. dose of mexiletine HCl 150 mg on 10/20/2024 and indicated to see progress notes. The MAR further indicated NA (not applicable) was documented in place of a pulse reading six times in 10/2024 and NA was documented 13 times instead of a pulse reading for 11/2024 for the amiodarone HCl Tablet 200 mg, give one tablet by mouth twice daily for arrhythmia, hold for heart rate less than 60 BPM. During a review of Resident 26's Administration Note (Progress Notes) dated 10/20/2024 and timed at 3:34 p. m., the note indicated awaiting delivery. The MAR further indicated NA (not applicable) was documented in place of a pulse reading six times in the month of 10/2024 and NA was documented 13 times instead of a pulse reading for 11/2024 for amiodarone HCl Tablet 200 mg, one tablet by mouth twice daily for arrhythmia, hold for heart rate less than 60 BPM. (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 26's Medication Admin Audit Report (MAAR- a document indicating the exact time medications were documented as administered dated 11/1/2024 to 12/4/2024, the MAAR indicated mexiletine HCl was administered to Resident 26 as follows: 1. On 11/8/2024 - mexiletine HCl was scheduled to be administered at 12 a.m., however, according to the MAAR, mexiletine HCL was administered to Resident 26 at 5:12 a.m. (5 hours and 12 minutes after the scheduled administration time). 2. On 11/8/2024 - mexiletine HCl was scheduled to be administered at 8 a.m., however, according to the MAAR, mexiletine HCL was administered at 7:45 a.m. (less than 2 hours and 33 minutes between doses that the physician prescribed). 3. On 11/26/2024 - mexiletine HCl the 12 a.m. dose was given at 3:02 a.m., (3 hours and 2 minutes late and 9 hours 38 minutes after the last dose on 11/25/2024 that was given at 5:24 p.m.) and the 8:00 a.m. dose was given at 7:46 a.m. (4 hours and 44 minutes since the last dose). 4. On 12/2/2024 - mexiletine HCl 12 a.m. dose was given at 2:42 a.m., (2 hours and 42 minutes late) and the 8:00 a.m. dose was given at 7:51 a.m. (5 hours and 9 minutes apart). c. During a review of Resident 29's Admission Record, the Admission Record indicated Resident 29 was admitted to the facility 9/27/2023 with diagnoses of hypotension (low blood pressure) and atrial fibrillation (AFib- an irregular and often rapid heartbeat). During a review of Resident 29's MDS dated [DATE], the MDS indicated Resident 29 had moderate cognitive (relating to the mental process involved in knowing, learning, and understanding things) impairment. During a review of Resident 29's Order Summary Report (Physician's Orders), the report indicated Resident 29 was to receive midodrine (used to treat low blood pressure) HCl 2.5 mg one tablet by mouth three times a day for hypotension and hold if systolic blood pressure (SBP- the force produced by the heart when it pumps blood out to the body) is greater than 130 BPM, ordered on 9/27/2023. During a review of Resident 29's untitled Care Plan initiated 10/6/2023, the Care Plan indicated Resident 29 had hypotension related to heart disease. The Care Plan goal indicated for Resident 29 to maintain blood (BP- the force of your blood pushing against the walls of your arteries [a blood vessel that carries blood from the heart to tissues and organs in the body]) pressure within an acceptable range as determined by the physician. Under this Care Plan, the interventions included Resident 6 to receive midodrine as ordered. During a review of Resident 29's MAR, dated 10/2024 and 11/2024 was reviewed. The MAR indicated for midodrine HCl 2.5 mg, NA was documented 14 times from 10/1/2024 to 10/31/2024 and 13 times from 11/1/2024 to 11/30/2024 in place of the pulse reading and was marked as given. The MAR further indicated midodrine HCl tablet 2.5 mg was given above the parameter of SBP 130 on the following dates: 1. On 10/3/2024, the 6 a.m. dose was given to Resident 29, when Resident 29 had a BP of 133/63. 2. On 10/4/2024, the 6 a.m. dose was given to Resident 29, when Resident 29 had a BP of 138/67. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 11/7/2024, the 10 p.m. dose was given to Resident 29, when Resident 29 had a BP of 149/54. 4. On 11/17/2024 the 6 a.m. dose was given to Resident 29, when Resident 29 had a BP of 147/63. 5. On 11/28/2024 the 6 a.m. dose was given to Resident 29, when Resident 29 had a BP of 131/69. d. During a review of Resident 30's Admission Record, the Admission Record indicated Resident 30 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including of AFib and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 30's MDS dated [DATE], the MDS indicated Resident 30 had moderate cognitive impairment. During a review of Resident 30's Order Summary Report (Physician's Orders), the report indicated Resident 30 was to receive the following medications: 1. Amiodarone HCl 200 mg, one tablet by mouth twice a day for CHF, and hold if heart rate is less than 60 BPM, ordered on 9/22/2024. 2. Amlodipine besylate (medication used to treat high blood pressure [HTN- hypertension] and chest pain) 10 mg, one tablet by mouth once a day for HTN and hold if SBP is less than 110 BPM, ordered on 9/23/2024 and updated on 10/25/2024, which indicated the parameter was changed to hold the medication if the pulse rate was less than 60 BPM. During a review of Resident 30's untitled Care Plan initiated 9/23/2024, the Care Plan indicated Resident 30 was at risk for cardiac distress related to heart failure. The Care Plan goal indicated Resident 30 will be free from cardiac distress. Under this Care Plan, the interventions included monitoring Resident 30's pulse rate, blood pressure, and administering medications as ordered. During a review of Resident 30's MAR dated 10/2024 and 11/2024, the MAR indicated for the administration of amlodipine besylate oral tablet 10mg, NA was documented seven times between 10/1/2024 to 10/31/2024 instead of the blood pressure and NA was documented three times between 10/1/2024 to 10/31/2024 instead of the pulse rate. For the administration of amlodipine besylate oral tablet 10mg, NA was documented 16 times between 11/1/2024 to 11/30/2024 instead of the blood pressure and pulse rate. For the administration of Amiodarone HCl oral tablet 200mg, NA was documented one time between 10/1/2024 to 10/31/2024 and seven times between 11/1/2024 to11/30/2024 instead of the pulse rate. During an interview on 12/5/2024 at 3:58 p.m., the Director of Nursing (DON) stated based on the identified deficiencies during the survey process regarding medication administration and identified medication errors, the facility identified LVN 1, 2, 3, 6, and LVN 8 were not competent regarding medication administration (giving late doses, missed doses, and not following physician's orders by documenting necessary vital signs). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/6/2024 at 1:10 p.m., the Director of Staff development (DSD) stated they do not teach their nurses to document NA under vital signs, and the licensed nurses were not competent regarding the facility policy. The DSD stated the potential outcome of nurses not being competent for medication administration included: administering late medications can cause double dosing, missed medications which can put the resident's safety at risk, and not checking vital signs prior to giving heart or blood pressure medications can cause serious issues for the resident like decreased heart rate and blood pressure. The DSD stated nurses not being competent for medication administration had the potential to result in medication errors. During an interview on 12/6/2024 at 2:29 p.m., the DON stated medication administration errors were not part of their Quality Assurance Performance Improvement ([QAPI] a group who takes a systemic, interdisciplinary, comprehensive, and data driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) program and issues were not identified prior to learning about the deficiencies related to missed doses of medication, late administration of medication, and not following physician's orders during medication administration. The DON stated if they had been aware of the medication errors, they would have been added to the QAPI program to prevent the errors from occurring again. During a review of the facility's undated policy and procedure (P&P), titled Administering Medications, the P&P indicated medication errors were to be documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. The P&P indicated medications were to be administered in accordance with prescriber orders, including any required time frame. The P&P further indicated the following: medication administration times were determined based on the resident need and benefit and not staff convenience, factors that were considered for medication administration time included enhancing optimal therapeutic effect of the medication, medications were to be administered within one hour of their prescribed time, vital signs were to be checked if necessary for each resident prior to administering medications, and the individual administering the medication was to document the date and time the medication was administered in the resident's medical record. During a review of the facility's P&P titled Competency of Nursing Staff, dated 5/2019, the P&P indicated competency in skills and techniques necessary to care for residents' needs included medication management. During a review of the facility's P&P titled Documentation of Medication Administration, dated 11/2022, the P&P indicated administration of medication was to be documented immediately after the medication was given. During a review of the facility's P&P titled Adverse Consequences of Medication Errors, dated 2/2023, the P&P indicated a medication error was defined as the preparation or administration of drugs which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards. The P&P indicated examples of medication errors included the medication being given at the wrong time or a drug is ordered but not administered. A significant medication error is determined as one that is life threatening. The P&P indicated the physician was to be promptly notified of any significant error, the resident was to be monitored for 24 to 72 hours after a significant medication error, and the significant medication error was to be communicated to the oncoming shift as needed to alert staff of the need for continued monitoring.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review the facility failed to monitor one of two resident's (Resident 146) behaviors while prescribed psychotropic medications (medications can alter brain chemistry, impact body functions, and modify a person's thoughts, moods, feelings, awareness, and perceptions). This failure had the potential to result in unnecessary medications. Findings: During a review of Resident 146's Admission Record, the Admission Record indicated Resident 146 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), PTSD, and acquired absence of left foot, and acquired absence of right leg below the knee. During a review of Resident 146's MDS, dated [DATE], the MDS indicated Resident 146's cognitive skills for daily decision-making was moderately impaired. The MDS indicated Resident 146 required set up assistance when with eating, partial assistance (helper does less than half the effort) with oral hygiene, substantial assistance (helper does more than half the effort) with showering and dressing, and resident was dependent on staff with toileting hygiene. During a review of Resident146's Order Summary Report, 8/2/2024 to 8/15/2024, the report indicated: a) Escitalopram Oxalate (medication treats depression) 5 milligrams (mg) one tablet by mouth for depression manifested by feeling of hopelessness causing anxiety (excessive worry). b) Mirtazapine (Medication to treat depression) 15 mg one tablet by mouth at bedtime for depressive disorder for inability to sleep. During an interview and record review on 12/6/2024 10:34 a.m. with the Director of Staff Development (DSD), Resident 146's Medication Administration record (MAR) for 8/2024, was reviewed. The DSD stated, after reviewing the MAR, Resident 146 was receiving Escitalopram for depression manifested by feelings of hopelessness and anxiety. The DSD also stated Resident 146 was taking Mirtazapine for inability to sleep. The DSD stated there was no documented evidence Resident 146 was monitored hopelessness, anxiety, and for hours of sleep. The DSD stated he should have been monitored to ascertain the adequacy of medications he was taking. During an interview on 12/7/2024 at 12:30 p.m., with the Director of Nursing (DON) the DON stated when residents were on psychotropic medications the facility was supposed to monitor for behaviors manifesting so we know if the behaviors were a continuing issue or if the behaviors have subsided. During a review of the facility's policy and procedure (P&P) titled, Behavioral Assessment, Intervention, and Monitoring, revised 2001, the P&P indicated ; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. If the resident was being treated for altered behavior or mood, the Interdisciplinary team (IDT) will seek and document any improvements or worsening in the individual's behavior, mood, and function. 2.The IDT will monitor the progress of individuals with impaired cognition and behavior until stable. New or emergent symptoms will be documented and reported.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on interview and record review the facility failed to ensure four out of eight sampled residents (Resident 6, Resident 26, Resident 29, and Resident 30) were free of a significant medication error. The facility failed to: 1. Ensure the licensed nurses checked Resident 6's heart rate prior to administering Amiodarone on as ordered 13 times from 10/1/2024 to 10/31/2024, and 13 times from 11/1/2024-11/20/2024. 2. Ensure Resident 26's Mexiletine (medication for the treatment of life-threatening heart disease including ventricular arrhythmias [an irregular heartbeat], such as sustained ventricular tachycardia [a rapid, irregular heartbeat], a life-threatening arrhythmia [an irregular heartbeat) 150 milligrams ([mg] a unit of weight measurement) was administered every eight hours as prescribed by the cardiologist (heart doctor [MD 2]). 3. Ensure Resident 26's medication Mexiletine 150 mg, was available for administration on 10/20/2024 to receive at 4 pm as ordered and scheduled. 4. Ensure the Quality Assurance Performance Improvement ([QAPI] a group who takes a systemic, interdisciplinary, comprehensive, and data driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) identified and acted to correct the error in Mexiletine administration Resident 26 per facility's policy and procedure titled Adverse Consequences and Medication Errors dated 2/2023. 5. Ensure Resident 26 received Mexiletine on 10/20/2024 at 4 p.m. and on 11/8/2024, 11/26/2024 and 12/2/2024 at 8:00 a.m., 4 p.m. and 12:00 a.m. as ordered and not in less than eight hours between doses as ordered. 6. Ensure licensed vocational nurse (LVN 2) communicated Resident 26's late administration of Mexiletine to LVN 5 from oncoming shift, who would be administering the next dose to Resident 26 to prevent Mexiletine administration in less than eight hours. 7. Ensure licensed nurses monitored Resident 26 for Mexiletine adverse effects, including cardiac arrhythmias, when LVN 1 missed administering dose of Mexiletine on 10/20/2024 at 4 p.m. as ordered and scheduled. 8. Ensure the licensed nurses did not administer Midodrine to Resident 29 when the resident's systolic blood pressure ([SBP] the pressure of blood against the blood vessel walls when the heart contracts and pumps blood. It's the top number in a blood pressure reading) was greater than 130 as ordered by the physician and indicated in Resident 29's untitled Care Plan initiated on 10/6/2023. 9. Ensure the licensed nurses check Resident 30's blood pressure and pulse rate before administering Amiodarone as ordered. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10. Ensure the licensed nurses followed the facility's policy and procedure titled, Administering Medications to act upon the physician's orders to administer medication as ordered to minimize the risk of adverse consequences (an undesired effect of a drug) including chest pain and palpitations [a skipped, irregular, or extra heartbeat]) to Resident 6, 26, 29 and 30. These deficient practices resulted in: 1. Resident 26 missing one dose of Mexiletine on 10/20/2024 which can cause worsening cardiac arrhythmia. Resident 26 complained of feeling severe palpitations and feeling scared when he did not receive the ordered/scheduled dose. 2. Resident 26 was placed at high risk for liver toxicity (a condition that occurs when the liver is damaged by a harmful substance, such as a chemical, medication, supplement, or alcohol) and fatal (deadly) arrhythmias due to receiving Mexiletine in less than eight hours between doses. 3. Residents 6, 11, 20, 26, 30, 43, 51, and 70 who were receiving antiarrhythmic (used to treat irregular heart rhythm) medications were placed at risk to not receive medication as ordered resulting in potential worsening of cardiac arrhythmia. 4. Residents 6, 29, and 30 were placed at risk for low heart rate and low blood pressure (the pressure of blood on the walls of the arteries as the heart pumps blood around your body) when a physician's parameters (specific instructions that you can measure before medication administration) for administration of Amiodarone, Midodrine (used to treat low blood pressure) and Amlodipine Besylate (blood pressure medication) were not followed. On 12/6/2024 at 9:17 a.m., an Immediate Jeopardy ([IJ] a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Director of Nursing (DON) and the facility's Administrator (ADMIN) due to the facility's failure to prevent significant medication errors. On 12/7/2024 at 8:05 a.m., the facility submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). After onsite verification of the facility's IJRP's implementation through observation, interview, and record review, the IJ was removed on 12/7/2024 at 12:50 p.m., in the presence of the DON and ADMIN. The IJRP included the following immediate actions: a. Resident 26 was seen by MD 2 on 12/6/2024. The DON spoke to MD 2 and informed him Resident 26 missed a dose of Mexiletine on 10/20/2024 and was given a late dose on 11/8/2024, 11/26/2024 and 12/2/2024. b. On 12/6/2024, the DON provided one on one (1:1) training to the Licensed Vocational Nurses (LVNs) who documented Mexiletine's late and missed administration The DON discussed the importance of making sure medications are available, the process of when to reorder medications, and process if dose was late or missed, physician notification, monitoring of residents for adverse effect for missing medications and development of change of condition Situation, Background, Assessment, Recommendation ([SBAR] a significant change in a resident's health that requires attention) and care plan. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c. On 12/6/2024, the DON provided one on one counseling and in-service (staff training and education) with LVN 2 in failing to administer the Mexiletine dose as scheduled and as ordered by the physician on 11/8/2024, the possible adverse effects of late administration (beyond 1-hour-before and 1-hour-after the scheduled time) and notification to the physician and monitoring of resident and/or responsible party if the schedule of the medication dose needs to be altered or changed, such as d. On 12/4/2024, the DON provided a phone 1:1 counseling and in-service with involved LVN 3 in failing to administer the Mexiletine dose on 11/26/24 and on 12/2/24 as scheduled and as ordered by the physician, and about the adverse effects of late administration including the process if the medication dose schedule needs to be altered or change such as notification to the physician. The DON will provide in-person counseling and in-service upon return to work of LVN 3 who failed to administer Mexiletine dose on 11/26/2024 and 12/2/2024. e. The facility's contracted Pharmacy Consultant initiated an in-service with thirteen LVNs on 12/6/2024 regarding administration of medications, the adverse effects of missing the dose and/or late medication administration. In-services will continue until all twenty-five LVNs have participated (remaining 12 LVNs) by 12/16/2024. f. The facility contracted Pharmacy Consultant is scheduled to do a Medication Regimen Review (MRR, a process that evaluates a patient's medications to identify and address issues that could be clinically significant) for Residents receiving antiarrhythmic medications including Residents 6, 11, 20, 26, 30, 43, 51 and 70 on 12/6/2024. g. The facility's Medical Director will initiate an in-service training with the seven LVNs on 12/06/2024 on the importance of administering antiarrhythmic medications as ordered and at the specified time; the adverse effects of not administering medications or late administration, and adverse effects of overdosing on medications when administered medication too close between doses . The Medical Director will continue to conduct the in-service until the remaining eighteen LVNs have participated by 12/16/2024. (Cross reference: F580, F726) Findings: 1. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including type 2 diabetes (a condition that occurs when the body doesn't use insulin properly, leading to high blood sugar levels), supraventricular tachycardia (SVT, an abnormally rapid heart rate and occurs when electrical impulses in the heart are out of sync [not happened at the same time], causing the heart to beat at least 100 beats per minute [bpm] and sometimes as high as 300 bpm), and heart failure. During a review of Resident 6's Minimum Data Set ([MDS] a resident assessment tool) dated 9/25/2024, the MDS indicated Resident 6 had severe impairment of cognitive (a condition that makes it difficult for a person to remember things, learn, concentrate, make decisions, or understand the meaning of things) skills for daily decision making. (continued on next page)

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 12/06/2024

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 6's untitled Care Plan initiated on 5/2/2019 and revised on 11/15/2022, the Care Plan indicated Resident 6 had heart disease and was at risk of SVT with a goal for Resident 6 not to have any chest pain. The Care Plan interventions included for Resident 6 receiving her Amiodarone (a medication that prevents and treats arrhythmia) medication as ordered. During a review of Resident 6's Physician's Order Listing Report, the Physician's Order Listing Report indicated an order was placed on 10/5/2022 for Amiodarone tablet 200 mg, one tablet by mouth once daily, hold if pulse (heart rate) is less than 60. During a review of Resident 6's Medication Administration Record (MAR), the MAR indicated Not Applicable (NA) was documented 14 times from 10/1/2024 to10/31/2024 and 13 times from 11/1/2024-11/30/2024 instead of Resident 6's pulse reading which should have been checked and documented before the administration of Amiodarone The MAR indicated Amiodarone was marked as given. 2. During a review of Resident 26's Admission Record, the Admission Record indicated Resident 26 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of ventricular tachycardia ([VT] is a type of irregular heartbeat that occurs when the heart's lower chambers beat too fast. VT is defined as a heart rate of more than 100 beats per minute with at least three irregular heartbeats in a row) and with a cardiac pacemaker (a small, battery-powered device surgically placed under the skin of the chest that signals the heart to beat when the heartbeat is too slow or irregular). During a review of Resident 26's MDS dated [DATE], the MDS indicated Resident 1 had moderate cognitive impairment and had no behaviors of rejecting care such as medications. During a review of Resident 26's History and Physical (H&P) report dated 9/26/2024, the H&P indicated Resident 26 had the capacity to understand and make decisions. During a review of Resident 26's H&P/ Admission Notes from a General Acute Care Hospital (GACH) dated 2/15/2024, Resident 26 was transferred to the GACH for an automatic implantable cardioverter defibrillator ([AICD] is a small device that's surgically implanted in the chest to monitor and correct an irregular heartbeat, or arrhythmia) interrogation (assessment of AICD because it engaged four times due to Resident 26's high heart rate). The GACH's record indicated Resident 26's electrocardiogram ([ECG] non-invasive test that measures the electrical activity of the heart) in the Emergency Department dated 2/15/2024, indicated the resident had SVT. During a review of Resident 26's GACH's MAR dated 2/15/2024- 2/24/2024 Resident 26 was started on Mexiletine 150 mg every eight hours on 2/22/2024 due to Resident 26's heart rate remaining elevated even after treatment with only Amiodarone 200 mg three times a day. During a review of Resident 26's Physician's Order Summary Report (from the facility), the Physician's Order Summary Report indicated the following orders dated 9/20/2024: a. Amiodarone Tablet 200 mg, one tablet twice a day for arrhythmia, hold for heart rate less than 60. b. Mexiletine oral capsule 150 mg, one capsule every eight hours for arrhythmia (administer at midnight, 8 a. m., and 4 p.m.). (continued on next page)

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 26's untitled Care Plan initiated on 9/21/2024, the care plan indicated there was a Black Box Warning (the most serious warning that the U.S. Food and Drug Administration [FDA-a US federal agency that protects public health by regulating the safety of many products] can issue for a prescription drug) for the use of Mexiletine with a goal for Resident 26 to not experience side effects with the use of Mexiletine. The care plan indicated there was a Black Box Warning that indicated there was a risk of acute (severe and sudden) liver injury with the use of Mexiletine. Resident 26's care plan initiated 9/22/2024 indicated Resident 26 had altered cardiovascular (the heart [cardio] and the blood vessels ([vascular]) status related to arrhythmia with a goal for Resident 26 to be free from complications of cardiac problems. The Care Plan interventions included monitoring Resident 26's vital signs (measurements of the body's essential functions) and notifying the physician of any significant abnormalities. During a review of Resident 26's MAR, the MAR indicated the following: a. From10/1/2024 to 10/31/2024 Resident 26 did not receive his scheduled 4 p.m. dose of Mexiletine 150 mg on 10/20/2024. The MAR indicated to see progress notes for the reason Resident 26's 4 p.m. dose of Mexiletine was not administered. A review of the Medication Administration Progress Notes for 10/20/2024 at 3:34 p.m., indicated awaiting medication delivery. b. The MAR indicated NA was documented instead of a pulse reading six times in the month of October 2024 and NA was documented 13 times instead of Resident 26's pulse reading for November 2024 before the administration of Amiodarone 200 mg Resident 26's pulse was not checked before administration of Amiodarone 200 mg as ordered. During a review of Resident 26's Medication Administration Audit Report for 11/1/2024 to 12/4/2024, the Medication Administration Audit Report indicated the resident's midnight dose for 11/8/2024 was given at 5:12 a.m., on 11/8/2024, which was five hours and 12 minutes later than scheduled and dose of Mexiletine ordered for 8:00 a.m. was given at 7:45 a.m. on 11/8/2024, which was two hours and 33 minutes after the last dose was given at 5:12 a.m. During a review of Resident 26's Medication Administration Audit Report for 11/1/2024 to -12/4/2024, the Medication Administration Audit Report indicated the resident's midnight dose on 11/26/2024 was given at 3:02 a.m., which was three hours and two minutes later and nine hours 38 minutes after the last dose given on 11/25/2024 at 5:24 p.m. The Medication Administration Audit Report indicated the resident's Mexiletine dose scheduled at 8:00 a.m. was given at 7:46 a.m., which was four hours and 44 minutes after the dose given at 3:02 a.m. During a review of Resident 26's Medication Administration Audit Report for 11/1/2024 to -12/4/2024, the Medication Administration Audit Report indicated the resident's midnight dose on 12/2/2024 was given at 2:42 a.m., which was two hours and 42 minutes later than scheduled and ordered and the 8:00 am. dose was given at 7:51 a.m., which was five hours and 9 minutes apart from the dose given at 2:42 a.m. instead of the ordered eight hours between doses. During a review of Resident 26's SBAR Communication Form dated 12/4/2024, the SBAR indicated Resident 26 informed LVN 10 he received a late dose of Mexiletine on 12/2/2024. Resident 26's primary care physician (MD 3) was informed two days later, on 12/4/2024 at 6:39 p.m., regarding the late dose administration on 12/2/2024. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 26's medical record and SBAR form from 10/2024 through 12/2024, the medical record and SBAR form did not indicate MD 3 was notified of Resident 26's missed dose of Mexiletine on 10/20/2024 or receiving the late doses on 11/8/2024 and 11/26/2024. During a review of the Manufacturers Insert for Mexiletine, revised on 1/2023, the Manufacturers Insert indicated Mexiletine was indicated for the treatment of documented ventricular arrhythmias, such as sustained ventricular tachycardia, that in the judgement of the physician were life-threatening. The peak (when the level of the drug in the patient's body is the highest) blood levels of Mexiletine were reached in two to three hours after intake. In most patients, the time it takes for Mexiletine's action in the body to reduce by half is approximately 10 to 12 hours. During an interview on 12/3/2024 at 10 a.m., Resident 26 stated he had a pacemaker placed in January 2024 and he was not receiving his heart medicine (Mexiletine) on time. Resident 26 stated he was supposed to get a midnight dose of Mexiletine and sometimes it would be after 2 a.m. without receiving the medication so he had to go hunt down the nurses to get his medications. During an interview on 12/4/2024 at 4 p.m., Resident 26 stated he missed a dose of Mexiletine in October 2024 (10/20/2024) because the facility did not order it in time from the pharmacy and his heart was beating out of control and he felt scared. Resident 26 stated he was very sensitive to how his heartbeat felt and when his medications were given late, he felt his heart beating differently and just did not feel good. Resident 26 stated there was an instance on 11/8/2024 where his midnight dose of medication was given at around 5 a.m. , and then the 8 a.m. dose was given around 7 a.m. Resident 26 stated it was very scary for him because the doses were very close to each other. Resident 26 stated he did not like to complain so he just took the medication like the nurse said but deep down inside he was nervous because MD 2 told him, he could die if he did not take Mexiletine as prescribed. During an interview on 12/4/2024 at 4:15 p.m., LVN 5 stated Resident 26 was taking antiarrhythmic medications (Mexiletine and Amiodarone) for his history of VT, arrhythmia, and having a pacemaker. LVN 5 stated the nurses had to monitor Resident 26's heartrate and ensure it was not below 60 bpm when administering these medications. LVN 5 stated the Black Box warning for Mexiletine indicated Mexiletine can cause acute liver injury and Mexiletine should be reserved for residents with life threatening ventricular arrhythmias. LVN 5 stated it was very important to abide by the administration scheduled/ordered times for Resident 26's Mexiletine (8 a.m., 4 p.m., and midnight) and nurses were allowed only one hour before or after a scheduled administration time to give medication. LVN 5 stated if you gave Mexiletine too close to the next dose it could suddenly drop the blood pressure or heart rate too low. During an interview on 12/4/2024 at 4:20 p.m., MD 3 stated it was important to administer antiarrhythmics such as Mexiletine as ordered (every eight hours) for effectiveness. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/4/2024 at 4:24 p.m., the facility's Pharmacy Consultant (PC) stated antiarrhythmic medications were high risk medications and were managed closely by cardiologists. The PC stated it was important to give Mexiletine every eight hours as ordered because of the pharmacokinetics (the movement of drug into, through, and out of the body) of the medication to maintain therapeutic effects (the response(s) after a treatment of any kind, the results of which are judged to be useful or favorable). The PC stated it was important not to miss any doses of Mexiletine because it could cause worsening of arrhythmias. The PC stated if a dose was given within four hours of the next dose it would be considered a double dose and there was a risk for toxicity (the degree to which a substance can harm an organ). The PC stated that too much of the medication given could cause liver toxicity, a different cardiac arrhythmia and a too close or missed dose could worsen a cardiac arrythmia and was potentially life threatening. The PC stated the facility nurses should notify the physician of a late or missed dose right away. During an interview on 12/4/2024 at 4:51 p.m., the facility's Quality Assurance Consultant (QAC) stated the time documented on the Medication Administration Audit Report as administered was the time the nurse gave the medication. During an interview on 12/5/2024 at 8:05 a.m., Resident 26 stated he felt stressed in the facility because MD 2 made it clear to him that the Mexiletine needed to be taken every eight hours to be effective and that was why he would have to get out of bed, get dressed, and go look for the nurse when his midnight dose was late. Resident 26 stated he was fearful he would suffer from a massive heart attack or some other issue if he didn't get his medication as ordered ad scheduled. During an interview on 12/5/2024 at 8:20 a.m., the Director of Nursing (DON) stated the facility policy was to remove the pill out of the bubble pack (how the medication is dispensed from the pharmacy), give the medication to the resident, and then immediately document the medication administration and time in the resident's MAR. During an interview on 12/5/2024 at 10:29 a.m., MD 2 stated a missed dose or late dose of Mexiletine had the potential to cause a worsening of cardiac arrhythmia. During an interview on 12/5/2024 at 3:04 p.m., LVN 5 stated the computer system the licensed staff used to document medication administration did not have an alert that would inform her that the nurse from the shift prior gave the medication to the resident late. LVN 5 stated the only way to know the nurse from the prior shift did not give the medication or if it was administered late was if the nurse informed her (LVN 5). LVN 5 stated LVN 2 did not report to her that Mexiletine was administered late (12 a.m. dose given at 5:12 a.m.) on 11/8/2024 and that was why she gave the scheduled dose at 7:45 a.m. LVN 5 stated a late dose or a missed dose of medication was considered a medication administration error and the nursing staff should notify the physician of the missed or late dose, and the resident needed to be monitored and assessed for any changes in condition due to the late or missed dose. LVN 5 stated a check mark on the MAR meant the medication was given and it was important to follow the physician's orders for parameters because the vital signs could go below the normal range (BP reference range is less than 120 systolic and less than 80 diastolic [bottom number]) and heart rate normal range between 60 and 100 BPM) and that would not be good for the resident. LVN 5 stated there was an option to choose on the MAR that indicated NA but that should never be used and the actual vital sign should have been documented. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 12/5/2024 at 3:22 p.m., the DON stated the importance of following physician's orders for Mexiletine was the resident could develop problems or irregularities in heart rate if the physician's orders were not followed. The DON stated the doses given on 11/8/2024 for Resident 26's Mexiletine at 5:12 a.m. and 7:45 a.m. were considered a double dose and Resident 26 should have been monitored for adverse reactions. The DON stated the physician should have been notified of the late and missed doses of Mexiletine and Resident 26 should have been monitored for adverse reactions for three days. During a concurrent interview and record review on 12/5/2024 at 3:30 p.m., with the DON, the Administration Progress Note for Resident 26 dated 10/20/2024 was reviewed. The DON stated Resident 26's Mexiletine was not given because the facility was awaiting delivery of the Mexiletine from the pharmacy. The DON stated it was facility's process to order medications 3 to 5 days prior to running out so there would not be any missed doses, but it does not appear the Mexiletine was ordered in time. The DON stated arrhythmias were a life-threatening condition and the facility should always have the necessary antiarrhythmic medications available in the facility. The DON stated it was important to follow physician's orders for parameters relating to the BP and pulse because it was important for the nurses to know if they must hold (not administer) the medication, so the blood pressure or pulse did not drop causing weakness, dizziness, or the potential for the loss of consciousness. The DON stated nurses should never document NA instead of measuring and documenting the actual vital sign. 3. During a review of Resident 29's Admission Record, the Admission Record indicated Resident 29 was admitted to the facility 9/27/2023 with diagnoses of hypotension (low blood pressure) and atrial fibrillation ([AFib], a rapid irregular heartbeat). During a review of Resident 29's MDS dated [DATE], the MDS indicated Resident 29 had moderate cognitive impairment. During a review of Resident 29's Physician's Order Summary Report, the Physician's Order Summary Report indicated Resident 29 had an order dated 9/27/2023 for Midodrine 2.5 mg three times a day for hypotension, hold if SBP is greater than 130. During a review of Resident 29's untitled Care Plan initiated on 10/6/2023, the Care Plan indicated Resident 29 had hypotension related to heart disease with a goal to maintain Resident 29's blood pressure within an acceptable range as determined by the physician with interventions that included giving Midodrine as ordered. During a review of Resident 29's MAR, the MAR indicated NA was documented 14 times from 10/1/2024 to 10/31/2024 and 13 times from 11/1/2024 to 11/30/2024 instead of the pulse reading before the administration of Midodrine 2.5 mg tablet. The MAR indicated Midodrine 2.5 mg tablet was administered without Resident 29's pulse being checked first. The MAR indicated that Midodrine 2.5 mg tablet was given to Resident 29 on the following dates when Resident 29's SBP was above130: a. On 10/3/2024 6 a.m. for BP 133/63. b. On 10/4/2024 6 a.m. for BP 138/67. c. On 11/7/2024 10 p.m. for BP 149/54. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. On 11/17/2024 6 a.m. for BP 147/63. e. On 11/28/2024 6 a.m. for BP 131/69. During an interview on 12/6/2024 at 1:10 p.m., the Director of Staff Development (DSD) stated she was unsure why nurses were documenting NA on the MAR instead of the actual pulse rate and/or blood pressure reading because that was not the facility's policy. The DSD stated if the pulse rate and/or blood pressure reading was not documented, it was not measured, it was not done. The Director of Staff Development (DSD) stated if Resident 29's Midodrine was given when Resident 29's SBP was greater than 130, there was a risk for an increase in blood pressure which could place the resident at the risk of stroke [blood vessel bursting, causing bleeding and brain tissue damage]), heart attack, and chest pain. 4. During a review of Resident 30's Admission Record, the Admission Record indicated Resident 30 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of AFib and congestive heart failure ([CHF] a chronic condition that occurs when the heart can't pump enough blood to meet the body's needs). During a review of Resident 30's Physician's Order Summary Report, the Physician's Order Summary Report indicated an order dated 9/22/2024 for Amiodarone 200 mg, one tablet twice a day for CHF, hold if heart rate is less than 60 and the order dated 9/23/2024 for Amlodipine Besylate (blood pressure medication) 10 mg tablet daily for hypertension ([HTN] high blood pressure), hold if SBP is less than 110 bpm. The order for Amlodipine administration parameter was updated on 10/25/2024 indicating to hold the medication if the resident's pulse rate was less than 60 bpm. During a review of Resident 30's untitled Care Plan initiated on 9/23/2024, the Care Plan indicated Resident 30 was at risk for cardiac distress (a group of heart-related symptoms that can quickly become life-threatening, including shortness of breath, chest pain, and feeling of a pounding heartbeat) related to heart failure with a goal for Resident 30 to be free from cardiac distress. The Care Plan interventions included monitoring the pulse rate and blood pressure, and administering medications as ordered. During a review of Resident 30's MDS dated [DATE], the MDS indicated Resident 30 was moderately cognitively impaired. During a review of Resident 30's MAR, for the administration of Amlodipine Besylate 10 mg tablet, the MAR indicate the following: a. There was NA documented seven times between 10/1/2024 to 10/31/2024 instead of the having Resident 30's documented blood pressure reading. b. There was NA documented three times between 10/1/2024 to 10/31/2024 instead of Resident 30's documented pulse rate. c. There was NA documented 16 times between 11/1/2024 to11/30/2024 instead of Resident 30's documented blood pressure and pulse rate readings. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. There was NA documented seven times between 11/1/2024 to 11/30/2024 instead of the resident's pulse rate. During an interview on 12/6/2024 at 2:29 p.m., the director of nursing (DON) stated medication administration errors were not part of their current QAPI program and issues were not identified by the QAPI team prior to learning about the deficiencies related to missed doses of medication, late administration of medication, and not following physician's orders during medication administration. The DON stated if they had been aware of the medication errors, they would have been added to the QAPI program to prevent the errors from occurring again. During a review of the facility's policy and procedure (P/P) titled Administering Medications undated, the P/P indicated medications were to be administered in accordance with prescriber orders, including any required time frame. Medication administration times were determined based on the resident need and benefit and not staff convenience. Factors that were considered for medication administration time included enhancing optimal therapeutic effect of the medication. Medications were to be administered within one hour of their prescribed time. Vital signs were to be checked if necessary for each resident prior to administering medications. The individual administering the medication was to document the date and time the medication was administered in the resident's medical record. The P/P indicated medication errors were to be documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. During a review of the facility's P/P titled Documentation of Medication Administration dated 11/2022, the P/P indicated administration of medication was to be documented immediately after the medication was given. During a review of the facility's P/P titled Adverse Consequences of Medication Errors dated 2/2023, the P/P indicated a medication error was defined as the preparation or administration of drugs which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards. Examples of medication errors included the medication being given at the wrong time or a drug is ordered but not administered. A significant medication error is determined as one that is life threatening. The physician was to be promptly notified of any significant error. The resident was to be monitored for 24 to 72 hours after a significant medication error. The significant medication error was to be communicated to the oncoming shift as needed to alert staff of the need for continued monitoring.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on observation, interview, and record review the facility failed to ensure one of three resident's (Resident 70) medication was not left on top of the medication cart unattended. This failure had the potential to result in visitors, residents, and staff unauthorized access to Resident 70's medication. Findings: During a review of Resident 70's Admission Record, the Admission Record indicated Resident 70 was readmitted to the facility on [DATE] with diagnoses including ventricular fibrillation (life threatening irregular heart beat), paroxysmal atrial fibrillation (type of irregular heart beat that usually end on their own within a week), and hypertensive heart disease (group of heart conditions caused by long-term high blood pressure - force of the blood pushing against the artery walls is consistently too high)with heart failure (serious condition that occurs when the heart is unable to pump enough blood and oxygen to the body's organs). During a review of Resident 70's Minimum Data set (MDS), A resident assessment tool, dated 11/23/2024, the MDS indicated Resident 70's cognitive skills (functions your brain uses to think, pay attention, process information, and remember things) for daily decision-making was severely impaired. During a review of Resident70's Order Summary Report as of 12/5/2024, the report indicated amiodarone 200 milligrams, give one tablet by feeding tube one time a day for ventricular fibrillation. During an observation during medication pass on 12/4/2024 at 9:30 a.m., Licensed Vocational Nurse (LVN) 7 was observed placing Resident 70's Amiodarone on the medication cart and then leaving the medication cart unattended. During an observation and interview on 12/4/2024 at 9:50 a.m. with the Director of Staff Development (DSD), the DSD observed the unattended medication on the medication cart and the DSD stated medications should not be left on top of the medication cart unattended because other residents can grab it. During an interview on 12/7/2024 at 12:30 p.m., with the Director of Nursing (DON) the DON stated medications cannot be left unattended for resident safety because anyone can take it. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, undated, the P&P indicated medication supply is only accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 45891 Based on interview and record review, the facility's Quality Assessment and Assurance committee ([QAA] a group of facility staff who identifies, evaluates, and implements measures to improve the quality care and life for the residents in the facility) and Quality Assurance Performance Improvement ([QAPI] a group who takes a systemic, interdisciplinary, comprehensive, and data driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families, and all nursing home caregivers in practical and creative problem solving) committee failed to identify concerns related to significant medication errors (a preventable event that jeopardizes a patient's health and safety) in the facility. This deficient practice had the potential for continued significant medication errors, (a failure in drug therapy that may result in harmful effects to patents) and placed all residents residing in the facility at risk for adverse effects (unwanted undesirable effects) because of the medication errors and mismanagement of their medication regimen. (Cross reference to F726 and 760) Findings: During an interview on 12/6/2024 at 2:29 p.m., the director of nursing (DON) stated the current QAPI plan was focusing on falls and leaving against medical advice (AMA) discharges. The DON stated medication administration errors were not part of their QAPI program and issues were not identified prior to learning about the deficiencies related to missed doses of medication, late administration of medication, and not following physician's orders during medication administration. The DON stated if they had been aware of the medication errors, they would have been added to the QAPI program to prevent the errors from occurring again. During a review of the facility's undated P&P, titled Administering Medications, the P/P indicated medication errors were to be documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. During a review of the facility's policy and procedure (P&P), titled Quality Assurance and Performance (QAPI) Program, revised 2/2020, the P&P indicated the facility implements and maintains an ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) Program focused on the indicators of the outcomes of care and quality of life for our residents. The P&P indicated the objective of the QAPI program was to provide a means to measure current and potential indicators for outcomes of care and quality of life and establish a system through which to monitor and evaluate corrective actions.

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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** 45777 Based on observation, interview, and record review, the facility failed to observe infection control measures for 2 of 3 sampled residents (Residents 14 and 69) by failing to: Sanitize the Mechanical lift between caring for Resident 14 and Resident 69 This deficient practice had the potential to spread infections to other residents in the facility. Findings: During a review of Resident 69's Admission Record, the Admission Record indicated the facility initially admitted Resident 69 to the facility on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease (kidney failure-a condition in which the kidney's loose ability to remove waste and balance fluids in the body), generalized muscle weakness, and hypertension (high blood pressure). During a review of Resident 69's history and physical (H&P), dated 3/20/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 69's Minimum Data Set ([MDS] a resident assessment tool), dated 8/30/2024, the MDS indicated Resident 69 required substantial/maximal assistance (helper lifts or hold trunk of limbs and provides more than half the effort) with shower and bathing, changing positions from lying to sitting on side of bed, and sit to lying. Resident 69 was dependent (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). During a review of Resident 14's Admission Record, the Admission Record indicated the facility initially admitted Resident 14 to the facility on [DATE] and readmitted on [DATE] with diagnoses of chronic kidney disease , unspecified (a disease means your kidneys slowly get damaged and can't do important jobs like removing waste and keeping blood pressure normal), anxiety disorder (a feeling of fear dread and uneasiness) and unspecified glaucoma (damage to the part of the eye affecting vision). During a review of Resident 14's H&P, dated 10/20/2024, the H&P indicated Resident 14 does not have the capacity to understand and make decisions. During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14 is dependent in eating, upper and lower body dressing, and personal hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/4/2024 at 1:25 p.m., Certified Nursing Assistant (CNA 1) and CNA 2 placed Resident 69 in a Mechanical lift and transferred him to his wheelchair. CNA 1 then pushed the Mechanical lift out of Resident 69's room and placed it in the hallway. When CNA 1 was finished securing Resident 69 in his wheelchair, CNA 1 washed her hands and proceeded to enter resident 14 room, provided care to Resident14. CNA 1 left Resident 14's room took the Mechanical lift that was in the hallway into the room and CNA 1 and CNA 2 placed Resident 14 into the Geri chair (a comfortable, padded, and reclining chair with wheels that's designed to help people with limited mobility). During an interview on 12/4/2024 at 1:41 p.m., with CNA 1, CNA 1 stated after finishing with Resident 69 and placing the Mechanical lift outside of Resident 69's room she did not remember to clean it before taking the Mechanical lift to Resident 14's room. CNA 1 stated it was important to clean the Mechanical lift before and after caring for a resident to prevent spreading infections. During an interview on 12/4/2024 at 2:00 p.m., with the Director of Staff Development (DSD) stated when equipment like a Mechanical lift is used for the residents it must be cleaned before and after use to prevent the spread of infection from resident to resident. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention Quality and Control Program dated October 10, 2018 the P&P indicated, an infection prevention and control program is established and maintained to provide a safe sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 44055 Based on interview and record review the facility failed to ensure two out of two sampled staff, Licensed Vocational Nurse (LVN) 2 and 3, received mandatory training of effective communications upon hire. This failure had the potential to result in staff with poor communication skills and may negatively affect the residents' quality of care. Findings: During an interview and record review on 12/6/2024 at 11:50 a.m. with the Director of Staff Development (DSD), LVN 2 and 3's personnel records were reviewed, and the orientation training indicated no documented evidence effective communication was taught to LVN 2 and 3. The DSD stated effective communication was not part of the orientation in services upon hire of staff. During an interview on 12/7/2024 at 12:30 p.m., with the Director of Nursing (DON) the DON stated mandatory training need to be implemented in the facility. During a review of the facility's policy and procedure (P&P) titled, Competency of Nursing Staff, 5/2019, the P&P indicated all nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. Competency skills and techniques necessary to care for residents needs includes but is not limited to competencies in areas such as communication.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility’s Quality Assurance and Performance Improvement Program. 44055 Based on interview and record review the facility failed to ensure two out of two sampled staff, Licensed Vocational Nurse (LVN) 2 and 3, received mandatory training of Quality Assurance and Performance Improvement (QAPI- systematic and interdisciplinary approach to maintaining and improving safety and quality in nursing homes while involving residents and families in practical problem solving) upon hire. This failure had the potential to negatively affect the residents' quality of care. Findings: During an interview and record review on 12/6/2024 at 11:50 a.m. with the Director of Staff Development (DSD), LVN 2 and 3's personnel records were reviewed, and the orientation training indicated no documented evidence QAPI training was taught to LVN 2 and 3. The DSD stated QAPI training was not part of the orientation in services upon hire of staff. During an interview on 12/7/2024 at 12:30 p.m., with the Director of Nursing (DON) the DON stated mandatory training need to be implemented in the facility. During a review of the facility's policy and procedure (P&P) titled, Competency of Nursing Staff, 5/2019, the P&P indicated all nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law.