#37861

PRINTED: 10/08/2020 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	3 18		MR MO. 0838-0381
STATEMENT AND PĻAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		056124	B. WING _		C 10/08/2020
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			ŀ	6660 RESEDA BLVD	
TARZAN	A HEALTH AND REHA	ABILITATION CENTER		TARZANA, CA 91358	
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 000	INITIAL COMMENT	rs	F 00	(Revised 11/17/20)	·
	The following refle	cts the findings of the		Preparation and/or execution	ı of
•	California Departm	ent of Public Health during an		this plan of correction does	not
	investigation of a co	omplaint.		constitute an admission or	
		0.400004750		agreement by the provider of	f the
	Complaint Number	: CA00691552		truth of the facts alleged or	
	Representing the C	California Department of Public		conclusions set forth in the	
	Health:			statement of deficiencies. The	ıis
				plan of correction is prepare	
	Health Facilities Ev	aluator Nurse: 42508		and/ or executed because it	
	The inspection was	limited to the specific		required by the provision of	ļ
		s not represent the findings of		Health and Safety code	
	a full inspection of			section 1250 and 44 C.F.R. 405.1907.	
	Three deficiencies number: CA006915	were issued for complaint 552	·	"This plan of correction constitu	utes
		(Injury/Decilne/Room, etc.)	F 5	my written credible allegation of	of
SS≔D	CFR(s): 483.10(g)(	14)(i)-(iv)(15)		compliance	<u>'</u>
	6483 10(a)(14) Not	ification of Changes.		for the deficiencies noted"	
		mediately inform the resident;			
	consult with the res	sident's physician; and notify,		PLAN OF CORRECTIO	<u>N</u>
		or her authority, the resident			
	representative(s) w	nen there is- clving the resident which		<u>F580</u>	
		i has the potential for requiring		Notify of Changes Injury/Dec	:line /
	physician interventi			Room, etc)	
		ange in the resident's physical,		CFR(s): 483.10(g)(14)(i)-(v	<u>)(15)</u>
		ocial status (that is, a			
		lith, mental, or psychosocial threatening conditions or		Corrective action for the res	
	clinical complication			affected by the deficient prac	:tice:
	(C) A need to aiter	treatment significantly (that is,		A Desident d No Income to 14 To	
		ue an existing form of		1. Resident 1 No longer is at T	arzana
	treatment due to ac	iverse consequences, or to	l	Healthcare.	j

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

commence a new form of treatment); or

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.

2. An in-service regarding facility's

policy and procedure titled "Changes

(X8) DATE

A BUILDING  O56124  NAME OF PROVIDER OR SUPPLIER  TARZANA HEALTH AND REHABILITATION CENTER  (X4) ID PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  IDENTIFICATION NUMBER:  A. BUILDING  C  C  10/08/2020  STREET ADDRESS, CITY, STATE, ZIP CODE  5650 RESEDA BLVD  TARZANA, CA 91356  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE PREFIX TAG)  CROSS-REFERENCED TO THE APPROPRIATE DATE  COMPLETED  C  (X5)  COMPLETED  C  (X5)  COMPLETED  COMPLETED  C  (EACH CORRECTION SHOULD BE DATE  CROSS-REFERENCED TO THE APPROPRIATE DATE		r of deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	.TIPL	E CONSTRUCTION	(X3) DATE	
NAME OF PROVIDER OR SUPPLIER  TARZANA HEALTH AND REHABILITATION CENTER  (X4) ID PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE 5650 RESEDA BLVD TARZANA, CA 91356  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DATE)  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILD	ING.			
TARZANA HEALTH AND REHABILITATION CENTER  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  5650 RESEDA BLVD  TARZANA, CA 91356  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE DATE)						•	_	•
TARZANA HEALTH AND REHABILITATION CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DATE DATE DEFICIENCY)			056124	B. WING			10/0	8/2020
TARZANA HEALTH AND REHABILITATION CENTER  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TARZANA, CA 91356  TARZANA, CA 91356  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE DEFICIENCY)	NAME OF	PROVIDER OR SUPPLIER						
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5) PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X6) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DATE)  (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)	WA DWA 1	IA USALTU AND BEU	ADII ITATION CENTED		_	•••		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE DATE	IAKZAN	IA REALIN AND REDA	ABILITATION CENTER		T.			
	PRĒFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	(X5) COMPLETION DATE
F 580 Continued From page 1  (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.  (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-  (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.  (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).  §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).  This REQUIREMENT is not met as evidenced by:  Based on interview and record review, the facility falled to notify the physician of a change of condition as evidenced by:  -Resident 1 had multiple days of low fluid intake, from 6/4/2020 to 6/7/2020, for one of three sampled residents (Residents 1)	F 580	(D) A decision to the resident from the fa §483.15(c)(1)(ii). (ii) When making in (14)(i) of this sectic all pertinent inform is available and prophysician. (iii) The facility must resident and the rewhen there is-(A) A change in resident and the rewhen there is-(A) A change in resident and the rewhen there is-(A) A change in resident and the rewhen there is-(A) A change in resident and regular (e)(10) of this section. (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a conthat is a composite §483.5) must discuit is physical configurations that compart, and must sper room changes between the resident section of the representative (s).  This REQUIREME by: Based on interview falled to notify the prondition as evider-Resident 1 had mission to a continuous configuration as evider-Resident 1 had mission to a continuous configuration as evider-Resident 1 had mission to a continuous configuration as evider-Resident 1 had mission to a continuous configuration as evider-Resident 1 had mission to a continuous configuration as evider-Resident 1 had mission to a continuous configuration as evider-Resident 1 had mission to a continuous configuration as evider-Resident 1 had mission to a continuous configuration and continuous configuration and continuous	ansfer or discharge the acility as specified in ottification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the st also promptly notify the sident representative, if any, or or roommate assignment 3.10(e)(6); or sident rights under Federal or tions as specified in paragraph on. It is the street of and periodically is (mailing and email) and the resident mose in its admission agreement aration, including the various orise the composite distinct city the policies that apply to ween its different locations and record review, the facility physician of a change of need by:  uitiple days of low fluid intake,	F		conducted by the DSD on Octo 23, 2020 to the Licensed Nurse Identification of residents have the potential to be affected by deficient practice and corrective action taken:  The facility has identified 54 out 116 residents, however all residents of the facility have the potential affected.  Residents who in the last 30 datrigger for eating less than 50% meals in a day will be reviewed for accuracy in coding and pote change of condition related to pmeal and fluid intake.  On 10/30/20, an audit was cond by Unit manager to validate information in the PCC dashboa and if SBAR was done if determinformation is validated and if the been a change of condition warrants intervention not alread addressed. They will see that appropriate individuals are notified including the resident, resident's responsible party, resident's physician and	s.  ving vine tof lents to be ys for 2 ntial coor ducted ard nined nere that	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_			
		056124	B. WING		10/08/2020		
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				66	80 RESEDA BLVD		
TARZAN	A HEALTH AND REH	ABILITATION CENTER		T/	Arzana, ca 91356		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(XS) COMPLETION DATE
F 580	have a change of c	potential for Resident 1 to condition which may lead to	F	580	validated, resident's care plan v reviewed and updated as need	vill be ed.	
	acute care hospitalization for dehydration and altered nutrition.				Systemic changes to ensure deficient practice does not re	the cur:	
	Findings:				•		
•	Sheet) indicated the on 12/15/2019, with mellitus (a condition processes blood sugar in the blood) blood cholesterol for the condition of the	nt 1's Nutrition Registered ent, dated 12/15/2019, signed d Resident 1's dally fluid d from 1400 to1680 milliliters			On 10/12/20, 10/13/20 & 10/23 inservice was conducted by the (Director of Staff Development) designee to the CNA's on mon and accurately reporting reside meal and fluid intake and impo of observing for potential chang condition which would affect the residents ability to eat or drink report this as needed to the resilicensed nurse.	e DSD   or itoring ents' rtance ge of e and	
	A review of Reside Report indicated the intake during the millular intake ranged day (ml/day). On 6 fluids was 200 ml it was 860 ml, on 6/6/7/2020, Resident ml/day. Resident 1 assessed daily fluid on 7/31/2020, at 4 and concurrent recipies.	eview of Resident 1's Meal Consumption port indicated the resident's measured fluid ke during the month of 5/2020 Resident 1's inteke ranged from 700 to 850 milliliters per (ml/day). On 6/4 Resident 1's total intake of its was 200 ml in 24 hours; on 6/5 the total a 860 ml, on 6/6 the total was 410 ml and on (2020, Resident 1 received a total of 180 day. Resident 1 was consuming less than the essed daily fluid needs (1400 to 1680 ml).  7/31/2020, at 4:40 p.m, during an interview concurrent record review, the Director of			Licensed nurses were in service the DSD or designee on 10/12/10/13/20 & 10/23/20 on monitoresidents for change of conditional during their shift and reporting resident physician, resident's, responsible party and other disciplines as needed. If validate need for resident's care plan to updated to reflect change and interventions being taken.	/20, oring of on to	·
• .	Nursing (DON) cor Resident 1 from 6/ DON stated the lice	nfirmed the fluid intake of 4 - 6/7/2020 was low. The ensed nurse should have nge of condition and notified			CNA's will chart residents m fluid intake during their shift ar report any resident who does	nd 🧪	 

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES						(X3) DATE SURVEY	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	PLETED
	• • • • • • • • • • • • • • • • • • • •		~ 50.00				
		056124	B. WING			10/0	08/2020
NAME OF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
TARZAN	A HEALTH AND REHA	ABILITATION CENTER			850 RESEDA BLVD ARZANA, CA 91356		
				L_ <u>"</u>	PROVIDER'S PLAN OF CORRECTION	u l	(X6)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	(D PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X6) COMPLETION DATE
F 580	documentation the Resident 1 for sign dehydration The Dodocumentation the Resident 1's low fluth on 8/5/2020, at 2:2 Resident 1's attend stated the licensed about Resident 1's deterioration in conference order intravenous for 8/5/2020, at 3:1 CNA 1 stated she will coronavirus-infect and cared for Resident order intravenous for the sassisted with formeals and fluids are food and fluid intak Report and notified 1's low food and	he RD. The DON did not find licensed nurses monitored is and symptoms of ON confirmed there was no physician was made aware of aid intake.  19 p.m., during an interview, ling physician (Physician 1) nurses did not notify him low fluid intake, and addition before Resident 1's ron 6/7/2020. Physician 1 is he was not aware, he did not liuid for hydration.  19 p.m., during an interview, was assigned to the COVID-19 thous disease) designated unit dent 1 from 6/4 to 6/7/2020 of 7 p.m. shift. CNA 1 stated seding Resident 1 with her and documented Resident 1's is in the Meal Consumption LVNs 1 and 2 about Resident aid intake.  It is policy on Changes in a prevised on 2/2017, indicated esident, the attending resident's legal representative thanges in the resident's significant change in the mental, or psychosocial deterioration in health, mental,	F	580	consume at least 50% of their to the licensed staff. Also repor change of condition which wou affect the residents' ability to ead drink and to the resident's licen nurse.  Licensed nurses will monitor residents for change of conditions their shift and report to resident physician, resident's, responsible party and other disciplines as needed.  Any issue or concern not reading resolved will be reported to the manager / supervisor for review they are unable to resolve them will report to the Director of Nurfor resolution.  Unit managers will review Monifor resolution.  Unit managers will review Monifor resolution.  Concern not reading appropriate interventions and up has occurred. Also, review residents who have triggered for eating <50% of meal x 2 in a divalidate appropriate intervention follow up has occurred.  Any issue or concern not reading some concern not reading some concern not reading some concern not reading the staff.	t any ld at or ased on ly unit v and if a they rsing day to a in late follow or ay to ons and	
		itus in either life threatening all complications; or a need to ilificantly.			resolved will be forwarded to the Director of Nursing for resolution		

CENTER	WIEKS FOR MEDICAKE & MEDICAID SEKVIOLO			LTIPLE CONSTRUCTION (X3) DATE SURVEY			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMP	PLETED
AND PLAN C	of Correction	PERTITIONION ROMBEN.	A BUILE	MG.		ا ا	,
		055474	B. WING				, 18/2020
		056124	D. VVIIVO		TREET ADDRESS, CITY, STATE, ZIP CODE	10/0	1012020
NAME OF F	PROVIDER OR SUPPLIER						
TAR7AN.	A HEALTH AND REH	ABILITATION CENTER			850 RESEDA BLVD		
170122-110				TARZANA, CA 91356  (D PROVIDER'S PLAN OF CORRECT			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	N RE	(XS) COMPLETION
PRÉFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		CROSS-REFERENCED TO THE APPROP	RIATE	DATE
ING					DEFICIENCY)		
						-	
F 656	Continued From pa	age 4	F	656			
		t Comprehensive Care Plan	F	656	Banana that will be implem	ontod	;
	CFR(s): 483.21(b)(		`		Megantes Mar will be mibiem	enteu	
	0, 1,(0), 100,21,(0),	••			to monitor for the continued		
	§483,21(b) Compre	ehensive Care Plans			effectiveness of the correctiv	e [	
	§483.21(b)(1) The	facility must develop and			action taken to see that this		
	implement a comp	rehensive person-centered			deficiency has been correcte	d and	
		resident, consistent with the	<b>!</b>		will not recur		
	resident rights set	forth at §483.10(c)(2) and					
		includes measurable	ŀ		Medical Records will audit PCC	at .	
		eframes to meet a resident's	۱.		least weekly x 4 week then bi-w		
	medical, nursing, a	ind mental and psychosocial			times 3 months for residents w		
		ntified in the comprehensive			have been reported to have ea		
	describe the follow	comprehensivé care plan must			50% or less for 2 or more meal		
		at are to be furnished to attain	i		the day.		
		ident's highest practicable	l		1. Check to see if this was val	hatchi	
		nd psychosocial well-being as	l		by a unit manager with a pr		
	required under §48	3.24, §483.25 or §483.40; and			note to indicate action need	byless	
	(ii) Any services the	at would otherwise be required			1	ied Oi	
	under §483.24, §48	33.25 or §483.40 but are not			not.		
		resident's exercise of rights		•	2. If validated was a change of	T	
		luding the right to refuse			condition identified.		
	treatment under §4		l		3. If so, was an SBAR comple	tea	
		I services or specialized	1		with parties being notified.		
	provide as a result	ces the nursing facility will			4. Where new orders received	ı	
		If a facility disagrees with the	l		5. Were orders carried out.		
	findings of the DAG	ARR, it must indicate its	ŀ		Report to be given to Director of	f	
		ident's medical record.			Nursing for follow up as neede	i.	
		with the resident and the			,		
	resident's represen		1		Findings will be reviewed durin	a QAPI	
	(A) The resident's	goals for admission and	Ī		meeting for further discussion a		ļ
	desired outcomes.	-	l		needed action by the Director of		
	(B) The resident's (	preference and potential for	l		Nursing x 3 months. QAPI com		
		acilities must document	1		will meet monthly and review		
. •		nt's desire to return to the			progress and make changes as	<b>,</b> i	
· ••		sessed and any referrals to	• •	• •		•	
	local contact agent	cies and/or other appropriate			deemed necessary.		

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP C	LETED
		056124	B. WING			10/0	8/2020
	ROVIDER OR SUPPLIER A HEALTH AND REHA	ABILITATION CENTER		56	TREET ADDRESS, CITY, STATE, ZIP CODE 350 RESEDA BLVD ARZANA, CA 91366		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE I	(X5) COMPLETION DATE
F 656	plan, as appropriate requirements set for section. This REQUIREME by: Based on interview	rpose. s in the comprehensive care e, in accordance with the orth in paragraph (c) of this  NT is not met as evidenced w and record review, the facility	F	656	Completion Date THRC will correct this deficience later than 11/6/20.  F656	y no	
	for one of three say This failure has the meet sufficient ora	t a care plan for dehydration, mpled residents (Resident 1). e potential for Resident 1 not to I intake needs which lead to dehydration.			Develop/Implement Comprehensive Care Pla CFR(s): 483.21(b)(1)	<u>ın</u>	
	Findings:	icad to deliyaradon			Corrective action for the resident practice of the deficient practice.		
	Sheet) indicated the on 12/15/2019, with meilitus (a condition processes blood si	ent 1's Admission Record (Face the facility admitted the resident the diagnoses including diabetes on that affects how the body ugar causing high levels of and hyperlipidemia (increased evels).			1. Resident 1 No longer is at Tall Healthcare. 2 On 10/29/20, Lead RD for Hondred an in-service to the review of each new resident an review residents at least quarter as needed. Based on his/her residents.	ISG RD on d then erly and	
	Dietician Assessm by the RD indicate	ent 1's Nutrition Registered ent, dated 12/15/2019, signed d Resident 1's daily fluid d from 1400 to1680 milliliters rement) per day.			will initiate a care plan which w address interventions based or review.	ill	
	A review of Reside 12/15/2019 for the nutrition related to therapeutic diet, in resident would ma 50-75% and adequinterventions include	ent 1's Care Plan Initiated on resident's risk for altered diagnoses and need for a dicated in the goals the intain consistent food intake of uate body weight. The ded providing therapeutic dieting dietary preferences,			Identification of residents hat the potential to be affected by deficient practice and corrective action taken:  The facility has identified 54 out 116 residents, however all residents.	y the	•
		ntake, and referring to RD as			of the facility have the potential		

STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	PLETED
		056124	B, WING			_	8/2020
	PROVIDER OR SUPPLIER A HEALTH AND REH	ABILITATION CENTER		56	reet address, city, state, zip code 850 reseda blvd Arzana, ca 91356	·	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 656	12/22/2020 for the (activities of daily il deficit related to phe intolerance, limited process, indicated assistance to eat.  A review of Reside Report indicated the intake during the nature of the fluid intake ranged day (ml/day). On 6 fluids was 200 ml it was 860 ml, on 6/6/7/2020, Resident 1 assessed daily fluid There was no document of the interventional care interventions, did in RD. LVN 1 stated evidence of a care On 7/31/2020, at 4 and concurrent record Nurse 1 (LVN 1), Lette nutritional care interventions, did in RD. LVN 1 stated evidence of a care On 7/31/2020, at 4 and concurrent record Nurse 1 (LVN 1), Lette nutritional care interventions, did in RD. LVN 1 stated evidence of a care On 7/31/2020, at 4 and concurrent record Nurse 1 (IVN 1), Lette nutritional care interventions, did in RD. LVN 1 stated evidence of a care On 7/31/2020, at 4 and concurrent record Nurse 1 (IVN 1), Lette nutritional care interventions, did in RD. LVN 1 stated evidence of a care On 7/31/2020, at 4 and concurrent record Nurse 1 (IVN 1), Lette nutritional care interventions, did in RD. LVN 1 stated evidence of a care On 7/31/2020, at 4 and concurrent record Nurse 1 (IVN 1), Lette nutritional care interventions, did in RD. LVN 1 stated evidence of a care On 7/31/2020, at 4 and concurrent record Nurse 1 (IVN 1), Lette nutritional care interventions, did in RD. LVN 1 stated evidence of a care lutritional care interventions and lutritional care in	nt 1's Care Plan Initiated on resident's deficit with ADL wing) self-care performance hysical limitations, activity mobility secondary to aging the resident required  ant 1's Meal Consumption he resident's measured fluid month of 5/2020 Resident 1's from 700 to 850 milliliters per 1/4 Resident 1's total intake of 1/12 hours; on 6/5 the total 1/13 the total was 410 ml and on 1/14 to received a total of 180 was consuming less than the 1/14 needs (1400 to 1680 ml). The mentation Resident 1 was 1/14 and sand symptoms of 1/14 plan to attempt new 1/14 not interview and 1/14 not interview, the physician or the 1/14 not interview, the Director of 1/14 not interview, the Director of 1/14 not interview, the Director of 1/14 not interview and 1/14 not interview, the Director of 1/14 not interview, the Director of 1/14 not interview and 1/14 not interview, the Director of 1/14 not interview and	F		have a care plan to address nutritional needs if resident dea at risk.  Residents will be review who trefor:  1. Eating less than 50% for 2 in a day in the last 30 day. Residents will be reviewed accuracy of documentation review of care plan and if not include but not limited to interventions of  a. Notify physician b. Referral to RD c. Monitoring for s/s or deficit if appropriate  2. Monthly weight loss of 5% days, 7 ½% in 90 or 10% in days for care plan review to include but not limited to R informed for evaluation and recommendation. Physicials be notified and follow recommendations.  Systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure deficient practice does not recommended to the systemic changes to ensure	igger meals for and eeded  f fluid  in 30 n 180 D to be d an to  the ecur:	
		e care plan should have been			each new resident and then re	view	l

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		riple construction	(X3) DATE S COMPL	SURVEY LETED
	,	056124	B. WING _		10/0F	B/2020
NAME OF	PROVIDER OR SUPPLIER	050124	T	STREET ADDRESS, CITY, STATE, ZIP CODE	10/00	012020
*		ABILITATION CENTER		6660 RESEDA BLVD Tarzana, ca 91356		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE (	(X5) COMPLETION DATE
F 692	have followed. Nutrition/Hydration CFR(s): 483.25(g)( §483.25(g) Assisted	ssion and interventions should Status Maintenance	F 6	needed.	tiate a	
	both percutaneous percutaneous endo enteral fluids). Bas comprehensive assensure that a reside	endoscopic gastrostomy and scopic jejunostomy, and sed on a resident's sessment, the facility must ent-		DSD or designee on 10/23/20 of 10/28/20 on monitoring of reside for possible change of condition during their shift in regards to residents eating less than 50% meals in a day. If change of conditions in the conditions in the conditions of the co	ients n for 2	
	of nutritional status desirable body weig balance, unless the	tains acceptable parameters, such as usual body weight or ght range and electrolyte resident's clinical condition this is not possible or resident e otherwise;		is identified that involves conceresident intake then review of oplan to see that it includes:  a. Notify physician if change of condition has occurred whi	ern with care	
	maintain proper hyd §483.25(g)(3) is off there is a nutritional provider orders a the This REQUIREMENT by: Based on interview	ered a therapeutic diet when I problem and the health care terapeutic diet.  NT is not met as evidenced and record review, the facility		includes resident not meeti assessed intake needs.  b. Referral to RD if change of condition has occurred whi includes resident not meeti assessed intake needs.  c. Monitoring for s/s of fluid de appropriate.	ng ch ng	
	nutrition (food for he recommended daily weight loss and der sampled residents (  1. Notify the physic!	ceptable in quality or quantity ealth and growth) to meet the value and prevent outritional intake and prevent outrition for one of three (Resident 1) by failing to:  an of Resident 1's low fluid the assessed needs.		Unit managers will review residuho have triggered for eating 50% or less for 2 me every Monday to Friday. If change of condition is identification a concern of lack of intake the	als, ed with	·

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		ATE SURVEY	
			A BUILL	MNG.		C	2	
	İ	056124	B. WING	_			8/2020	
NAME OF	PROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		-	
<b>TARTAN</b>	A USALTU AND DEÙ	ABILITATION CENTER		5	650 RESEDA BLVD			
IARZAN	A REALIN AND KEN	ABILITATION CENTER		T	ARZANA, CA 91356			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	COMPLETION DATE	
E 802	Continued From as		E (	202				
L 095	Continued From pa	_	F 1	692	high will be reviewed to	l		
		an of care on Nutrition by not I to the RD for evaluation.			see that it includes			
	3. Refer Resident 1 (RD) for evaluation the resident sustair in six months and v consuming the assimates to General 1) on 6/7/2020 whe intravascular voluming a volume intravascular voluming the sustain to dehydration of the sustain to dehydration of the sustain the sust	to the Registered Dietitian and recommendations when hed a weight loss of 10 pounds when the resident was not essed fluid needed in a day.  Incitices resulted in Resident 1 hange in condition, requiring Acute Care Hospital 1 (GACH are she was diagnosed with of the depletion (reduction in in blood vessels), and imuch sodium in the blood ion). Resident 1 expired at later on 6/9/2020 due to acute loss of renal function due to		:	<ul> <li>a. Notify physician if change of condition has occurred whic includes resident not meetin assessed intake needs.</li> <li>b. Referral to RD if change of condition has occurred whic includes resident not meetin assessed intake needs</li> <li>c. Monitoring for s/s fluid defici appropriate.</li> <li>Unit managers or designee will monthly weights every 1st Friday the month and report to check the any resident with a significant whose of 5% in 30 days, 7 ½% in standard with a significant with a significant whose of 5% in 30 days, 7 ½% in standard with a significant whose of 5% in 30 days, 7 ½% i</li></ul>	h g t if review of hat eight		
	Findings:				days and/or 10% in 180 days ha	as a		
	Sheet) indicated the on 12/15/2019, with mellitus (a condition processes blood susugar in the blood)	nt 1's Admission Record (Face e facility admitted the resident n diagnoses including diabetes n that affects how the body igar causing high levels of and hyperlipidemia (increased			care plan to notify the residents physician and referral to RD for evaluation and recommendation that these interventions have be carried out.  Any issue or concern will be rep	ns and een		
	blood cholesterol (e	evels).			to the Director of Nursing for	, J, LJG		
	Dietician Assessme by the RD indicated	nt 1's Nutrition Registered ent, dated 12/15/2019, signed il Resident 1's daily fluid il from 1400 to1680 milliliters ement) per day.			resolution.  Measures that will be implement	ented		
		* *			to monitor for the continued effectiveness of the corrective	e		
		ted 12/15/2019, electronically	[		action taken to see that this			

DENTERO I ON MEDIONINE	W MILDIONIS CENTROLO				THE MATE	CHONEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	LETED
AND I DAY OF COMMENTAL		A BUILL	ang,			•
	056124	B. WING	<b>:</b>	·	_	<i>)</i> 8/2020
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			•	650 RESEDA BLVD		
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DIRECTOR OF THE PROPERTY OF TH	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	<u> </u>	(XŚ)
PREELY (FACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
body weight was 12 indicate the ideal be indicated to the nutrition related to the therapeutic diet, incresident would mais 50-75% and adequinterventions include as ordered, honoring encouraging oral in needed.  A review of Resider 12/22/2020 for the (activities of daily like deficit related to phe intolerance, limited process, indicated assistance to eat.  A review of Resider Summary, indicated weighed 123 pound A review of Resider - a standardized as tool), dated 12/22/2 welghed 123 pound A review of Resider 12/22/2019 for the (activities of daily like indicated to phe intolerance, limited	adicated Resident 1's usual 20 pounds. The record did not ody weight.  Int 1's Care Plan initiated on resident's risk for altered diagnoses and need for a dicated in the goals the intain consistent food intake of ate body weight. The led providing therapeutic diet ing dietary preferences, take, and referring to RD as int 1's Care Plan initiated on resident's deficit with ADL wing) self-care performance ysical limitations, activity mobility secondary to aging the resident required int 1's Weights and Vitals don 12/16/2019, Resident 1 is.  Int 1's Minimum Data Set (MDS sessment and care-screening 2019, indicated Resident 1		692		at weekly no egards or 2 a care of ich ing hly ort if t 90 e a d care will be for g QAPI and of meet	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DA A BUILDING CO			
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		056124	B. WING			10/0	8/2020
	PROVIDER OR SUPPLIER A HEALTH AND REHA	ABILITATION CENTER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 850 RESEDA BLVD ARZANA, CA 91356		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE I	(XS) COMPLETION DATE
F 692	A review of Resider indicated the resider make decisions and problems. Resident with eating and extraobility, dressing, the statement of the s	nt 1's MDS, dated 3/22/2020, ent was able to understand and did not have memory t 1 required limited assistance ensive assistance with bed tollet use, and personal weighed 119 pounds.	F	<b>592</b>	make changes as deemed necessary.  Completion Date THRC will correct this deficiency later than 11/6/20.	y no	
	A review of Resident 1's Nutrition Status Review record, dated 3/22/2020, indicated Resident 1 was re-evaluated by the RD on 3/22/2020 due to a weight loss of greater than 5% in 30 days, the most recent weight was 119 pounds. Resident 1 had a variable intake and recommended staff to encourage intake.				F692 Nutrition/Hydration Statu Maintenance CFR(s): 483.25(g)(1)-(3)		
	Summary, indicate welghed 113 pound or 11% weight in sit A review of Resider Report indicated the intake during the military fluid intake ranged day (ml/day). On 6/6 fluids was 200 ml in was 860 ml, on 6/6 6/7/2020, Resident ml/day. Resident 1 assessed daily fluid There was no documonitored for signs dehydration.	nt 1's Meal Consumption e resident's measured fluid conth of 5/2020 Resident 1's from 700 to 850 milliliters per 4 Resident 1's total intake of n 24 hours; on 6/5 the total the total was 410 ml and on 1 received a total of 180 was consuming less than the il needs (1400 to 1680 ml), mentation Resident 1 was and symptoms of		Corrective action for the resident affected by the deficient practice:  1. Resident 1 No longer is at Tarzana Healthcare 2. On 10/29/20, an audit was conducted by the Unit Manager and or designee to review residents who in the last 30 days trigger for eating less than 50% for 2 meals in a day, every Monday to Friday. If change of condition is identified with a concern of lack of intake will validate that  d. Physician notification. e. Referral to RD. f. Monitoring for s/s fluid deficit if		arzana and who ating day, nge of	•
e i di se	Background, Asses	nt 1's the Situation, ssment, Recommendation ation Form and Progress			appropriate. g. Update of plan of care has occurred if needed. Validate	e data	

INAME OF PROVIDER OR SUPPLIER TARZANA HEALTH AND REHABILITATION CENTER  TARZANA HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCES PAGETY TAG  PAGETY TAG  CONTINUED FROM DEFICIENCY MART SE PRECIDED BY PULL REGULATORY OR LOC IDENTIFIANCE SHF ORBIGING INCIDENCE WAS A STATE OR SUBMITTED AND THE PROPERTY OF DEFICIENCY TAG  F 692  Continued From page 11  Note, dated 6/17/20/20, timed at 5:30 p.m., Indicated Resident 1 had change of condition Including altered level of consciousness (non-responsive as usual, difficult to arouse), tachycardia (incressed heart rate), and desaburation (low coxygen in blood). The blood pressure was 77/56 millimeters of mercury (mmitg - normal below 12/08 mmitg and above 90/80 mmitg), the heart rate was 12 heats per minute (ppn - normal 60 to 100 bpm), the coxygen saturation was 86% (normal above 94%). Resident 1 was transferred to GACH 1 at 5:52 p.m. via paramedical (emergency medical transportation).  A review of Resident 1's GACH 1's Laboratory Results dated 6/17/20/20 at 7:10 p.m., Indicated Resident 1's endlum (one of the body's electrolyte, increased level can be indicative of dehydration) level was 155 milliequivalents per liter (mEq normal range 138 to 145 mEq.).  A review of Resident 1's GACH 1's Laboratory Results dated 6/17/20/20 at 7:10 p.m., Indicated Resident 1's endlum (one of the body's electrolyte, increased level can be indicative of dehydration) level was 155 milliequivalents per liter (mEq normal range 138 to 145 mEq.).  A review of Resident 1's GACH 1's Discharge Summary dated 6/17/20/20, Incideated Resident 1's primary disgnosis included pneumonis (lung infection) due to COUID-19, septic shock (iffe-threatening condition caused by a severe infection in blood), intravascular volume depletion (reduction in circulating volume in blood vessels), acute renal fallure and hypernatremia (high sodium level in the blood). Resident 1's condition clinically declined during the duration of the stay at the hospital as she was transferred to intensive care unt		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER  TARZANA HEALTH AND REHABILITATION CENTER  PARETY SUMMARY STATEMENT OF DEPCIENCIES (SACH DEPOINCY BUST BE PRECEDED BY FULL REGULATORY OR LSC BENTIFYING INFORMATION)  F 692  Continued From page 11 Note, dated 617/2020, timed at 5:30 p.m., Indicated Resident 1 had change of condition including altered level of consciousness (non-responsive as usual, difficult to arouse), tachycardia (increased heart rate), and desaturation (tow oxygen in blood). The blood pressure was 77/58 millimeters of mercury (mmitg - normal below 120/80 mmitg), the oxygen saturation was 85% (normal above 94/8). Resident 1 was transferred to GACH 1 at 5:52 p.m. Via paramedics (emergency medical transportation).  A review of Resident 1's GACH 1's Laboratory Results dated 67/7/2020 at 7:10 p.m., indicated Resident 1's oxiditun (one of the body's electrolytes, increased level can be indicative of dehydration) level was 155 millinequivalents per liter (mEq.1 – normal range 136 to 145 mEq/L).  A review of Resident 1's GACH 1's Discharge Summary dated 67/2020, indicated Resident 1's primary disgnosts included preumonia (lung infection) due to COVID-19, septic shock (life-threatening condition caused by a severe infection in blood), Intravascular volume depletion (reduction in circulating volume in blood vessels), acute renal failure and hypernatremia (high) sodium level in the blood). Resident 1's condition clinically declined during the duration of the stay at the hospital as she was transferred to intensive care unit (ICU) and became DNR (to not resuscitate - allow natural death), developed cardiopulmorary arrest (the heart stopped							1	
TARZANA HEALTH AND REHABILITATION CENTER    TARZANA CA 91356   TARZANA			066424	R. WING			'	
TARZANA HEALTH AND REHABILITATION CENTER    CAPI D	MAME OF	DOMINED OD GLIDDI IED	050124	3		REET ADDRESS, CITY, STATE, ZIP CODE	10/0	JUIZUZU
SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   REGULATORY OR LOC IDENTIFYING INFORMATION   PREFIX   TAG			A DU ITATION CENTED					
F 692 Continued From page 11 Note, dated 67/2020, timed at 5:30 p.m., indicated Resident 1 had change of condition including altered level of consciousness (non-responsive as usual, difficult to arouse), tachycardia (increased heart rate), and desaturation (low oxygen in blood). The blood pressure was 77/53 millimeters of mercury (mmHg - normal 8blow 120/80 mmHg and above 90/60 mmHg), the heart rate was 121 beats per minute (ppm - normal 60 to 100 bpm), the oxygen saturation was 85% (normal above 94%). Resident 1 was transferred to QACH 1 at 5:52 p.m. via paramedics (emergency medical transportation).  A review of Resident 1's GACH 1's Laboratory Results dated 67/2020 at 7:10 p.m., indicated Resident 1's sodium (one of the body's electrolytes, increased level can be indicative of dehydration) level was155 milliequivelents per ilter (mEqA). – normal range 135 to 145 mEqA).  A review of Resident 1's GACH 1's Liboratory Results dated 67/2020, indicated Resident 1's primary diagnosis included pneumonia (lung infection) due to COVID-19, septic shock (life-threatening condition caused by a severe infection in blood), intravascular volume depletion (reduction in circulating volume in blood vessels), acute renal failure and hypernatremia (high sodium level in the blood). Resident 1's condition cilnically declined during the duration of the stay at the hospital as she was transferred to intensive care unit (ICU) and became ONR (Do not resusculate - allow natural death), developed ardiopulmorary arrest (the heart stopped).	TARZAN	A HEALTH AND REM	ABILITATION CENTER		TA	RZANA, CA 91356		
Note, dated 677/2020, timed at 5:30 p.m., indicated Resident 1 had change of condition including altered level of consciousness (non-responsive as usual, difficult to arouse), tachycardia (increased heart rate), and desaturation (low oxygen in blood). The blood pressure was 77/53 millimeters of mercury (mmHg - normal 80 to 100 bpm), the oxygen saturation was 85% (normal above 94%). Resident 1 was transferred to GACH 1 at 5:52 p.m. via paramedics (emergency medical transportation).  A review of Resident 1's GACH 1's Laboratory Results dated 67/2020 at 7:10 p.m., indicated Resident 1's sodium (one of the body's electrolytes, increased level can be indicative of dehydration) level was 155 milliequivalents per liter (mEq/L - normal range 135 to 145 mEq/L).  A review of Resident 1's GACH 1's Discharge Summany dated 67/2020, indicated Resident 1's primary diagnosts included pneumonia (lung infection) due to COVID-19, septic shock (life-threataning condition caused by a severe infection in blood), intravascular volume depletion (reduction in circulating volume in blood vessels), acute renal failure and hypernatremia (high sodium level in the blood). Resident 1's condition clinically declined during the duration of the stay at the hospital as she was transferred to intensive care unit (ICU) and became DNR (Op not resusciate - allow natural death), developed cardiopulmonary arrest (the heart stopped	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	
A review of Resident 1's Certificate of Death	F 692	Note, dated 6/7/20: Indicated Resident including altered te (non-responsive as tachycardia (increa desaturation (low o pressure was 77/5: (mmHg - normal be 90/60 mmHg), the minute (bpm - norm saturation was 85% Resident 1 was tra p.m. via paramedic transportation).  A review of Reside Results dated 6/7/2 Resident 1's sodius electrolytes, increa dehydration) level vi liter (mEq/L - norm  A review of Reside Summary dated 6/ primary diagnosis i infection) due to Co (life-threatening co infection in blood), (reduction in circula acute renal failure sodium level in the clinically declined o at the hospital as s care unit (ICU) and resuscitate - allow cardiopulmonary a working) and expire	20, timed at 5:30 p.m.,  1 had change of condition vel of consciousness is usual, difficult to arouse), ised heart rate), and oxygen in blood). The blood illimeters of mercury alow 120/80 mmHg and above heart rate was 121 beats per nal 60 to 100 bpm), the oxygen (normal above 94%). Insferred to GACH 1 at 5:52 is (emergency medical  at 1's GACH 1's Laboratory consciousness milliequivalents per al range 135 to 145 mEq/L).  Int 1's GACH 1's Discharge 7/2020, indicated Resident 1's included pneumonia (lung OVID-19, septic shock Indition caused by a severe intravascular volume depletion ating volume in blood vessels), and hypernatremia (high blood). Resident 1's condition during the duration of the stay whe was transferred to intensive the became DNR (Do not natural death), developed rrest (the heart stopped ed on 6/9/2020 at 7:40 p.m.	F6		the potential to be affected by deficient practice and corrective action taken:  The facility has identified 54 out 116 residents, however all residents of the facility have the potential have decline in meal and fluid is and weight loss.  An audit was conducted by the Manager / Designee on 10/30/2 review if the residents trigger for a day In the last 30 days reviewed for accuracy of documentation found that resident is at rising exhibiting decline due to do in meal and fluid intake will d. Notify physician and implement any new order. Referral to RD for evaluation for monitoring for fluid/formanications.	t of dents to intake  Unit 20 to or:  meals will be and if k or ecline:  lers ation f care	

CENTERS FOR MEDICARE & MEDICAID SERVICES							
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	056124		B. WING			C 10/08/2020	
NAME OF F	ROVIDER OR SUPPLIER			81	TREET ADDRESS, CITY, STATE, ZIP CODE	•	-
				56	660 RESEDA BLVD		
TARZAN	A HEALTH AND REH	ABILITATION CENTER		T/	Arzana, ca 91356		
(VA) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	iD.	П	PROVIDER'S PLAN OF CORRECTION	1	(X5) COMPLETION
(X4) (D PREFIX TAG	(FACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
F 692	Immediate cause of Cn 7/31/2020, at 11 the RD stated she ascreening, within so newly admitted residensed nurses we have inadequate for residents have unpreassesses the resident RD stated Resident weight loss by 6/1/2/	dicated Resident 1's f death was acute renal failure. I:45 a.m., during an interview, conducts initial nutritional even days from admission, to idents and conducts quarterly ents. The RD stated the uid notify her when residents od and fluid intake and when lanned weight loss for her to idents' nutritional needs. The it 1 sustained a 10-pound 2020, had inadequate daily days in 6/2020 but the	F	592	2. Monthly weight loss of 5% in days, 7 ½% in 90 Or 10% in days will be reviewed and suppropriate intervention has occurred which would include informed for evaluation and recommendation along with physician being informed as orders if any have been act upon. Review and updating care plan for weight loss if needed.  Systemic changes to ensure deficient practice does not result to the days of the day	n 180 see de RD nd ed of	
	concurrent record of Nurse 1 (LVN 1) stated and 1 stated she deared plan to attempt notify the physician 1 from 6/4 and concurrent reconcurrent reconcurrent from 6/4 DON stated the lice documented a characteristic of the physician and the physician and the Resident 1 for sign dehydration The DON stated the DON stated the Resident 1 for sign dehydration The DON stated the Resident 1 for sign dehydration The DON stated the DON stated the Resident 1 for sign dehydration The DON stated	p.m, during an interview and eview, Licensed Vocational ated she was assigned to 6/6, and 6/7/2020 during the 7 LVN 1 stated Certified (CNA 1) notified her about eal and fluid consumption. Id not update the nutritional of new interventions, did not or the RD.  40 p.m, during an interview ord review, the Director of firmed the fluid intake of 4 - 6/7/2020 was low. The ensed nurse should have nige of condition and notified he RD. The DON did not find licensed nurses monitored and symptoms of DN confirmed there was no physician was made aware of			RD was inserviced by Lead RD HSG on October 29, 2020 on p for review of each new resident then at least quarterly and as n Based on his/her review, RD winitiate a care plan which will idrisk any interventions which mainclude risk for food or fluid defappropriate.  Also inserviced on the process review of monthly weights, which would include weight loss of 30 days, 7 ½ in 90 days and 190 days.  All recommendations by RD wingiven to the Director of Nursing action CNA will be in serviced to the Designee on accurately reported.	rocess and eeded. iill entify icit if for ch % in 0% in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	DENTIFICATION NUMBER: A BUILDING		-	C .		
	056124		8. WING	·		10/08/2020		
NAME OF PROVIDER OR SUPPLIER TARZANA HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5650 RESEDA BLVD TARZANA, CA 91356					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP OEFICIENCY)	BE I	(X5) COMPLETION DATE	
F 692	Resident 1's low fit 10:01 a.m., during confirmed there was developed for Resi DON stated the care developed on adminate followed.  On 8/5/2020, at 2:2 Resident 1's attends the licensed about Resident 1's and deterioration in emergency transfe further stated since order intravenous if CNA 1 stated she (coronavirus-contal and cared for Residenting the 7 a.m. to she assisted with fineals and fluids at food and fluid intak Report and notified 1's low food and fluid Resident 1 did not drinks ordered.  A review of the fact Management dates are provided with a proper hydration at Residents' hydratic regular basis. Sufficient of fluid needed to president in the alth. Ti	an interview, the DON as no documented care plan dent 1's dehydration risk. The re plan should have been ission and interventions should  29 p.m., during an interview, ding physician (Physician 1) ) I nurses did not notify him weight loss, low fluid intake, n condition before Resident 1's r on 6/7/2020. Physician 1 a he was not aware, he did not fluid for hydration.  19 p.m., during an interview, was assigned to the COVID-19 glous disease) designated unit dent 1 from 6/4 to 6/7/2020 o 7 p.m. shift. CNA 1 stated eeding Resident 1 with her and documented Resident 1's te in the Meal Consumption I LVNs 1 and 2 about Resident uid Intake. CNA 1 stated have nutritional supplement  illity's policy on Hydration d 7/2017, indicated residents sufficient fluid intake to maintain and nutritional status. on will be monitored on a icient fluid means the amount brevent dehydration and the amount needed is specific		892	of food and fluid intake and inforthe licensed staff of residents with don't consume 50% of meal and fluids for the meals served on state of the meals of th	tho d or shift.  ed by & ents or for 2 ondition  fluid  if for 2 ondition		
		ne amount needed is specific and fluctuates as the resident's			Unit managers will review resid	ents	1	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & I			1			(Y3) DATE	
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
and Plan of Correction		IDENTIFICATION NUMBER:	A BUILDING			С	
			5 46MG				
		056124	B. WING			10/0	8/2020
NAME OF F	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		1
TADZANI	A LIEALTH AND DEH	ABILITATION CENTER			SSO RESEDA BLVD		
IARZAN	4 LEVELLI VILD IVELI			T/	ARZANA, CA 91356		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	(D		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	N E	(X5) COMPLETION
(X4) ID PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREF		CROSS-REFERENCED TO THE APPROP	RIATE	DATE
TAG	REGODATORY ON EDGE MARKET THE WAR CHARLES		1		DEFICIENCY)		
F 692	Continued From pa	nae 14	l Fe	692	who have trimpered for esting 6	006 or	
	· ·	s (e.g., increase fluids if			who have triggered for eating 5	0% 01	
		or diarrhea). A general			less for 2 meals every Monday	10	
	guideline for deterr	nining baseline daily fluid	<b>!</b>		Friday. If change of condition	5	
	needs is to multiply	the resident's body in	1	- 1	identified with a concern of lack	OI	
	kilograms times 30	ml, except for residents with	1		intake will validate that		
į	renal or cardiac dis	itress.					
		No. 4			h. Physician notification.		
	A review of the faci	lity's policy on Changes in			i. Referral to RD.	., .,	
	Resident Condition	, revised on 2/2017, indicated	ļ		j. Monitoring for s/s fluid defic	at ar	
	nursing stan, the re	esident, the attending resident's legal representative	1		appropriate.		
	physician, and the	changes in the resident's	ļ		k. Update of plan of care has		
	condition occur. A	significant change in the	ĺ		occurred if needed.		
	condition occur. A significant change in the resident's physical, mental, or psychosocial						
	status, including a	deterioration in health, mental,	1		Unit managers or designee will	review	,
		atus in either life threatening			monthly weight report to check	that	
	conditions or clinic	al complications; or a need to			any resident with a		
		nificantly. The SBAR			significant weight loss of 5% ir	30	
	Communication Fo	orm and the Progress Note are			days, 7 1/2% in 90 days and/or	10% in	
		d document changes in	ļ		180 days has a care plan to no	tify the	
		clent and effective manner;	Ī		residents physician and referra	I to RD	
	provide assessmen	nt information to the physician comprehensive documentation.			for evaluation and recommend	ations	
	Changes in the res	sident's status that affect the			and that these interventions ha		
	problems/goals or	approaches on his or her care			been carried out.		
	plan, are documen	ted as revisions and	1				l
		he interdisciplinary caregivers.	1		Any issue or concern will be re	ported	
			1		to the Director of Nursing for	<b></b>	
					resolution.		
					16301411011.		
Į							
Ì		•			Manager that will be implem	antad	
					Measures that will be implen	ISIILEU	j
			1		to monitor for the continued	•	
					effectiveness	. 4 -	
			1		of the corrective action take		
İ			İ		see that this deficiency has	een	
			1		corrected and will not recur		

CENTERS FOR WEDICARE & WEDICAID SERVICES			MALE AND RIVER				
STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NON		DERTHOUTHOUTHOUSER.	A. BUILDING		С		
056124		B, WING_		10/08/2020			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1		
				6650 RESEDA BLVD			
TARZAN	A HEALTH AND REHA	ABILITATION CENTER		TARZANA, CA 91356		•	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DAYE	
F 692	condition fluctuates resident has fever or guideline for determ needs is to multiply kilograms times 30 renal or cardiac dis A review of the faci Resident Condition nursing staff, the rephysician, and the are notified when a condition occur. A resident's physical, status, including a or psychosocial state conditions or clinical alter treatment sign Communication Foused to assess and condition in an efficiency of the provide assessment and provide clear of Changes in the resproblems/goals or plan, are document.	is (e.g., increase fluids if or diarrhea). A general nining baseline daily fluid the resident's body in mi, except for residents with	F 69	Medical Records will audit PCO least weekly x 4 week then bi-witimes 3 months for residents with have a change of condition in reto resident eating 50% or less fineals in a day and check.  a. Notify physician if change of condition has occurred involved includes needs not being met.  b. Referral to RD if change of condition has occurred which includes resident not meeting assessed intake needs.  Medical records will audit montoweight report x 3 months to report assessed intake needs.  Medical records will audit montoweight report x 3 months to report in a month weight report x 3 months to report in a month of 5% in 30 days, 7 ½ in 90 and 10% in 180 days have a caplan to notify physician and carfor referral to RD. Report will be given to the Director of Nursing review & follow up as needed.  Findings will be reviewed during meeting for further discussion and needed action by the Director of Nursing x 3 months. QAPI will monthly and review progress a make changes as deemed necessary.	reekly no egards or 2 f living hly ort if t o days e plan e for g QAPI and of meet		
	problems/goals or plan, are documen	approaches on his or her care ted as revisions and		plan to notify physician and car for referral to RD. Report will be given to the Director of Nursing review & follow up as needed.  Findings will be reviewed during meeting for further discussion an eeded action by the Director of Nursing x 3 months. QAPI will a monthly and review progress a make changes as deemed	e plan e for g QAPI and of meet		

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION			A BUILDING		<del></del>	С	
056124		B. WING			10/08/2020		
NAME OF PROVIDER OR SUPPLIER  TARZANA HEALTH AND REHABILITATION CENTER				5	TREET ADDRESS, CITY, STATE, ZIP CODE 660 RESEDA BLVD ARZANA, CA 91356		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY PULL			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE I	(X5) COMPLETION DATE
F 692	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		F	692	Completion Date THRC will correct this deficiency later than 11/6/20.	/ no	•