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	04/03/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review the facility failed to ensure one of three sampled residents' (Resident 1), physician was notified of Resident 1's refusal of potassium chloride (medication used to prevent low blood potassium levels) and metoprolol succinate (a medication that lowers blood pressure and heart rate) for three or more consecutive doses. This failure had the potential to result in Resident 1 having decreased levels of potassium (a vital mineral and electrolyte necessary for nerve function and maintaining a regular heartbeat), increased blood pressure, and placed Resident 1 at risk for a decline in overall health status. Findings:During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 on 1/19/2026 with diagnoses that included chronic respiratory failure (improper lung function which may lead to shortness of breath), pneumonia (an infection/inflammation in the lungs), dysphagia (difficulty swallowing), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hypertension (HTN-high blood pressure).During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition) dated1/20/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/26/2026, the MDS indicated Resident 1's cognition (ability to think and make decisions) was intact. The MDS further indicated Resident 1 required set-up assistance with eating, supervision with oral hygiene, upper body dressing and personal hygiene. Resident 1 dependent on staff for toileting hygiene and showering. During a review of Resident 1's Physician Order Summary, dated 1/20/2026, the Physician Order Summary indicated Resident 1 had a physician order for potassium chloride extended release oral tablet 20 milliequivalent (MEQ-unit of measurement), give 1 tablet by mouth one time a day for potassium supplement adjunction due to use of Lasix (a medication used to decrease swelling and lowers blood pressure) medication. The Physician Order Summary further indicated a physician order dated 2/1/2026, for metoprolol succinate extended-release oral tablet 50 milligrams (mg-unit of measurement), give 1 tablet in the morning for hypertension.During a review of Resident 1's Medication Administration Record (MAR) dated February 2026, the MAR indicated Resident 1 refused potassium chloride extended release from 2/17/2026 to 2/19/2026, and 2/23/2026 to 2/28/2026. The MAR also Resident 1 refused metoprolol succinate extended-release oral tablet from 2/3/2026 to 2/6/2026, 2/9/2026 to 2/12/2026, 2/16/2026 to 2/18/2026, and 2/20/2026 to 2/22/2026. During a review of Resident 1's MAR dated March 2026, the MAR indicated Resident 1 refused potassium chloride extended release from 3/4/2026 to 3/9/2026 and 3/11/2026 to 3/14/2026.During an interview on 4/2/2026 at 3:20 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that LVN 1 administered medications to Resident 1 during Resident 1's admission to the facility. LVN 1 stated that Resident 1 at times refused medication ordered by the physician. LVN 1 stated that when a resident refuses medication 3 or more times, the physician should be notified. LVN 1 stated that LVN 1 did not document that the physician was notified of Resident 1's refusal of medications. During a concurrent interview and record review (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
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Tarzana Health and Rehabilitation Center	5650 Reseda Blvd Tarzana, CA 91356

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 4/3/2026 at 3:00 p.m. with the Director of Nursing (DON), Resident 1's MAR dated February 2026 and March 2026 were reviewed. The DON stated that the MAR dated February 2026 and March 2026 indicated Resident 1 refused potassium chloride and metoprolol succinate multiple times. The DON stated when a resident refuses medications three consecutive times the licensed nurse should notify the prescribing physician. The DON stated that the nursing staff should have informed Resident 1's physician regarding Resident 1's refusal of potassium chloride and metoprolol succinate. During a review of the facility policy and procedure (P&P) titled Medication Administration last reviewed on 4/24/2026, the P&P indicated Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.report and document any adverse side effects or refusals.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) had weekly skin assessments completed in accordance with the facility's policy and procedure (P&P) titled Skin Assessment. This failure had the potential to result in the delay of identification and timely intervention of skin breakdown and pressure injuries (also known as pressure sores and decubitus ulcers, localized damage to the skin and/or underlying tissue caused by prolonged pressure or friction, often over bony areas) and placed Resident 1 at risk for a decline in overall health status.Findings:During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 on 1/19/2026 with diagnoses that included chronic respiratory failure (improper lung function which may lead to shortness of breath), pneumonia (an infection/inflammation in the lungs), dysphagia (difficulty swallowing), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and hypertension (HTN-high blood pressure). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition) dated 1/20/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/26/2026, the MDS indicated Resident 1's cognition (ability to think and make decisions) was intact. The MDS further indicated Resident 1 required set-up assistance with eating, supervision with oral hygiene, upper body dressing and personal hygiene, and was dependent on staff for toileting hygiene and showering. During an interview on 4/3/2026 at 12:45 p.m. with the Medical Records Director (MRD), the MRD stated that during the MRD's review of Resident 1's medical record, Resident 1's skin assessment was completed on 1/19/2026, 1/20/2026, 2/2/2026 and 3/1/2026. The MRD stated there were no other documented skin assessments found in Resident 1's medical record. During a concurrent interview and record review on 4/3/2026 at 3:00 p.m. with the Director of Nursing (DON) the facility's P&P tilted, Skin Assessment with a last review date of 4/24/2026 was reviewed. The P&P indicated a full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. The DON stated that licensed nurses should have conducted Resident 1's weekly skin assessment during Resident 1's admission in the facility.During a review of the facility P&P titled Skin Assessment with a last review date of 4/24/2025 indicated, It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedure guidelines in performing the full body skin assessment.a full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury.