

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2024
NAME OF PROVIDER OR SUPPLIER Tarzana Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5650 Reseda Blvd Tarzana, CA 91356	

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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550</p> <p>Based on interview and record review, the facility failed to protect the resident ' s right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm by one resident towards another) for one of three sampled residents (Resident 4) when on 10/17/2024 at around lunch time, Registered Nurse 2 (RN 2) witnessed Resident 5 punched Resident 4 with his (Resident 5) closed fist twice on the right side of face while Resident 4 was sitting on the wheelchair.</p> <p>This deficient practice resulted in Resident 4 being subjected to physical abuse by Resident 5 while under the care of the facility. Based on the Reasonable Person Concept (the usual behavior of an average person under the same circumstances), due to Resident 4 ' s severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and medical condition, an individual subjected to physical abuse may have physical pain, psychological pain (mental or emotional) effects including feelings of hopelessness (a feeling or state of despair or lack of hope), helplessness (the belief that there is nothing that anyone can do to improve a bad situation, and humiliation (the feeling of being ashamed or losing respect for own self).</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record, the Admission Record indicated the facility admitted Resident 4 on 12/6/2022 with diagnoses that included hemiplegia (total or partial paralysis [loss of the ability to move] of one side of the body) and hemiparesis (one-side muscle weakness) following cerebral infarction (damage to the tissues in the brain due to a loss of oxygen to the area) affecting right dominant side and dysphagia (difficulty swallowing) following cerebral infarction.</p> <p>During a review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/16/2024, the MDS indicated Resident 4 had severely impaired cognition. The MDS also indicated Resident 4 required partial or moderate assistance (helper does less than half the effort) with eating, and is dependent with oral hygiene, toileting hygiene, and personal hygiene.</p> <p>During a review of Resident 4 ' s Change in Condition (COC- a significant change in resident ' s health status) Evaluation, dated 10/17/2024, timed at 4:36 p.m., the COC indicated the resident (Resident 4) received punch from another resident (Resident 5) while sitting in wheelchair.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 5 ' s Admission Record, the Admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizophrenia (a mental illness that affects a person ' s thoughts, feelings, and behaviors), unspecified mood disorder (a mental health condition that primarily affects a person ' s emotional state), and personal history of traumatic brain injury (a brain injury caused by an external force such as a blow, jolt or impact to the head).</p> <p>During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had severely impaired cognition. The MDS also indicated Resident 5 required partial/moderate assistance with eating and oral hygiene, dependent with toileting hygiene, and required substantial/maximal assistance (helper does more than half the effort) with personal hygiene.</p> <p>During a review of Resident 5 ' s Change in Condition Evaluation dated 10/17/2024, timed at 1:19 p.m., indicated the resident (Resident 5) was noted with episode of attempting to attack another resident (Resident 4).</p> <p>During a review of Resident 5 ' s Physician Orders dated 10/17/2024, timed at 7:12 p.m., the Physician Order indicated to transfer Resident 5 to General Acute Care Hospital 1 (GACH 1) due to physical aggression (behavior directed toward another person that results in physical harm or has the potential to cause physical harm) towards the other Resident.</p> <p>During an interview on 11/4/2024 at 11:41 a.m., with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated that on 10/17/2024 around lunch time, he (CNA 3) was washing his hands in station 4. CNA 3 heard Resident 5 yell and when he (CNA 3) turned around, CNA 3 witnessed Resident 5 punched Resident 4 with his (Resident 5 ' s) closed fist twice on the right side of Resident 4 ' s face.</p> <p>During an interview on 11/4/2024 at 3:45 p.m., with RN 2, RN 2 stated that on 10/17/2024 at around lunch time, RN 2 witnessed Resident 5 punched Resident 4. RN 2 stated that RN 2 was at station 4 at around lunch time RN 2 witnessed Resident 4 being wheeled next to Resident 5, Resident 5 reached over and pulled Resident 4 ' s wheelchair close to Resident 5 and punched Resident 4 with a closed fist twice in the face.</p> <p>During an interview on 11/5/2024 at 10:51 a.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated she (LVN 2) was assigned to Resident 5 on 10/17/2024. LVN 2 stated that on 10/17/2024 at around lunch time, LVN 2 witnessed Resident 5 punched Resident 4 with his (Resident 5 ' s) closed fist twice on the right side of Resident 4 ' s face.</p> <p>During a follow-up interview on 11/5/2024 at 11:00 a.m., with LVN 2, LVN 2 stated that physical abuse did occur because Resident 5 was witnessed punching Resident 4 in the face.</p> <p>During an interview on 11/5/2024 at 1:48 p.m., with the Social Services Director (SSD), when asked if the incident (Resident 5 punched Resident 4 in the face on 10/17/2024) between Resident 4 and Resident 5 was physical abuse, the SSD stated that he (SSD) did not feel comfortable answering the question. The SSD stated that Resident 5 had history of aggressive behavior and that the facility should have been more proactive in monitoring Resident 5 ' s behavior to ensure other residents were not within range for Resident 5 to punch or hit.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the facility ' s policy and procedure titled, Abuse, Neglect (fail to care properly), and Exploitation (taking advantage of a resident), last reviewed in 9/25/2024, indicated it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550</p> <p>Based on interview, and record review, the facility failed to implement its policy and procedure by failing to conduct a thorough investigation for an allegation of physical abuse (deliberately aggressive or violent behavior with the intention to cause harm by one resident towards another) for two of three sampled residents (Resident 4 and Resident 5) when on 10/17/2024 at around lunch time, Registered Nurse 2 (RN 2) witnessed Resident 5 punched Resident 4 with his (Resident 5) closed fist twice on the right side of face while Resident 4 was sitting on the wheelchair.</p> <p>This deficient practice had the potential to place the residents at risk for further abuse and may lead to serious outcomes.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record, the Admission Record indicated the facility admitted Resident 4 on 12/6/2022 with diagnoses that included hemiplegia (total or partial paralysis [loss of the ability to move] of one side of the body) and hemiparesis (one-side muscle weakness) following cerebral infarction (damage to the tissues in the brain due to a loss of oxygen to the area) affecting right dominant side and dysphagia (difficulty swallowing) following cerebral infarction.</p> <p>During a review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/16/2024, the MDS indicated Resident 4 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS also indicated Resident 4 required partial or moderate assistance (helper does less than half the effort) with eating, and is dependent with oral hygiene, toileting hygiene, and personal hygiene.</p> <p>During a review of Resident 4 ' s Change in Condition (COC- a significant change in resident ' s health status) Evaluation, dated 10/17/2024, timed at 4:36 p.m., the COC indicated the resident (Resident 4) received punch from another resident (Resident 5) while sitting in wheelchair.</p> <p>During a review of Resident 5 ' s Admission Record, the Admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included schizophrenia (a mental illness that affects a person ' s thoughts, feelings, and behaviors), unspecified mood disorder (a mental health condition that primarily affects a person ' s emotional state), and personal history of traumatic brain injury (a brain injury caused by an external force such as a blow, jolt or impact to the head).</p> <p>During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had severely impaired cognition. The MDS also indicated Resident 5 required partial/moderate assistance with eating and oral hygiene, dependent with toileting hygiene, and required substantial/maximal assistance (helper does more than half the effort) with personal hygiene.</p> <p>During a review of Resident 5 ' s Change in Condition Evaluation dated 10/17/2024, timed at 1:19 p.m., indicated the resident (Resident 5) was noted with episode of attempting to attack another resident (Resident 4).</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 5 ' s Physician Orders dated 10/17/2024, timed at 7:12 p.m., the Physician Order indicated to transfer Resident 5 to General Acute Care Hospital 1 (GACH 1) due to physical aggression (behavior directed toward another person that results in physical harm or has the potential to cause physical harm) towards the other Resident.</p> <p>During a concurrent interview and record review on 11/4/2024 at 9:17 a.m., with the Social Services Director (SSD), the SSD stated that he (SSD) was designated to investigate the resident-to-resident altercation between Resident 4 and Resident 5 that occurred on 10/17/2024 at around lunch time. The SSD reviewed the facility ' s investigation summary dated, 10/22/2024 and stated that all staff that were interviewed during the SSD ' s investigation was included in the investigation summary. The SSD stated two (2) Certified Nursing Assistants, the Director of Nursing (DON), and one (1) Registered Nurse was interviewed. The SSD continued to state that based on the facility ' s investigation, Resident 5 ' s arms were flailing (to move energetically in an uncontrolled way) around when Resident 5 ' s arm made contact with Resident 4 ' s cheek.</p> <p>During an interview on 11/4/2024 at 3:45 p.m., with RN 2, RN 2 stated that on 10/17/2024 at around lunch time, RN 2 witnessed Resident 5 punched Resident 4. RN 2 stated that RN 2 was at station 4 at around lunch time. RN 2 witnessed Resident 4 being wheeled next to Resident 5, Resident 5 reached over and pulled Resident 4 ' s wheelchair close to Resident 5 and punched Resident 4 with a closed fist twice in the face.</p> <p>During a concurrent interview and record review on 11/4/2024 at 3:59 p.m., with the SSD, the SSD reviewed the facility ' s investigation summary dated, 10/22/2024. The SSD stated that because the DON was present during the alleged altercation between Resident 4 and Resident 5 on 10/17/2024, the SSD ' s investigation was based on the names the DON provided. The SSD further stated that the facility is a skilled nursing facility, and these things happen. The SSD stated that it is hard for the facility to prevent these incidents from occurring. When asked if the SSD conducted a record review of the incident, the SSD stated that he could not recall. When asked if the SSD interviewed RN 2 as part of his investigation, the SSD stated he could not recall. When asked if the SSD interviewed Resident 5 ' s assigned charge nurse, the SSD stated he could not recall. The SSD was unable to provide documented evidence that RN 2 and Resident 5 ' s assigned licensed nurse was interviewed during his investigation.</p> <p>During a follow up interview on 11/4/2024 at 4:11 p.m., with the SSD, when asked if a thorough investigation was conducted, the SSD stated that he did not conduct thorough interviews, nor did he conduct a thorough investigation. The SSD stated that the SSD will need to investigate again and turn in a new report. SSD stated that he (SSD) should have conducted a thorough investigation of the resident-to-resident altercation (Resident 5 [with a closed fist] punched Resident 4 in the face twice on 10/17/2024) for resident ' s safety.</p> <p>During an interview on 11/5/2024 at 10:51 a.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated she (LVN 2) was assigned to Resident 5 on 10/17/2024. LVN 2 stated that on 10/17/2024 at around lunch time, LVN 2 witnessed Resident 5 punched Resident 4 with his (Resident 5 ' s) closed fist twice on the right side of Resident 4 ' s face. LVN 2 stated that the SSD asked her (LVN 2) what happened during the altercation between Resident 4 and Resident 5. LVN 2 stated that it was a verbal discussion (a conversation where people exchange ideas, feelings, and thoughts using spoken words), and that the SSD did not formally write down her (LVN 2) statement.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/5/2024 at 1:48 p.m., with the SSD, when asked if SSD interviewed LVN 2 during his initial investigation into Resident 4 and Resident 5 ' s altercation, the SSD stated that there was so many things going on that day that the SSD does not recall.</p> <p>A review of the facility's policy and procedure titled Abuse, Neglect (failure to care properly), Exploitation (taking advantage of a resident), last reviewed in 9/25/2024, indicated it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect . Under investigation of alleged abuse, neglect, and exploitation: B. Written procedures for investigations include: 4. Identifying and interviewing all involved persons, including alleged victim, alleged perpetrator, witnesses, others who might have knowledge of the allegations; 6. Providing complete and thorough documentation of the investigation.</p>