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	11/21/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain room temperatures within the required range of 71 degrees Fahrenheit (F - a scale of temperature) to 81 F for one of three sampled residents (Resident 1) room and in the facility's lobby areas. This deficient practice violated residents' rights to a comfortable, homelike environment and had the potential to adversely affect their quality of life.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 5/1/2022 and re-admitted on [DATE] with diagnoses including Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills, eventually making it difficult to carry out daily tasks) and UTI. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 9/25/2025, the MDS indicated that Resident 1 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and requires maximal assistance from staff with toileting hygiene, shower, lower body dressing, bed mobility (movement), and transfer. 1. During a concurrent observation and interview on 11/20/2025 at 8:10 a.m., in Resident 1's room, with Certified Nursing Assistant 1 (CNA 1), observed Resident 1 lying in bed with three (3) layers of blankets over the sheet. When asked whether she (Resident 1) did not respond to the question. During a concurrent observation and interview on 11/20/2025 at 8:35 a.m., Maintenance Assistant 1 (MA 1) checked Resident 1's room temperature using a facility infrared thermometer (a non-contact device that measures temperature by detecting the thermal radiation, or infrared energy, emitted by an object). MA 1 stated the readings ranged from 69.6 F at Resident 1's bedside to 70 F at the bedsides of the other two residents in the room. MA 1 further stated that Temperature Control Box 1 (TCB 1), mounted next to Nurse Station 1 (NS 1) and responsible for regulating Resident 1's room temperature, displayed the following settings: set temperature - 72ˆ, inside temperature - 72ˆ, fan - Auto, and system - Cool. During a concurrent observation and interview on 11/20/2025, at 9:04 a.m., in Resident 1's room, with the Maintenance Supervisor (MS), the MS checked Resident 1's room temperature and stated that the temperature at Resident 1's bedside was 68.5ˆ. The MS further stated that the system on TCB 1 should have been set to heat but when he checked it earlier, it was set to cool. During a concurrent observation and interview on 11/20/2025, at 11 a.m., in Resident 1's room, with the MS, the MS checked Resident 1's room temperature and stated that the temperature at Resident 1's bed side was 69.3ˆ, which was still below the set point of 72ˆ. The MS further stated that it would take some time for the temperature to increase. 2. During a concurrent observation and interview on 11/20/2025, at 8:43 a.m., in the facility lobby, with MA 1 and Receptionist 1, MA 1 checked the temperature in the lobby and stated that the readings ranged from 63.1ˆ to 65.1ˆ. MA 1 then checked the Temperature Control Box 2 (TCB 2) and stated that the current temperature displayed was 69ˆ and that the system was turned off. MA 1 used a key to open TCB 2 and turned the system on, setting the temperature to 72ˆ. When MA 1 was asked why TCB 2 had not been turned on, MA 1 stated that the staff member (did not specify) responsible for turning it on each morning at approximately 7:30 a.m. had been busy and occupied with other tasks at that time. During a phone (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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tarzana Health and Rehabilitation Center	5650 Reseda Blvd Tarzana, CA 91356

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 11/20/2025 at 10:32 a.m., with Family Member 1 (FM 1), FM 1 stated that whenever FM 1 met Resident 1 in the facility lobby, Resident 1's hands were always cold, and Resident 1 appeared to be cold at all times. During an interview on 11/20/2025 at 2:23 p.m., with the Director of Nursing (DON), the DON stated that temperatures should be maintained between 71ˆ and 81ˆ in all areas, including residents' rooms and lobby areas. The DON further stated that the facility would need to revise its Policy and Procedure (P&P) to reflect the correct required temperatures range, changing it from 72ˆ-82ˆ to 71ˆ-81ˆ. During a concurrent interview and record review on 11/21/2025, at 2:07 p.m., the MS reviewed the Maintenance Room/Air Temperature Logs for October 2025 and November 2025 in the Room Temperature binder and stated that the facility had only been documenting temperatures for residents' rooms, not for other areas. The MS stated that this practice had been in place for the two years he (MS) had worked at the facility. The MS stated that he would begin adding lobby temperature checks to the log. The MS stated that the facility had been checking lobby temperatures when checking residents' room temperatures. During a review of the facility's P&P titled, Safe and Homelike Environment last reviewed on 4/24/2025, the P&P indicated, Comfortable and safe temperature levels mean the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility loss of body heat and risk of hypothermia/hyperthermia and is comfortable for the residents. Environment refers to any environment in the facility that is frequented by resident's including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. The facility should strive to keep the temperature in common areas between 72 and 82 degrees Fahrenheit.

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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 observation, interview, and record review, the facility failed to ensure a resident who was incontinent (having no or insufficient voluntary control) of bladder (a hollow, muscular organ that stores urine before it is expelled from the body) and bowel (the long tube that carries solid waste from the stomach out of the body) function, received appropriate care and services for one of six sampled residents (Resident 1) by failing to implement its policy and procedures (P&P) on Perineal (the area of the body between the anus [the opening at the end of the digestive tract where stool {feces} exits the body] and the genitals) Care when Certified Nursing Assistant (CNA 1) used a soiled towel to wipe the perineal areas and did not rinse the perineal area while providing perineal care. This deficient practice had the potential to result in urinary tract infection (UTI- an infection in any part of the urinary system, most commonly caused by bacteria), skin irritation, and unpleasant odor.During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 5/1/2022 and re-admitted on [DATE] with diagnoses including Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills, eventually making it difficult to carry out daily tasks) and UTI. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 9/25/2025, the MDS indicated that Resident 1 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and requires maximal assistance from staff with toileting hygiene, shower, lower body dressing, bed mobility (movement), and transfer. The MDS further indicated Resident 1 was occasionally incontinent of both bladder and bowel function. During a concurrent observation and interview on 11/20/2025 at 8:10 a.m., with Certified Nursing Assistant 1 (CNA 1), observed CNA 1 providing perineal care to Resident 1 while Resident 1 was in bed. CNA 1 prepared a big towel by wetting it in the bathroom within Resident 1's room and applying perineal cleanser. CNA 1 did not use a basin and used the same towel throughout Resident 1's perineal care. CNA 1 cleaned Resident 1's front perineal area using one end (wet end of the towel) of the towel, then dried the area using the other end (dried end of the towel). CNA 1 then turned Resident 1 to clean the buttocks with the same towel previously used for the front perineal area. CNA 1 did not fold the towel or rinse Resident 1's perineal area during care. When CNA 1 was further interviewed after completing Resident 1's perineal care, CNA 1 stated that only one big towel was used to clean Resident 1's front and back perineal areas because total morning care was to be provided (by CNA 1) later. CNA 1 stated that the perineal areas were not cleaned thoroughly at that time. During an interview on 11/20/2025 at 2:14 p.m., with the Director of Nursing (DON), the DON stated that CNA 1 used only one towel to provide Resident 1's perineal care, which did not follow the facility's perineal care protocol. The DON stated that CNA 1 should have used at least two separate towels - one for the front perineal area and another for the buttocks area. The DON further stated that using a single towel for both front and back perineal areas violated infection control practices and could result in cross contamination (the physical movement or transfer of harmful germs from one person, object or place to another). During a review of the facility's P&P titled, Perineal Care last reviewed on 4/22/2025, the P&P indicated, It is the practice of this facility to provide perineal care to all incontinent residents in order to promote cleanliness and comfort, prevent, skin irritation and to observe resident's skin condition. Gather supplies needed. Females: Assist resident bending her knees and spreading her legs. Gently rinse and dry the area. Repeat on opposite side using separate section of washcloth or new disposable wipe. using clean portion of washcloth or new disposable wipe with each stroke.