STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056124	A. BUILDING _____ B. WING _____	09/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' call light were within reach and properly functioning for three of three sampled residents (Residents 1, 2, and 3). This deficient practice placed the residents at risk of delayed care and not receiving the needed care. Findings: 1. A review of Resident 1's Admission Record (Face Sheet) indicated the facility readmitted the resident on 6/11/2020 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 7/6/2020, indicated the resident had the ability to make self understood and understand others. Resident 1 had functional limitations requiring one-person assist in bed mobility and moving between surfaces including to or from bed, chair, wheelchair, standing position. During a concurrent observation and interview on 8/19/2020 at 1:30 p.m., Resident 1 stated his call light did not work. Resident 1 pressed the call light button to show that the light above the room door was not lighting up to indicate the call light was pressed. The light above the room door, which had the room number indicated on the light, was not lit up. Nursing staff did not respond to the call light for approximately 20 minutes. During a concurrent observation and interview on 8/19/2020 at 1:55 p.m., Assistant Maintenance 1 (AM 1) verified the call light above Resident 1's door was not on and not functioning. AM 1 further verified the call light sound was not working. AM 1 stated he did not know how long the call light was not working because it was not reported to maintenance department. During an interview on 8/19/2020 at 2:15 p.m., the Director of Nursing (DON) stated the call lights were needed for residents to call for assistance. 2. On 8/19/2020 at 2:46 p.m., during and observation and concurrent interview, Resident 2 stated he did not know where his call light was. The DON verified Resident 2 did not have a call light nearby. The DON found Resident 2's call light coiled several times around the bed siderail on the left side tucked away and out of reach of the resident. While the DON uncoiled the call light, Resident 2's roommate, Resident 3 was asked if he knew where his call light was, Resident 3 shook his head left and right indicating no. The DON was not able to find his call light. Resident 3 did not have a call light. A review of Resident 2's Admission Record indicated the facility admitted the resident on 7/24/2020 with [DIAGNOSES REDACTED]. A review of Resident 2's MDS dated [DATE], indicated the resident had the ability to make self understood and understand others. Resident 1 had functional limitations requiring one-person assist in bed mobility and moving between surfaces including to or from bed, chair, wheelchair, standing position. A review of Resident 3's Admission Record indicated the facility readmitted the resident on 7/23/2020 with [MEDICAL CONDITION] (long-term condition that affects the pumping power of the heart muscles because fluid builds up around the heart) and [MEDICAL CONDITION]. A review of Resident 3's MDS dated [DATE], indicated the resident had the ability to make self understood and understand others. Resident 1 was totally dependent on staff for care. A review of facility's policy and procedures titled, Routine Resident Care revised 9/2011, indicated Resident call lights are answered timely and resident requests are addressed, if permitted. Call lights should always be placed within easy reach of the resident. Call lights should be easily accessible to the resident at all times.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was provided soap to maintain good grooming and personal hygiene. This deficient practice resulted in Resident 1 not being able to wash his hands inside his bathroom which placed the resident at risk for infection. Findings: A review of Resident 1's Admission Record indicated the facility readmitted the resident on 3/2/2020 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 7/6/2020, indicated the resident has the ability to make self understood and understand others. Resident 1 had functional limitations requiring one-person assist in bed mobility and moving between surfaces including to or from bed, chair, wheelchair, standing position. During a concurrent observation and interview on 8/19/2020 at 1:30 p.m., Resident 1 stated he did not have any soap inside his restroom for over two weeks. Resident 1 stated he asked multiple staff but was not assisted with getting soap. Resident 1 further stated he feels he's going to get sicker staying at the facility. No soap was found in Resident 1's restroom. During a concurrent observation and interview on 8/19/2020 at 1:50 p.m., Rehabilitation Aid 1 (RA 1) came to Resident 1's room. Prior to leaving resident's room, RA 1 was asked to perform hand hygiene. RA 1 went inside the restroom and stated he could not perform hand hygiene because there was no soap. RA 1 stated the soap dispenser was not working. During a concurrent observation and interview on 8/19/2020 at 1:55 p.m., assistant Maintenance Staff 1 (MS 1) verified there was no working soap dispenser inside Resident 1's restroom. MS 1 stated he did not receive any report about Resident 1 did not have a working soap dispenser. During an interview on 8/19/2200 at 2:15 p.m., the Director of Nursing (DON) stated she did not know why Resident 1 did not have access to a working soap dispenser in his bathroom. DON stated that having soap in the bathroom accessible to the resident is important because of infection and safety. A review of facility policies and procedures titled, Routine Resident Care dated 4/2005 and revised 09/2011, indicated, Resident receive necessary assistance to maintain good grooming and personal/oral hygiene.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the handwashing sink for one of three sampled residents (Resident 1) had available soap for Resident 1 and for staff caring for the resident to perform hand hygiene with soap and water to prevent the spread of infections was provided soap to maintain good grooming and personal hygiene. This deficient practice had the potential to spread infection. Findings: A review of Resident 1's Admission Record indicated the facility readmitted the resident on 3/2/2020 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 7/6/2020, indicated the resident has the ability to make self understood and understand others. Resident 1 had functional limitations requiring one-person assist in bed mobility and moving between surfaces including to or from bed, chair, wheelchair, standing position. During a concurrent observation and interview on 8/19/2020 at 1:30 p.m., Resident 1 stated he did not have any soap inside his restroom for over two weeks. Resident 1 stated he asked multiple staff but was not assisted with getting soap. Resident 1 further stated he feels he's going to get sicker staying at the facility. No soap was found in Resident 1's restroom. During a concurrent observation and interview on 8/19/2020 at 1:50 p.m., Rehabilitation Aid 1 (RA 1) came to Resident 1's room. Prior to leaving resident's room, RA 1 was asked to perform hand hygiene. RA 1 went inside the restroom and stated he could not perform hand hygiene because there was no soap. RA 1 stated the soap dispenser was not working. During a concurrent observation and interview on 8/19/2020 at 1:55 p.m., assistant Maintenance Staff 1 (MS 1) verified there was no working soap dispenser inside Resident 1's restroom. MS 1 stated he did not receive any report about Resident 1 did not have a

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) working soap dispenser. During an interview on 8/19/2200 at 2:15 p.m., the Director of Nursing (DON) stated she did not know why Resident 1 did not have access to a working soap dispenser in his bathroom. DON stated that having soap in the bathroom accessible to the resident is important because of infection and safety.
F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' call system were properly functioning for two of three sampled residents (Residents 1 and 3). This deficient practice placed the residents at risk of delayed care and not receiving the needed care. Findings: 1. A review of Resident 1's Admission Record (Face Sheet) indicated the facility readmitted the resident on 6/11/2020 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care-screening tool) dated 7/6/2020, indicated the resident had the ability to make self understood and understand others. Resident 1 had functional limitations requiring one-person assist in bed mobility and moving between surfaces including to or from bed, chair, wheelchair, standing position. During a concurrent observation and interview on 8/19/2020 at 1:30 p.m., Resident 1 stated his call light did not work. Resident 1 pressed the call light button to show that the light above the room door was not lighting up to indicate the call light was pressed. The light above the room door, which had the room number indicated on the light, was not lit up. Nursing staff did not respond to the call light for approximately 20 minutes. During a concurrent observation and interview on 8/19/2020 at 1:55 p.m., Assistant Maintenance 1 (AM 1) verified the call light above Resident 1's door was not on and not functioning. AM 1 further verified the call light sound was not working. AM 1 stated he did not know how long the call light was not working because it was not reported to maintenance department. 2. On 8/19/2020 at 2:46 p.m., during and observation and concurrent interview, Resident 3 was asked if he knew where his call light was, Resident 3 shook his head left and right indicating no. The DON was not able to find his call light. Resident 3 did not have a call light. A review of Resident 3's Admission Record indicated the facility readmitted the resident on 7/23/2020 with [MEDICAL CONDITION] (long-term condition that affects the pumping power of the heart muscles because fluid builds up around the heart) and [MEDICAL CONDITION]. A review of Resident 3's MDS dated [DATE], indicated the resident had the ability to make self understood and understand others. Resident 1 was totally dependent on staff for care. During a concurrent observation and interview on 8/19/2020 at 1:55 p.m., AM 1 verified Resident 3's call light was missing. AM 1 stated he did not know how long the call light was missing and if it was broken because it was not reported to maintenance department.