| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056124 | A. Building<br>B. Wing | 06/04/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Tarzana Health and Rehabilitation Center | 5650 Reseda Blvd<br>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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report timely to the State Survey Agency (the Department) an acute fracture of the tip of the right olecranon process (a break in the bone of the tip of the elbow) with associated soft tissue swelling and a suspected fracture involving the greater tuberosity of the right humerus (a break in the bony prominence at the top of your upper arm bone) from an unknown cause for one of three sampled residents (Resident 1). This deficient practice resulted in a delay of investigation to rule out abuse.During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (when the brain has trouble working due to an underlying condition and can cause confusion and memory loss), unspecified psychosis (a mental health symptom where a person struggles to tell the difference between what is real and what is not) and unspecified dementia (a loss of brain function that affects memory, thinking, language, and reasoning). During a review of Resident 1's History and Physical Examination, dated 11/3/2025, the History and Physical Examination indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/15/2026, the MDS indicated Resident 1 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 1's Physician's Orders, the Physician's Orders indicated Resident 1 had an order dated 5/5/2026 for a stat (derived from the Latin word statim, meaning immediately or without delay) X-ray (a test that takes pictures of the inside of your body using a small amount of radiation) of the right shoulder and elbow related to pain. During a review of Resident 1's Radiology (a branch of medicine that uses imaging technology such as X-rays to diagnose and treat diseases) Results Report for the right elbow dated 5/5/2026, the Radiology Results Report indicated an acute fracture of the tip of the olecranon process with associated soft tissue swelling. During a review of Resident 1's Radiology Results Report for the right shoulder dated 5/5/2026, the Radiology Results Report indicated a suspicion of a fracture involving the greater tuberosity of the right humerus. During a review of Resident 1's Nurses Progress Note dated 5/7/2026 at 2:38 a.m., the Nurses Progress Note indicated Resident 1's X-ray results were reported to Resident 1's physician and Resident 1 was transferred to the emergency room (ER - part of a hospital where people go when they are seriously sick or injured and need treatment quickly) for further evaluation and treatment. During a review of Resident 1's Transfer Form dated 5/7/2026, the Transfer Form indicated Resident 1 was transferred to the ER for further evaluation and treatment due to a fracture (a crack or break in a bone). During an interview on 6/4/2026 at 12:40 p.m., with the Director of Nursing (DON), the DON stated Resident 1 did not have any witnessed falls or accidents. The DON further stated Resident 1 did not have the cognitive ability to explain the cause of the right shoulder and right elbow pain and the resulting injuries. The DON stated Resident 1's abnormal X-ray results dated 5/5/2026 were not reported or investigated because she (DON) had not been informed of Resident 1's abnormal X-ray results. The DON further stated that had she been notified of Resident (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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1's abnormal X-ray results dated 5/5/26, she would have conducted an investigation and would have reported the incident to the appropriate entities, as this was a case of an injury of unknown origin/source. During a review of the facility's policy and procedure (P&P) titled, Unexplained Injuries, last reviewed/revised on 4/20/2026, the P&P indicated that all unexplained injuries, including bruises, abrasions, and injuries of unknown source will be investigated. The P&P also indicated an injury should be classified as an injury of unknown source when both of the following conditions are met:The source of the injury was not observed by any person, or the source of injury could not be explained by the resident; andThe injury is suspicious because of:The extent of the injury orThe location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) orThe number of injuries observed at one particular point in time orThe incidence of injuries over time. The P&P further indicated if the injury is of an unknown source, reporting and investigation procedures shall be implemented in accordance with the facility's abuse policies and procedures. During a review of the facility's P&P titled, Compliance with Reporting Allegations of Abuse/Neglect/Exploitation, last reviewed/revised on 4/20/2026, the P&P indicated it is the policy of the facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. The Administrator or designee will notify appropriate agencies immediately; as soon as possible but no later than 24 hours after discovery of the incident. In the case of serious bodily injury, no later than 2 hours after discovery or forming the suspicion. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a comprehensive person-centered care plan (a written course of action that helps a resident achieve outcomes that improve their quality of life) for one of three sampled residents (Resident 1) to address the use of a right arm sling (a supportive device, usually made of fabric, used to hold an injured arm, wrist, or shoulder in a resting position to relieve pain and prevent further injury) following an injury. This deficient practice had the potential to result in unmet care needs and negatively affect the delivery of care and services to Resident 1. During a review of Resident 1's admission Record, the admission Records indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (when the brain has trouble working due to an underlying condition and can cause confusion and memory loss), unspecified psychosis (a mental health symptom where a person struggles to tell the difference between what is real and what is not) and unspecified dementia (a loss of brain function that affects memory, thinking, language, and reasoning). During a review of Resident 1's History and Physical Examination, dated 11/3/2025, the History and Physical Examination indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/15/2026, the MDS indicated Resident 1 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 1's Order Summary Report, the Order Summary Report indicated Resident 1 had a physician's order dated 5/22/2026 for Resident 1 to wear a right arm sling at all times. During a review of Resident 1's Medication Administration Record (MAR - a report detailing the medications administered to a resident by the licensed nurse in the facility) from 5/22/2026 to 6/9/2026, the MAR indicated Resident 1's right arm sling was in place at all times as ordered. During an observation on 6/3/2026 at 10:50 a.m., Resident 1 was observed in his room, sitting in a wheelchair, with a black sling in place on the right arm. During an interview on 6/4/2026 at 11:14 a.m., with the Director of Rehabilitation (DOR), the DOR stated Resident 1 was transferred to the hospital on 5/7/2026 for evaluation and treatment following X-ray (a test that takes pictures of the inside of your body using a small amount of radiation) findings obtained at the facility on 5/5/2026 that indicated fractures (crack or break in a bone) of the right shoulder and right elbow. The DOR stated Resident 1 returned from the hospital (did not specify) on 5/7/2026 with a sling in place on the right arm. The DOR further stated Resident 1's physician placed an order for Resident 1 to wear the sling at all times until Resident 1's orthopedic (branch of medicine that focuses on the musculoskeletal system that includes the bones, joints, ligaments, tendons, and muscles) appointment to determine whether continued use of the sling was necessary. During a concurrent interview and record review on 6/4/2026 at 9:35 a.m., with the Medical Records Director (MRD), Resident 1's care plans from 11/3/2025 to 6/3/2026 were reviewed. The MRD stated the care plans reviewed were all the care plans that were in Resident 1's medical records as of the morning of 6/3/2026. The MRD stated there was no care plan in Resident 1's medical records addressing Resident 1's right arm sling. During a concurrent interview and record review on 6/4/2026 at 12:40 p.m., with the Director of Nursing (DON), Resident 1's care plans from 11/3/2025 to 6/3/2026 were reviewed. The DON stated there was no care plan developed to address Resident 1's right arm sling. The DON stated that a care plan should have been developed to address Resident 1's right arm sling and related care needs. The DON further stated care plans are important to set appropriate goals and provide necessary services and interventions for residents. During a review of the facility's policy and procedure titled, Comprehensive Care Plans, last reviewed/revised on 4/30/2026, the P&P indicated it is the policy of the facility to develop and implement a comprehensive person-centered care plan for<br>(continued on next page) |

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| | 056124 | A. Building<br>B. Wing | 06/04/2026 |

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| Tarzana Health and Rehabilitation Center | 5650 Reseda Blvd<br>Tarzana, CA 91356 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs that are identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete medical records by failing to document a change of condition (COC - any significant improvement or decline in a resident's physical, mental or functional health) for one of three sampled residents (Resident 1). This deficient practice placed Resident 1 at risk of not receiving appropriate care due to incomplete resident medical care information.During a review of Resident 1's admission Record, the admission Records indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy (when the brain has trouble working due to an underlying condition and can cause confusion, memory loss and loss of consciousness), unspecified psychosis (a mental health symptom where a person struggles to tell the difference between what is real and what is not) and unspecified dementia (a loss of brain function that affects memory, thinking, language, and reasoning). During a review of Resident 1's History and Physical Examination, dated 11/3/2025, the History and Physical Examination indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/15/2026, the MDS indicated Resident 1 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 1's Physician's Orders, the Physician's Orders indicated Resident 1 had an order dated 5/5/2026 for a stat (derived from the Latin word statim, meaning immediately or without delay) X-ray (a test that takes pictures of the inside of your body using a small amount of radiation) of the right shoulder and elbow related to pain. During a review of Resident 1's Nurses Progress Note dated 5/7/2026 at 2:38 a.m., the Nurses Progress Note indicated Resident 1's X-ray results were reported to Resident 1's physician and Resident 1 was transferred to the emergency room (ER - part of a hospital where people go when they are seriously sick or injured and need treatment quickly) for further evaluation and treatment. During a review of Resident 1's Transfer Form dated 5/7/2026, the Transfer Form indicated Resident 1 was transferred to the ER for further evaluation and treatment due to a fracture (a crack or break in a bone). During a concurrent interview and record review on 6/4/2026 at 9:51 a.m., with the MDS Coordinator (MDSC), Resident 1's electronic medical record was reviewed. The MDSC stated she looked through Resident 1's nursing progress notes and could not find any documentation as to why the physician was contacted on 5/5/2026 that resulted in a stat X-ray order. The MDSC stated that based on the physician's order for the stat X-ray dated 5/5/2026, the reason for the stat X-ray was due to pain, however, there were no progress notes in Resident 1's medical record documenting Resident 1's complaints of pain that prompted the physician notification on 5/5/2026. The MDSC further stated that because Resident 1 subsequently required transfer to the hospital on 5/7/2026, Resident 1's medical record should have included a nursing progress note or Change of Condition Form (COC Form - a document used to officially record and report a new medical, physical, or mental shift in a resident) documentation describing Resident 1's change in status and the events leading to the hospital transfer on 5/7/2026. During an interview on 6/4/2026 at 12:40 p.m. with the Director of Nursing (DON), the DON stated she reviewed Resident 1's electronic medical record and was unable to find any documentation regarding why Resident 1's physician was contacted on 5/5/2026, resulting in the stat X-ray order. The DON stated the licensed nurses caring for Resident 1 should have documented the resident's condition, assessment findings, and physician notification in the progress notes or created an SBAR (Situation, Background, Assessment, Recommendation - a communication tool that allows healthcare team members to provide essential, concise information about an individual's condition) to establish a timeline of events leading to the physician contact because obviously something happened with Resident 1 that resulted in calling Resident 1's physician on 5/5/2026. The DON further stated<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | documentation is so important, especially if there is a change in condition, to ensure there is no delay in the care of the resident and to ensure proper treatment is provided accordingly. During a review of the facility's policy and procedure (P&P) titled, Documentation in Medical Record, last reviewed/revised on 4/30/2026, the P&P indicated each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress. The P&P further indicated licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. |