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	05/05/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to remain free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 1), when on 4/16/2026, Resident 2 punched Resident 1 in the face several times with a closed fist (a person's hand when the fingers are bent in toward the palm and held there tightly). This deficient practice resulted in Resident 1 being subjected to physical abuse by Resident 2 while under the care and supervision of the facility. Resident 1 sustained a loose tooth and bleeding gums.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 7/20/2023, with diagnoses that included hypertensive heart disease (heart damage caused by long-term high blood pressure) with heart failure, osteoporosis (bone disease that makes the bones weak, increasing the risk for fractures [break in the bone]) and bed confinement status (a person's inability to leave their bed without significant assistance, typically due to illness, injury, or frailty [significant decline in physical, mental, or physiological [relating to how the physical body and its parts work] function]). During a review of Resident 1's History and Physical Examination (H&P - medical evaluation consisting of a detailed resident interview regarding their health history and a structured physical assessment) dated 12/10/2025, the H&P indicated Resident 1 can make needs known but cannot make medical decisions. During a review of Resident 1's Physician Progress Notes dated 4/18/2026, the Physician Progress Notes indicated that on 4/16/2026 Resident 1 reported that another resident (Resident 2) walked up to him and hit him (Resident 1) on the face, unprovoked (an action, attack, or outburst that occurs without any identifiable cause, justification, or warning). The Physician Progress Notes further indicated that Resident 1 is bedbound (when a person is unable to get out of bed without significant assistance due to illness, injury, or severe weakness). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/24/2026, the MDS indicated Resident 1 had intact cognition (ability to think and make decisions). The MDS further indicated Resident 1 required extensive assistance with activities of daily living (ADLs- activities related to personal care such as bathing, dressing and toileting). During a review of Resident 1's Progress Notes dated 4/16/2026, timed at 2:54 p.m., the Progress Notes indicated that on 4/16/2026 Resident 1 sustained bleeding gums and a loose tooth after his roommate (Resident 2) became aggressive (an active, forceful, or hostile approach intended to intimidate or harm the other person) toward him. During a review of Resident 1's Progress Notes dated 4/16/2026, timed at 3:46 p.m., the Progress Notes indicated that on 4/16/2026 Resident 1 was witnessed being punched. The Progress Notes further indicated Resident 1 was lying in bed when his roommate (Resident 2) walked over and punched him repeatedly in the face. Blood was observed in Resident 1's mouth and was cleansed with sterile water (highly purified water) and gauze. During a review of Resident 1's Change in Condition Evaluation dated 4/16/2026, the Change in Condition Evaluation indicated that on 4/16/2026, Resident 1 was physically attacked by his roommate (Resident 2). The Change in Condition Evaluation further indicated a Certified Nursing Assistant (CNA 1) witnessed Resident 1 being punched in the face by the (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	roommate (Resident 2). Upon assessment, bleeding was noted from Resident 1's gums. During a review of Resident 1's Interdisciplinary (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) Care Conference Notes dated 4/20/2026, the IDT Care Conference Notes indicated Resident 1 expressed feeling very disturbed about the incident with his roommate (Resident 2) that occurred on 4/16/2026. The IDT Care Conference Notes further indicated that when the police arrived at the facility to investigate the incident, Resident 2 was removed from the facility. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted the resident on 4/10/2026, with diagnoses that included polyneuropathy (a condition in which a person's peripheral nerves [nerves located outside of the brain and spinal cord] are damaged causing tingling, numbness and/or pain in the hands and feet), epilepsy (brain disorder in which nerve cells in the brain sometimes send the wrong signals and cause seizures [a sudden burst of electrical activity in the brain that can cause changes in behavior, movements, feelings and levels of consciousness]) and depression (mood disorder that causes a constant, deep feeling of sadness and a loss of interest in activities). During a review of Resident 2's H&P, dated 4/12/2026, the H&P indicated diagnoses that included violent behavior and anxiety disorder (mental health condition characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life). The H&P further indicated Resident 2 exhibited acute agitation (a state of severe restlessness, worry, or mental distress accompanied by physical tension), verbal aggression (using hostile, insulting, or threatening language to attack someone else's self-concept with the intent to cause psychological pain, dominate them, or gain control) and physical aggression (the use of physical force or actions intended to harm, injure or intimidate another person) at his previous facility. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had intact cognition. During a review of Resident 2's Progress Notes dated 4/16/2026, timed at 4:34 p.m., the Progress Notes indicated that on 4/16/2026 Resident 2 was witnessed punching his roommate (Resident 1) in the face. The Progress Note further indicated Resident 2 stated he (Resident 2) was tired of talking and hit Resident 1 in the face. During a review of Resident 2's Change in Condition Evaluation dated 4/16/2026, the Change in Condition Evaluation indicated that on 4/16/2026, at approximately 2:30 p.m., a CNA (CNA 1) witnessed Resident 2 striking his bedbound roommate (Resident 1) in the face multiple times with a closed fist. During a review of Local Law Enforcement 1's calling card dated 4/16/2026 at 4:00 p.m., the calling card indicated an arrest of Resident 2 was made for elder abuse. During a review of the facility's conclusion letter regarding the resident-to-resident physical altercation (a physical confrontation or conflict between two residents, includes any unwanted physical interaction) between Resident 1 and Resident 2 dated 4/20/2026, the conclusion letter indicated the facility's IDT concurred that the resident-to-resident physical altercation did occur and resulted in injury to Resident 1. The conclusion letter further indicated Resident 2 was taken to the local police department by law enforcement officers on 4/16/2026. During an interview on 5/4/2026 at 10:34 a.m., with Resident 1, Resident 1 stated he remembered the incident involving his roommate (Resident 2). Resident 1 stated that for no reason, his roommate (Resident 2) attacked him. Resident 1 stated his roommate (Resident 2) was yelling and cursing at him before repeatedly punching him in the face, causing bleeding in his mouth and loosening one of his teeth. Resident 1 was observed wiggling his upper left incisor (a sharp, flat, front tooth used for cutting and biting food), indicating that it was loose. Resident 1 stated The guy (Resident 2) was an insane person. Resident 1 further stated that he (Resident 1) was startled and felt scared during the altercation. Resident 1 stated he only feels okay now because the police arrested Resident 2 after the incident. Resident 1 stated That man (Resident 2) is a criminal, and I'm glad he went to jail. During an interview on 5/5/2026 at 9:10 a.m., with CNA 1, CNA 1 stated that on 4/16/2026, he was charting when another CNA (did not specify) informed him that his two residents in Room A were yelling at each other. CNA 1 stated he immediately went to Room A to see what was happening and saw Resident 2 punching Resident 1. CNA 1 stated Resident 1 was lying in bed while Resident 2 was (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	standing on the right side of the bed, punching Resident 1 with his closed fist. CNA 1 stated he observed approximately two to three punches land on Resident 1's face before he (CNA 1) was able to separate Resident 2 from Resident 1. CNA 1 stated Resident 2 was punching Resident 1 with only one hand, his (Resident 2's) right hand. CNA 1 stated he could not remember where exactly the punches landed on Resident 1's face but did see blood in Resident 1's mouth. During an interview on 5/5/2026 at 9:46 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that on 4/16/2026, she was passing medications when a CNA (did not specify) alerted her that that her residents in Room A were fighting. LVN 1 stated by the time she arrived at the room, CNA 1 was already holding back Resident 2. LVN 1 stated that when she asked Resident 2 what happened, Resident 2 stated he punched Resident 1 because Resident 1 was talking nonstop while he was trying to sleep. LVN 1 stated that when she assessed Resident 1, she observed bleeding from the upper, front gums. LVN 1 stated she did not observe a specific wound but noted blood around and between Resident 1's upper front teeth. During an interview on 5/5/2026 at 4:10 p.m., with the Director of Nursing (DON), the DON stated that she (DON) was involved in the investigation of the physical altercation that occurred between Resident 1 and Resident 2 on 4/16/2026. The DON stated that Resident 2 walked from his bed, located near the door of the room, to Resident 1's bed, located near the window, and punched Resident 1 in the face several times. The DON stated Resident 2's actions towards Resident 1 were willful and intentional. The DON stated that the incident between Resident 1 and Resident 2 constituted physical abuse. During a review of the facility's policy and procedure titled, Abuse, Neglect (failure to provide necessary care, supervision, or basic needs to a resident) and Exploitation (illegal, improper, or unauthorized use of a resident's funds, property or assets for someone else's personal profit or advantage), last reviewed and revised on 4/24/2025, indicated, it is the policy of the facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedure that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. According to the policy and procedure, abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. The policy and procedure further indicated physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the attending physician (AP 1) provided a History and Physical (H&P- medical evaluation consisting of a detailed resident interview regarding their health history and a structured physical assessment) note following the initial visit for one (1) of three (3) sampled residents (Resident 2). This deficient practice had the potential to negatively affect the delivery of care and services for Resident 2.During a review of Resident 2's admission Record, the admission Record indicated the facility admitted the resident on 4/10/2026, with diagnoses that included polyneuropathy (a condition in which a person's peripheral nerves [nerves located outside of the brain and spinal cord] are damaged causing tingling, numbness and/or pain in the hands and feet), epilepsy (brain disorder in which nerve cells in the brain sometimes send the wrong signals and cause seizures [a sudden burst of electrical activity in the brain that can cause changes in behavior, movements, feelings and levels of consciousness]) and depression (mood disorder that causes a constant, deep feeling of sadness and a loss of interest in activities). During a review of Resident 2's H&P, dated 4/12/2026, the H&P indicated diagnoses that included violent behavior and anxiety disorder (mental health condition characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life). The H&P further indicated Resident 2 exhibited acute agitation (a state of severe restlessness, worry, or mental distress accompanied by physical tension), verbal aggression (using hostile, insulting, or threatening language to attack someone else's self-concept with the intent to cause psychological pain, dominate them, or gain control) and physical aggression (the use of physical force or actions intended to harm, injure or intimidate another person) at his previous facility. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had intact cognition. During a review of Resident 2's Change in Condition Evaluation dated 4/16/2026, the Change in Condition Evaluation indicated that on 4/16/2026, at approximately 2:30 p.m., a CNA (CNA 1) witnessed Resident 2 striking his bedbound roommate (Resident 1) in the face multiple times with a closed fist. During a review of an email sent to the Medical Records Director (MRD) from the office of AP 1, dated 4/16/2026, the email indicated AP 1's office sent Resident 2's H&P to the MRD on 4/16/2026 at 4:25 p.m. During an interview on 5/5/2026 at 11:10 a.m., with the MRD, the MRD stated Resident 2 was seen by the attending physician on 4/12/2026 for the initial visit, however, the attending physician did not provide the H&P notes to the facility at that time. The MRD stated AP 1's office subsequently emailed the H&P on 4/16/2026 at 4:25 p.m. The MRD further stated the H&P was not uploaded into Resident 2's electronic medical record until 4/17/2026, after Resident 2 had already been discharged from the facility. During an interview on 5/5/2026 at 4:10 p.m., with the Director of Nursing (DON), the DON stated attending physicians are expected to provide documentation of resident visits to the facility on the same day the visit occurs. The DON stated a newly admitted resident should have a completed H&P on file following the attending physician's initial visit. The DON further stated that the timely availability of the H&P is important to ensure the facility has the information necessary to provide appropriate care and services to the resident. The DON stated that because Resident 2's History and Physical was not received timely, the facility was unaware of Resident 2's documented history of violent behavior and aggression. The DON further stated that had Resident 2's H&P been available on 4/12/2026, the facility could have implemented interventions and services to address Resident 2's history of violent behavior and potentially could have prevented Resident 2's physical altercation (a physical confrontation or conflict between two residents, includes any unwanted physical interaction) involving Resident 2 and his roommate (Resident 1) on 4/16/2026. During a review of the facility's policy and procedure titled, Physician Visits and Physician Delegation, last reviewed/revised on 4/24/2025, indicated, it is the policy of the facility to ensure the physician takes an active role in supervising the care of residents. The policy and procedure further indicated the physician should date, write and sign a progress note for each visit.