

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  09/10/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to implement infection control practices during a Coronavirus Disease 2019 (COVID-19 - a highly contagious respiratory illness in humans capable of producing severe symptoms caused by the SARS-CoV-2 virus) outbreak (OB - when more people than usual get sick with a particular disease in a specific area over a certain time period) by:1. Failing to ensure two of 13 sampled staff (Activity Assistant 1 [AA 1] and Certified Occupational Therapy Assistant 1 [COTA 1]) wore masks properly, covering both nose and mouth while in resident care areas2. Failing to ensure two of 13 sampled staff (Physical Therapist 1 [PT 1] and Housekeeping 1 [HK 1]) performed hand hygiene (HH - cleaning hands by either washing with soap and water, or by using a hand sanitizing [removing germs] gel) when:a. PT 1 failed to perform HH after Resident 6's physical therapy session and before touching the resident's body, wheelchair, and other objects.b. HK 1 failed to perform HH after handling trash in Restroom [ROOM NUMBER]. 3. Failing to ensure one of 13 sampled staff (HK 1) observed proper trash handling, as four trash bags touched HK 1's body during transport to the outside bin.These deficient practices had the potential to result in the spread of infection placing residents, staff, and visitors at risk of being infected with COVID-19. Findings:During an observation on 9/10/2025 at 7:55 a.m. observed a sign posted at the facility entrance indicating COVID-19 Exposure, dated 8/29/2025 and timed at 10:30 a.m.During an interview on 9/10/2025 at 2 p.m., with the Infection Prevention Nurse (IPN), the IPN stated that as of 9/10/2025, there are a total of 15 residents and eight staff with confirmed COVID-19 cases, since the initial exposure on 8/28/2025, and the outbreak (OB) is still ongoing.1.a. During a concurrent observation and interview on 9/10/2025 at 8:20 a.m., with AA 1, observed AA 1 sitting in the facility entrance area, wearing a surgical mask, positioned below the nose, covering only the mouth. AA 1 stated that he was assigned as a companion for residents who go out to medical appointments and was waiting for a resident. When AA 1 was asked if he was aware there is an ongoing COVID-19 OB in the facility, AA 1 responded that he has received training on proper mask use and that he should have covered both his mouth and nose with the surgical mask.1.b. During a record review of Resident 5's admission Record, the admission Record indicated that the facility admitted Resident 5 on 8/25/2025 with diagnoses including malignant (harmful or cancerous) neoplasm (an abnormal growth of cells that can form a mass or tumor) of tongue.During a review of Resident 5's Minimum Data Set (MDS - a comprehensive assessment and screening tool) dated 8/30/2025, the MDS indicated that Resident 5's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS further indicated that Resident 5 required moderate assistance with toileting hygiene, dressing, and bed mobility (movement). During a review of Resident 5's Care Plan (CP) Report on COVID-19 Infection initiated on 9/4/2025, the CP indicated that Resident 5 required care and isolation precautions specifically related to COVID-19 infection and was exposed to the COVID-19 positive roommate on 9/3/2025. The intervention indicated to follow current policy and procedures for management of COVID-19.During a concurrent observation and interview on 9/10/2025 at 9:10 a.m., with COTA 1 observed a novel respiratory precaution (NRP - precautions should be used for residents known or suspected of being infected with COVID-19) sign posted outside Resident 5's room. Observed COTA 1 standing in Resident 5's doorway, talking to Resident 5. COTA 1 was wearing a surgical mask positioned below the nose, covering only the mouth. COTA 1 stated that he was aware of the ongoing COVID-19 OB and did not notice that his (COTA 1) surgical mask slid down and was covering only his mouthDuring an interview on 9/10/2025 at 1:45 p.m. with the DON, the DON stated that during a COVID-19 OB, all staff should wear well-fitted surgical mask covering both their mouths and noses in the resident care areas to protect residents and staff. During a review of the facility policy and procedure (P&amp;P) titled Infection Outbreak Response and Investigation revised 4/24/2025, the P&amp;P indicated, The facility promptly responds to outbreaks of infectious diseases within the facility to stop transmission of pathogens (any organism that causes disease) and prevent additional infections. Staff will be educated on the mode of transmission of the organism, symptoms of infection, and isolation or other special procedures. This includes special environmental infection control measures that are warranted based on the organism and the current Centers for Disease Control and Prevention (CDC) guidelines,During a review of the facility P&amp;P titled Transmission-Based (Isolation) Precautions revised 4/24/2025, the P&amp;P indicated, Initiation of Transmission-Based (Isolation) Precautions. Signage that includes instructions for use of specific PPE will be</p>		