STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056124	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tarzana Health and Rehabilitation Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43636 Based on interview and record review the facility failed to document wound care treatment provided for one of three sampled residents (Resident 2) in the Treatment Administration Record (TAR-medical record indicating treatment provided to the resident). This deficient practice had the potential for inconsistent treatment as ordered by the physician, worsening of current pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and worsening skin condition. Findings: During a review of Resident 2 ' s Admission Record dated 2/28/2025, the Admission Record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), alcoholic cirrhosis of liver (a condition in which your liver Is scarred and permanently damaged), dysphagia (difficulty in swallowing), and chronic kidney disease (decreased function of the kidneys). During a review of Resident 2 ' s physician orders dated 3/1/2025, the physician orders indicated an order to cleanse gastrostomy tube (a tube used for feeding) with normal saline (a solution that contains salt water) and pat dry and cleanse (pressure ulcer of the sacrum [bone located at the base of the spine] with normal saline, pat dry then paint betadine and cover with a boarder dressing everyday shift. During a review of Resident 2 ' s skin assessment (a complete evaluation of a person ' s skin, hair, and nails to identify any signs of damage) dated 3/1/2025, the assessment indicated, Resident 2 was admitted to the facility with an unstageable pressure ulcer of the sacrum area and a gastrotomy tube. During a review of Resident 2 ' s History and Physical (H&P) dated 3/2/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/6/2025, the MDS indicated, Resident 2 was dependent on staff for assistance with activities of daily (ADL-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056124	A. Building B. Wing	04/03/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review Resident 2 ' s TAR dated March 2025, the TAR indicated, from 3/1/2025 to 3/3/2025, documentation for treatment to clean the gastrotomy tube site and cleansing the (sacrum) wound site with normal saline were left blank. During an interview on 4/3/2025 at 1:15 p.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated on 3/3/2025, LVN 2 was working as a treatment nurse and he (LVN 2) provided treatment to Resident 2 and completed the physician orders for treatment to the sacrum and gastrotomy tube site. LVN 2 stated stated he should have documented in the TAR indicating the treatment was completed, after providing treatment to Resident 2 During an interview on 4/3/2025 at 2:00 p.m. with LVN 3, LVN 3 stated on 3/1/2025 and 3/2/2025 she was working as a treatment nurse. LVN 3 stated that on 3/1/2025, LVN 1 completed the skin assessment and provided the treatment to Resident 2's sacrum and gastrotomy tube site. LVN 3 stated on 3/2/2025, LVN 3 also provided the treatment to Resident 2's sacrum and gastrotomy tube site. LVN 3 stated she should have documented in the TAR, indicating that the treatment was completed, after providing the treatment to Resident 2. During an interview with the Director of Nursing (DON) on 4/3/2025 at 3:45 p.m., the DON stated after the licensed nurses provided the treatment to Resident 2's sacrum and gastrotomy tube site, the licensed nurses should have documented in the TAR that the treatment had been completed as ordered by the physician. During a review of the facility policy and procedure (P&P) titled Documentation in Medical Record dated 4/25/2024, the P&P indicated, each resident ' s medical record shall contain a representation of the experiences of the resident an include enough information to provide a picture of the resident ' s progress . Documentation can be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.