STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056367	A. Building B. Wing	12/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of North Hills	9655 Sepulveda Boulevard North Hills, CA 91343

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45978 Based on interview and record review, the facility failed to ensure that one of three sampled residents (Resident 1), was kept free from neglect (a situation in which not enough care or attention is provided to someone or something) when facility staff failed to call paramedics (person trained to give emergency medical care to people who are injured or ill) when the resident first exhibited signs and symptoms of decompensating (a sudden worsening of a resident ' s medical condition) as evidence by a blood pressure of ,d+[DATE] millimeters of mercury (mmHg-unit of measure, normal blood pressure is ,d+[DATE]mmHg); Oxygen Saturation level (O2 sat- the amount of oxygen in the blood) of 77 percent (%-unit of measure; normal level is 95% or higher); pulse (heart rate) of 111 beats per minute (BPM; normal range is 60 to 100 bpm); and respiration (beathing) rate of 26 breaths per minute (normal range is 16 to 20 breaths per minute) on [DATE] at 6:30 a.m. As a result, Resident 1 ' s decompensating condition was not immediately treated, and 911 (telephone number used to request for emergency medical assistance) was not called until 7:56 a.m. when the oncoming shift nurse (Registered Nurse 2 [RN 2]) went to assess the resident during her morning rounds (when the nurse first checks on all their assigned resident at the start of their shift). RN 2 noted that Resident 1 was in distress. Facility staff then initiated the transfer of Resident 1 to General Acute Care Hospital (GACH) via 911. While at the emergency department (ER- department within the GACH for residents requiring immediate medical care) of the GACH, Resident 1 expired (died) on [DATE] at 10:19 a.m. while GACH staff were attempting to draw laboratory blood test (a test done on a sample of blood to determine overall health). On [DATE] at 6:09 p.m., the State Survey Agency called an Immediate Jeopardy (IJ-a situation in which the facility ' s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Assistant Facility Administrator (AFA) and the Director of Nursing (DON) due to the facility's failure to ensure staff did not act negligently towards Resident 1, who exhibited a decline in overall health condition, when they did not immediately call 911. On [DATE] at 11:11 a.m., the Facility Administrator (FA) provided an IJ Removal Plan which included the following summarized actions: 1. On [DATE], the Director of Nursing began immediate in-servicing of the RN Supervisor and Licensed Vocational Nurse (LVN) assigned to Resident 1 on [DATE], on the facility's policies and procedures regarding neglect. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The DON began immediate in-servicing of licensed staff (RN Supervisors and LVNs) scheduled on [DATE]. Director of Nursing/Designee continued to in-service licensed staff until [DATE] on the facility's policies and procedures regarding neglect. One LVN will be in-serviced on [DATE] upon his return from his leave. 3. The DON audited 127 residents for changes of condition. There were 23 of 127 residents identified on [DATE], who were currently being monitored and managed for active changes in conditions. 4. RN Supervisor for each shift will continue to monitor and assess the 23 residents with change of condition for a minimum of 72 hours or until condition has resolved. 5. Effective [DATE], under the guidance and direction of each resident's Primary Care Physician (PCP) or designee, the RN Supervisors implemented resident-directed care and treatment interventions, consistent with the residents' goals and preferences to address the changes. 6. The DON and RN Supervisors reviewed and revised resident care plans effective [DATE] to address the changes in condition and to ensure continued care and services to maintain their highest practicable outcomes. 7. The RN Supervisor for each shift shall inform the resident, the resident's physician and the resident's representative when there are changes involving life threatening conditions to ensure residents receive the necessary staff, supplies, services, policies, training, or staff supervision and oversight to meet their needs 8. The Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the resident) reviewed all changes in condition effective [DATE] and continued to review daily the 23 resident's change in condition to ensure required notifications, interventions, care planning and immediacy of interventions to reduce the potential for further decline in health to the extent possible. On [DATE] at 4:21 p.m., while onsite and after verifying the facility ' s full implementation of the IJ removal plan, the State Survey Agency accepted the IJ Removal Plan and removed the Immediate Jeopardy in the presence of the DON and Director of Staff Development (DSD). Findings: A review of Resident 1 ' s face sheet (admission record) indicated that the resident was admitted on [DATE] with diagnoses including hypertension (high blood pressure [BP-a measure of the force that your heart uses to pump blood around your body]), diabetes mellitus type II (DM Type II- an impairment in the way the body regulates and uses glucose [sugar]) and thrombocythemia (platelet [disc-shaped piece of cell that is found in the blood] disorder in which one ' s body produces too many platelets). A review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool) dated [DATE], indicated that the resident had intact cognition (ability to think and make decisions). The MDS also indicated that the resident needed extensive assistance from staff with mobility, transfer, toilet use, dressing, and personal hygiene. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1 ' s Physician Orders for Life-Sustaining Treatment (POLST-form that gives residents control over their end-of-life-care) dated [DATE] indicated the resident was under the order of Do Not Resuscitate (DNR- if found pulseless or breathless, medical staff is not to perform cardiopulmonary resuscitation [CPR - an emergency life-saving procedure that is done when someone's breathing or heartbeat has stopped]) with Selective Treatment (a goal of treating a medical condition without invasive [aggressive] medical procedures, such as the use of ventilators [machine that helps you breathe or breathes for you] or major surgery). The POLST was signed by the physician and Resident 1 on [DATE]. A review of Resident 1 ' s Change of Condition (COC) Assessment Form completed by Registered Nurse 4 (RN 4) dated [DATE] and timed at 8:46 a.m., indicated that on [DATE] at around 6:30 a.m., Resident 1 complained of shortness of breath (SOB). The form indicated that Resident 1 ' s initial vital signs (measurements of the body's most basic functions) were as follows: 1. Blood pressure was ,d+[DATE] mmHg. 2. O2 sat- was at 77 %. The COC form indicated that facility staff elevated Resident 1 ' s legs (elevating ones legs above the heart allows the blood to circulate back to the heart without fighting gravity) and provided the resident with supplemental oxygen (treatment in which a tank of oxygen is used to give oxygen to people with breathing problems) of five (5) liters (L-unit of measure) via nasal canula (a device that has two prongs and sits below the nose that delivers oxygen directly into one ' s nostrils). The form further indicated that upon reassessment, Resident 1 ' s vital signs were as follows: 1. Pulse was 111 bpm 2. Respiration rate was 26 breaths per minute 3. Blood Pressure of ,d+[DATE] mmHg 4. Temperature of 97.3 Degrees Fahrenheit (F-unit of measure; normal temperature range is 97 to 99 F) 5. O2 sat 94% The COC form further indicated that Resident 1 was noted with bloody urine from in and out catheterization (a tube is inserted in a person ' s bladder to drain urine). The COC indicated that a message was left with Resident 1 ' s physician. RN 4 documented that the facility received a call back with instructions to transfer Resident 1 via 911 which was called at around 8:00 a.m. The form indicated that paramedics came and took over the care of Resident 1 at 8:05 a.m., assessed the resident and left the facility with Resident 1 to GACH ER at 8:13 a.m. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1 ' s Paramedic Patient Care Report, dated [DATE], indicated that Paramedics were called by the facility at 7:56 a.m. and arrived at the facility at 8:02 a.m. The form indicated that Resident 1 was found to have low O2 Sat levels of 77% at approximately 6:30 a.m. and was provided with supplemental oxygen. The form indicated that there was minimal improvement to Resident 1, and as a result the facility contacted 911 services. The report indicated that upon the Paramedic ' s arrival to the facility, Resident 1 had an O2 sat of 78%. The record further indicated that Resident 1 was noted to be in a moderate level of distress with the chief complaint being shortness of breath. A review of the GACH ' s Daily Focus Assessment Report, dated [DATE], indicated that on [DATE] at 8:39 a. m., Resident 1 was admitted in the emergency department with labored breathing (having a hard time breathing), slurred speech, hypothermia (dangerously low body temperature), oriented (level of awareness) to self and place, and unable to complain of pain. The Daily Focus Assessment Report further indicated that Resident 1 was noted with tenderness (pain) on palpation (feeling with the fingers or hands) of abdomen. The record indicated that when GACH staff was attempting to draw blood for laboratory testing, Resident 1 was noted to no longer be breathing and was pulseless. The GACH physician was made aware, and Resident 1 was pronounced dead on [DATE] at 10:19 a.m. On [DATE] 10:04 a.m., during an interview, Registered Nurse 5 (RN 5) stated that on [DATE], Resident 1 was under her direct care. RN 5 stated that at approximately 6:30 a.m. on [DATE], she checked Resident 1 ' s blood pressure and O2 Sat levels and noted that Resident 1 ' s blood pressure reading was ,d+[DATE] mmHg with an O2 sat level at 77%. RN 5 stated that due to the resident ' s hypotension (low blood pressure), the resident ' s legs were elevated. RN 5 stated that Resident 1 was also started on oxygen at five (5) liters per min (LPM- unit of measurement) via nasal cannula. RN 5 stated that Resident 1 ' s O2 sat had increased to 94% and the blood pressure increased to ,d+[DATE] mmHg. RN 5stated that she did not monitor Resident 1 any further. RN 5 stated that Resident 1 should have been transferred to the GACH with their initial blood pressure of ,d+[DATE] mmHg. RN 5 stated that 911 should have been called immediately as Resident 1 was in noted distress. RN 5 stated that she considered questioning Registered Nurse 4 (RN 4) who was the RN supervisor, if the resident needed to be transferred via 911. RN 5 stated that because the facility nurses did not immediately call 911, there was a delay in transferring Resident 1 to the GACH. RN 5 stated that if Resident 1 was transferred to the GACH sooner, there is a possibility that the resident would still be alive. On [DATE] at 9:25 p.m., during an interview, Licensed Vocational Nurse 3 (LVN 3) stated that on [DATE] at approximately 6:30 a.m., RN 4 and RN 5 called her to Resident 1 ' s room. LVN 3 stated that upon entering the resident ' s room, Resident 1 was complaining of abdominal pain. LVN 3 stated that RN 4 and RN 5 were having difficulty with obtaining Resident 1 ' s blood pressure because the machine was not getting a reading. LVN 3 stated that Resident 1 appeared to be in distress. LVN 3 stated that she informed RN 4 and RN 5 that Resident 1 needed to be transferred to the GACH as Resident 1 continued to have unrelieved pain. LVN 3 stated that if facility staff had called 911 right away, there would be a possibility that Resident 1 would still be alive. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:25 p.m., during an interview, RN 4 stated that she was the RN Supervisor on [DATE]. RN 4 stated that at around 6:30 a.m., she was called by RN 5 to Resident 1 ' s room because the resident had a blood pressure reading of ,d+[DATE] mmHg and an O2 sat level of 77%. RN 4 indicated that Resident 1 was also complaining of abdominal pain, so she asked RN 5 and LVN 3 to perform an in and out catheterization, which revealed that Resident 1 had hematuria (blood in the urine). RN 4 stated that after Resident 1 ' s blood pressure and O2 sat levels improved, she then left a message with Resident 1 ' s physician regarding the COC. RN 4 stated that at 8:46 a.m., she received a call back from the on-call RN informing her that Resident 1 needed to be transferred to the GACH via 911. RN 4 stated that RN 2 had already assessed Resident 1, and the resident had already been transferred to the GACH before receiving the call. RN 4 stated that she should have called 911 when Resident 1 ' s health condition first declined at 6:30 a.m. so that the resident could have been transferred to the GACH sooner. RN 4 stated that she did not call 911 immediately because she was first waiting to receive a call back from Resident 1 ' s physician. RN 4 stated that calling 911 could have possibly saved Resident 1 ' s life. During an interview on [DATE] at 12:06 p.m., Registered Nurse 2 (RN 2) stated that on [DATE], she was the oncoming morning shift (7:00 a.m. to 3:30 p.m.) nurse supervisor. RN 2 stated that on [DATE], she arrived at the facility at approximately 7:45 a.m. RN 2 stated that RN 4 informed her that Resident 1 had experienced a COC at 6:30 a.m. that same morning. RN 2 stated that immediately after being told of Resident 1 ' s COC, she rushed into Resident 1 ' s room. RN 2 stated she had asked RN 4 if 911 had been called, to which RN 4 indicated that she did not call 911 because the resident had a code status of Do Not Resuscitate (DNR). RN 2 stated that she corrected RN 4 that Resident 1 had a code status of DNR with selective treatment. RN 2 stated that she informed RN 4 that 911 needed to be called immediately as Resident 1 appeared to be in distress. RN 2 stated that after 911 was called for Resident 1, paramedics arrived at the facility and Resident 1 was transferred to the GACH. RN 2 stated that Resident 1 should have been transferred to the GACH when the resident first exhibited signs and symptoms of desaturation (low levels of oxygen in the blood), hypotension, rapid respiratory rate (taking more than 20 breaths per minute; normal range is 10 to 20 breaths per minute), and tachycardia (heart rate greater than 100 beats per minute). RN 2 stated that RN 4 apologized to her for not calling 911 for Resident 1. RN 2 stated that there was a greater chance of saving a resident ' s life if emergency treatment had been given as soon as possible. On [DATE] at 2:57 p.m., during an interview with the DON, DON stated that on [DATE] at 6:30 a.m., licensed nurses should have immediately called 911 if Resident 1 exhibited signs and symptoms of desaturation, hypotension, and tachycardia so that the resident could have gotten the help and care he needed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:40 p.m., during a follow up interview with RN 2, RN 2 stated that she was familiar with Resident 1 because the resident resided in the facility for a long period of time. RN 2 stated that when she arrived on shift on [DATE] at approximately 7:45 a.m. she was informed by RN 4 that Resident 1 had a change in condition. RN 2 stated that she immediately went to Resident 1 ' s room and noted that the resident looked different. RN 2 stated that the resident looked pale (having less color than usual) in color and was complaining of abdominal pain. RN 2 stated that within minutes of being in the room with Resident 1, she could tell that the resident needed emergent transfer to the GACH. RN 2 stated that it was important to call 911 because the resident was in distress. RN 2 stated that if they waited for orders to transfer the resident via an ambulance (non-emergency transport to the GACH), the ambulance would refuse transportation of Resident 1 due to the resident ' s condition being unstable. RN 2 stated the reason 911 needed to be called is so that the resident can be transferred to the GACH immediately. On [DATE] at 1:38 p.m., during a follow up interview and concurrent record review with the DON, Resident 1 ' s Change of Condition form dated [DATE] at 8:46 a.m. was reviewed. DON stated that from her investigation of the event that occurred on [DATE] regarding Resident 1 ' s change of condition at 6:30 a.m., that the resident was stabilized and did not require emergent transfer to the GACH. The DON reviewed Resident 1 ' s COC dated [DATE] time at 8:46 a.m. and confirmed that while Resident 1 ' s blood pressure had improved to ,d+[DATE] mmHg and the O2 sat levels had improved to 94% on five (5) L via nasal cannula, the resident still had an elevated heart rate of 111 and an elevated respiratory rate of 26. DON stated that if she was the nurse caring for Resident 1, she would have re-assessed and re-evaluated Resident 1 because the resident ' s vital signs were outside of the normal range. When the DON was asked if Resident 1 had been reassessed or re-evaluated, the DON stated, I know my nurses. The DON stated that her nurses reassessed Resident 1. When the DON was asked if there was documented evidence that Resident 1 had been reassessed to ensure the resident ' s condition had been stabilized, DON stated that there was no documented evidence that the resident had become stable during the shift and that she cannot prove the nurses reassessed or reevaluated the resident because they did not document. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:17 p.m. during a follow up interview and concurrent record review with RN 5, Resident 1 ' s Change of Condition form dated [DATE] at 8:46 a.m. was reviewed. RN 5 stated that on [DATE] at approximately 6:30 a.m. she obtained a blood pressure of ,d+[DATE] mmHg and on O2 sat level of 77% for Resident 1. RN 5 stated she took a full set of initial vital signs for Resident 1 at 6:30 a.m. which included their temperature, pulse rate, and respiratory rate, but was unable to find documented evidence when looking through Resident 1 ' s medical record. RN 5 stated that after they elevated Resident 1 ' s legs and provided the resident with supplemental oxygen, the residents blood pressure improved to ,d+[DATE] mmHg and the O2 sat levels had improved to 94% on five (5) L via nasal cannula. RN 5 reviewed Resident 1 ' s COC dated [DATE] at 8:46 a.m. and stated that she was the one who obtain Resident 1 ' s vital signs that showed an elevated heart rate of 111 bpm and an elevated respiratory rate of 26 breaths per minute. RN 5 confirmed that a heart rate of 111 and a respiratory rate of 26 was not normal. RN 5 stated that even though Resident 1 ' s vital signs were not normal, she did not reassess the resident to ensure the resident ' s condition had stabilized. RN 5 stated that her assessment of Resident 1 ' s condition was that the resident was stable and did not require emergent transfer to the GACH. When asked how RN 5 was able to determine if Resident 1 was stable if the resident ' s vital signs were outside the normal range, and RN 5 had admitted to not reassessing or reevaluating the resident, RN 5 stated that based on what she saw, the resident was not in distress and did not need to be transferred to the GACH. When RN 5 was asked how come she indicated in her previous interview that Resident 1 appeared to be in distress, and she questioned if RN 4 was going to transfer the resident to the GACH, RN 5 stated that she does not recall making that statement. When RN 5 was asked if Resident 1 ' s elevated heart rate and respiratory rated needed to be reassessed, RN 5 stated she should have reassessed the resident. When asked if Resident 1 was provided with the care needed, RN 5 stated that she did not provide the resident with the care needed. RN 5 stated that she should have reassessed the resident because the resident was not stable and did not have stable vital signs. RN 5 stated that Resident 1 had just recovered from hypotension, and desaturation, but she failed to continue to monitor the resident to follow up with the elevated heart rate and respiratory rate. RN 5 stated that neglect is when a resident is in need, and the staff can provide that need but does not. RN 5 stated that she did not provide the care needed by Resident 1 when she did not reassess or re-evaluate the resident. RN 5 stated she should have reassessed the resident because the vital signs were still not within normal range, and because she did not reassess, she was not able to ensure the resident was stable. When asked if she acted neglectful by not reassessing or re-evaluating Resident 1 during his COC on [DATE] at 6:30 a.m., RN 5 stated Yes it was neglectful. A review of the facility ' s policy and procedure, titled, Change of Condition Notification, revised [DATE], indicated that if the resident deteriorates, the resident ' s symptoms are serious, and the most rapid intervention available by a physician would place the resident in great jeopardy, the facility is to call 911 for transport to hospital. A review of the facility ' s policy and procedure, titled, Abuse Prevention and Prohibition Program, revised [DATE], indicated that: 1. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. Resident assessments and care planning are performed to monitor resident needs. The facility provides covered individuals with training to enable the identification of the following signs and symptoms of potential resident abuse and neglect including leaving someone unattended who needs supervision.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45978 Based on interview and record review, the facility failed to immediately call the paramedics (person trained to give emergency medical care to people who are injured or ill) for one of three sampled residents (Resident 1), when the resident first exhibited signs and symptoms of decompensating (a sudden worsening of a resident ' s medical condition) as evidence by a blood pressure of ,d+[DATE] millimeters of mercury (mmHg-unit of measure, normal blood pressure is ,d+[DATE]mmHg); Oxygen Saturation level (O2 sat- the amount of oxygen in the blood) of 77 percent (%-unit of measure; normal level is 95% or higher); pulse (heart rate) of 111 beats per minute (BPM; normal range is 60 to 100 bpm); and respiration (beathing) rate of 26 breaths per minute (normal range is 16 to 20 breaths per minute) on [DATE] at 6:30 a.m. As a result, Resident 1 ' s decompensating condition was not immediately treated, and 911 (telephone number used to request for emergency medical assistance) was not called until 7:56 a.m. when the oncoming shift nurse (Registered Nurse 2 [RN 2]) went to assess the resident during her morning rounds (when the nurse first checks on all their assigned resident at the start of their shift). RN 2 noted that Resident 1 was in distress. Facility staff then initiated the transfer of Resident 1 to General Acute Care Hospital (GACH) via 911. While at the emergency department (ER- department within the GACH for residents requiring immediate medical care) of the GACH, Resident 1 expired (died) on [DATE] at 10:19 a.m. while GACH staff were attempting to draw laboratory blood test (a test done on a sample of blood to determine overall health). On [DATE] at 6:09 p.m., the State Survey Agency called an Immediate Jeopardy (IJ-a situation in which the facility ' s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Assistant Facility Administrator (AFA) and the Director of Nursing (DON) due to the facility's failure to ensure staff immediately called 911 for Resident 1, who exhibited signs and symptoms of decline in overall health condition. On [DATE] at 11:11 a.m., the DON provided an IJ Removal Plan which included the following summarized actions: 1. On [DATE], the DON in-serviced the Registered Nurse (RN) Supervisor and Licensed Vocational Nurse (LVN) assigned to Resident 1 on the night of [DATE] on the facility's policies and procedures regarding changes in condition. 2. On [DATE], the Director of Nursing/ Designee began immediate in-servicing of the facility's licensed staff (RN Supervisors and LVNs) regarding the facility's policy and procedures regarding changes in condition. All available licensed staff have been in-serviced as of [DATE]. 3. On [DATE], the Director of Nursing began immediate in-servicing of the facility's licensed staff (RN Supervisors and LVNs), regarding understanding the code status (type of emergent treatment a person would or would not receive) of residents who experience changes in condition and how their code status will impact interventions implemented to address the specific changes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. On [DATE], the Director of Nursing audited the facility's 127 residents for changes of condition. There were 23 out of 127 residents identified as currently being monitored and managed for active changes in condition. 5. Effective [DATE], the RN Supervisor for each shift will continue to monitor and assess the 23 residents with change of condition (COC- a deterioration in health) for a minimum of 72 hours or until condition has resolved to ensure all needed care or services to address the residents' well-being are provided for in collaboration with their primary care physician or designees. 6. Effective [DATE], under the guidance and direction of each resident's Primary Care Physician (PCP) or designee, the RN Supervisors implemented resident-directed care and treatment interventions, consistent with the residents' goals and preferences to address the changes. 7. The Interdisciplinary Team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the resident) reviewed all changes in condition effective [DATE] and continued to review daily the 23 resident's change in condition to ensure required notifications, interventions, care planning and immediacy of interventions to reduce the potential for further decline in health to the extent possible. 8. Following completion of code status education on [DATE], the Director of Nursing validated licensed nurses ' competency of change in condition, code status and how it impacts interventions. 9. The facility's policy and procedure on change of condition will be added to the new hire orientation checklist effective [DATE] and will be part of the annual competency program. 10. Director of Nursing or designee will discuss during morning stand up meeting regarding residents identified with any new or on-going changes of condition to ensure their needs are being met. 11. The Director of Nursing, Director of Staff Development (DSD), Assistant Director of Nursing (ADON), or designee will provide clinical oversight and will evaluate and supervise all staff through clinical rounds every shift to identify non-compliance with change of condition protocols. On [DATE] at 4:21 p.m., while onsite and after verifying the facility ' s full implementation of the IJ removal plan, the State Survey Agency accepted the IJ Removal Plan and removed the Immediate Jeopardy in the presence of the DON and DSD. Findings: A review of Resident 1 ' s face sheet (admission record) indicated that the resident was admitted on [DATE] with diagnoses including hypertension (high blood pressure [BP-a measure of the force that your heart uses to pump blood around your body]), diabetes mellitus type II (DM Type II- an impairment in the way the body regulates and uses glucose [sugar]) and thrombocythemia (platelet [disc-shaped piece of cell that is found in the blood] disorder in which one ' s body produces too many platelets). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056367	A. Building B. Wing	12/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center of North Hills	9655 Sepulveda Boulevard North Hills, CA 91343

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool) dated [DATE], indicated that the resident had intact cognition (ability to think and make decisions). The MDS also indicated that the resident needed extensive assistance from staff with mobility, transfer, toilet use, dressing, and personal hygiene. A review of Resident 1 ' s Physician Orders for Life-Sustaining Treatment (POLST-form that gives residents control over their end-of-life-care) dated [DATE] indicated the resident was under the order of Do Not Resuscitate (DNR- if found pulseless or breathless, medical staff is not to perform cardiopulmonary resuscitation [CPR - an emergency life-saving procedure that is done when someone's breathing or heartbeat has stopped]) with Selective Treatment (a goal of treating a medical condition without invasive [aggressive] medical procedures, such as the use of ventilators [machine that helps you breathe or breathes for you] or major surgery). The POLST was signed by the physician and Resident 1 on [DATE]. A review of Resident 1 ' s Change of Condition (COC) Assessment Form completed by Registered Nurse 4 (RN 4) dated [DATE] and timed at 8:46 a.m., indicated that on [DATE] at around 6:30 a.m., Resident 1 complained of shortness of breath (SOB). The form indicated that Resident 1 ' s initial vital signs (measurements of the body's most basic functions) were as follows: 1. Blood pressure was ,d+[DATE] mmHg. 2. O2 sat- was at 77 %. The COC form indicated that facility staff elevated Resident 1 ' s legs (elevating ones legs above the heart allows the blood to circulate back to the heart without fighting gravity) and provided the resident with supplemental oxygen (treatment in which a tank of oxygen is used to give oxygen to people with breathing problems) of five (5) liters (L-unit of measure) via nasal canula (a device that has two prongs and sits below the nose that delivers oxygen directly into one ' s nostrils). The form further indicated that upon reassessment, Resident 1 ' s vital signs were as follows: 1. Pulse was 111 bpm 2. Respiration rate was 26 breaths per minute 3. Blood Pressure of ,d+[DATE] mmHg 4. Temperature of 97.3 Degrees Fahrenheit (F-unit of measure; normal temperature range is 97 to 99 F) 5. O2 sat 94% The COC form further indicated that Resident 1 was noted with bloody urine from in and out catheterization (a tube is inserted in a person ' s bladder to drain urine). The COC indicated that a message was left with Resident 1 ' s physician. RN 4 documented that the facility received a call back with instructions to transfer Resident 1 via 911 which was called at around 8:00 a.m. The form indicated that paramedics came and took over the care of Resident 1 at 8:05 a.m., assessed the resident and left the facility with Resident 1 to GACH ER at 8:13 a.m. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1 ' s Paramedic Patient Care Report, dated [DATE], indicated that Paramedics were called by the facility at 7:56 a.m. and arrived at the facility at 8:02 a.m. The form indicated that Resident 1 was found to have low O2 Sat levels of 77% at approximately 6:30 a.m. and was provided with supplemental oxygen. The form indicated that there was minimal improvement to Resident 1, and as a result the facility contacted 911 services. The report indicated that upon the Paramedic ' s arrival to the facility, Resident 1 had an O2 sat of 78%. The record further indicated that Resident 1 was noted to be in a moderate level of distress with the chief complaint being shortness of breath. A review of the GACH ' s Daily Focus Assessment Report, dated [DATE], indicated that on [DATE] at 8:39 a. m., Resident 1 was admitted in the emergency department with labored breathing (having a hard time breathing), slurred speech, hypothermia (dangerously low body temperature), oriented (level of awareness) to self and place, and unable to complain of pain. The Daily Focus Assessment Report further indicated that Resident 1 was noted with tenderness (pain) on palpation (feeling with the fingers or hands) of abdomen. The record indicated that when GACH staff was attempting to draw blood for laboratory testing, Resident 1 was noted to no longer be breathing and was pulseless. The GACH physician was made aware, and Resident 1 was pronounced dead on [DATE] at 10:19 a.m. On [DATE] 10:04 a.m., during an interview, Registered Nurse 5 (RN 5) stated that on [DATE], Resident 1 was under her direct care. RN 5 stated that at approximately 6:30 a.m. on [DATE], she checked Resident 1 ' s blood pressure and O2 Sat levels and noted that Resident 1 ' s blood pressure reading was ,d+[DATE] mmHg with an O2 sat level at 77%. RN 5 stated that due to the resident ' s hypotension (low blood pressure), the resident ' s legs were elevated. RN 5 stated that Resident 1 was also started on oxygen at five (5) liters per min (LPM- unit of measurement) via nasal cannula. RN 5 stated that Resident 1 ' s O2 sat had increased to 94% and the blood pressure increased to ,d+[DATE] mmHg. RN 5stated that she did not monitor Resident 1 any further. RN 5 stated that Resident 1 should have been transferred to the GACH with their initial blood pressure of ,d+[DATE] mmHg. RN 5 stated that 911 should have been called immediately as Resident 1 was in noted distress. RN 5 stated that she considered questioning Registered Nurse 4 (RN 4) who was the RN supervisor, if the resident needed to be transferred via 911. RN 5 stated that because the facility nurses did not immediately call 911, there was a delay in transferring Resident 1 to the GACH. RN 5 stated that if Resident 1 was transferred to the GACH sooner, there is a possibility that the resident would still be alive. On [DATE] at 9:25 p.m., during an interview, Licensed Vocational Nurse 3 (LVN 3) stated that on [DATE] at approximately 6:30 a.m., RN 4 and RN 5 called her to Resident 1 ' s room. LVN 3 stated that upon entering the resident ' s room, Resident 1 was complaining of abdominal pain. LVN 3 stated that RN 4 and RN 5 were having difficulty with obtaining Resident 1 ' s blood pressure because the machine was not getting a reading. LVN 3 stated that Resident 1 appeared to be in distress. LVN 3 stated that she informed RN 4 and RN 5 that Resident 1 needed to be transferred to the GACH as Resident 1 continued to have unrelieved pain. LVN 3 stated that if facility staff had called 911 right away, there would be a possibility that Resident 1 would still be alive. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 5:25 p.m., during an interview, RN 4 stated that she was the RN Supervisor on [DATE]. RN 4 stated that at around 6:30 a.m., she was called by RN 5 to Resident 1 ' s room because the resident had a blood pressure reading of ,d+[DATE] mmHg and an O2 sat level of 77%. RN 4 indicated that Resident 1 was also complaining of abdominal pain, so she asked RN 5 and LVN 3 to perform an in and out catheterization, which revealed that Resident 1 had hematuria (blood in the urine). RN 4 stated that after Resident 1 ' s blood pressure and O2 sat levels improved, she then left a message with Resident 1 ' s physician regarding the COC. RN 4 stated that at 8:46 a.m., she received a call back from the on-call RN informing her that Resident 1 needed to be transferred to the GACH via 911. RN 4 stated that RN 2 had already assessed Resident 1, and the resident had already been transferred to the GACH before receiving the call. RN 4 stated that she should have called 911 when Resident 1 ' s health condition first declined at 6:30 a.m. so that the resident could have been transferred to the GACH sooner. RN 4 stated that she did not call 911 immediately because she was first waiting to receive a call back from Resident 1 ' s physician. RN 4 stated that calling 911 could have possibly saved Resident 1 ' s life. During an interview on [DATE] at 12:06 p.m., Registered Nurse 2 (RN 2) stated that on [DATE], she was the oncoming morning shift (7:00 a.m. to 3:30 p.m.) nurse supervisor. RN 2 stated that on [DATE], she arrived at the facility at approximately 7:45 a.m. RN 2 stated that RN 4 informed her that Resident 1 had experienced a COC at 6:30 a.m. that same morning. RN 2 stated that immediately after being told of Resident 1 ' s COC, she rushed into Resident 1 ' s room. RN 2 stated she had asked RN 4 if 911 had been called, to which RN 4 indicated that she did not call 911 because the resident had a code status of Do Not Resuscitate (DNR). RN 2 stated that she corrected RN 4 that Resident 1 had a code status of DNR with selective treatment. RN 2 stated that she informed RN 4 that 911 needed to be called immediately as Resident 1 appeared to be in distress. RN 2 stated that after 911 was called for Resident 1, paramedics arrived at the facility and Resident 1 was transferred to the GACH. RN 2 stated that Resident 1 should have been transferred to the GACH when the resident first exhibited signs and symptoms of desaturation (low levels of oxygen in the blood), hypotension, rapid respiratory rate (taking more than 20 breaths per minute; normal range is 10 to 20 breaths per minute), and tachycardia (heart rate greater than 100 beats per minute). RN 2 stated that RN 4 apologized to her for not calling 911 for Resident 1. RN 2 stated that there was a greater chance of saving a resident ' s life if emergency treatment had been given as soon as possible. On [DATE] at 2:57 p.m., during an interview with the DON, DON stated that on [DATE] at 6:30 a.m., licensed nurses should have immediately called 911 if Resident 1 exhibited signs and symptoms of desaturation, hypotension, and tachycardia so that the resident could have gotten the help and care he needed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:40 p.m., during a follow up interview with RN 2, RN 2 stated that she was familiar with Resident 1 because the resident resided in the facility for a long period of time. RN 2 stated that when she arrived on shift on [DATE] at approximately 7:45 a.m. she was informed by RN 4 that Resident 1 had a change in condition. RN 2 stated that she immediately went to Resident 1 ' s room and noted that the resident looked different. RN 2 stated that the resident looked pale (having less color than usual) in color and was complaining of abdominal pain. RN 2 stated that within minutes of being in the room with Resident 1, she could tell that the resident needed emergent transfer to the GACH. RN 2 stated that it was important to call 911 because the resident was in distress. RN 2 stated that if they waited for orders to transfer the resident via an ambulance (non-emergency transport to the GACH), the ambulance would refuse transportation of Resident 1 due to the resident ' s condition being unstable. RN 2 stated that the reason 911 needed to be called, was so that the resident could be transferred to the GACH immediately. On [DATE] at 1:38 p.m., during a follow up interview and concurrent record review with the DON, Resident 1 ' s Change of Condition form dated [DATE] at 8:46 a.m. was reviewed. DON stated that from her investigation of the event that occurred on [DATE] regarding Resident 1 ' s change of condition at 6:30 a.m., that the resident was stabilized and did not require emergent transfer to the GACH. The DON reviewed Resident 1 ' s COC dated [DATE] time at 8:46 a.m. and confirmed that while Resident 1 ' s blood pressure had improved to ,d+[DATE] mmHg and the O2 sat levels had improved to 94% on five (5) L via nasal cannula, the resident still had an elevated heart rate of 111 and an elevated respiratory rate of 26. DON stated that if she was the nurse caring for Resident 1, she would have re-assessed and re-evaluated Resident 1 because the resident ' s vital signs were outside of the normal range. When the DON was asked if Resident 1 had been reassessed or re-evaluated, the DON stated, I know my nurses. The DON stated that her nurses reassessed Resident 1. When the DON was asked if there was documented evidence that Resident 1 had been reassessed to ensure the resident ' s condition had been stabilized, DON stated that there was no documented evidence that the resident had become stable during the shift and that she cannot prove the nurses reassessed or reevaluated the resident because they did not document. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:17 p.m. during a follow up interview and concurrent record review with RN 5, Resident 1 ' s Change of Condition form dated [DATE] at 8:46 a.m. was reviewed. RN 5 stated that on [DATE] at approximately 6:30 a.m. she obtained a blood pressure of ,d+[DATE] mmHg and on O2 sat level of 77% for Resident 1. RN 5 stated she took a full set of initial vital signs for Resident 1 at 6:30 a.m. which included their temperature, pulse rate, and respiratory rate, but was unable to find documented evidence when looking through Resident 1 ' s medical record. RN 5 stated that after they elevated Resident 1 ' s legs and provided the resident with supplemental oxygen, the residents blood pressure improved to ,d+[DATE] mmHg and the O2 sat levels had improved to 94% on five (5) L via nasal cannula. RN 5 reviewed Resident 1 ' s COC dated [DATE] at 8:46 a.m. and stated that she was the one who obtain Resident 1 ' s vital signs that showed an elevated heart rate of 111 bpm and an elevated respiratory rate of 26. RN 5 confirmed that a heart rate of 111 and a respiratory rate of 26 was not normal. RN 5 stated that even though Resident 1 ' s vital signs were not normal, she did not reassess the resident to ensure the resident ' s condition had stabilized. RN 5 stated that her assessment of Resident 1 ' s condition was that the resident was stable and did not require emergent transfer to the GACH. When asked how RN 5 was able to determine if Resident 1 was stable if the resident ' s vital signs were outside the normal range, and RN 5 had admitted to not reassessing or reevaluating the resident, RN 5 stated that based on what she saw, the resident was not in distress and did not need to be transferred to the GACH. When RN 5 was asked how come she indicated in her previous interview that Resident 1 appeared to be in distress, and she questioned if RN 4 was going to transfer the resident to the GACH, RN 5 stated that she does not recall making that statement. When RN 5 was asked if Resident 1 ' s elevated heart rate and respiratory rated needed to be reassessed, RN 5 stated she should have reassessed the resident. When asked if Resident 1 was provided with the care needed, RN 5 stated that she did not provide the resident with the care needed. RN 5 stated that she should have reassessed the resident because the resident was not stable and did not have stable vital signs. RN 5 stated that Resident 1 had just recovered from hypotension, and desaturation, but she failed to continue to monitor the resident to follow up with the elevated heart rate and respiratory rate. RN 5 stated that she did not provide the care needed by Resident 1 when she did not reassess or re-evaluate the resident. RN 5 stated she should have reassessed the resident because the vital signs were still not within normal range, and because she did not reassess, she was not able to ensure the resident was stable. A review of the facility ' s policy and procedure, titled, Change of Condition Notification, revised [DATE], indicated: 1. That if the resident deteriorates, the resident ' s symptoms are serious, and the most rapid intervention available by a physician would place the resident in great jeopardy, the facility is to call 911 for transport to hospital. 2. That a COC is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death. A review of the facility ' s policy and procedure titled, Emergency Care-General, revised [DATE], indicated that for Emergency - Serious but Not Life Threatening, staff is to summon help and request that someone call 911 if indicated. The resident's vital signs including blood pressure, pulse, respirations, and temperature is to be documented.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45978 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1), who had an indwelling catheter (a tubing that drains urine from the bladder into a bag outside the body), was monitored for catheter dislodgement (unintentional catheter removal) and followed the physician's order for an intermittent catheterization (IC, also known as an in and out catheterization; this means that the catheter is inserted and left in only long enough to empty the bladder and then is removed) without first obtaining a physician's order. These deficient practices placed Resident 1 at increased risk for urinary retention. Findings: A review of Resident 1's Admission Record indicated the facility admitted the resident (a male) on 5/20/2021 with diagnoses of essential hypertension (abnormally high blood pressure), diabetes mellitus type II (impairment in the way the body regulates and uses sugar [glucose] as a fuel),essential thrombocythemia (the body produces too many platelets which are the part of the blood that sticks together to form clots), and history of gross hematuria (produces pink, red or cola-colored urine due to the presence of red blood cells). A review of the Minimum Data Set (MDS, standardized assessment and care-planning tool), dated 8/28/2022, indicated the resident was able to remember, communicate needs and was able to make decisions. Resident 1 needed extensive assistance in mobility, transfer, toilet use, dressing, and personal hygiene. Resident 1 had an indwelling catheter for urine drainage. A review of Resident 1's nursing notes dated 10/31/2022, indicated the resident's indwelling catheter was present during night shift (11 p.m. to 7 a.m.). A review of Resident 1's nursing notes dated 11/1/2022, for the day shift (7 a.m. to 3 p.m.) did not indicate if the resident's indwelling catheter was present. A review of Resident 1's Activities of Daily Living (ADLs) Tasks, completed by Certified Nursing Assistant 1 (CNA 1) on 11/1/2022 day shift, indicated the resident was incontinent of urine. The amount and color of the urine was not documented. A review of the Physician's Orders for Resident 1, dated 11/1/2022, indicated to perform bladder scan (using a device that allows to assess the volume of urine retained within the bladder) every six hours for 72 hours and to do in and out catheter for urinary retention over 250 ml. On 11/15/2022 at 12:13 p.m., during an interview, CNA 1 stated that on 11/1/2022 during the day shift, Resident 1 did not have a catheter. CNA 1 stated Resident 1 told her the catheter came off but did not specify when or how. CNA 1 stated she then reported it to Registered Nurse 6 (RN 6). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/15/2022 at 12:38 p.m., during an interview with the Director of Nursing (DON) and Resident 1's nursing notes review, the DON stated that licensed nurses (unidentified) stated Resident 1's catheter was dislodged. The DON stated the licensed nurses should have documented the dislodgement, monitored the resident for urinary retention and bleeding, and notified the physician. The DON confirmed there was no documentation in the nursing progress notes about the lack of catheter. On 11/17/2022 at 10:49 a.m., during an interview, Licensed Vocational Nurse 1 (LVN 1) stated if the urinary catheter became dislodged, she would report it to the RN supervisor and the physician and would check for bleeding and pain. On 12/17/2022 at 9:25 p.m., during an interview with LVN 3 and concurrent review of Resident 1's clinical record, LVN 3 stated that on 11/4/2022, she performed in and out catheterization, did not feel any resistance during insertion but there was thick, bloody urine in the tubing. LVN 3 stated the bladder scan showed 82 ml in the bladder distention. LVN 3 stated RN 4 instructed her to do the in and out catheterization. On 12/20/2022 at 9:41 a.m., during and interview, RN 6 stated that on 11/1/2022 CNA 1 informed her that Resident 1 did not have the catheter and he was using a urinal (a bottle for urination). RN 6 stated she was not aware if the catheter was dislodged or removed. Upon record review, RN 6 stated there was no physician's order to discontinue the indwelling catheter until she got the order on 11/1/2022, at 2 p.m. after being notified by CNA 1. RN 6 stated the physician ordered to perform bladder scan every six hours for 72 hours and perform in and out catheter if the bladder had over 250 milliliters (ml) of urine. RN 6 stated an initial bladder scan after receiving the order indicated the resident had over 100 ml of urine. On 12/18/2022 at 10:04 a.m., during an interview and concurrent record review, RN 5 stated on 11/4/2022, RN 4 instructed LVN 3 to perform in and out catheterization. RN 5 confirmed the physician's order was not followed as the bladder scan showed less than 250 ml of urine. A review of the facility's policy and procedure titled, Physician's Orders, revised 5/1/2019, indicated orders will include a description complete enough to ensure clarity of the physician's plan of care treatment orders will include the following: a) A description of the treatment, including the treatment site, if applicable; b) The frequency of treatment and duration of order (when appropriate); and c) The condition/diagnosis for which the treatment is ordered.