STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. Building B. Wing	03/12/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on interview and record review, the facility failed to ensure two of four sampled residents' (Resident 1 and 79) had current and accurate Advance Directives ([AD]-written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) correctly in their medical records when:The facility failed to obtain a copy of Resident 1's AD despite documentation of acknowledgement, confirming and documenting the resident's wishes when the resident was deemed capable after another individual had signed the form. The facility failed to Provide written information and follow through to complete the AD acknowledgement/Physician Orders for Life-Sustaining Treatment ([POLST]- a medical order that helps give people with serious illness more control over their care during a medical emergency) for Resident 79.These failures had the potential to result in care being provided that was inconsistent with the residents' wishes and could compromised the residents' rights to make decisions regarding their medical care during emergencies, end of life, and changes in condition.Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including Intervertebral disc degeneration (the natural wear and tear of the cushiony pads between your backbones), acute pulmonary edema (a dangerous, sudden buildup of fluid inside the lungs that makes it feel like you are drowning) and type 2 diabetes mellitus (a long-term condition where the body cannot use sugar for energy properly, causing it to build up in the blood). The admission Record also indicated Resident 1's family members were listed as emergency contacts #1 and #2 and did not identify any family member as the resident's power of attorney (POA- a legal document that lets you pick a trusted person to make decisions on your behalf). During a review of Resident 1's History and Physical (H&P), dated [DATE], the H&P indicated Resident 1 had the capacity (ability) to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 1's cognitive (functions your brain uses to think, pay attention, process information, and remember things) was moderately impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort to complete the task) with eating, oral hygiene, maximal assistance (helper does more than half the effort to complete task) with toileting hygiene, and showering. During a concurrent interview and record review on [DATE] at 2:42 p.m., with the Social Service Director (SSD), Resident 1's ADA dated [DATE] was reviewed. without verifying supporting documentation and allowed the family to complete the ADA. The SSD stated the facility had not obtained a copy of the resident's AD after the acknowledgement, for about two months after the (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admission. The SSD stated the facility failed to obtain the ADA from the resident after the physician assessed the resident and determined the resident was capable on [DATE]. The SSD stated it was her responsibility to ensure the AD was documented, available, and completed as required to honor the residents' wishes regarding care and treatment. During an interview on [DATE], a.m., with the Director of Nursing (DON), the DON stated completion of the AD should have been completed sooner not approximately 2 months later. The DON stated completion of the AD is essential to ensure the resident's wishes are honored and to guide care and treatment decisions during emergency situations. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, revised [DATE], the P&P indicated, If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. If the resident becomes able to receive and understand this information later, he or she will be provided with the same written materials as described above, even if his or her legal representative has already been given the information. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. 2. During a review of Resident 79's admission Record, the admission Record indicated, Resident 79 was initially admitted to the facility on [DATE] and last readmission was on[DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 79's H&P, dated [DATE], the H&P indicated, Resident 79 could make needs known but could not make medical decisions. During a review of Resident 79's MDS, dated [DATE], the MDS indicated Resident 79 was dependent and required dependent assistance (Helper does all of the effort) from two or more staff for, hygiene, shower/bath, dressing, bed mobility, transfer, and maximal assistance (Helper does more than half the effort) from one staff for eating. During a concurrent interview and record review on [DATE], at 10:33 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 79's Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE] was reviewed. The POLST indicated, Resident 79 had an order for Do Not Attempt Resuscitation (DNR- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating). The POLST indicated, comfort-focused treatment only. The POLST indicated, Resident Representative (RR) elected no AD. RNS 1 stated, Resident 79 was Full Code (FC- a directive indicating that all possible life-saving measures will be used to revive the resident whose heart or breathing has stopped) before, but recently changed to DNR after being admitted to hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility). During a concurrent interview and record review on [DATE], at 10:45 a.m., with RNS 1, Resident 79's Order Summary Report (OSR), dated [DATE] was reviewed. The OSR indicated, attempt cardiopulmonary resuscitation (CPR- an emergency lifesaving procedure performed when the heart stops beating), provide full treatment, and provide long-term artificial nutrition was ordered on [DATE]. RNS 1stated, the staff should have followed up with Resident 79's Primary Care Physician (PCP) to reflect recent changes in POLST from the hospice. RNS 1 stated, there are two conflicting orders regarding Resident 79's code status. RNS 1 stated, Resident 79 would be at risk of being (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treated as FC against his/her wish. During a concurrent interview and record review on [DATE], at 11:36 a.m., with the Social Service Director (SSD), Resident 79's Advance Directive (AD) Acknowledgement, dated [DATE] was reviewed. The AD Acknowledgement indicated, there was no name of Resident Representative (RR) who consented verbally via phone. The AD Acknowledgement indicated, written materials were given to RR and there were no signatures from witnesses. The SSD stated, there was no evidence that written materials regarding the right to accept or refuse medical treatments were provided to RR and Resident 79. The SSD stated, the residents and RR might not be fully informed of their rights and to have their wishes honored if AD Acknowledgement was not done correctly and incompletely. The SSD stated, AD Acknowledgement would be invalid and incomplete if there was missing information. The SSD stated, the staff, including herself, should ensure that the residents and RR fully understood how they want to precede care and treatment as they wish. During an interview on [DATE], 12:47 p.m., with the Director of Nursing (DON), the DON stated, AD and POLST should be available for all residents regardless. The DON stated, the SSD and staff should have ensured the completion of POLST and provided written information regarding AD. The DON stated, any verbal or telephone consent should be signed by two witnesses to be valid. The DON stated, AD and POLST were important to honor residents' wishes and the guideline for how to treat residents in emergency situation. The DON stated, the staff should have followed up with both hospice and the PCP to clarify the order to prevent confusion during the emergency. During a review of Resident 79's Care Plan Report (CPR) titled, POLST: Requested for CPR with full treatment and artificial nutrition via tube feeding, revised on [DATE], the CPR Goal indicated, Resident 79 will be cared for with respect and dignity and will be comfortable during the end-of-life process through [DATE]. The CPR Interventions indicated, keep POLST document in chart specifying resident's wishes and provide RR and resident with educational material regarding AD as needed. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, revised 12/2016, the P&P indicated, Policy Interpretation and Implementation: 1. the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 2.Written information will include a description of the facility's policies to implement advance directives and applicable state law .17. The Interdisciplinary Team will conduct ongoing review of the resident's decision-making capacity and communicate significant changes to the resident's legal representative. Such changes will be documented in the care plan and medical record . 19. Changes or revocations of a directive must be submitted in writing to the Administrator. The Administrator may require new documents if changes are extensive. The Care Plan Team will be informed of such changes and/or revocations so that appropriate changes can be made to the resident assessment (MDS) and care plan. During a review of the facility's Policy and Procedure (P&P) titled, Advance Healthcare Directives/POLST, revised 12/2024, the P&P indicated, Purpose: To provide residents with the opportunity to make decisions regarding their healthcare and treatment options . Policy Interpretation and Implementation: Once POLST is executed a Licensed nurse will contact the residents' primary care physician and inform him/her of the residents' healthcare decisions and obtain orders to support these decisions. Physician orders to withhold or withdraw treatment may be taken over the telephone, with two (2) licensed nurses' signatures.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to improve or maintain range of motion (ROM, full movement potential of a joint) for two of five sampled residents (Residents 6 and 8) with ROM concerns by failing to: 1.Ensure Resident 6's left shoulder and left elbow were objectively (unbiased, based on facts) measured and assessed after orthopedics (specialty area in medicine referring to the management of the muscles, bones, and their connective structures) cleared Resident 6 for left shoulder and left elbow ROM exercises. 2.Ensure Resident 6's left wrist and left-hand ROM limitations were objectively measured during the Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation, dated 9/13/2025. 3.Ensure a licensed physical therapist (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) or OT assessed Resident 6's left shoulder and left elbow prior to establishing a Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain their function and joint mobility) program for left shoulder and left elbow passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises. 4.Ensure RNA provided ROM exercises to Resident 8's both hips and both ankles as ordered by the physician. 5.Ensure Resident 8's ROM limitations of both knees were objectively measured during the PT Evaluation, dated 12/12/2025. These deficient practices had the potential for Residents 6 and 8 to experience further decline in ROM resulting in contracture (loss of motion of a joint associated with stiffness and joint deformity) development and have a decline in physical functioning, mobility (ability to move), and activities of daily living (ADL, basic activities such as eating, dressing, toileting).Findings:1. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including a left humeral shaft fracture (break in the long bone of the upper arm), muscle weakness, and polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain).During a review of Resident 6's History and Physical (H&P) Note, dated 9/12/2025, the H&P indicated Resident 6 was transferred to the hospital for surgery of the left humerus after sustaining a fall at the facility. The H&P indicated Resident 6 had surgery for the left humerus on 9/9/2025 and was re-admitted to the facility on [DATE] for skilled care (high level medical or rehabilitative care provided by licensed professionals), PT, and OT.During a review of Resident 6's Orthopedic Consultation Progress Note (Ortho Note), dated 10/6/2025, the Ortho Note indicated the visit was Resident 6's first orthopedic follow up appointment since surgery to the left arm on 9/9/2026. The Ortho Note indicated Resident 6 was non-weight bearing (NWB, restriction in which a person is not allowed to put any weight through the operated body part) to the left arm and was able to participate in ROM exercises to the left shoulder and left elbow with PT and OT. During a review of Resident 6's Joint Mobility Screening assessment (JMA, a brief assessment of a resident's ROM in both arms and both legs), dated 10/31/2025, the JMA indicated Resident 6's left elbow had minimal ROM loss (less than 25 percent loss) and Resident 6's left shoulder had severe ROM loss (greater than 50 percent loss). The JMA portion of the assessment titled Comments indicated Resident 6 had loss of motion in the left elbow and left shoulder. The JMA indicated recommendations for Resident 6 to continue with the RNA program. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 1/26/2026, the MDS indicated Resident 6 had moderate cognitive (mental action or process of acquiring knowledge and understanding) impairment. The MDS indicated Resident 6 required set up/clean up assistance (helper sets up or clean up) for eating and oral hygiene and was dependent (helper does all the effort) with toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 6 had functional limitations in ROM (limited ability to move a joint that interferes with daily (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	functioning, including activities of daily living, or places the resident at risk of injury) in one arm.During an observation and interview on 3/9/2026 at 10:24 am with Resident 6 in Resident 6's room, Resident 6 was lying in bed with the left elbow bent and the left wrist and hand resting on her stomach. Resident 6 stated her left shoulder was broken but did not recall when. Resident 6 reached across the body with the right arm, grabbed her left arm, and used the right arm to assist raising the left arm to less than shoulder height. Resident 6 bent the left elbow upwards towards the body but could not fully straighten the arm. Resident 6 was unable to lift the left wrist upwards or close the fingers of the hand into a fist.During a concurrent interview and record review on 3/11/2026 at 10:14 am with the Director of Rehabilitation (DOR), the DOR stated the facility monitored for changes in joint ROM by JMAs conducted by the Rehabilitation Department (Rehab) upon admission and quarterly and by staff report. The DOR stated PTs and OTs used goniometers (instrument used for the precise measurement of angles) to measure joint mobility to objectively (unbiased, based on facts) determine a resident's baseline ROM and detect changes in joint ROM. The DOR reviewed Resident 6's H&P, 9/12/2025, and confirmed Resident 6 had surgery for the left humerus on 9/9/2025 and was re-admitted back to the facility on 9/12/2025. The DOR reviewed Resident 6's Ortho Note, dated 10/6/2025, and confirmed Resident 6 was cleared by the orthopedic physician to begin post-op (after surgery) left shoulder and left elbow ROM exercises. The DOR reviewed Resident 6's JMA, dated 10/31/2025, and confirmed Resident 6 had minimal ROM loss at the left elbow which meant less than 25 percent loss and severe ROM loss at the left shoulder which meant greater than 50 percent loss. The DOR stated Resident 6's baseline ROM of the left shoulder and left elbow after surgery were not determined because the ROM limitations were not measured with a goniometer. The DOR stated that Resident 6's left shoulder and left elbow ROM impairments should have been measured using a goniometer because it was the first opportunity to record Resident 6's baseline ROM after receiving orthopedic clearance on 10/6/2025. The DOR stated JMA ROM loss indicators such as minimal and severe ROM loss were partially subjective (information, feelings, or opinions that arise from an individual's personal perspective rather than external, verifiable facts), included a wide range of variability (tendency of something to change or differ, not constant), did not indicate in which direction the joint was limited, and could not accurately detect subtle changes in ROM. The DOR stated lack of objective ROM measurements had the potential to negatively impact the staff's ability to detect changes such as improvements or declines in Resident 6's ROM. During an interview on 3/12/2026 at 11:29 am with the Director of Nursing (DON), the DON stated the facility monitored changes in ROM by staff report, observations during daily care, and JMAs done quarterly and annually by Rehab. The DON stated it was important for staff to objectively measure ROM during ROM evaluations to ensure the facility had an accurate assessment of a resident's joints since it affected their ability to effectively monitor changes and provide the appropriate services to address any declines. 2. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including a left humeral shaft fracture, muscle weakness, and polyneuropathy.During a review of Resident 6's H&P, dated 9/12/2025, the H&P indicated Resident 6 was transferred to the hospital for surgery of the left humerus after sustaining a fall at the facility. The H&P indicated Resident 6 had surgery for the left humerus on 9/9/2025 and was re-admitted to the facility on [DATE] for skilled care, PT, and OT.During a review of Resident 6's OT Evaluation and Plan of Treatment (OT Eval), dated 9/13/2025, the OT Eval indicated Resident 6's left arm ROM was impaired. The OT Eval indicated Resident 6 had minimal loss of motion in the left wrist and the left hand.During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 had moderate cognitive impairment. The MDS indicated Resident 6 required set up/clean up assistance for eating and oral hygiene and was dependent with toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 6 had functional limitations in ROM in one arm.During a concurrent interview and record review on 3/11/2026 at 10:14 am with the (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DOR, the DOR stated the facility monitored for changes in joint ROM by JMAs conducted by the Rehab upon admission and quarterly and by staff report. The DOR stated PTs and OTs used goniometers to measure joint mobility to objectively determine a resident's baseline ROM and detect changes in joint ROM. The DOR stated any limitations in joint ROM observed in an OT or PT evaluation should be measured with a goniometer and documented in the evaluation because it was an objective way of establishing a resident's ROM baseline and monitoring for changes in ROM. The DOR reviewed Resident 6's OT Eval, 9/13/2025, and confirmed Resident 6's ROM of left wrist and left hand were impaired and had minimal loss of motion. The DOR stated Resident 6's ROM of the left wrist and left hand should have been measured with a goniometer since they were impaired but were not. The DOR stated Resident 6's baseline ROM of the left wrist and left hand were not determined due to lack of objective measurements in the OT evaluation which in turn affected staff's ability to monitor and detect any changes in ROM.During an interview on 3/12/2026 at 11:29 am with the DON, the DON stated the facility monitored changes in ROM by staff report, observations during daily care, and JMAs done quarterly and annually by Rehab. The DON stated it was important for staff to objectively measure ROM during ROM evaluations to ensure the facility had an accurate assessment of a resident's joints since it affected their ability to effectively monitor changes and provide the appropriate services to address any declines. 3. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including a left humeral shaft fracture, muscle weakness, and polyneuropathy.During a review of Resident 6's H&P, 9/12/2025, the H&P indicated Resident 6 was transferred to the hospital for surgery of the left humerus after sustaining a fall at the facility. The H&P indicated Resident 6 had surgery for the left humerus on 9/9/2025 and was re-admitted to the facility on [DATE] for skilled care, PT, and OT.During a review of Resident 6's OT Evaluation and Plan of Treatment (OT Eval), dated 9/13/2025, the OT Eval indicated Resident 6's left shoulder and left elbow were not assessed due to Resident 6's left shoulder surgery.During a review of Resident 6's JMA, dated 9/13/2025, the JMA indicated Resident 6's left elbow and left shoulder were not tested due to Resident 6's left humerus surgery. During a review of Resident 6's Ortho Note, dated 10/6/2025, the Ortho Note indicated the visit was Resident 6's first orthopedic follow up appointment since surgery to the left arm on 9/9/2026. The Ortho Note indicated Resident 6 was NWB to the left arm and was able to participate in ROM exercises to the left shoulder and left elbow with PT and OT. During a review of Resident 6's Order Summary Report, the Order Summary Report indicated a physician's order, dated 10/9/2025, for RNA to provide PROM exercises to Resident 6's left arm to tolerable range on the left elbow and shoulder, five times a week. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 had moderate cognitive impairment. The MDS indicated Resident 6 required set up/clean up assistance for eating and oral hygiene and was dependent with toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 6 had functional limitations in ROM in one arm.During an observation of an RNA session on 3/10/2026 at 2:05 pm, Resident 6 was lying in bed with the head of bed elevated. Resident 6 repeatedly stated her left shoulder was broken but did not recall when. Restorative Nursing Assistant 2 (RNA 2) assisted with PROM exercises to Resident 6's left shoulder, elbow, wrist, and hand. RNA 2 fully bent and was unable to fully straighten Resident 6's left elbow. RNA 2 raised Resident 6's left arm upwards and to the side to less than shoulder height for 15 repetitions. Resident 6 reported pain to the left shoulder with PROM exercises. RNA 2 stated Resident 6's participation and tolerance to left shoulder ROM exercises varied daily due to pain. During a concurrent interview and record review on 3/11/2026 at 10:14 am with the DOR, the DOR stated the purpose of the RNA program was to maintain and improve a resident's functional level and ROM. The DOR stated PT and OT formally assessed residents prior to writing RNA orders to determine what type of exercises to prescribe and to ensure an RNA program was appropriate and safe based on the resident's needs. The DOR reviewed Resident 6's H&P, 9/12/2025, and confirmed Resident 6 had (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surgery for the left humerus on 9/9/2025 and was re-admitted back to the facility on 9/12/2025. The DOR reviewed Resident 6's OT Eval, dated 9/13/2025, and confirmed OT did not assess Resident 6's left shoulder and elbow due to surgery. The DOR reviewed Resident 6's JMA, dated 9/13/2025, and confirmed OT did not assess Resident's left elbow and shoulder due to surgery. The DOR reviewed Resident 6's Ortho Note, dated 10/6/2025, and confirmed orthopedics cleared Resident 6 to participate in ROM exercises to the left shoulder and left elbow. The DOR reviewed Resident 6's physician's orders and confirmed there was a physician's order, dated 10/9/2025, for RNA to provide PROM exercises to Resident 6's left arm to tolerable range on the left elbow and shoulder, five times a week. The DOR confirmed PT and/or OT did not assess Resident left's shoulder and elbow prior to establishing an RNA program for left shoulder and elbow PROM exercises but should have. The DOR stated PT and/or OT should have formally assessed Resident 6's left shoulder and elbow by requesting a formal evaluation or performing a JMA before ordering RNA for PROM exercises to the left shoulder and elbow, particularly because Resident 6 had surgery to the left humerus on 9/9/2025. The DOR stated if an RNA program was established prior to assessing a resident for appropriateness and needs, it could cause harm or injury to the residents and a decline in ROM. During an interview on 3/12/2026 at 11:29 am with the DON, the DON stated Rehab determined which residents were appropriate for an RNA program, the types of exercises RNA should perform with a resident, and the frequency of RNA services. The DON stated a licensed therapist must assess a resident prior to establishing an RNA program to ensure RNA services were appropriate and safe for the resident. The DON stated if an assessment was not done prior to establishing an RNA program, it could cause harm or injury to the residents. 4. During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including senile degeneration of the brain (progressive decline in cognitive function), dementia (decline in mental ability severe enough to interfere with daily life), and peripheral vascular disease (reduced circulation of blood to a body part due to a narrowed or blocked blood vessel).During a review of Resident 8's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/8/2025 for RNA to provide PROM exercises to Resident 8's both legs, five times a week. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 had severe cognitive impairment for daily decision making. The MDS indicated Resident 8 was dependent with eating, oral hygiene, toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 8 had functional limitations in ROM in both legs.During an observation and interview of Resident 8's RNA session on 3/10/2026 at 10:24 am in Resident 8's room, Resident 8 was lying in bed. Resident 8's both legs were bent at the hips and knees and rotated to the right side of the bed. RNA 1 stated Resident 8's both legs were contracted and very stiff. After assisting with PROM to Resident 8's both arms, RNA 1 stood on the left side of the bed and assisted with PROM exercises to Resident 8's right knee. RNA 1 did not assist with PROM exercises to Resident 8's right hip and right ankle. RNA 1 moved to the right side of the bed and attempted to assist Resident 8 with PROM exercises to Resident 8's left knee but stopped after one repetition. RNA 1 stated she stopped assisting with left knee PROM exercises because the left knee felt very stiff and was scared to cause pain or injury. RNA 1 did not attempt PROM exercises to Resident 8's left hip and left ankle.During an interview on 3/10/2026 at 10:42 am with RNA 1, RNA 1 confirmed Resident 8 had RNA orders for PROM exercises to Resident 8's both legs which meant assisting Resident 8 with ROM exercises to the entire leg, including the hips, knees, and ankles. RNA 1 confirmed she did not assist with ROM exercises to Resident 8's both hips and both knees as ordered because she forgot. RNA 1 stated Resident 8 required encouragement and assistance with ROM exercises to both legs because Resident 8's joints were very stiff and contracted. RNA 1 stated she should have assisted Resident 8 with both hip and both ankle ROM exercises as ordered but did not. RNA 1 stated Resident 8 could have a decline in ROM if RNA exercises were not provided as ordered.During an interview on 3/10/2026 at 11:15 am with the DOR, the DOR stated the purpose of (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the RNA program was to maintain and improve a resident's functional level and ROM. The DOR stated Rehab determined the types of exercises RNAs were to perform when creating an RNA program. The DOR stated if an RNA order was written for ROM exercises to both legs, it was expected the RNA provide ROM to the entire leg, which included the hips, knees, and ankles. The DOR stated if RNA did not provide RNA services as ordered, it could potentially result in a decline in ROM and ADLs.During an interview on 3/12/2026 at 11:29 pm with the DON, the DON stated it was important for RNA to provide exercises as ordered to ensure the residents in the facility maintained their level of function and to prevent potential declines in mobility, ADLs, and contracture development.5. During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including senile degeneration of the brain, dementia, and peripheral vascular disease.During a review of Resident 8's PT Evaluation and Plan of Treatment (PT Eval), dated 12/12/2025, the PT Eval indicated Resident 8's ROM in both knees were impaired.During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 had severe cognitive impairment for daily decision making. The MDS indicated Resident 8 was dependent with eating, oral hygiene, toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 8 had functional limitations in ROM in both legs.During a concurrent interview and record review on 3/11/2026 at 10:14 am with the DOR, the DOR stated the facility monitored for changes in joint ROM by JMAs conducted by the Rehab upon admission and quarterly and by staff report. The DOR stated PTs and OTs used goniometers to measure joint mobility to objectively determine a resident's baseline ROM and detect changes in joint ROM. The DOR stated any limitations in joint ROM observed in an OT or PT evaluation should be measured with a goniometer and documented in the evaluation because it was an objective way of establishing a resident's ROM baseline and monitoring for changes in ROM. The DOR reviewed Resident 8's PT Eval, 12/12/2025, and confirmed Resident 8's ROM of both knees were impaired. The DOR stated Resident 8's ROM of both knees should have been measured with a goniometer since they were impaired but were not. The DOR stated Resident 8's baseline ROM of both knees were not determined due to lack of objective measurements in the PT evaluation which in turn affected staff's ability to monitor and detect any changes in ROM.During an interview on 3/12/2026 at 11:29 am with the DON, the DON stated the facility monitored changes in ROM by staff report, observations during daily care, and JMAs done quarterly and annually by Rehab. The DON stated it was important for staff to objectively measure ROM during ROM evaluations to ensure the facility had an accurate assessment of a resident's joints since it affected their ability to effectively monitor changes and provide the appropriate services to address any declines. During a review of the facility's job description titled, Restorative Care Nurse, revised 10/2020, the job description indicated one of the duties and responsibilities of the Restorative Care Nurse was to assist residents with OT and PT exercises as directed. During a review of the facility's P/P titled Specialized Rehabilitative Services, revised 12/2009, the P/P indicated a licensed professional can either discontinue treatment or initiate a maintenance program which either nursing or restorative aides would implement to assure the resident maintained his or her functional and physical status once a resident has met his or her care plan goals. During a review of the facility's Policy and Procedure (P/P) titled Resident Mobility and ROM, revised 7/2017, the P/P indicated resident would not experience an avoidable reduction in ROM and residents with limited ROM would receive treatment and services to increase and/or prevent a further decrease in ROM. The P/P indicated documentation of the resident's progress toward the goals and objectives will include attempts to address any changes or decline in the resident's condition or needs.During a review of the facility's P/P titled Rehab Screening and JMAs, revised 5/2025, the P/P indicated the purpose of the Rehab Screening and JMAs were to identify residents with functional changes and/or changes in ROM and allow those residents to receive therapy services if declines or improvements were present and skilled services were required.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident receiving hemodialysis ([HD]a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) resident's (Resident 11) blood pressure was not taken in the left upper extremity where Resident 11's arteriovenous (AV) shunt (a direct connection between an artery and a vein, bypassing the capillary network, which can be natural or surgically created for medical access) was located.These deficient practices had the potential to result in clotting (process that prevents excessive bleeding when a blood vessel is injured), damage, or inaccurate high readings.Findings:During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD -irreversible kidney failure) and dependence on renal dialysis.During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 2/19/2026, the MDS indicated Resident 11's cognition (ability to think) was intact. The MDS indicated Resident 11 needed set up assistance when eating, oral hygiene and substantial assistance (helper does more than half the effort) with toileting hygiene.During a review of Resident 11's Order Detail, the order indicated, starting 11/10/2025, no blood pressure on left upper extremity with AV shunt.During a concurrent observation and interview on 3/10/2026 at 2 p.m., with Licensed Vocational Nurse (LVN) 1, at Resident 11's bedside, there was no signage indicating not measure Resident 11's blood pressure on Resident 11's Left upper extremity. LVN 1 stated Resident 11 did not have signage at the bedside indicating not to take Resident 11's BP on the left upper extremity. During a concurrent interview and record review on 3/10/2026 at 2 p.m. with LVN 1, Resident 11's blood pressure readings, 2/1/2026 to 3/9/2026, were reviewed and LVN 1 confirmed and stated Resident 11's blood pressure was taken on the left upper arm on several occasions. LVN 1 stated Resident 11's blood pressure should not be measured on the left upper arm because it can cause a clot. During an interview on 3/12/2026 at 7:48 a.m., with the Director of Nursing (DON), the DON stated blood pressure should not be taken from the arm with the AV shunt because it can cause a clot. During a review of the facility's policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with revised 9/2010, the P&P indicated Residents with ESRD will be cared for according to currently recognized standards of care and standards. The P&P indicated not to use access arm to take blood pressure.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medically related social services (professional interventions provided by social workers to help residents manage the emotional, social, and financial impacts of illness) for two of six sampled residents (Resident 27 and Resident 49) as evidence by:A. Failing to ensure Resident 27 was seen by an ophthalmologist (a medical doctor specializing in eye and vision care, qualified to perform complex surgeries and treat severe eye diseases) as requested.B. Failing to ensure Resident 49 did not miss a Nerve Conduction Study (NCS-a test that measures how fast an electrical impulse moves through the nerve) and Electromyography (EMG- measures muscle electrical activity to identify nerve or muscle damage) procedure on [DATE].This failure had the potential to result in delay in the delivery of care and services.Findings:A. During a review of Resident 27's admission record, the admission record indicated Resident 27 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and blindness on left eye.During a review of Resident 27's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 27 had the capacity (ability) to understand and make decisions.During a review of Resident 27's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 27 required moderate assistance (Helper does less than half the effort) from one staff for toilet hygiene, dressing, transfer, maximal assistance (Helper does more than half the effort) from one staff for shower, personal hygiene, bed mobility, transfer, toilet hygiene, dressing, and eating.During an interview on [DATE], at 10:25 a.m., with Resident 27 in her room, Resident 27 stated, she was blind in her left eye and worried about her right eye vision. Resident 27 stated, she was admitted to the facility on 1/2026, but no one helped her to be seen by an ophthalmologist Resident 27 stated, she was very worried about her right eye, because her the facility staff from her previous did not really help her to see an ophthalmologist and she ended up losing her vision on left eye.During a concurrent interview and record review on [DATE], at 10:12 a.m., with Registered Nurse Supervisor (RNS) 1, Resident 27's Progress Notes (PN), dated from 1/2026 to 3/2026 were reviewed. The PN indicated, there was no documentation regarding Resident 27 being seen by an ophthalmologist. RNS 1 stated, she was not aware of Resident 27's concern and agreed that Resident 27 should be seen by a specialist since she had DM and poor control of blood sugar levels that could lead to blindness. RNS 1 stated, the staff should have communicated with the Social Service Director (SSD) to arrange the appointment for Resident 27.During an interview on [DATE], at 11:40 a.m., with the Social Services Director (SSD), the SSD stated, she was not aware of Resident 27's concern regarding her vision. The SSD stated, she could not recall that Resident 27 expressed her concern during her room visits and assessments. The SSD stated, she would arrange the ophthalmologist appointment if she knew about her current concerns and conditions. The SSD stated, it was important to accommodate Resident 27's concern to preserve her right eye vision with specialty care.During a review of Resident 27's Care Plan Report (CPR) titled, Resident 27 has impaired (damaged) visual function related to blindness on left eye, revised on [DATE], the CPR Goal indicated, Resident 27 would show no decline in visual function through review date of [DATE]. The CPR Interventions indicated, arrange consultation with eye care practitioners as required.During a review of Resident 27's Order Summary Report (OSR), dated [DATE], the OSR indicated, annual eye exam with follow up as needed ordered on [DATE].B. During a review of Resident 49's admission record, the admission record indicated Resident 49 was initially admitted to the facility on [DATE] and last readmission was on [DATE] with diagnoses including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury) and generalized muscle weakness.During a review of Resident 49's H&P, dated [DATE], the (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H&P indicated, Resident 49 had the capacity to understand and make decisions.During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49 required dependent assistance (Helper does all of the effort) from two or more staff for transfer, shower, toilet hygiene, lower body dressing, and maximal assistance (Helper does more than half the effort) from one staff for upper body dressing, personal hygiene, bed mobility, eating.During an interview on [DATE], at 11:31 a.m., with Resident 49 in her room, Resident 49 stated, she missed important appointments on [DATE] because the nursing staff did not prepare the required documentation for her appointments. Resident 49 stated, no one rescheduled the appointments for her.During a concurrent interview and record review on [DATE], at 10:17 a.m., with RNS 1, Resident 49's Progress Notes (PN), dated [DATE] was reviewed. The PN indicated, Resident 49 refused to go for the NCS and EMG procedures on [DATE]. The PN did not indicate a reason for refusal by Resident 49 and did not indicate a information about rescheduling the appointments for Resident 49. RNS 1 stated, the staff should have notified the Primary Care Physician (PCP) and followed up with the reason for refusal and rescheduled. RNS 1 stated, Resident 49 had generalized muscle weakness and quadriplegia. RNS 1 stated, NCS and EMG procedures were important to evaluate Resident 49's current status.During a concurrent interview and record review on [DATE], 11:50 a.m., with the SSD, Resident 49's Order Summary Report (OSR), dated [DATE] was reviewed. The OSR indicated, Nerve Conduction Study/EMG Procedure on [DATE] with appointment time at 10:30 a.m. was ordered on [DATE]. The SSD stated, she did not know Resident 49 refused to go. The SSD stated, it was important to find out the reason Resident 49 refused to go to the appointments, and encourage Resident 49 to go to specialty appointment because it would be more difficult to reschedule the appointment and Resident 49 missed an opportunity to get treatment.During an interview on [DATE], at 12:57 p.m., with the DON, the DON stated, the SSD should be proactive with assisting the residents. The DON stated it was SSD's responsibility to assist residents with all aspects of their lives. The DON stated, it was important to ensure specialty consult appointments were made in timely manner and the staff should have assisted the residents to go to appointments without any difficulty. The DON stated, the staff should have identified the residents' needs and arranged necessary services.During a review of the facility's Policy and Procedure (P&P) titled, Ancillary Services, revised 12/2016, the P&P indicated, Policy: Routine and emergency ancillary services such as dental, eye, podiatry, psychiatry, psychology, optometry, ophthalmology and other services are available to meet the residents' health needs in accordance with the resident's assessment and plan of care. Policy Interpretation and Implementation: 6. Social services or designee will assist residents with appointments, referrals, transportation arrangemen1s, and for reimbursement of services under the state plan, if eligible. 7. order/s for ancillary services will be relayed to the provider by social services or designee.During a review of the facility's P&P titled, Referrals, Social Services, revised 2001, the P&P indicated, Policy Statement: Social services personnel shall coordinate most resident referrals with outside agencies. Policy Interpretation and Implementation:1. Social services shall coordinate most resident referrals. Exceptions might include emergency or specialized services that are arranged directly by a physician or the nursing staff . 3. Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician. 4. Social services will document the referral in the resident's medical record . 6.Social services will help arrange transportation to outside agencies, clinic appointments, etc., as appropriate.During a review of the facility's P&P titled, Job Description: Social Worker, revised 10/2020, the P&P indicated, Duties and Responsibilities: Assist in obtaining resources from community social, health and welfare agencies to meet the needs of the resident. Ensure that each resident receives necessary care and services to obtain and maintain the highest practical physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records for two of five sampled residents (Residents 6 and 8) were accurately documented and readily accessible: 1.For Resident 6, the facility failed to:a.Ensure Resident 6's orthopedic (specialty area in medicine referring to the management of the muscles, bones, and their connective structures) consultation note was in the medical record and readily accessible.b.Ensure the physician's order, dated 12/10/2025, reflecting Resident 6's left arm weightbearing restriction (guidance from a physician limiting the amount of weight a person can put through a specific arm or leg after surgery) was changed from non-weight bearing (NWB, restriction in which a person is not allowed to put any weight through the operated body part) to weightbearing as tolerated (WBAT, a person is medically cleared to place as much weight through the affected arm or leg to the point of comfort or tolerance) as ordered by the consulting orthopedic physician on 11/3/2025 to accurately reflect Resident 6's current weightbearing status. 2.For Resident 8, the facility failed to ensure Resident 8's right-hand splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) assessment was in the medical record and readily accessible. These deficient practices had the potential to delay and negatively affect the delivery of necessary care and services.CROSS-REFERENCE TO F684 Findings: 1. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including a left humeral shaft fracture (break in the long bone of the upper arm), muscle weakness, and polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain). During a review of Resident 6's History and Physical (H&P) Note, dated 9/12/2025, the H&P indicated Resident 6 was transferred to the hospital for surgery of the left humerus after sustaining a fall at the facility. The H&P indicated Resident 6 had surgery for the left humerus on 9/9/2025 and was re-admitted to the facility on [DATE] for skilled care (high level medical or rehabilitative care provided by licensed professionals), Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities).During a review of Resident 6's OT Evaluation and Plan of Treatment (OT Eval), dated 9/13/2025, the OT Eval indicated Resident 6's left arm ROM was impaired at the wrist and the hand, and the left shoulder and elbow ROM were not assessed due to Resident 6's left humerus surgery.During a review of Resident 6's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated Resident 6 was discharged from OT services per physician or Case Manager.During a review of Resident 6's Orthopedic Consultation Progress Note (Ortho Note), dated 10/6/2025, the Ortho Note indicated the visit was Resident 6's first orthopedic follow up appointment since surgery to the left arm on 9/9/2026. The Ortho Note indicated Resident 6 was NWB to the left arm and was able to participate in ROM exercises to the left shoulder and left elbow with PT and OT. The Ortho Note indicated Resident 6 was to follow up with orthopedics in four weeks. During a review of Resident 6's Order Summary Report, the Order Summary Report indicated a physician's order, dated 10/6/2025, for Resident 6 to follow up with orthopedics on 11/3/2025 at 9:45 am.During a review of Resident 6's Ortho Note, dated 11/3/2025, the Ortho Note indicated Resident 6 presented to the orthopedic appointment three months after undergoing surgery of the left humerus. The Ortho Note indicated Resident 6's left arm was WBAT. The Ortho Note indicated Resident 6 could participate in ROM and strengthening exercises to the left shoulder, elbow, wrist, and fingers and instructed Resident 6 to follow up with orthopedics through her Health Maintenance Organization (HMO, type of insurance plan that limits coverage to doctors and facilities within a specific network).During a review of Resident 6's Order Summary Report, the Order Summary Report indicated (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a physician's order, dated 12/10/2025, for Resident 6's left arm to be NWB.During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 1/26/2026, the MDS indicated Resident 6 had moderate cognitive (mental action or process of acquiring knowledge and understanding) impairment. The MDS indicated Resident 6 required set up/clean up assistance (helper sets up or clean up) for eating and oral hygiene and was dependent (helper does all the effort) with toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 6 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm.During an observation and interview on 3/9/2026 at 10:24 am with Resident 6 in Resident 6's room, Resident 6 was lying in bed with the left elbow bent and the left wrist and hand resting on her stomach. Resident 6 stated her left shoulder was broken but did not recall when. Resident 6 reached across the body with the right arm, grabbed her left arm, and used the right arm to assist raising the left arm to less than shoulder height. Resident 6 bent the left elbow upwards towards the body but could not fully straighten the arm. Resident 6 was unable to lift the left wrist upwards or close the fingers of the hand into a fist.During a concurrent interview and record review on 3/10/2026 at 2:50 pm with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated a licensed nurse was responsible for accepting a resident's paperwork and implementing new physician orders and recommendations when a resident returned to the facility from a consultation appointment. LVN 1 stated if follow up appointments were recommended by the consulting physician, the licensed nurse or the Assistant Director of Nursing (ADON) scheduled the follow up appointment based on the physician recommendations, updated the physician orders, and placed all consultation notes in the EMR. LVN 1 reviewed Resident 6's physician's orders and Ortho Note, dated 10/6/2025, and confirmed Resident 6 was supposed to follow up with Orthopedics on 11/3/2025 per physician's orders, dated 10/6/2025, but was unable to confirm if Resident 6 went to the scheduled orthopedic appointment because she could not locate the Ortho Note, dated 11/3/2025. LVN 1 stated Resident 6's Ortho Notes were supposed to be in the resident's electronic medical record (EMR) but were not. LVN 1 stated she was unsure if orthopedics made any additional recommendations for follow up or updated Resident 6's left arm restrictions because she could not locate the Ortho Note. LVN 1 stated it was important that consultation notes were readily accessible and scanned into the EMR to ensure staff were aware of any recommendations, instructions, follow-up appointments, and changes to the plan of care. During a concurrent interview and record review on 3/10/2026 at 3:09 pm with the ADON, the ADON stated a licensed nurse was responsible for accepting a resident's paperwork and implementing new physician orders and recommendations when a resident returned to the facility from a consultation appointment. The ADON stated if follow up appointments were recommended by the consulting physician, the licensed nurse scheduled the follow up appointment based on the physician recommendations, contacted the Transportation Coordinator to arrange transportation for the scheduled appointment, and placed all consultation notes in the EMR. The ADON reviewed Resident 6's clinical record and confirmed Resident 6 had a follow-up orthopedic appointment scheduled for 11/3/2025 but did not know if Resident 6 went to the appointment because she could not find the Ortho Note, dated 11/3/2025. The ADON stated Resident 6's Ortho Note, dated 11/3/2025, should be scanned into the EMR but was not.During a follow up interview on 3/11/2026 at 9:45 am, the ADON stated she looked extensively for Resident 6's Ortho Note, dated 11/3/2025, but was unable to locate it. The ADON stated she called Resident 6's orthopedic clinic and asked the clinic to fax Resident 6's Ortho Note, dated 11/3/2025, to the facility because the facility was unable to locate it. The ADON reviewed Resident 6's Ortho Note, dated 11/3/2025, and confirmed the Ortho Note indicated Resident 6's left arm weightbearing status was changed from NWB to WBAT. The ADON confirmed the Ortho Note, dated 11/3/2025, recommended Resident 6 begin ROM and strengthening exercises for the left arm, and instructed Resident 6 to follow up with orthopedics through her HMO. The ADON reviewed Resident 6's physician's orders and Ortho Notes, dated 10/6/2025 and 11/6/2025, and confirmed (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 6's physician order, dated 12/20/2025, which indicated Resident 6's left arm was NWB was inaccurate as the Ortho Note, dated 11/3/2025, indicated Resident 6's left arm weightbearing status was upgraded to WBAT. The ADON stated Resident 6's left arm weightbearing status was likely not changed on the physician's order because the Ortho Note, dated 11/3/2026, was missing and staff was unaware of the change and recommendations. The ADON stated the case manager typically followed up with scheduling follow up appointments for residents with HMO and was unsure if a follow up ortho appointment was scheduled as recommended by the physician since the Ortho Note was missing. The ADON stated it was important that consultation notes were readily accessible and in the resident's EMR to ensure the facility provided the appropriate care and services and followed up with any recommendations and orders given by the consulting physician. The ADON stated it was important to accurately document Resident 6's weightbearing status to prevent unnecessary restrictions and allow Resident 6 to progress in strength and ROM which improved ADLs and reduced the risk of decline. During a concurrent interview and record review on 3/11/2026 at 9:59 am with the Case Manager (CM), the CM stated she was responsible for obtaining insurance authorization (health insurance requirement where providers must obtain approval from the insurance plan before a specific treatment, medication, or service is covered) and scheduling follow up appointments for residents with HMOs. The CM stated that once staff, typically a licensed nurse, became aware of a recommendation for follow up consultation appointments, she was either given the resident's consultation note or notified directly by staff of the resident's follow up instructions and recommendations. The CM stated once she was notified or given the resident's consultation note, she contacted the resident's HMO immediately and/or within the week to verify authorization and schedule the appointment. The CM reviewed Resident 6's Ortho Note, dated 11/3/2025, and confirmed she never received the Ortho Note and was not notified by staff of any recommendations for Resident 6 to follow up with orthopedics through her HMO. The CM stated the Ortho Note, dated 11/3/2026, was required to schedule Resident 6's appointment and should have been in the EMR but was not. The CM stated the follow up appointment should have been scheduled immediately or generally within a week of receipt of Resident 6's orthopedic consultation follow up instructions and recommendations but was not because she was never notified by staff and the Ortho Note was not in the EMR. The CM stated inaccessible consultation notes could result in missed follow up appointments and instructions, delay in care, and ADL decline.During a concurrent interview and record review on 3/11/2026 at 10:14 am with the Director of Rehabilitation, the DOR reviewed Resident 6's therapy notes and confirmed Resident 6 was evaluated by OT on 9/11/2025 and discharged from OT services on 9/27/2025 due to lack of insurance coverage for skilled services. The DOR stated Resident 6 no longer required skilled therapy services (services that require specialized training and experience of a licensed therapist or therapy assistant) at the time she was discharged from OT services because Resident 6 had reached her highest level of functioning due to the NWB and ROM restrictions to the left arm. The DOR stated staff typically informed the Rehabilitation Department (Rehab) if a resident's weightbearing or activity restrictions changed after a resident returned from a follow up orthopedic appointment and updated the physician's order to reflect the resident's current weightbearing status. The DOR stated if any changes in a resident's weightbearing status occurred, Rehab would re-assess the resident and/or modify the plan of care. The DOR reviewed Resident 6's physician's orders and Ortho Notes, dated 10/6/2025 and 11/3/2025, and confirmed Resident 6's physician order, dated 12/20/2025, which indicated Resident 6's left arm was NWB was inaccurate as the Ortho Note, dated 11/3/2025, indicated Resident 6's left arm weightbearing status was upgraded to WBAT. The DOR stated Resident 6's left arm weightbearing status was likely not changed on the physician's order because the Ortho Note, dated 11/3/2025, was missing and staff were unaware of the change and recommendations. The DOR stated staff must accurately document a resident's weightbearing status in the physician's orders and keep consultation notes readily accessible to ensure staff were aware of any changes to a resident's care plan, including weightbearing and activity restrictions, which (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	directly affected the resident's progress in therapy and ability to perform ADLs.During an interview on 3/12/2026 at 11:29 am with the Director of Nursing (DON), the DON stated consultation notes should always be in the EMR and readily accessible. The DON stated inaccessible consultation notes could result in missed appointments and a delay in necessary care and services. The DON stated inaccurate documentation of a resident's weightbearing status could result in lack of progression and/or decline in a resident's level of function. 2. During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including senile degeneration of the brain (progressive decline in cognitive function), dementia (decline in mental ability severe enough to interfere with daily life), and peripheral vascular disease (reduced circulation of blood to a body part due to a narrowed or blocked blood vessel).During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 had severe cognitive impairment for daily decision making. The MDS indicated Resident 8 was dependent with eating, oral hygiene, toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 8 had functional limitations in ROM in both legs.During a review of Resident 8's Rehab Screen/Recommendations (Rehab Screen), dated 12/8/2025, the Rehab Screen indicated the DOR referred Resident 8 to OT to assess Resident 8's right hand.During a review of Resident 8's Order Summary Report, the Order Summary Report indicated a physician's order, dated 2/25/2026 for RNA to apply a hand roll to Resident 8's right hand for four hours, every day, seven times a week or as tolerated to prevent a decline in ROM and skin integrity. During an observation on 3/10/2026 at 10:24 am of Resident 8's Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) session in Resident 8's room, Resident 8 was laying in bed. RNA 1 assisted with passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 8's both arms and both legs. At the end of the session, RNA 1 applied a splint to Resident 8's right hand.During a concurrent record review and interview on 3/11/2026 at 2:11 pm with the Director of Rehabilitation (DOR), the DOR stated the purpose of splints was to improve or maintain a resident's ROM and prevent contractures. The DOR stated a licensed PT or OT must assess a resident's need for splints if indicated. The DOR stated the licensed therapist must determine the splint wear tolerance and schedule by periodically assessing the splint for safety, comfort or need for modification. The DOR stated that after the therapist assessed a resident for the correct type of splint and established the wear tolerance, the therapist transitioned the splinting plan of care to nursing, specifically the RNA program and documented the assessments, precautions, and wear time (length of time and frequency a person can tolerate wearing the splint for safety, comfort, and maximal benefits) in the EMR. The DOR reviewed Resident 8's physician's orders and confirmed Resident 8 had an RNA order to apply a hand roll to Resident 8's right hand for four hours, seven days a week. The DOR stated a hand roll was considered a splint and required a formal assessment by a licensed therapist to determine the appropriate fit and wear time. The DOR stated splinting assessments should always be documented in the therapy evaluation and/or a progress note and filed in a binder titled Rehab Screenings in the therapy gym. The DOR reviewed Resident 8's clinical record, therapy notes, and the Rehab Screening binder in the therapy gym and could not find Resident 8's therapy assessment for the right-hand splint. During a concurrent interview and record review on 3/11/2026 at 3:41 pm with the DOR and Occupational Therapist 1 (OT 1), OT 1 stated she assessed and issued Resident 8 a right splint but could not recall when.During a concurrent interview and record review on 3/11/2026 at 3:41 pm with the DOR and Occupational Therapist 1 (OT 1), OT 1 stated she assessed and issued Resident 8 a right splint after the DOR referred Resident 8 to OT for a splint evaluation but could not recall when. OT 1 stated she recalled initially trialing Resident 8's right hand with a rolled-up towel and eventually progressed Resident 8 to a right-hand splint as his tolerance for the splint and ROM improved. OT 1 stated all splint assessments should either be in the therapy evaluation or notes, in the Rehab Screening binder, or in her personal binder. OT 1 reviewed (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 8's clinical record, therapy notes, Rehab Screening binder, and her personal binder and could not find Resident 8's assessment for the right-hand splint. The DOR and OT 1 stated it was important splint assessments were readily accessible to ensure staff were aware of treatments provided and any recommendations and/or precautions indicated. OT 1 stated she recalled initially trialing Resident 8's right hand with a rolled up towel and eventually progressed Resident 8 to a right-hand splint as his tolerance for the splint and ROM improved. OT 1 stated all splint assessments should either be in the therapy evaluation or notes, in the Rehab Screening binder, or in her personal binder. OT 1 reviewed Resident 8's clinical record, therapy notes, Rehab Screening binder, and her personal binder and could not find Resident 8's assessment for the right-hand splint. The DOR and OT 1 stated it was important splint assessments were readily accessible to ensure staff were aware of treatments provided and any recommendations and/or precautions indicated.During an interview on 3/12/2026 at 11:29 am with the DON, the DON stated all assessments and services provided should be readily accessible and in the EMR. The DON stated it was important for splint assessments to be readily accessible to ensure staff can clearly identify which type of splint was provided to the residents and be aware of any special instructions or safety precautions associated with its use.During a review of the facility's Policy and Procedure (P/P) titled Charting and Documentation, revised 2001, the P/P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The P/P indicated the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P/P indicated documented in the medical record would be objective, complete, and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement infection control policies and procedure (P&P) when:The facility failed to provide documented evidence of all employees, including physicians, Annual Influenza ([Flu] highly contagious respiratory infection) vaccine (medications used to prevent diseases usually given by injection or by mouth) status and the provision of education on benefits and potential side effects and offering of the 2025 to 2026 flu vaccine. The facility failed to ensure one of two residents' (Resident 39) foley catheter drainage bag (collects urine drained from the bladder via a tube) was kept off the floor. These failures had the potential to result in staff and residents contracting infectious diseases which can cause serious illness, hospitalization, and death. Findings: a. During a concurrent interview and record review on 3/11/2026 at 9:15 a.m., with Infection Prevention Nurse (IPN 1), the facility's Staff Vaccination Status, updated 3/5/2026, was reviewed. IPN 1 stated there was no documented evidence for physician or licensed practitioners' education on benefits and side effects was provided and the offering of 2025 to 2026 flu vaccine. IPN 1 stated the roster did not include physicians and it should include everyone that has direct access to the residents. During an interview on 3/12/2026 at 7:48 a.m. with the Director of Nursing (DON), the DON stated staff need to be educated and offered the current annual flu vaccine because its mandated. During a review of the facility's policy and procedure (P&P) titled, Influenza Vaccine, revised 5/29/2025, the P&P indicated all healthcare Providers (HCP) will be provided with information regarding the requirement to receive the flu vaccine and IP will document the status of Flu vaccination of all HCP. b.During a review of Resident 39's admission Record, the admission Record indicated the facility admitted Resident 1 on 8/30/2024, and readmitted on [DATE] with diagnoses including neuromuscular dysfunction of bladder (or neurogenic bladder happens when damaged nerves stop the brain and bladder from talking, causing trouble holding or releasing urine), gastro esophageal reflux disease (GERD-a chronic condition where stomach acid frequently flows back up into the tube connecting your mouth to your stomach), and fusion of spine (a surgery that joins two or more backbones together so they grow into one solid bone). During a review of Resident 39's History and Physical (H&P), dated 5/15/2025, the H&P indicated Resident 39 had the capacity (ability) to understand and make decisions. During a review of Resident 39's Minimum Data Set (MDS- a resident assessment tool), dated 6/12/2025, the MDS indicated Resident 39's cognitive (functions your brain uses to think, pay attention, process information, and remember things) was intact. The MDS indicated Resident 39 required setup assistance with eating, oral hygiene, moderate assistance with personal hygiene, maximal assistance with toileting hygiene, showering, and dressings. During a review of Resident 39's Order Summary Report, orders as of 3/9/2026, the Order Summary Report indicated a physician order, effective 6/12/2025, for placement of an 18 French (size indicates how thick the tube is) foley catheter to drainage bag for non-patency as needed one time a day related to neuromuscular dysfunction of bladder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/09/2026 at 8:55 a.m., with Resident 39 in the resident's room, the resident's foley catheter drainage bag was observed touching the floor. The resident stated she had been experiencing burning and cramping sensations in her abdominal area for the previous couple of days. Resident 39 stated a staff collected a specimen the day prior and she was waiting for the results. During a concurrent observation and interview on 3/9/2026 at 9:15 a.m., in Resident 39's room with Licensed Vocational Nurse (LVN) 4, LVN 4 stated Resident 39's foley catheter drainage bag was touching the floor. LVN 4 stated this placed Resident 39 at a higher risk for a urinary tract infection ([UTI] a bacterial infection in the body's pee system, causing burning, frequent urges to pee, and pain). LVN 4 stated the drainage bag should always be kept off the floor to maintain infection control standards. During an interview on 3/12/2026 at 9:59 a.m., with the Director of Nursing (DON), the DON stated the foley catheter drainage bag should always be maintained off the floor to ensure infection control. During a review of the facility's policy and procedure (P&P), titled Catheter Care, Urinary, undated, the P&P indicated staff must Be sure the catheter tubing and drainage bag are kept off the floor for Infection control.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of five sampled resident's (Resident 81) influenza ([flu] highly contagious respiratory infection) and pneumococcal (bacterial infection) vaccine (medications used to prevent diseases usually given by injection or by mouth) was administered timely after Resident 81 consented to receive the vaccines. This deficient practice resulted in a delay of services and placed the residents at risk of contracting influenza or pneumococcal disease.Findings:During a review of Resident 81's admission Record, the admission Record indicated Resident 81 was admitted to the facility on [DATE] with diagnosis including acute respiratory failure (lungs cannot release enough oxygen [vital gases for life] into your blood), dependence on supplemental oxygen, acute pulmonary edema (life-threatening buildup of fluid in lungs), and chronic kidney disease (progressive damage and loss of kidney function).During a review of Resident 81's Minimum Data Set ([MDS] a resident assessment tool), dated 1/16/2026, the MDS indicated Resident 81 cognition was intact.During a review of Resident 81's Consent/Declination for Influenza vaccine and pneumococcal vaccine, the consents indicated Resident 81 consented to vaccinations on 10/15/2025.During a concurrent interview and record review on 3/11/2026 at 9:09 a.m., with the Infection Prevention Nurse (IPN) 1, Resident 's 81's Immunization records and consents were reviewed. IPN 1 stated Resident 81's vaccinations were administered on 3/5/2026 and Resident 81 consented to receive the vaccines on 10/15/2025. IPN 1 stated the vaccinations should not have been administered five months later.During an interview on 3/12/2026 at 7:48 a.m. with the Director of Nursing (DON), the DON stated vaccines should be administered within 90 days once resident consents to the vaccination.During a review of the facility's Policy and Procedure (P&P) titled, Vaccination of Residents, revised 12/20/2024, the P&P indicated if the resident is unvaccinated and needs additional vaccine doses the required or recommended vaccine will be administered within ninety days when consented.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement infection prevention policies and procedures (evidence-based practices designed to prevent the spread of infections in healthcare settings, primarily following CDC guidelines) for one of one resident (Resident 81) when the facility failed to:1. Ensure Resident 81 Covid-19 (infectious disease resulting in mild to moderate respiratory illness) vaccine (medications used to prevent diseases usually given by injection or by mouth) was administered within 90 days after Resident 81 agreed to receive it. This failure had the potential to result in staff and residents contracting COVID-19 which can cause serious illness, hospitalization, and death.Findings: During a review of Resident 81's admission Record, the admission Record indicated Resident 81 was admitted to the facility on [DATE] with diagnosis including acute respiratory failure (lungs cannot release enough oxygen [vital gases for life] into your blood), dependence on supplemental oxygen, acute pulmonary edema (life-threatening buildup of fluid in lungs), and chronic kidney disease (progressive damage and loss of kidney function).During a review of Resident 81's Minimum Data Set ([MDS] a resident assessment tool), dated 1/16/2026, the MDS indicated Resident 81 cognition was intact.During a review of Resident 81's Covid-19 Vaccine Information and Declination Form, the form indicated Resident 81 consented to vaccination on 10/15/2025.During a concurrent interview and record review on 3/11/2026 at 9:09 a.m., with Infection Prevention Nurse (IPN) 1, Resident 's 81's Immunization records and consents were reviewed. IPN 1 stated Resident 81's vaccination was administered on 3/6/2026 and Resident 81 consented to receive the vaccine on 10/15/2025. IPN 1 stated the vaccination should not have been administered 5 months later.During a review of the facility's Policy and Procedure (P&P) titled, Vaccination of Residents, revised 12/20/2024, the P&P indicated if the resident is unvaccinated and needs additional vaccine doses the required or recommended vaccine will be administered within ninety days when consented.

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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** Based on interview and record review, the facility failed to ensure Resident 28 had an Interdisciplinary Team (IDT-group of healthcare professionals) meeting after a change of condition (COC) was identified for increasing delusions (holding a firm, false belief that is not based on reality) and paranoia (unfounded mistrust of others). This failure led to resident feeling ignored and distressed and violates his right to participate in person-centered care.Findings: During a review of Resident 28's Face Sheet, the Face Sheet indicated, Resident 28 was admitted on [DATE] with diagnoses of type 2 diabetes mellitus with hyperglycemia (chronic metabolic disease where the body cannot properly manage blood sugar levels), legal blindness (vision loss), unspecified glaucoma (eye disease that leads to blindness, if untreated), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and unspecified psychosis (a mental health condition where a person loses touch with reality, causing difficulty distinguishing what is real from what is not) not due to a substance or known physiological condition. During a review of Resident 28's History & Physical (H&P) dated 2/4/26, the H&P indicated, Resident 28 is alert, oriented, and has the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set (MDS-a resident assessment tool) dated 2/3/26, the MDS indicated, Resident 28 is able to understand others and makes self-understood. The MDS indicated, Resident 28 participates and is involved in assessment and goal setting. The MDS indicated, Resident 28 uses a wheelchair and walker for mobility and is dependent with activities of daily living (ADLs). The MDS also indicated Resident 28 has delusions. During a review of Resident 28's SBAR (stands for Situation, Background, Assessment, and Recommendation, a structured, four-step communication framework) dated 2/25/26, the SBAR indicated, new or worsening behavioral symptoms. Resident 28's change in condition as being paranoid and delusional, calling 911 multiple times. The SBAR indicated, Resident 28 exhibiting paranoid ideation, verbalizing persistent delusions that staff and/or others are attempting to poison him. Resident 28 stated, They're putting something in my food and drinks, and reports fear of consuming meals and medications. Resident 28 appears visibly distressed, anxious, and hypervigilant. Resident 28 has contacted 911 multiple times during shift, reporting belief of being poisoned. During a review of Progress Notes dated 3/9/26, the Progress Notes indicated, the facility was informed/updated of resident's current condition and behaviors related to episode of verbalization of paranoia saying that staff is poisoning his food. During a review of Resident 28's Care Plan dated 2/27/26, the Care Plan indicated diagnosis of unspecified psychosis manifested by being paranoid, has delusions that he is being poisoned causing distress, where he has called 911 multiple times. The Care Plan indicated, Goals such as to participate in making decisions for health and personal care, be assisted by family/staff in making decisions for health and personal care; to maintain normal sleep pattern. The Care Plan indicated, Interventions such as: IDT meeting with the resident, monitor episodes of paranoia and delusions as evidenced by verbalizing staff is poisoning his food every shift and record number of episodes, assess resident for behavior manifestations. During an interview on 3/11/2026 at 12:00p.m. with Resident 28, Resident 28 stated, the facility did not involve me in the second IDT meeting. Resident 28 stated he wanted to tell them I must buy my food because I am being poisoned. I cannot sleep. I look like a sick person, not enjoying. I want to know exactly what they plan for me. During an interview on 3/11/2026 at 2:40p.m. with MDS Nurse 1, MDS Nurse 1 stated the facility did not do an IDT Meeting after the second COC. MDS Nurse 1 stated usually IDT Meeting was conducted upon admission, then quarterly. MDS stated it is necessary to do IDT after COC on 2/25/26, to prevent him from having this feeling of being poisoned and to follow up to make sure this will not worsen. During a concurrent interview and record review on 3/11/26 at 3:01pm with MDS Nurse 1, Resident 28's Care Plan dated 3/11/26 was reviewed. The Care Plan indicated no (continued on next page)

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	056234	A. Building B. Wing	03/12/2026

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation or Progress Notes of Care Plan Interventions such as IDT meeting with the resident, monitoring of episodes of paranoia and delusions as evidenced by verbalizing staff is poisoning his food every shift and record number of episodes, nor assessment of resident for behavior manifestations. During an interview on 3/12/26 at 8:00am with the Director of Nursing (DON), DON stated, if there is a COC, we do the Care Plan first, then IDT. We will revise CP whatever happens based on IDT. The DON stated it's important to hold an IDT Meeting; it is resident's right to be involved in planning Resident 28's care. During a review of facility's P&P titled Resident Rights, undated, the document indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: p. be informed of, and participate in, his or her care planning and treatment.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement it's policy and procedure (P&P) , titled Change in a Resident's Condition or Status, for reporting a change in condition for one of three sample residents (Resident 1) to the physician when Resident 1's blood glucose levels exceeded 400 per deciliter (mg/dL- a unit measure for concentration of substances, normal blood glucose range 70-99 mg/dL) on 2/6/2026, 2/8/2026, and 2/22/2026.This failure placed Resident 1 at risk for treatment and services for high glucose levels and had the potential to lead to adverse health outcomes, including dehydration, kidney failure and ketoacidosis (breakdown of fat in the body that leads to acid in the blood).Findings:During a review of Resident 1's admission Record, the admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis including Intervertebral disc degeneration (the natural wear and tear of the cushiony pads between your backbones), acute pulmonary edema (a dangerous, sudden buildup of fluid inside the lungs that makes it feel like you are drowning) and Type 2 diabetes mellitus ([DM]- a long-term condition where the body cannot use sugar for energy properly, causing it to build up in the blood).During a review of Resident 1's History and Physical (H&P), dated 2/4/2026, the H&P indicated Resident 1 had the ability to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 1/22/2026, the MDS indicated Resident 1's cognitive (functions your brain uses to think, pay attention, process information, and remember things) was moderately impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort to complete the task) with eating, oral hygiene, maximal assistance (helper does more than half the effort to complete task) with toileting hygiene, and showering.During a review of Resident 1's Order Summary Report, the Order Summary Report indicated an order initiated on 1/15/2026 and discontinued on 2/24/2026, to administer Lispro injection solution (a fast-acting, liquid medicine under the skin to manage diabetes) subcutaneously (below the skin) and to call the physician when the blood glucose was above 400 mg/dL.During a concurrent interview and record review on 3/10/2026 at 2:48 p.m. with Registered Nurse Supervisor (RNS) 1, Resident 1's Medication Administration Records (MAR), for the month of February 2026 were reviewed. RNS 1 stated Resident 1's blood glucose levels were 430 mg/dL on 2/6/2026 at 4:30 p.m., 419 mg/dL on 2/8/2026 at 4:30 p.m., and 437 mg/dL on 2/22/2026 at 4:30 p.m., and these elevated blood glucose levels represented a change of condition. RNS 1 stated the facility failed to follow its policy for change of condition, including completing a SBAR (stands for situation, background, assessment, and recommendation- four step communication tool used by health professionals to share urgent patient information quickly and accurately), notifying the physician and the resident's family regarding these elevated blood glucose readings.During an interview on 3/12/2026 at 9:59 a.m. with the Director of Nursing (DON), the DON stated staff were required to follow physician orders and the facility's change of condition protocol, including notifying the physician when the resident's BS were above 400 mg/dL per the physician's order. During a review of the facility's Policy and Procedure (P&P), titled Change in a Resident's Condition or Status, undated, the P&P indicated the nurse will notify the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotion/mental condition.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of one resident's (Resident 6) Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder are placed in facilities that can provide the appropriate care) was filled out to indicate an existing psychiatric condition. This deficient practice had the potential to result in improper placement and unidentified specialized services for Resident 6. Findings:During a review of Resident 6's admission Record (Face Sheet), the admission Record indicated the facility originally admitted Resident 6 on 5/06/2022 and was re-admitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 1/26/2026, the MDS indicated Resident 6's cognition (ability to think and make decisions) was moderately impaired. The MDS indicated Resident 6 was dependent (helper does all the effort) on staff with all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an interview and record review on 3/10/2026 at 9:56 a.m. with the Minimum Date Set Nurse (MDSN) 1, Resident 6's admission Record and Resident 6's PASARR and Resident Review Level I Screening, dated 11/12/2025 was reviewed. The MDSN 1 coordinator stated Resident 6 had a diagnosis of schizoaffective disorder. The MDSN 1 stated Resident 6's PASARR Level I Screening diagnosis of schizophrenia should have been checked (as yes). The MDSN 1 stated completing the PASARR Level 1 screening correctly was important to be able to meet the needs of the resident. During an interview on 3/12/2026 at 8 a.m. with the Director of Nursing (DON), the DON stated PASARR should be accurate for proper recommendation and appropriate resident placement. During a record review of the facility's policy and procedure (P&P) titled, admission Criteria, revised 3/2019, the P&P indicated the facility conducts Level I PASARR screen for all admissions and readmissions. The P&P indicated all residents are screened for mental disorders per PASARR Process.

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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** Based on observation, interview, and record review, the facility failed to implement a care plan for one of five residents (Resident 89) by failing to inform Resident 89 of the risks and consequences of refusing to take Keppra ([generic name - levetiracetam] a medication used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) as indicated in Resident 89's care plan.This deficient practice failed to explain to Resident 89 about the risk of seizures due to refusal of Keppra and had the potential of causing seizures, falls and hospitalization.Findings:During a review of Resident 89's admission Record, dated 3/11/2026, the admission record indicated the facility originally admitted Resident 89 on 6/16/2013 and readmitted on [DATE] with diagnoses that included epilepsy, intractable, unspecified without status epilepticus (a condition of recurrent seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] that are not fully managed by medication) and other specified disorders of bone density and structure. During a review of Resident 89's History and Physical (H&P) dated 10/26/2025, the H&P indicated Resident 89 had the capacity to understand and make decisions.During a review of Resident 89's Minimum Data Set (MDS - a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 89's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was intact. The MDS indicated Resident 89 needed moderate assistance from the facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, toileting hygiene, upper body dressing and personal hygiene, needed maximal assistance for lower body dressing and putting on/taking off footwear, and dependent on facility staff for showering. During an observation on 3/10/2026 at 4:07 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 prepared the following four medications to be administered to Resident 89. a. One tablet of glycopyrrolate (a medication used to treat chronic drooling) 1 milligram ([mg] metric unit of measurement, used for medication dosage and/or amount)b. One tablet of levetiracetam 1000 mgc. One tablet of Eliquis ([generic name - apixaban] a medication used to treat atrial fibrillation [an irregular, often rapid heart rate that starts suddenly and stops on its own], prevent clots and stroke [loss of blood flow to a part of the brain] 5 mgd. One tablet of calcium (an important supplement to maintain strong bones and teeth) 500 mg plus vitamin D (a vitamin used to treat low level of vitamin D and support bone health and absorb calcium) 5 micrograms ([mcg] metric unit of measurement, used for medication dosage and/or amount)LVN 3 stated to Resident 89 that she (LVN 3) had four medications to administer to Resident 89. LVN 3 was observed handing over one tablet of levetiracetam 1000 mg to Resident 89 and Resident 89 refused to take levetiracetam 1000 mg stating, not today. LVN 3 then continued to give one tablet of glycopyrrolate 1 mg, one tablet of Eliquis 5 mg and one tablet of calcium 500 mg plus vitamin D 5 mcg, by explaining only glycopyrrolate that it was for Resident 89's drooling symptoms. LVN 3 only offered levetiracetam 1000 mg one time to Resident 89. LVN 3 did not explain to Resident 89 about the benefits and purpose of taking levetiracetam and the risk for seizures if levetiracetam was not taken as prescribed. During a subsequent interview on 3/10/2026 at 4:07 p.m., with LVN 3, LVN 3 stated she would try to offer the medication to Resident 89 again before the end of her shift and then stated she would document medication as refused and inform the physician. LVN 3 stated she did not offer the levetiracetam three times as she should have and did not explain the risks and benefits of taking and not taking levetiracetam to Resident 89. LVN 3 stated by not taking levetiracetam, Resident 89 was placed at risk for seizures, falls and hospitalization.During a medication reconciliation review on 3/11/2026, Resident 89's Order Summary Report (a document containing a summary of all active physician (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders), dated 3/11/2026 was reviewed. The order summary report indicated, but not limited to the following physician orders: Monitor for seizure activity. Notify medical doctor (MD) if noted, (Keppra) every shift Document if notes: Y = Yes; N = No, order date 5/10/2024, start date: 5/10/2024. Keppra tablet 1000 mg (levetiracetam), give 1 tablet by mouth two times a day related to epilepsy, unspecified, intractable, without status epilepticus, order date 8/29/2022, start date 8/30/2022. Apixaban tablet 5 mg, give 1 tablet by mouth two times a day related to unspecified atrial fibrillation, order date 8/29/2022, start date 8/30/2022. Glycopyrrolate oral tablet 1 mg, give 1 tablet by mouth two times a day for hypersalivation, order date 1/21/2026, start date 1/22/2026. Oscal 500-200 D3 tablet 500 mg-200 international units ([IU] a unit of measurement for mass) mg-IU (calcium carbonate-vitamin D), give 1 tablet by mouth two times a day for supplement, order date 8/29/2022, start date 8/30/2022. During a review of Resident 89's Medication Administration Record (MAR - daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/1/2026 to 3/11/2026, the MAR indicated, levetiracetam 1000 mg was documented as 2 = drug refused, three times. During a review of Resident 89's Care Plan dated 3/10/2026, the Care Plan indicated, Focus: Refusal of medication: Keppra; Goal: Resident will demonstrate improved compliance with medication regimen and remain free from seizure activity; Interventions: Educate resident on the importance of taking Keppra for seizure prevention, monitor resident for signs and symptoms of seizure activity.During a review of Resident 89's Care Plan dated 2/13/2026, the Care Plan indicated, Focus: Resident is at risk for clinical or social decline due to non-compliance, non-adherence, refusal of medications, 1. Oscal, 2. Apixaban, 3. Keppra, 4. Vitamin D3, 5. Glycopyrrolate; Goal: Resident right to choose will be honored daily, Resident will be informed of risks and consequences of choices that they make daily; Interventions: Establish daily routine based on input from the resident, Do not force resident to comply against their wishes when resident refuses any food, treatment, care, etc. return later and try again, re-affirm resident's rights to make their own choices, inform of risks and consequences of choices, assess resident for ability to control behavior and express needs.During a review of Resident 89's Care Plan date initiated 8/30/2022, revision date 3/5/2026, the Care Plan indicated, Focus: Resident is at risk for injury due to diagnosis of seizure disorder; Goal: Will be free from injury daily through next review for 3 months; Interventions: Padded 1/4 siderails as ordered, Medication levetiracetam as ordered.monitor for change in level of consciousness. Protected environment when having seizure. During a concurrent interview and record review on 3/11/2026 at 2:02 p.m., with Registered Nurse Supervisor (RNS) 1, the care plans dated 3/10/2026 and 2/13/2026 were reviewed. RNS 1 stated that for residents who were alert and refused to take medications, the facility nurses should have offered the medications at least three times and explained risks and benefits of the medications. RNS 1 stated the care plan was not followed with regards to explaining levetiracetam and offering at least three times. RNS 1 stated not taking seizure medication could increase the risk for seizures, falls and hospitalization. RNS 1 stated Resident 89's levetiracetam was supposed to help prevent episodes of seizure and epilepsy, and if resident refused it, the facility nurse should document the refusal, initiate a change of condition and inform physician and family member. During an interview on 3/11/2026 at 3:11 p.m., with the Director of Nursing (DON), the DON stated in the case of refusal of seizure medications, the facility nursing staff should have informed the doctor when the resident refused the medication. The DON stated facility nurses should have explained to the resident the benefits and risks of taking or not taking levetiracetam and reminded Resident 89 that levetiracetam was to prevent seizures. The DON stated there Resident 89 was at risk for seizures, injury or hospitalization due to refusal of levetiracetam. During a review of facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives. is developed and implemented for each resident. The P&P indicated, The comprehensive, person-centered care plan will: m. aid in preventing or reducing decline in the resident's functional status and/or functional levels. The P&P indicated, Identifying problem areas and their causes.are the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	endpoint of an interdisciplinary process. a. no single discipline can manage an approach in isolation; b. The resident's physician (or primary healthcare provider) is integral in this process. Care plan interventions are chosen only after careful data gathering.benefit for the resident. The P&P indicated, The resident has the right to refuse to participate in.treatments. Such refusals will be documented.with established policies.During a review of facility's P&P titled, Medication Administration - General Guidelines, undated, the P&P indicated, If two consecutive doses of a vital medication are withheld or refused, the physician is notified.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one of five sampled residents (Residents 6) by failing to follow up with an orthopedic (specialty area in medicine referring to the management of the muscles, bones, and their connective structures) consultation appointment for Resident 6's left humerus (upper arm bone) fracture (broken bone) per consulting physician's recommendations.This deficient practice resulted in a delay of Resident 6's care and had the potential for worsening of the fracture, delayed healing, and a decline in mobility (ability to move), range of motion (ROM, full movement potential of a joint), activities of daily living (ADL, basic activities such as eating, dressing, toileting), physical comfort and psychosocial well-being. CROSS-REFERENCE TO F842 Findings: During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including a left humeral shaft fracture (break in the long bone of the upper arm), muscle weakness, and polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain). During a review of Resident 6's History and Physical (H&P) Note, dated 9/12/2025, the H&P indicated Resident 6 was transferred to the hospital for surgery of the left humerus after sustaining a fall at the facility. The H&P indicated Resident 6 had surgery for the left humerus on 9/9/2025 and was re-admitted to the facility on [DATE] for skilled care (high level medical or rehabilitative care provided by licensed professionals), Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities).During a review of Resident 6's OT Evaluation and Plan of Treatment (OT Eval), dated 9/13/2025, the OT Eval indicated Resident 6 was referred for OT services due to a decrease in strength, function, mobility, transfers (moving from one place to another), and ADL participation and an increased need of assistance from others. The OT Eval indicated Resident 6's left arm ROM was impaired at the wrist and the hand, and the left shoulder and elbow ROM were not assessed due to Resident 6's left humerus surgery.During a review of Resident 6's OT Discharge summary, dated [DATE], the OT Discharge Summary indicated Resident 6 was discharged from OT services per physician or Case Manager.During a review of Resident 6's Orthopedic Consultation Progress Note (Ortho Note), dated 10/6/2025, the Ortho Note indicated the visit was Resident 6's first orthopedic follow up appointment since surgery to the left arm on 9/9/2026. The Ortho Note indicated Resident 6 was non-weight bearing (NWB, restriction in which a person is not allowed to put any weight through the operated body part) to the left arm and was able to participate in ROM exercises to the left shoulder and left elbow with PT and OT. The Ortho Note indicated Resident 6 was to follow up with orthopedics in four weeks. During a review of Resident 6's Order Summary Report, the Order Summary Report indicated a physician's order, dated 10/6/2025, for Resident 6 to follow up with orthopedics on 11/3/2025 at 9:45 am.During a review of Resident 6's Ortho Note, dated 11/3/2025, the Ortho Note indicated Resident 6 presented to the orthopedic appointment three months after undergoing surgery of the left humerus. The Ortho Note indicated Resident 6's left arm was weight bearing as tolerated (WBAT, a person is medically cleared to place as much weight through the affected arm or leg to the point of comfort or tolerance). The Ortho Note indicated Resident 6 could participate in ROM and strengthening exercises to the left shoulder, elbow, wrist, and fingers and instructed Resident 6 to follow up with orthopedics through her Health Maintenance Organization (HMO, type of insurance plan that limits coverage to doctors and facilities within a specific network).During a review of Resident 6's Order Summary Report, the Order Summary Report indicated a physician's order, dated 12/10/2025, for Resident 6's left arm to be NWB.During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 1/26/2026, the MDS indicated Resident 6 had moderate (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitive (mental action or process of acquiring knowledge and understanding) impairment. The MDS indicated Resident 6 required set up/clean up assistance (helper sets up or clean up) for eating and oral hygiene and was dependent (helper does all the effort) with toileting hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 6 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in one arm.During an observation and interview on 3/9/2026 at 10:24 am with Resident 6 in Resident 6's room, Resident 6 was lying in bed with the left elbow bent and the left wrist and hand resting on her stomach. Resident 6 stated her left shoulder was broken but did not recall when. Resident 6 reached across the body with the right arm, grabbed her left arm, and used the right arm to assist raising the left arm to less than shoulder height. Resident 6 bent the left elbow upwards towards the body but could not fully straighten the arm. Resident 6 was unable to lift the left wrist upwards or close the fingers of the hand into a fist.During a concurrent interview and record review on 3/10/2026 at 2:50 pm with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated a licensed nurse was responsible for accepting a resident's paperwork and implementing new physician orders and recommendations when a resident returned to the facility from a consultation appointment. LVN 1 stated if follow up appointments were recommended by the consulting physician, the licensed nurse or the Assistant Director of Nursing (ADON) scheduled the follow up appointment based on the physician recommendations. LVN 1 reviewed Resident 6's physician's orders and Ortho Note, dated 10/6/2025, and confirmed Resident 6 was supposed to follow up with Orthopedics on 11/3/2025 per physician's orders, dated 10/6/2025, but was unable to confirm if Resident 6 went to the scheduled orthopedic appointment because she could not locate the Ortho Note, dated 11/3/2025. LVN 1 stated Resident 6's Ortho Notes were supposed to be in the resident's electronic medical record (EMR) but were not. LVN 1 stated she was unsure if orthopedics made any additional recommendations for follow up or updated Resident 6's left arm restrictions because she could not locate the Ortho Note. LVN 1 stated the lack of orthopedic follow-up as recommended could potentially result in a decline in function and a delay of necessary treatments and services such as therapy.During a concurrent interview and record review on 3/10/2026 at 3:09 pm with the ADON, the ADON stated a licensed nurse was responsible for accepting a resident's paperwork and implementing new physician orders and recommendations when a resident returned to the facility from a consultation appointment. The ADON stated if follow up appointments were recommended by the consulting physician, the licensed nurse scheduled the follow up appointment based on the physician recommendations and contacted the Transportation Coordinator to arrange transportation for the scheduled appointment. The ADON reviewed Resident 6's clinical record and confirmed Resident 6 had a follow-up orthopedic appointment scheduled for 11/3/2025 but did not know if Resident 6 went to the appointment because she could not find the Ortho Note, dated 11/3/2025. The ADON stated Resident 6's Ortho Note, dated 11/3/2025, should be scanned into the EMR but was not. During a follow up interview on 3/11/2026 at 9:45 am, the ADON stated she looked extensively for Resident 6's Ortho Note, dated 11/3/2025, but was unable to locate it. The ADON stated she called Resident 6's orthopedic clinic and asked the clinic to fax Resident 6's Ortho Note, dated 11/3/2025, to the facility because the facility was unable to locate it. The ADON reviewed Resident 6's Ortho Note, dated 11/3/2025, and confirmed the Ortho Note indicated Resident 6's left arm weightbearing status was changed from NWB to WBAT. The ADON confirmed the Ortho Note recommended Resident 6 begin ROM and strengthening exercises for the left arm, and instructed Resident 6 to follow up with orthopedics through her HMO. The ADON reviewed Resident 6's physician's orders and confirmed Resident 6's physician order, dated 12/20/2025, which indicated Resident 6's left arm was NWB was inaccurate as the Ortho Note, dated 11/3/2025, indicated Resident 6's left arm weightbearing status was upgraded to WBAT. The ADON stated Resident 6's left arm weightbearing status was likely not changed on the physician's order because the Ortho Note, dated 11/3/2026, was missing and staff was unaware of the change and recommendations. The (continued on next page)

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Marlora Post Acute Rehab Hosp	3801 E Anaheim St Long Beach, CA 90804

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents, follow up on critical labs, order requests, and physician notifications and assist in coordinating nursing services with other resident services to ensure the continuity of the residents' plan of care. The P/P indicated one of the duties and responsibilities of the Charge Nurse/Nurse Supervisor was to arrange for diagnostic and therapeutic services as ordered by the physician and in accordance with established facility procedures. The P/P indicated two of the charting and documentation functions of the Charge Nurse/Nurse Supervisor was to complete and file required recordkeeping forms/charts and perform routine charting duties as required and in accordance with established charting and documentation policies and procedures. During a review of the facility's job description titled, Case Manager/Discharge Planner, dated 7/2024, the job description indicated two of the specific job functions included obtaining continued authorization for placement and treatment of managed care patients and negotiating with service providers, payers, and members of the facility's care team to meet the patient's care needs and assists in arranging for services. During a review of the facility's P/P titled, Quality of Care, revised 8/2009, the P/P indicated each resident shall be care for in a manner that promoted and enhanced quality care. The P/P indicated health services must be timely, equitable, integrated, and efficient.

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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** Based on interview and record review the facility failed to ensure one out of one sampled resident (Resident 11) with a nephrostomy tube (thin, flexible catheter inserted through the back into the kidney to drain urine directly into an external bag) had documented evidence of assessing and monitoring of the urine for signs and symptoms of infection.The deficient practice had the potential to result in urinary tract infections ([UTI] an infection in the bladder/urinary tract).Findings:During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was admitted to the facility on [DATE] with diagnoses including artificial openings of urinary tract status (covers the presence of surgically created, permanent, or temporary, urinary diversion), obstructive and reflux uropathy (dangerous blockage of urine flow).During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 2/19/2026, the MDS indicated Resident 11's cognition (ability to think) was intact. The MDS indicated Resident 11 needed set up assistance when eating, oral hygiene and substantial assistance (helper does more than half the effort) with toileting hygiene.During a review of Resident 11's Order summary, the order summary dated 11/10/2025 indicated to provide nephrostomy care every shift.During a review of Resident 11's Care Plan titled, Alteration in bowel and bladder manifested by nephrostomy, initiated 7/5/2025, the care plan intervention indicated to monitor for signs and symptoms of UTI , blood in the urine, sedimentation [physical process where suspended particles settle out of a fluid, dysuria [pain on urination], and flank pain).During a concurrent interview and record review on 3/10/2026 at 3:50 p.m., with MDS nurse (MDSN)1, Resident 11's care plan was reviewed. MDSN 1 stated the care plan should have been implemented and it indicated monitoring urine for signs and symptoms of UTI. MDSN 1 stated there was no documentation of any assessment of urine characteristics in the drainage bag noted in Resident 11's medical records.During an interview on 3/12/2026 at 7:48 a.m., with the Director of Nursing (DON), the DON stated it was important to monitor the urinary drainage to detect any problems.During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, revised 9/2014, the P&P indicated to check the urine for unusual appearance and urine characteristic need to be documented in the resident's medical record.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure a physician assessed one of three sampled residents (Resident 1) within 72 hours after admission.This failure resulted in a delayed physician assessment which placed Resident 1's health status and safety at risk for timely medical interventions.Findings:During a review of Resident 1's admission Record, the admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis including Intervertebral disc degeneration (the natural wear and tear of the cushiony pads between your backbones), acute pulmonary edema (a dangerous, sudden buildup of fluid inside the lungs that makes it feel like you are drowning) and Type 2 diabetes mellitus (a long-term condition where the body cannot use sugar for energy properly, causing it to build up in the blood). During a review of Resident 1's History and Physical (H&P), dated 2/4/2026, the H&P indicated Resident 1 had the ability to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 1/22/2026, the MDS indicated Resident 1's cognitive (functions your brain uses to think, pay attention, process information, and remember things) was moderately impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort to complete the task) with eating, oral hygiene, maximal assistance (helper does more than half the effort to complete task) with toileting hygiene, and showering. During a concurrent interview and record review on 3/10/2026 at 3:21 p.m. with Registered Nurse Supervisor (RNS) 1, Resident 1's H&P, dated 2/4/2026 and Progress notes, for the month of January and February 2026 were reviewed. RNS 1 stated the facility admitted Resident 1 on 1/15/2026 and the physician conducted an in-person visit on 2/4/2026, approximately three weeks later, and there was no documentation that the medical director evaluated the resident within the required time frame. RNS 1 stated the physician is expected to see the resident within three days after admission to complete an assessment and evaluation.During an interview on 3/12/2026 at 9:59 a.m. with the Director of Nursing (DON), the DON stated the facility failed to ensure the physician to see the resident in person within 3 days after admission.During a review of the facility's Policy and Procedure (P&P), titled Physician Documentation, undated, the P&P indicated ?History and Physical Examination': a patient evaluation including a written report of a physical examination shall be provided by the attending physician within 72 hours following admission.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of one resident (Resident 6) was followed up by a psychologist (medical doctor who can diagnose and treat mental health conditions) as ordered by the resident's primary physician. This failure resulted in Resident 6 not receiving a psychology follow-up while in the facility to attain mental and psychosocial well-beingFindings:During a review of Resident 6's admission Record (Face Sheet), the admission Record indicated the facility originally admitted Resident 6 on 5/06/2022 and was re-admitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 1/26/2026, the MDS indicated Resident 6's cognition (ability to think and make decisions) was moderately impaired. The MDS indicated Resident 6 was dependent (helper does all the effort) on staff with all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 6 physician orders, dated 9/12/2025, the physician's order indicated a psychological (psych) evaluation and follow up treatment. During a review of Resident 6's Care Plan titled Behavior dated 1/30/2026, the Care Plan indicated Monitor behavior and notify Medical Doctor (MD) if it interferes with functioning, psych consult as orderedDuring a concurrent interview and record review on 3/10/2026 at 3:43 p.m., with the Minimum Date Set Nurse (MDSN) 1, Resident 6's care plan for behavior was reviewed. The MDSN 1 stated Resident 6 needed behavioral services and maybe a psychology follow up. During a concurrent interview and record review on 3/11/2026 at 11:15 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 6's behavior care plan was reviewed. LVN 1 stated the resident required a follow up with psychology based on Resident 6 behavior and ongoing verbal repetition of past traumatic events. During an interview with the Director of Nursing (DON) on 3/12/2026 at 8:00 a.m. the DON stated if the resident has psychiatric symptoms, the resident should be referred to psych, requires an interdisciplinary team (a group of professionals from diverse fields working together to achieve shared, patient-center goals) meeting, the care plan should be updated, and behavior should be monitored. The DON stated a psych follow-up was important to assist the resident with what he/she are experiencing mentally. During a review of the facility's Policy and Procedure (P&P) titled, Behavioral Health Services dated 2001, the P&P indicated the facility will provide and residents will receive behavior health services as needed to attain or maintain highest practicable mental, physical, and psychosocial well-being.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1. Ensure one of five residents' (Resident 36's) instructions for holding parameters on medication bubble pack (sealed card containing individual, daily, or weekly doses of medication in clear, push-through plastic bubbles) for amlodipine (a medication used to treat hypertension [HTN - high blood pressure] and heart conditions) matched with physician's order, before medication administration during medication pass observation. 2. Ensure one of five residents (Resident 62's) polyethylene glycol powder (a medication in powder form used to treat constipation after being dissolved in a specific amount of water) was dissolved in the correct volume of water, in accordance with physician's order and manufacturer's specifications while preparing for administration during medication pass observation.These deficient practices increased the risk of medication errors for Residents 36 and 62 and had the potential to result in abnormal heart rate, abnormal blood pressure, swallowing difficulty and stomach discomfort.Findings: 1. During a review of Resident 36's admission Record, dated 3/10/2026, the admission record indicated the facility admitted Resident 36 on 1/21/2026 with diagnoses that included but not limited to unspecified polyneuropathy (a condition where multiple peripheral nerves throughout the body are damaged), essential (primary) hypertension and paroxysmal atrial fibrillation (an irregular, often rapid heart rate that starts suddenly and stops on its own).During a review of Resident 36's History and Physical (H&P) dated 2/4/2026, the H&P indicated Resident 36 had the capacity to understand and make decisions.During a review of Resident 36's Minimum Data Set (MDS - a resident assessment tool), dated 1/28/2026, the MDS indicated Resident 36's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 36 needed moderate assistance from facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, upper body dressing and personal hygiene, and needed maximal assistance for toileting hygiene, showering, lower body dressing and putting on or taking off footwear. During a concurrent observation and interview on 3/10/2026 at 8:37 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 prepared and administered the following five medications to Resident 36. LVN 2 stated she (LVN 2) checked Resident 36's blood pressure on 3/10/2026 around 8:36 a.m., and Resident 36's blood pressure reading was 126/78 (systolic blood pressure [SBP - measures the pressure in the arteries when the heart contracts to pump blood] at 126) and (diastolic blood pressure [DBP - measures the pressure in the arteries when the heart muscle relaxes between beats] at 78 and heart rate (HR) was at 68 beats per minute. During a record review on 3/10/2026 at 8:37 a.m., during medication administration, the pharmacy label on morning medication bubble pack for Resident 36's amlodipine 5 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) was reviewed. The pharmacy label indicated, Amlodipine besylate 5 mg, take one tablet by mouth daily for HTN. Hold if SBP less than 110 or Pulse less than 60. a. One tablet of amlodipine 5 mg with medication card label that indicated, hold if SBP less than 110 or Pulse less than 60.b. Two capsules of gabapentin (a medication used to treat nerve pain) 300 mgc. One tablet of carvedilol (a medication used to treat high blood pressure and heart conditions) 25 mg, with medication card label that indicated, hold if SBP less than 110 or Pulse less than 60.d. One patch of lidocaine (a medication used to treat localized pain) 5 percent ([%] a unit used to show potency or strength of medication)e. One capsule of docusate sodium (a medication used to treat constipation) 100 mg During a medication reconciliation review on 3/10/2026, Resident 36's Order Summary Report (a document containing a summary of all active physician orders), dated 3/10/2026 was reviewed. The order summary report included the following physician orders: Amlodipine besylate tablet 5 mg, give 1 tablet by mouth one time a day for HTN, hold if SBP less than (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	110, order date 2/21/2026, start date 2/22/2026. Carvedilol tablet 25 mg, give 1 tablet by mouth two times a day for hypertension, hold if SBP less than 110 or Pulse less than 60, order date 1/21/2026, start date 1/22/2026. Colace capsule (docusate sodium), give 1 capsule by mouth two times a day for bowel management, hold for loose stools, order date 1/21/2026, start date 1/22/2026. Gabapentin capsule 300 mg, give 2 capsules by mouth in the morning for neuropathy, order date 1/21/2026, start date 1/22/2026. Lidoderm Patch 5% (lidocaine), apply to bilateral knees topically in the morning for pain management and remove per schedule, order date 2/12/2026, start date 2/13/2026. During an interview on 3/10/2026 at 12:15 p.m., with LVN 2, LVN 2 stated the pharmacy label on Resident 36's amlodipine 5 mg medication bubble pack and the physician order in the electronic medical record (eMAR) should always match and align to ensure that Resident 36 was receiving the medication based on correct parameters. LVN 2 stated the pharmacy label indicated to hold amlodipine 5 mg if Resident 36's pulse or heart rate was less than 60, but the physician order instructed to hold amlodipine 5 mg only if Resident 36's SBP was less than 110. LVN 2 stated this discrepancy could place Resident 36 at risk for high or low blood pressure and high or low heart rate. During an interview on 3/11/2026 at 3:43 p.m., with the Director of Nursing (DON), the DON stated facility nurses should be checking for right resident, right medication name, right dose, right frequency, right time, right parameters, etc. before medication administration. The DON stated that the physician order in eMAR and pharmacy label should match for instructions and if there was a change in order, there should be a label alerting change in directions and facility nurse should refer to the physician order in the chart. DON stated there was a risk that amlodipine could have been inadvertently held because of pharmacy label instructions whereas the physician's order was only to hold the medication based on SBP. DON stated this placed the resident at risk for abnormal changes in heart rate. 2. During a review of Resident 62's admission record, dated 3/10/2026, the admission record indicated the facility originally admitted Resident 62 on 2/5/2025 and readmitted on [DATE] with diagnoses that included enterocolitis due to recurrent clostridium difficile (a severe, often hospital-acquired infection causing inflammation of the colon [colitis] or small intestine [enteritis], triggered by antibiotic-induced disruption of normal gut flora) and unspecified noninfective gastroenteritis (an infection causing vomiting, diarrhea, abdominal cramps, and fever, typically lasting 1-3 days) and colitis (inflammation of the inner lining of the colon).During a review of Resident 62's H&P dated 3/15/2025, the H&P indicated Resident 62 had the capacity to understand and make decisions.During a review of Resident 62's MDS dated [DATE], the MDS indicated Resident 62's cognition was intact. The MDS indicated Resident 62 was independent in performing ADLs such as oral hygiene, needed setup or clean-up assistance from the facility staff for ADLs such as eating, toileting hygiene, upper body dressing, lower body dressing, putting on or taking off footwear and personal hygiene, and needed supervision assistance for showering. During a concurrent observation and interview on 3/10/2026 between 9:03 a.m., and 9:25 a.m., with LVN 2, LVN 2 prepared and administered the following nine medications to Resident 62. LVN 2 checked Resident 62's blood pressure using a manual blood pressure monitor and stated Resident 62's blood pressure reading was 122/76 (SBP at 122 and DBP at 76) and HR was at 64. During a concurrent observation and interview on 3/10/2026 at 9:15 a.m., with LVN 2, LVN 2 was observed measuring one capful of polyethylene glycol's cap and dropped it in a cup of water and stared stirring it with a spoon. The cup looked like it was one-half to three-fourth of the way filled with water which was less than four ounces ([oz] a unit of measurement for volume) or 120 milliliters ([mL] a unit of measurement for volume). Surveyor asked LVN 2 to indicate the volume of water that was being used to dissolve polyethylene glycol powder. LVN 2 stated it was 30 mL, then stated she (LVN 2) was not sure and needed to measure the water using one oz medicine cup. LVN 2 stated the water measured to 100 mL. LVN 2 stated one capful was 17 grams ([gm] a unit of measurement for mass) of polyethylene glycol and was supposed to be dissolved in four oz which would be 120 mL. LVN 2 then added 20 mL to the water cup with 100 mL to bring the water to 120 mL for polyethylene glycol powder. a. One tablet of amlodipine 10 mg, with indication to hold if SBP was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	less than 110 b. One capsule of celecoxib (a medication used to treat pain and inflammation) 200 mg c. One tablet of vitamin B12 (a vitamin used to treat low level of vitamin B12 and support nerve cell health)1000 micrograms ([mcg] a unit of measurement for mass)d. One capsule of gabapentin 300 mge. One tablet of oxybutynin chloride (a medication used to treat overactive bladder symptoms) extended release 10 mgf. One tablet of multivitamin g. One capsule of docusate sodium 250 mgh. One tablet of losartan (a medication used to treat high blood pressure) 50 mg with indication to hold if SBP less than 110 or HR less than 60i. 17 gm of polyethylene glycol powder dissolved in four to eight ounces of water During a medication reconciliation review on 3/10/2026, Resident 62's Order Summary Report, dated 3/10/2026, was reviewed. The order summary report indicated, but not limited to the following physician orders: Amlodipine besylate oral tablet 10 mg, give 1 tablet by mouth one time a day for HTN, Hold if SBP less than 110, order date 3/12/2025, start date 3/13/2025. Celebrex oral capsule 200 mg (celecoxib), give 200 mg by mouth one time a day for pain, order date 3/21/2025, start 3/22/2025. Cyanocobalamin oral tablet 1000 mcg, give 1 tablet by mouth one time a day for vitamin B12 deficiency, order date 3/12/2025, start date 3/13/2025. Docusate sodium oral capsule 250 mg, give 1 capsule by mouth one time a day for constipation, hold for loose stool, order date 1/24/2026, start date 1/25/2026. Gabapentin capsule 300 mg, give 1 capsule by mouth three times a day for diabetic neuropathy, order date 5/2/2025, start date 5/2/2025. Losartan potassium oral tablet 50 mg, give 1 tablet by mouth two times a day for HTN hold if SBP less than 110 or Pulse less than 60, order date 3/6/2026, start date 3/7/2026. Multivitamin oral tablet, give 1 tablet by mouth one time a day for supplement, order date 3/12/2025, start date 3/13/2025. Oxybutynin chloride ER oral tablet extended release 24-hour 10 mg, give 1 tablet by mouth one time a day for overactive bladder, order date 7/29/2025, start date 7/30/2025. Polyethylene Glycol 3350 Powder, give 17 grams by mouth one time a day for constipation, mix in 4 to 8 ounces of fluid. If no bowel movement (BM) in past 72 hours 17 gram = 1 scoop, order date 3/12/2025, start date 3/13/2025. During an interview on 3/10/2026 at 12:15 p.m., with LVN 2, LVN 2 stated polyethylene glycol powder should have been dissolved in the volume of water specified by manufacturer and physician's order to prevent the risk of difficulty in swallowing for Resident 62. LVN 2 stated there was a risk that Resident 62 could have received improperly dissolved medication. During an interview on 3/11/2026 at 3:33 p.m., with the DON, the DON stated polyethylene glycol powder usually should be mixed with eight ounces of water or juice to dissolve the powder. The DON stated if the order indicated four to eight oz, then it would be okay to use that volume. The DON stated there was a risk of not following manufacturer's specifications, and polyethylene glycol would not be effective and there would be a risk of swallowing discomfort and difficulty for the resident. The DON stated if polyethylene glycol was not administered in proper dosage, then the medication might not be effective for resident's bowel management. During a review of facility's policy and procedure (P&P) titled, VII. Preparation for Medication Administration - Medication Administration - General Guidelines, undated, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The P&P indicated, Prior to administration, the medication and dosage schedule on the resident's Medication Administration Record (MAR) is compared with the medication label. If the label and MAR are different.the physician's orders are checked for the correct dosage schedule. The P&P indicated, Medications are administered in accordance with written orders of the attending physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056234	A. Building B. Wing	03/12/2026

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

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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 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. Based on observation, interview, and record review, the facility failed to:1. Ensure one of five residents (Resident 36's) five (5) medications that included amlodipine (a medication used to treat hypertension [HTN - high blood pressure]), gabapentin (a medication used to treat nerve pain), carvedilol (a medication used to treat HTN), lidocaine patch (a medication applied on skin to treat localized pain) and docusate sodium (a medication used to treat constipation) were secured and not left unattended on bedside cart with the resident during medication pass observation.2. Ensure that the discarded medications in two of two inspected medication carts (Station 1 Morning Medication Cart 1 also known as split cart and Station 2 Medication Cart 4) were stored in a closed-lid container and/or disposed of in an irretrievable, safe and secure manner.These deficient practices failed to destroy the unidentifiable discarded medications and secure Resident 36's prepared medications, resulting in an unsafe and unsecure environment for medication storage in medication carts and Resident 36's room, increasing the risk of medication self-administration without supervision for Resident 36, and had the potential to result in medication errors and/or incorrect ingestion, and retrieval and/or misuse of discarded medications. Findings:1. During a review of Resident 36's admission Record dated 3/10/2026, the admission record indicated the facility admitted Resident 36 on 1/21/2026 with diagnoses that included but not limited to unspecified polyneuropathy (a condition where multiple peripheral nerves throughout the body are damaged), essential (primary) hypertension and paroxysmal atrial fibrillation (an irregular, often rapid heart rate that starts suddenly and stops on its own).During a review of Resident 36's History and Physical (H&P) dated 2/4/2026, the H&P indicated Resident 36 had the capacity to understand and make decisions.During a review of Resident 36's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/28/2026, the MDS indicated Resident 36's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was moderately impaired. The MDS indicated Resident 36 needed moderate assistance from the facility staff in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, upper body dressing and personal hygiene, and needed maximal assistance (helper does all the effort) for toileting hygiene, showering, lower body dressing and putting on or taking off footwear.During a concurrent observation and interview on 3/10/2026 at 8:37 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 prepared five medications for Resident 36 outside of Resident 36's room. LVN 2 stated she (LVN 2) checked Resident 36's blood pressure on 3/10/2026 around 8:36 a.m., and Resident 36's blood pressure reading was 126/78 (systolic blood pressure [SBP - measures the pressure in the arteries when the heart contracts to pump blood] at 126) and (diastolic blood pressure [DBP - measures the pressure in the arteries when the heart muscle relaxes between beats] at 78 and heart rate (HR) was at 68 beats per minute. LVN 2 entered Resident 36's room and placed the following five medications on Resident 36's bedside cart in front of her (Resident 36). Resident 36 was observed requesting juice instead of water to take with her (Resident 36's) medications. LVN 2 turned around, left the medications unattended and unsecured with Resident 36, walked to the medication cart and brought juice for Resident 36.1. One tablet of amlodipine 5 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) with medication card label that indicated, hold if SBP less than 110 or Pulse less than 60.2. Two capsules of gabapentin 300 mg3. One tablet of carvedilol 25 mg, with medication card label that indicated, hold if SBP less than 110 or Pulse less than 60.4. One patch of lidocaine 5 percent ([%] a unit used to show potency or strength of medication)5. One capsule of docusate sodium 100 mgDuring an interview on 3/10/2026 at 12:15 p.m. with LVN 2, LVN 2 stated she recalled that she turned away to go to the medication cart when Resident 36 requested to receive juice instead of water. LVN 2 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she left the medications unattended with Resident 36 which increased the risk that resident could have pocketed or taken medications incorrectly.During an interview on 3/11/2026 at 3:05 p.m. with the Director of Nursing (DON), the DON stated it was always important to secure meds and medications should not be left unattended with the residents. The DON stated if the medications went out of sight without supervision, you don't know what will happen. The DON stated if the residents took medication without supervision, there was a risk of not knowing what the resident would do if they took the medication or if they took them correctly. DON stated LVN should have taken the medications with them to the medication cart and returned with the juice.2a. During a concurrent observation and interview on 3/10/2026 at 3:04 p.m. with LVN 1 of Split Cart Station 1 Morning Medication Cart 1, the medication cart contained one red container with an open lid filled with a few unidentified white tablets of different shapes and sizes in the bottom drawer such that the medications were retrievable. LVN 1 stated, these tablets were probably medications that were refused or dropped on the floor and then discarded. LVN 1 stated they should have been in a closed bin and not retrievable because it would not be safe and had a risk of misuse.2b. During a concurrent observation and interview on 3/10/2026 at 3:38 p.m. with LVN 6 of Station 2 Medication Cart 4, the medication cart contained one red container with an open lid filled with a few unidentified tablets and capsules with varied shapes, sizes and colors, such as yellow, white, orange and pink, in the bottom drawer such that the medications were retrievable. LVN 6 was observed trying to close the lid and could not close. LVN 6 stated, it was not safe to have such a bin because anyone could go through the bin and retrieve medications for misuse. LVN 6 stated it was not in the medication cart on the day before and it was possible that these meds were placed in the red bin after they were refused. LVN 6 stated she would discard the red bin at the end of her shift.During an interview on 3/11/2026 at 3:22 p.m. with the DON, the DON stated the red bins were used to discard refused medications or for discarding capsule shells, for example, if a capsule needed to be opened and the shell needed to be discarded. The DON stated it would be safe if the red bins were closed. The DON stated the nursing staff should have added liquid or water to dissolve the discarded medications to ensure they were irretrievable and to prevent risk of misuse and inadvertent administration. During a review of the facility's policy and procedures (P&P) titled, Medication Storage in the Facility - Storage of Medications, undated, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. The P&P indicated, Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of .for medication disposal and reordered.if current order exists. Medication storage areas are kept clean, well lit, and free of clutter and extreme temperatures.During a review of the facility's P&P titled, Drug Disposition - Procedure for Disposal, undated, the P&P indicated, Discontinued or outdated non-controlled drugs are to be stored in a secured area designated for that purpose until picked up by the pharmaceutical waste disposal service or the pharmacy personnel. During a review of the facility's P&P titled, Medication Administration - General Guidelines, undated, the P&P indicated, During administration of medications.all other sides closed. No medications are kept on top of the cart. The resident is always observed after administration to ensure that the dose was completely ingested.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure Dietary Staff 1 (DS 1) changed gloves to prevent growth of microorganisms that could cause food borne illness (food poisoning: any illness resulting from the food spoilage of contaminated food, pathogenic bacteria, and viruses) in between tasks for 91 out of the 99 residents in the facility. This deficient practice had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever and can lead to other serious medical complications and hospitalization. During an observation and interview on 2/9/2026 at 8:31 a.m., with DS 1, DS 1 was observed going to the sanitation area and back to the clean dishwashing area with the same gloves on and received clean dishes without changing his gloves. DS 1 stated one must change gloves to prevent contamination. DS 1 stated he (DS 1) did not have to change his gloves from the sanitation area prior to going back to the dishwashing area since his gloves are still clean coming from the sanitation area. During an interview on 3/9/2026 at 8:39 a.m. with the Dietary Supervisor (DS), the DS stated gloves are changed when you are going from a dirty to a clean area or when doing a new task and indicated gloves are changed to prevent cross contamination as the resident can get sick.