

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 04/30/2026
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a call light (a device used by a resident to signal his/her need for assistance from staff) was within a resident's reach while in bed for one of three sampled residents (Resident 2). This deficient practice had the potential to delay the provision of services and residents' needs not being met. Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted Resident 2 on 1/29/2026 and re-admitted Resident 2 on 4/27/2026 with diagnoses including muscle weakness and diverticulitis (inflammation of irregular bulging pouches in the wall of the large intestine) of large intestine with perforation (a hole or tear that develops through the wall of a body organ) and abscess (a localized collection of pus that forms) with bleeding. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 2/23/2026, the MDS indicated Resident 2's cognitive (the mental process involved in knowing, learning, and understanding things) skills for daily decision making was moderately impaired. The MDS indicated Resident 2 required setup pr clean up assistance from staff with eating, required supervision with oral hygiene, required partial/moderate assistance from staff with toileting hygiene, and required substantial/maximal assistance from staff with showering or bathing. During an observation on 4/30/2026 at 9:00 a.m., in Resident 2's room, observed Resident 2 in bed, with their call light not within reach. Observed Resident 2's call light hanging on the wall behind Resident 2's headboard. During a concurrent observation and interview on 4/30/2026 at 9:24 a.m., with Licensed Vocational Nurse 1 (LVN 1), in Resident 2's room, observed Resident 2 in bed with their call light not within reach. Observed Resident 2's call light hanging on the wall behind Resident 2's headboard. Observed LVN 1 reach over Resident 2's headboard and observed LVN 1 clip and place the call light next to Resident 2's right hand. LVN 1 stated that the call light should always be next to the resident for safety. LVN 1 continued to state that Certified Nursing Assistants (CNAs) are responsible for making sure that call lights are within residents' reach because CNAs are always checking on the residents. During an interview on 4/30/2026 at 4:15 p.m., with the Director of Nursing (DON), the DON stated that call lights should always be within residents' reach, clipped by the bed. The DON stated that it is important to have residents' call light within reach for residents' to be able to reach the call light and whenever the residents need help or assistance residents can easily call staff. The DON stated if call lights are not within reach, residents may not be able to call for assistance when needed. During a review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, last reviewed on 4/24/2025, the P&P indicated staff will be educated on the proper use of the resident call light system including how the system works and ensuring resident access to the call light. Staff will ensure the call light is within reach of resident and secured. The call system will be accessible to residents while in their bed or other sleeping accommodations within the residence room.</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
-----------------------------------------------------------------------	-------	-----------

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 04/30/2026
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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>Based on interview and record review, the facility failed to develop a baseline care plan (a document designed to facilitate communication among members of the care team that summarizes a resident's health conditions, specific care needs, and current treatments) within 48 hours of a resident's admission to the facility to reflect the immediate needs that included interventions to address congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) for one of three sampled residents (Resident 1). This deficient practice placed Resident 1 at risk for not having goals and interventions specific to Resident 1's diagnosis of CHF and had the potential to negatively affect the health and well-being of Resident 1. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 4/2/2026 with diagnoses including CHF. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/8/2026, the MDS indicated Resident 1's cognitive (the mental process involved in knowing, learning, and understanding things) skills for daily decision making was moderately impaired. The MDS indicated Resident 1 required setup or clean up assistance from staff with oral hygiene, required supervision or touching assistance from staff with eating and personal hygiene, and is dependent with toileting hygiene and showering and bathing. During a concurrent interview and record review on 4/30/2026 at 1:30 p.m., with the MDS Nurse, the MDS Nurse stated that care plans related to residents' diagnosis are initiated by the MDS department. The MDS Nurse reviewed Resident 1's baseline care plans and stated that there is no documented evidence that Resident 1 has a baseline care plan for Resident 1's diagnosis of CHF. The MDS Nurse stated that Resident 1 should have had a baseline care plan specific to CHF because CHF was Resident 1's primary admitting diagnosis. During an interview on 4/30/2026 at 4:14 p.m., with the Director of Nursing (DON), the DON stated that baseline care plans are important to be initiated on admission to ensure nursing staff provide the appropriate care for residents based on their admitting diagnosis. The DON stated baseline care plans are important to be in place so facility staff will be able to evaluate interventions and if interventions are not appropriate for the resident facility staff will be able to revise, if needed. During a review of the facility's policy and procedure (P&P) titled, Baseline Care Plan, last reviewed on 4/24/2025, the P&P indicated the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. B. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders; ii. Physician orders; iii. Dietary orders; iv. Therapy services; v. Social services. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. b. Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury.</p>		

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 04/30/2026
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistant 1 (CNA 1) provided two-person physical assistance when using a mechanical lift machine (a device used to move those who are unable to stand on their own or whose weight makes it unsafe to move or lift them manually) when adjusting a resident while on the shower chair for one of three sampled residents (Resident 3). This deficient practice had the potential for the resident to experience discomfort during transfer by a mechanical lift and may lead to accident such as a fall and injury. Findings: During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 5/13/2025 with diagnoses including metabolic encephalopathy (a brain dysfunction caused by chemical imbalances in the body), abnormalities of gait and mobility, and lack of coordination. During a review of Resident 3's History & Physical (H&P- the initial, comprehensive assessment to understand a patient's health issues and determine a diagnosis and treatment) dated 11/3/2025, the H&P indicated that Resident 3 does not have the capacity to understand or make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 3/31/2026, the MDS indicated Resident 3 required setup or clean up assistance with eating and required partial moderate assistance with oral hygiene, shower/bathing self, and personal hygiene. During a review of Resident 3's care plan (a document that summarizes a resident's needs, goals, and care/treatment) for activities of daily living (ADL- fundamental, routine self-care tasks that individuals perform daily to maintain independence and personal hygiene, such as bathing, dressing, eating, toileting, and mobility) self-care performance initiated on 8/15/2025, the care plan indicated under interventions: Transfer: The resident requires mechanical lift with two (2) staff assistance for transfers. During an observation on 4/30/2026 at 9:31 a.m., in Resident 3's room, observed Resident 3 sitting on a shower chair with a mechanical lift sling on Resident 3, and the mechanical lift sling straps attached to the mechanical lift hooks. Observed Certified Nursing Assistant 1 (CNA 1) press buttons on the mechanical lift control and observed Resident 3 lifted slightly from the shower chair. Observed CNA 1 press buttons on the mechanical lift control and observed Resident 3 seated back on the shower chair. During an interview on 4/30/2026 at 2:35 p.m., with CNA 1, CNA 1 stated that CNA 1 is assigned to Resident 3 today (4/30/2026) and today (4/30/2026) was Resident 3's shower day. CNA 1 stated that she was setting up Resident 3 onto the mechanical lift by placing the mechanical lift sling straps on the mechanical lift handles. CNA 1 stated that she was waiting for another CNA to assist CNA 1 to transfer Resident 3 back to bed when CNA 1 noticed Resident 3's forehead was touching the metal bar of the mechanical lift. CNA 1 stated that because Resident 3 is tall, CNA 1 decided to elevate Resident 3 from the shower chair and adjust Resident 3 and the mechanical lift so that Resident 3 does not hit his head on the mechanical lift bar. CNA 1 stated that she is aware that Resident 3 is a two-person assist when transferring because he is a tall resident. CNA 1 continued to state that she made a mistake by elevating Resident 3 and moving the mechanical lift without a second staff member present to assist CNA 1. CNA 1 stated that when working with the mechanical lift and maneuvering residents while on the mechanical lift, there should always be two staff members present with the resident for resident safety. During an interview on 4/30/2026 at 4:18 p.m., with the Director of Nursing (DON), the DON stated that when staff use a mechanical lift to transfer residents, there should always be two staff members present for a two-person assist. The DON stated having two staff members present ensures the safety of the residents and to prevent accidents. The DON continued to state that CNA 1 should have waited for assistance prior to maneuvering the mechanical left by herself. During a review of the facility's policy and procedure (P&P) titled, Accidents and Supervision, last reviewed on 4/24/2025, the P&P indicated the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents.</p>		

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 04/30/2026
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interview and record review, the facility failed to ensure licensed nurses held (did not give) a resident's blood pressure (the force of blood pushing against the walls of the arteries) medications when the resident's blood pressure was outside of the physician's prescribed parameters (a set of defined limits) for one of three sampled residents (Resident 1). This deficient practice had the potential to place the resident at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention) from the medication. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 4/2/2026 with diagnoses including Diastolic (Congestive) Heart Failure (occurs when the heart muscle becomes stiff and cannot relax properly between beats) and essential HTN. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 4/8/2026, the MDS indicated Resident 1's cognitive (the mental process involved in knowing, learning, and understanding things) skills for daily decision making was moderately impaired. The MDS indicated Resident 1 required setup or clean up assistance from staff with oral hygiene, required supervision or touching assistance from staff with eating and personal hygiene, and is dependent with toileting hygiene and showering and bathing. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following orders- Furosemide (a prescription medication used to treat fluid retention and hypertension [high blood pressure- the force of the blood pushing on the blood vessel walls is too high]) oral tablet 40 milligrams (mg- unit of measurement). Give one tablet by mouth one time a day for diastolic heart failure. Hold for systolic blood pressure (SBP - the first number in a blood pressure reading, which measures the pressure in the arteries [pathway that carries blood away from the heart] when the heart beats) less than 110 millimeters of mercury (mmHg- unit of measurement). Order date: 4/3/2026. Start date: 4/4/2026.- Losartan potassium (medication used to treat hypertension) oral tablet 25 mg. Give 0.5 tablet by mouth one time a day for HTN. 0.5 Tab = 12.5 mg. Hold for SBP less than 110 mmHg or heart rate less than 60 beats per minute. Order date: 4/2/2026. Start date: 4/3/2026. During a concurrent interview and record review on 4/30/2026 at 3:06 p.m., with the MDS Nurse, reviewed Resident 1's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 4/2026. The MDS Nurse stated that prior to administering blood pressure medications, licensed nurses are to take residents' blood pressure, then check the physician's order to see if there are any parameters to follow. The MDS Nurse reviewed Resident 1's MAR for 4/2026 and stated that furosemide 40 mg and losartan 25 mg was administered to Resident 1 on 4/9/2026 with a SBP of 107 mmHg and on 4/14/2026 for a SBP of 98 mmHg. The MDS Nurse stated that Resident 1 should not have been administered furosemide 40 mg and losartan 25 mg on 4/9/2026 and on 4/14/2026 based on Resident 1's physician's ordered parameters. The MDS Nurse stated that potential negative outcomes that may occur from administering furosemide and losartan on 4/9/2026 and 4/14/2026 are low blood pressure which can cause Resident 1 to become lethargic (a state of sluggishness, profound tiredness, and lack of energy or motivation), dizziness, and may need to be transferred to the hospital for further evaluation. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, last reviewed on 4/24/2025, 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 the matter to prevent contamination or infection. Obtain and record vital signs, when applicable or per physician's order. When applicable, hold medication for this vital signs outside the physician's prescribed parameters.</p>		