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	04/19/2023

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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(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 - Some	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** 44244 Based on observation, interview, and record review the facility failed to protect one of three sampled resident's (Resident 1) right to be free from neglect (the failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress) by: 1. Failing to ensure that facility staff identified Resident 1's central venous catheter (CVC-a tube placed in a large vein [blood vessel that carries blood to the heart] also known as a central line, to give fluids, blood, medications or to do medical tests which includes taking blood when a resident needs to have blood test) upon admission on 4/5/2022 and readmission on 5/28/2022. 2. Failing to ensure that facility staff provided the necessary care and treatment for Resident 1's CVC which included routine inspection (daily and as needed), flushing (injecting a solution into the tube to keep it from getting clogged or blocked) and dressing changes (a transparent [clear] protective cover placed over the tube to be changed every seven days in order to prevent infection) from the resident's admission on 4/5/2022 to 4/11/2023. 3. Failing to ensure Licensed Vocational Nurse 1 (LVN 1) and Licensed Vocational Nurse 2 (LVN 2) notified a Registered Nurse (RN) supervisor of Resident 1's CVC when the line was first identified. 4. Failing to ensure LVN 1 acted on and reported Resident 1's concerns and requests regarding the resident's CVC being left without a dressing. 5. Failing to ensure LVN 1 and Certified Nursing Assistant 1 (CNA) did not provide treatments outside of their scope and practice when LVN 1 and CNA 1 applied dressings to Resident 1's CVC. These deficient practices had the potential to place Resident 1 at risk for sepsis (the body's extreme response to an infection. Sepsis is a life-threatening medical emergency) from a central line-associated bloodstream infection (CLABSI- a serious infection that occurs when germs [usually bacteria or viruses] enter the bloodstream through the central line). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(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 - Some	On 4/17/2023 at 3:49 p.m., the State Survey Agency (SSA) 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 Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to ensure staff did not act negligently towards Resident 1, when they failed to provide the necessary care and treatment for the resident's CVC line which included routine inspection, flushing and dressing changes from admission on 4/5/2022 to 4/11/2023. On 4/19/2023 at 1:40 p.m., the ADM provided an IJ Removal Plan which included the following summarized actions: I. Resident 1's CVC to his right upper chest (RUC) was assessed for complications, patency (the line is open and not blocked) and dressing change by the RN Supervisor on 4/11/2023. II. The Licensed Nurse notified Resident 1's primary care physician of the resident's CVC line on 4/11/2023 and obtained orders for routine central line dressing changes and monitoring. III. On 4/17/2023, the DON audited the facility for intravenous catheters (IV catheter- a thin plastic tube inserted into a vein using a needle). There were two (2) residents with central lines, two (2) residents with Peripherally Inserted Central Catheter lines (PICC lines- tube that is inserted into a vein in the upper arm and guided (threaded) into a large vein above the heart) and one (1) resident with a peripheral line (a tube that is placed through the skin into a vein, usually in the hand, elbow, or foot) identified. Resident 2, who was admitted on [DATE], was identified with no orders for PICC line use/maintenance. On 4/17/23, PICC line orders were obtained from Resident 2's physician. A care plan was initiated on 4/17/23 for management of PICC line for Resident 2. IV. DON in-serviced nursing staff, including licensed nurses and certified nurse assistants, on 4/17/2023, on the facility policy and procedures Abuse Prohibition/Neglect to include providing necessary care and services to ensure residents who receive intravenous (IV- within a vein) therapy (IV therapy- a way to give fluids, medicine, nutrition, or blood directly into the blood stream through a vein) are assessed and monitored for intravenous line patency and complications. V. The Admission Nurse for Resident 1 was in-serviced on 4/17/23 on performing a full body assessment (examining, measuring, or monitoring the resident's body) upon admission. VI. The Treatment Nurse responsible for assessing Resident 1 was in-serviced on 4/17/23 on performing a full body assessment for new admissions and indicate any lines such as IV lines. VII. Resident 1's care plan was reviewed and revised by the Interdisciplinary Team (IDT- a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the resident) to reflect Resident 1's current care and service interventions for his CVC on 4/17/2023. VIII. The DON in-serviced the licensed nurses on 4/17/2023 regarding central line access care including weekly dressing changes and routine assessments for any complications and patency, full body assessments, completion of treatments and documentation in the medical record of services provided for residents with intravenous lines. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	IX. The DON in-serviced each licensed nurse on 4/17/23 regarding understanding the standard of practice (a set of guidelines) for assessment of central lines and all other intravenous access sites for complications and patency. X. On 4/17/2023, the DON/ Designee in-serviced licensed staff (RN Supervisors and LVNs) regarding the facility's policy and procedures for parenteral (describes any drug administration other than by mouth) IV fluids including assessment and monitoring of intravenous sites for patency and complications as ordered by the physician. On 4/19/2023 at 2:03 p.m., while onsite and after verifying the facility's full implementation of the IJ removal plan, the SSA accepted the IJ Removal Plan and removed the IJ in the presence of the ADM and DON. Findings: 1. A review of Resident 1's Admission Record indicated the facility admitted the resident on 4/5/2022 and readmitted the resident on 5/28/2022 with diagnoses that included sepsis, left leg below the knee amputation (BKA-removal by surgery of a limb (arm or leg) or other body part because of injury or disease), end stage renal disease (ESRD, a medical condition in which the kidneys stop functioning) and dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working). A review of Resident 1's History and Physical, dated 6/2/2022, indicated the resident had the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS - an assessment and screening too) dated 4/12/2022, indicated the resident had the ability to understand others and had the ability to make himself understood. The MDS further indicated the resident required extensive staff assistance with transfers, dressing, and personal hygiene. Further review of Resident 1's Minimum Data Set (MDS - an assessment and screening too) dated 4/13/2023, indicated the resident had the ability to understand others and had the ability to make himself understood. The MDS further indicated the resident required extensive staff assistance with transfers, dressing, and personal hygiene. A review of Resident 1's General Acute Care Hospital (GACH) record titled Diagnostic Imaging report dated 3/31/2022, indicated that the resident had the follow central line inserted on 3/30/2022: a) Right intrajugular tunneled CVC (a thin tube that is placed under the skin in the internal jugular vein [IJV-vein under the collarbone] allowing long-term access to the vein). A review of Resident 1's Physician Orders indicated orders for the following: a) Body check upon returning to facility, every evening shift; every Monday, Wednesday, and Friday, dated 4/28/2022 and discontinued on 5/24/2022 b) Body check to be performed upon Resident 1's return to facility, every day shift; every Monday, Wednesday, and Friday, dated 5/30/2022. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c) IV central line active therapy orders: dressing change every seven days and as needed, remove old dressing, using sterile technique (technique used to prevent contamination of a site with microbes [bacteria], preventing infection), site cleanse with a chlorhexidine gluconate solution (a cleaning product that helps eliminate germs and bacteria) or povidone-iodine (a solution used on the skin to treat or prevent skin infection) as needed, every day shift every Sunday, dated 4/11/2023. d) IV central lines: flush each lumen (line) with 10 cubic centimeters (cc-a unit of measurement for liquids) with normal saline (solution used to clear the contents of a central line) before and after medication administration every shift, dated 4/11/2023. During a review of Resident 1's GACH Discharge to Skilled Nursing Facility (SNF) Summary and Transfer Orders, dated 4/5/2022 indicated Resident 1 with a five (5) french (fr- unit of measure) single lumen (one line) CVC placement on 3/30/2022. During an observation and interview on 4/14/2023 at 3:45 p.m., Resident 1 was observed lying in bed inside his room. Resident 1 stated, while tearful, that he had a CVC that the facility was not taking care of. Resident 1 pull up the right side of his t-shirt and observed was a purple, single lumen CVC sutured (held in place with stiches) to the resident's RUC. The CVC was covered with a chlorhexidine gluconate protective disk (a small circular dressing placed over the insertion site of a CVC to help reduce local infections) with a transparent dressing dated 4/11/2023. Resident 1 stated that the dressing currently on his CVC was the first dressing the facility applied since his admission on 4/5/2022. Resident 1 stated he had been asking the facility nurses to cover his CVC since his admission on 4/5/2022, but nothing was being done. Resident 1 stated that facility nursing staff would place a dressing or a plastic bag over his CVC during shower times, but all other times the CVC remained uncovered. Resident 1 stated his CVC line on his RUC goes to his heart and he is worried about infections. During an interview and record review on 4/14/2023 at 4:40 p.m., Registered Nurse 1 (RN 1) reviewed Resident 1's medical records including all face sheets, history and physical, physician orders, progress notes, care plans and skin assessments from 4/5/2022 to 4/14/2023. RN 1 stated that there was no documented evidence that the facility was aware or treated Resident 1's CVC prior to 4/11/2023. RN 1 stated she was not aware of Resident 1's CVC until 4/10/2023. RN 1 stated that Resident 1 had informed her that he had the CVC for over a year. During an interview and record review on 4/17/2023 at 9:00 a.m. with Treatment Nurse 1 (TN 1), Resident 1's Wound Weekly Monitoring Assessments, dated 4/6/2022 and 5/30/2023 documented by TN 1 were reviewed. TN 1 stated that when residents are admitted to the facility, the admitting nurse completes a full body skin assessment to identify any catheter lines such as CVCs. TN 1 stated that after the admitting nurse completes her full body assessment, the treatment nurse is to complete another full body assessment. TN 1 reviewed Resident 1's Wound Weekly Monitoring Assessments, dated 4/6/2022 and 5/30/2022 and stated there was no documented evidence that indicated Resident 1 had a RUC CVC. TN 1 stated that she completed a body check for Resident 1 on 4/6/2022 and 5/30/2022 but stated that she never saw Resident 1's CVC until 4/11/2023. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2023 at 10:10 a.m. with the DON, DON stated that she was unaware that Resident 1 had the CVC until the resident informed her on 4/11/2023. The DON stated that Resident 1 could have potentially developed an infection and become septic (a life-threatening condition that arises with the body's response to an infection) from the CVC on his RUC that was not provided the necessary care to prevent infection such as applying dressing to the CVC and monitoring the CVC for signs and symptoms of infection. During a concurrent interview and record review on 4/17/2023 at 12:00 p.m. with the DON, Resident 1's Wound and Weekly Monitoring Assessment forms dated 4/6/2022 and 5/30/2022 were reviewed. The DON stated that there was no documented evidence of Resident 1's RUC CVC on the Wound and Weekly Monitoring Assessment forms. The DON stated the licensed nurses were not doing their job because the licensed nurses either did not assess Resident 1's skin thoroughly since the nurses did not know the resident had a CVC to his RUC, or the licensed nurses did not document the presence of the RUC CVC. The DON stated if the licensed nurses were really conducting a full body assessment on Resident 1, then the licenses nurses would have identified Resident 1's CVC. The DON stated that the licenses nurse's failure to conduct a thorough body assessment on Resident 1 resulting in the resident's CVC being untreated and monitored for over one year could be considered neglect because the facility failed to provide the needed care and treatment for Resident 1's CVC placing the resident at continued risk for infection. A review of the facility policy and procedure titled, Admission Assessment, last reviewed 1/18/2023, indicated licensed nursing staff will complete an admission assessment for residents upon admission to the facility. The comprehensive assessment will consider factors pertaining to medical, behavioral, and social needs of the resident. The assessment process must include direct and indirect observation and communication with the residents, as well as communication with licensed and non-licensed direct care staff members on all shifts. Assessment findings may necessitate communication with attending physician for treatment or care orders. A review of the facility policy and procedure titled, Skin Assessment, last revised 3/2023, indicated the purpose of the policy was to provide guidelines for routine assessment of resident's skin to maintain skin integrity and promote healing in accordance with standard of care practices. The licensed nurse completes a head-to-toe skin assessment (process of examining entire skin for abnormalities) of the resident's skin during the admission process. The licensed nurse completes routine weekly assessments. Skin integrity should be assessed for pressure related discoloration or breakdown from positioning or use of medical devices applied for therapeutic purposes. The licensed nurse documents assessment findings in the resident's medical record weekly following completion of the skin assessment. Injurious or at-risk areas are documented on a change in condition form and reported to the primary physician for further instruction. A review of the facility policy and procedure titled, Accuracy of Assessments, last reviewed 1/18/2023, indicated the facility ensures each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility policy and procedure titled, Abuse Prevention and Prohibition Program, last reviewed 1/18/2023, indicated the program was designed to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. Each resident has the right to be free from mistreatment, neglect, and abuse. The facility has zero tolerance for abuse, neglect, and mistreatment. Staff must not permit anyone to engage in abuse, neglect, and mistreatment, or deprivation of goods necessary to attain or maintain physical, mental, and psychosocial well-being. The facility is committed to protecting residents from abuse by anyone including staff from other agencies serving residents. The facility provides covered individuals with training to enable the identification of the following signs and symptoms of potential physical neglect: poor hygiene, inadequate provision of care and caregiver indifference to resident's personal care and needs. 2. During an interview on 4/17/2023 at 9:45 a.m., CNA 1 stated that Resident 1 already had his CVC to his RUC when she first started caring for him six months ago. CNA 1 stated that Resident 1's CVC was left uncovered without a dressing during the time she cared for the resident. During an interview and record review on 4/17/2023 at 10:10 a.m. with the DON, Resident 1's medical records from 4/5/2022 to 4/17/2023 were reviewed. DON stated there was no documented evidence of a physician orders for Resident 1's CVC care that should have included central line dressing changes, central line flushing, or monitoring for signs and symptoms of infection prior to 4/11/2023. The DON stated she assessed Resident 1's CVC on 4/11/2023 and at the time it was not covered. During an interview and on 4/17/2023 at 10:45 a.m., the Nurse Practitioner (NP) stated that it was concerning that Resident 1 had a CVC without a dressing or monitoring being done because the CVC places Resident 1 at increased risk for infections. NP stated that the facility should have conducted a full physical assessment of Resident 1 upon admission that included a full skin check. The NP stated that the facility should have been able to identify Resident 1's CVC during their full skin check During an interview on 4/17/2023 at 11:20 a.m., LVN 1 stated she had cared for Resident 1 since his admission to the facility on [DATE]. LVN 1 stated that she has seen Resident 1's CVC on his right upper chest without a dressing for a couple of months. LVN 1 stated she notified the registered nurse to assess and monitor Resident 1's CVC. LVN 1 stated there were no orders for dressing changes or monitoring for Resident 1's CVC to his RUC prior to 4/11/2023. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent interview and record review on 4/17/2023 at 12:00 p.m. with the DON, Resident 1's Wound and Weekly Monitoring Assessment forms from 4/6/2022 to 4/12/2023 were reviewed. The DON stated that there was no documented evidence of Resident 1's RUC CVC on the Wound and Weekly Monitoring Assessment forms. The DON stated the facility's procedure for skin assessments is that they are done by a licensed nurse and documented on a resident's admissions and weekly forms because it is important to find wounds or anything new on the skin. The DON stated the nurses were not doing their job because the nurses either did not assess Resident 1's skin since nurses did not know the resident had a CVC to his RUC, or the nurses did not document the presence of the RUC CVC. The DON stated that licensed nurses should have done a full body assessment as ordered by the physician on 4/28/2022 and again on 5/30/2022 which was three times a week after Resident 1's hemodialysis (HD- a process where a machine filters the waste from your body because your kidneys have failed) treatments. The DON stated if the licensed nurses were really doing Resident 1's full body assessment as ordered, then the licenses nurses would have detected Resident 1's CVC. The DON stated that the licenses nurse's failure to identify and conduct a thorough body assessment on Resident 1 could be considered neglect because the facility failed to provide the needed care and treatment for Resident 1's CVC placing the resident at continued risk for infection. During an interview on 4/17/2023 at 12:28 p.m., LVN 1 stated that a resident's central lines needed to be monitored, flushed, and have weekly dressing changes. LVN 1 stated Resident 1 could have been harmed because the resident's CVC could have gotten infected. During a concurrent interview and record review on 4/18/2023 at 11:12 a.m., Registered Nurse 2 (RN 2) reviewed Resident 1's GACH Discharge to Skilled Nursing Facility Summary and Transfer Orders dated 4/5/2022 and stated that the summary indicated Resident 1 was admitted to the facility with the CVC on his RUC in place. RN 2 stated that the admitting nurse should have done a skin assessment on Resident 1 upon admission on 4/5/22 and 5/28/22 to identify any central lines such as Resident 1's CVC. RN 2 stated that the summary provided to the facility indicating that Resident 1 had a CVC in place should have alerted the admitting nurses of the presence of Resident 1's CVC. RN 2 stated TN 1 should have also performed a head-to-toe assessment on Resident 1 on admission and readmission and should have been able to identify Resident 1's CVC. RN 2 stated TN 1 should have performed weekly skin assessments on Resident 1 and had multiple opportunities to identify the resident's CVC. RN 2 stated central lines need dressings to keep them covered, secure, and safe. RN 2 stated a central line goes into the heart and you do not want germs and bacteria getting in there due to the risk of infection. RN 2 stated an LVN should be able to identify a central line and should notify the RNs. RN 2 stated if an RN was notified of a CVC, she should have assessed the resident, looked for documentation, then notified the physician for clarification and orders. RN 2 stated there were multiple missed opportunities to identify Resident 1's CVC that included the admitting nurse on 4/5/2022 and 5/28/2022, TN 1 upon admission on 4/5/2022 and 5/28/2022, treatment nurses conducting weekly skin assessments, and licensed nurses doing weekly and as ordered by the physician skin assessments. RN 2 stated that it was negligent that the facility did not identify Resident 1's CVC despite the resident telling facility staff of its presence. RN 2 stated it was negligent that the facility failed to provide Resident 1 with the needed care and treatment for the resident's CVC. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility policy and procedure titled, Dressing and Injection Cap Change of Central Venous Access Devices (devices that are inserted into the body through a vein, also known as CVC), last reviewed 1/18/2023, indicated an occlusive dressing (an air- and water-tight medical dressing) shall always be maintained over the central venous access site to reduce the risk of infection to the insertion or exit site and surrounding area of central venous access devices. Transparent Semipermeable Membrane (TSM, a dressing that allows visualization of the insertion site, and provides stabilization and protection from microorganisms) are the dressing of choice for all central catheters. Gauze dressings are only used with the initial dressing application at the time of catheter insertion and needs to be changed within 24 hours. Routine central catheter dressing changes shall be done every seven days and as needed using a TSM type dressing. During every dressing change, facility staff is to document concerns, site problems or any amount of the catheter out of the skin before the insertion into the skin. Only qualified staff shall do a dressing and cap change. To be considered qualified, the RN or IV certified LVN shall have return demonstrated skills with another qualified RN. If a chlorhexidine gluconate protective disk was used, remove after seven days from the day it was placed. Label with a dressing to indicate the type of device, time and date of dressing change, initials of the RN performing the procedure. Document the site appearance, ease of blood return, ease of flush and suture stability. Document in the IV Medication Administration Record the dressing change, securement device change, cap change for all lumens, flush for all lumens, any amount of catheter out of the skin before the insertion site and the arm circumference. Notify the MD of any complications and document notification of the MD. Check the patient's chart to confirm the insertion report and chest X-ray (special pictures of the inside of your body) report confirm tip placement are there. A review of the facility policy and procedure titled, Flushing of Central Venous Access Devices, last reviewed 1/18/2023, indicated flushing of central venous access devices shall be performed by an RN after each infusion, blood draw, per flushing guidelines, or as ordered by the attending physician. The solutions and volumes to be used for flushing shall be ordered by the attending physician. Document in the nurse's notes the condition of the resident's skin, the presence of any sutures or type of securement device, the presence of any redness, edema (swelling), drainage, or unusual complaints of pain. Document on the treatment record the number of lumens, the flushing, arm circumference, site checks and any amount of exposed catheter. A review of the facility policy and procedure titled, Abuse Prevention and Prohibition Program, last reviewed 1/18/2023, indicated the program was designed to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. Each resident has the right to be free from mistreatment, neglect, and abuse. The facility has zero tolerance for abuse, neglect, and mistreatment. Staff must not permit anyone to engage in abuse, neglect, and mistreatment, or deprivation of goods necessary to attain or maintain physical, mental, and psychosocial well-being. The facility is committed to protecting residents from abuse by anyone including staff from other agencies serving residents. The facility provides covered individuals with training to enable the identification of the following signs and symptoms of potential physical neglect: poor hygiene, inadequate provision of care and caregiver indifference to resident's personal care and needs. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. During an interview on 4/17/2023 at 11:20 a.m., LVN 1 stated she had cared for Resident 1 since his admission to the facility on [DATE]. LVN 1 stated she did not know Resident 1 had a CVC until the end of 2022. LVN 1 stated licensed vocational nurses do not provide care for central lines, and that it was the registered nurse's responsibility to provide care for the central lines. LVN 1 stated she notified the registered nurse to assess and monitor Resident 1's CVC, but she does not remember who she notified or what they said. During an interview on 4/17/2023 at 1:00 p.m., Resident 1 stated that there was a day he spoke with LVN 1 about his CVC and that it needed to be covered, to which LVN 1 informed the resident that she would speak with the RN Supervisors, but nobody came. During a concurrent interview and record review with LVN 1 on 4/19/2023 at 9:11 a.m., Resident 1's medical records from 4/5/2022 to 4/19/2023 were reviewed. LVN 1 stated that she did not document that Resident 1's CVC had been identified in the resident's medical records. LVN 1 stated that there was no documented evidence in Resident 1's medical records from 4/5/2022 to 4/19/2023 to indicate that LVN 1 had notified an RN regarding Resident 1's CVC. LVN 1 stated that since there was no documented evidence of her informing the RNs, it means that it was not done, and she had not informed the RNs of Resident 1's CVC. During an interview on 4/19/2023 at 10:38 a.m., LVN 2 stated that he was aware that Resident 1 had a CVC on his RUC, and during the times he observed the CVC, it was not covered or dressed. LVN 2 stated he did not inform any other facility staff of the presences of Resident 1's CVC. LVN 2 stated he should have checked Resident 1's physician orders to ensure there were orders for treatment and care for Resident 1's CVC when he observed the line uncovered without a dressing. LVN 2 stated he could not recall why he did not inform an RN regarding Resident 1's CVC. LVN 2 stated that he was under the impression that the facility was already aware that Resident 1 had a CVC. LVN 2 stated he should have questioned why Resident 1's CVC would be uncovered and that he should have reported his findings up the chain of command (reporting to your supervisor). During an interview with the DON on 4/19/2023 at 11:25 a.m., DON stated that LVN 1 acted negligently because LVN 1 was aware of Resident 1's CVC including the risk associated with having a CVC such as infection, but LVN 1 did not follow up with an RN Supervisors or the DON. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility policy and procedure titled, Dressing and Injection Cap Change of Central Venous Access Devices (devices that are inserted into the body through a vein, also known as CVC), last reviewed 1/18/2023, indicated an occlusive dressing (an air- and water-tight medical dressing) shall always be maintained over the central venous access site to reduce the risk of infection to the insertion or exit site and surrounding area of central venous access devices. Transparent Semipermeable Membrane (TSM, a dressing that allows visualization of the insertion site, is breathable, and provides stabilization and protection from microorganisms) are the dressing of choice for all central catheters. Gauze dressings are only used with the initial dressing application at the time of catheter insertion and needs to be changed within 24 hours. Routine central catheter dressing changes shall be done every seven days and as needed using a TSM type dressing. During every dressing change, facility staff is to document concerns, site problems or any amount of the catheter out of the skin before the insertion into the skin. Only qualified staff shall do a dressing and cap change. To be considered qualified, the RN or IV certified LVN shall have return demonstrated skills with another qualified RN. If a chlorhexidine gluconate protective disk was used, remove after seven days from the day it was placed. Label with a dressing to indicate the type of device, time and date of dressing change, initials of the RN performing the procedure. Document the site appearance, ease of blood return, ease of flush and suture stability. Document in the IV Medication Administration Record the dressing change, securement device change, cap change for all lumens, flush for all lumens, any amount of catheter out of the skin before the insertion site and the arm circumference. Notify the Medical Doctor (MD) of any complications and document notification of the MD. Check the patient's chart to confirm the insertion report and chest X-ray report confirm tip placement are there. A review of the facility policy and procedure titled, Abuse Prevention and Prohibition Program, last reviewed 1/18/2023, indicated the program was designed to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements. Each resident has the right to be free from mistreatment, neglect, and abuse. The facility has zero tolerance for abuse, neglect, and mistreatment. Staff must not permit anyone to engage in abuse, neglect, and mistreatment, or deprivation of goods necessary to attain or maintain physical, mental, and psychosocial well-being. The facility is committed to protecting residents from abuse by anyone including staff from other agencies serving residents. The facility provides covered individuals with training to enable the identification of the following signs and symptoms of potential physical neglect: poor hygiene, inadequate provision of care and caregiver indifference to resident's personal care and needs. 4. During an interview on 4/17/2023 at 11:20 a.m., LVN 1 stated she had cared for Resident 1 since his admission to the facility on [DATE]. LVN 1 stated she did not know Resident 1 had a CVC until around the end of 2022. LVN 1 stated that she continued to see Resident 1's CVC on his right upper chest without a dressing for a couple of months. LVN 1 stated that around the beginning of January 2023, Resident 1 had asked her on multiple occasions why he had the CVC and why was it not removed. During an interview on 4/17/2023 at 12:00 p.m., the DON stated that when R[TRUNCATED]

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review the facility failed to monitor and provide central venous catheter (CVC-a tube placed in a large vein [blood vessel that carries blood to the heart] also known as a central line, to give fluids, blood, medications or to do medical tests) line care for one of three sampled residents (Resident 1) by: 1. Failing to ensure that facility staff identified Resident 1's central venous catheter upon admission on 4/5/2022 and readmission on 5/28/2022. 2. Failing to ensure that facility staff provided the necessary care and treatment for Resident 1's CVC on the right upper chest (RUC) which included routine inspection (daily and as needed), flushing (injecting a solution into the tube to keep it from getting clogged or blocked) and dressing changes (a transparent [clear] protective cover placed over the tube to be changed every seven days in order to prevent infection) from the resident's admission on 4/5/2022 to 4/11/2023. 3. Failing to ensure Licensed Vocational Nurse 1 (LVN 1) and Licensed Vocational Nurse 2 (LVN 2) notified a Registered Nurse (RN) supervisor of Resident 1's CVC when the line was first identified. 4. Failing to ensure LVN 1 acted on and reported Resident 1's concerns and requests regarding the resident's CVC being left without a dressing. 5. Failing to ensure LVN 1 and Certified Nursing Assistant 1 (CNA) 1 did not provide treatments outside of their scope and practice when LVN 1 and CNA 1 applied dressings to Resident 1's CVC. These deficient practices had the potential to place Resident 1 at risk for sepsis (the body's extreme response to an infection. Sepsis is a life-threatening medical emergency) from a central line-associated bloodstream infection (CLABSI- a serious infection that occurs when germs [usually bacteria or viruses] enter the bloodstream through the central line). On 4/17/2023 at 3:49 p.m., the State Survey Agency (SSA) 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 Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to provide CVC line care to Resident 1 from 4/5/2022 to 4/11/2023. On 4/19/2023 at 1:40 p.m., the ADM provided an IJ Removal Plan which included the following summarized actions: I. Resident 1's CVC to his right upper chest (RUC) was assessed for complications, patency (the line is open and not blocked) and dressing change by the RN Supervisor on 4/11/2023. II. The Licensed Nurse notified Resident 1's primary care physician of the resident's CVC line on 4/11/2023 and obtained orders for routine central line dressing changes and monitoring. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	III. On 4/17/2023, the DON audited the facility for intravenous catheters (IV catheter- a thin plastic tube inserted into a vein using a needle). There were two (2) residents with central lines, two (2) residents with Peripherally Inserted Central Catheter lines (PICC lines- tube that is inserted into a vein in the upper arm and guided (threaded) into a large vein above the heart) and one (1) resident with a peripheral line (a tube that is placed through the skin into a vein, usually in the hand, elbow, or foot) identified. Resident 2, who was admitted on [DATE], was identified with no orders for PICC line use/maintenance. On 4/17/23, PICC line orders were obtained from Resident 2's physician. A care plan was initiated on 4/17/23 for management of PICC line for Resident 2. IV. DON in-serviced nursing staff, including licensed nurses and certified nurse assistants, on 4/17/2023, on the facility policy and procedures including providing the necessary care and services to ensure residents who receive intravenous (IV- within a vein) therapy (IV therapy- a way to give fluids, medicine, nutrition, or blood directly into the blood stream through a vein) are assessed and monitored for intravenous line patency and complications. V. The Admission Nurse for Resident 1 was in-serviced on 4/17/23 on performing a full body assessment (examining, measuring, or monitoring the resident's body) upon admission. VI. The Treatment Nurse responsible for assessing Resident 1 was in-serviced on 4/17/23 on performing a full body assessment for new admissions and indicate any lines such as IV lines. VII. Resident 1's care plan was reviewed and revised by the Interdisciplinary Team (IDT- a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the resident) to reflect Resident 1's current care and service interventions for his CVC on 4/17/2023. VIII. The DON in-serviced the licensed nurses on 4/17/2023 regarding central line access care including weekly dressing changes and routine assessments for any complications and patency, full body assessments, completion of treatments and documentation in the medical record of services provided for residents with intravenous lines. IX. The DON in-serviced each licensed nurse on 4/17/23 regarding understanding the standard of practice (a set of guidelines) for assessment of central lines and all other intravenous access sites for complications and patency. X. On 4/17/2023, the DON/ Designee in-serviced licensed staff (RN Supervisors and LVNs) regarding the facility's policy and procedures for parenteral (describes any drug administration other than by mouth) IV fluids including assessment and monitoring of intravenous sites for patency and complications as ordered by the physician. On 4/19/2023 at 2:03 p.m., while onsite and after verifying the facility's full implementation of the IJ removal plan, the SSA accepted the IJ Removal Plan and removed the IJ in the presence of the ADM and DON. Findings: (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. A review of Resident 1's Admission Record indicated the facility admitted the resident on 4/5/2022 and readmitted the resident on 5/28/2022 with diagnoses that included sepsis, left leg below the knee amputation (BKA-removal by surgery of a limb (arm or leg) or other body part because of injury or disease), end stage renal disease (ESRD, a medical condition in which the kidneys stop functioning) and dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working). A review of Resident 1's History and Physical, dated 6/2/2022, indicated the resident had the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS - an assessment and screening too) dated 4/12/2022, indicated the resident had the ability to understand others and had the ability to make himself understood. The MDS further indicated the resident required extensive staff assistance with transfers, dressing, and personal hygiene. Further review of Resident 1's Minimum Data Set (MDS - an assessment and screening too) dated 4/13/2023, indicated the resident had the ability to understand others and had the ability to make himself understood. The MDS further indicated the resident required extensive staff assistance with transfers, dressing, and personal hygiene. A review of Resident 1's General Acute Care Hospital (GACH) record titled Diagnostic Imaging report dated 3/31/2022, indicated that the resident had the following central line inserted on 3/30/2022: a) Right intrajugular (in the internal jugular vein [IJV- vein under the collarbone]) tunneled CVC (when a portion of the central line goes under the skin). A review of Resident 1's Physician Orders indicated orders for the following: a) Body check upon returning to facility, every evening shift; every Monday, Wednesday, and Friday, dated 4/28/2022 and discontinued on 5/24/2022 b) Body check to be performed upon Resident 1's return to facility, every day shift; every Monday, Wednesday, and Friday, dated 5/30/2022. c) IV central line active therapy orders: dressing change every seven days and as needed, remove old dressing, using sterile technique (technique used to prevent contamination of a site with microbes [bacteria], preventing infection), site cleanse with a chlorhexidine gluconate solution (a cleaning product that helps eliminate germs and bacteria) or povidone-iodine (a solution used on the skin to treat or prevent skin infection) as needed, every day shift every Sunday, dated 4/11/2023. d) IV central lines: flush each lumen (line) with 10 cubic centimeters (cc-a unit of measurement for liquids) with normal saline (solution used to clear the contents of a central line) before and after medication administration every shift, dated 4/11/2023. During a review of Resident 1's GACH Discharge to Skilled Nursing Facility (SNF) Summary and Transfer Orders, dated 4/5/2022 indicated Resident 1 with a five (5) french (fr- unit of measure) single lumen (one line) CVC placement on 3/30/2022. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 4/14/2023 at 3:45 p.m., Resident 1 was observed by surveyor lying in bed inside his room. Resident 1 stated, while tearful, that he had a CVC that the facility was not taking care of. Resident 1 pull up the right side of his t-shirt and observed by surveyor was a purple, single lumen CVC sutured (held in place with stiches) to the resident's RUC. The CVC was covered with a chlorhexidine gluconate protective disk (a small circular dressing placed over the insertion site of a CVC to help reduce local infections) with a transparent dressing dated 4/11/2023. Resident 1 stated that the dressing currently on his CVC was the first dressing the facility applied since his admission on 4/5/2022. Resident 1 stated he had been asking the facility nurses to cover his CVC since his admission on 4/5/2022, but nothing was being done. Resident 1 stated that facility nursing staff would place a dressing or a plastic bag over his CVC during shower times, but all other times the CVC remained uncovered. Resident 1 stated his CVC line on his RUC goes to his heart and he is worried about infections. During an interview and record review on 4/14/2023 at 4:40 p.m., Registered Nurse 1 (RN 1) reviewed Resident 1's medical records including face sheet, history and physical, admission assessment, physician orders, progress notes, skin assessments, and care plans from 4/5/2022 to 4/14/2023. RN 1 stated that there was no documented evidence that the facility was aware or treated Resident 1's CVC prior to 4/11/2023. RN 1 stated she was not aware of Resident 1's CVC until 4/10/2023. RN 1 stated that Resident 1 had informed her that he had the CVC for over a year. During an interview and record review on 4/17/2023 at 9:00 a.m. with Treatment Nurse 1 (TN 1), Resident 1's Wound Weekly Monitoring Assessments, dated 4/6/2022 and 5/30/2023 documented by TN 1 were reviewed. TN 1 stated that after the admitting nurse completes her full body assessment, the treatment nurse is to complete another full body assessment. TN 1 reviewed Resident 1's Wound Weekly Monitoring Assessments, dated 4/6/2022 and 5/30/2023 and stated there was no documented evidence that indicated Resident 1 had a RUC CVC. TN 1 stated that she completed a body assessment for Resident 1 on 4/6/2022 and 5/30/2022 but stated that she never saw Resident 1's CVC until 4/11/2023. During an interview on 4/17/2023 at 10:10 a.m. with the DON, DON stated that she was unaware that Resident 1 had the CVC until the resident informed her on 4/11/2023. The DON stated that Resident 1 could have potentially developed an infection and become septic (a life-threatening condition that arises with the body's response to an infection) from the CVC on his RUC that was not provided the necessary care to prevent infection such as applying dressing to the CVC and monitoring the CVC for signs and symptoms of infection. During a concurrent interview and record review on 4/17/2023 at 12:00 p.m. with the DON, Resident 1's Wound and Weekly Monitoring Assessment forms dated 4/6/2022 and 5/30/2022 were reviewed by the DON and surveyor. The DON stated that there was no documented evidence of Resident 1's RUC CVC on any of the Wound and Weekly Monitoring Assessment forms. The DON stated the licensed nurses were not doing their job because the licensed nurses either did not assess Resident 1's skin thoroughly since the nurses did not know the resident had a CVC to his RUC, or the licensed nurses did not document the presence of the RUC CVC. The DON stated if the licensed nurses were really conducting a full body assessment on Resident 1, then the licenses nurses would have identified Resident 1's CVC. The DON stated that the licenses nurse's failure to conduct a thorough body assessment on Resident 1 resulting in the resident's CVC being untreated and monitored for over one year, placed the resident at continued risk for infection due to the facility not providing the needed care and treatment for the resident's CVC. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility policy and procedure titled, Admission Assessment, last reviewed 1/18/2023, indicated licensed nursing staff will complete an admission assessment for residents upon admission to the facility. The comprehensive assessment will consider factors pertaining to medical, behavioral, and social needs of the resident. The assessment process must include direct and indirect observation and communication with the residents, as well as communication with licensed and non-licensed direct care staff members on all shifts. Assessment findings may necessitate communication with attending physician for treatment or care orders. A review of the facility policy and procedure titled, Skin Assessment, last revised 3/2023, indicated the purpose of the policy was to provide guidelines for routine assessment of resident's skin to maintain skin integrity and promote healing in accordance with standard of care practices. The licensed nurse completes a head-to-toe skin assessment (process of examining entire skin for abnormalities) of the resident's skin during the admission process. The licensed nurse completes routine weekly assessments. Skin integrity should be assessed for pressure related discoloration or breakdown from positioning or use of medical devices applied for therapeutic purposes. The licensed nurse documents assessment findings in the resident's medical record weekly following completion of the skin assessment. Injurious or at-risk areas are documented on a change in condition form and reported to the primary physician for further instruction. A review of the facility policy and procedure titled, Accuracy of Assessments, last reviewed 1/18/2023, indicated the facility ensures each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline. 2. During an interview on 4/17/2023 at 9:45 a.m., CNA 1 stated that Resident 1 already had his CVC to his RUC when she first started caring for him six months ago. CNA 1 stated that Resident 1's CVC was left uncovered without a dressing during the time she cared for the resident. During an interview and record review on 4/17/2023 at 10:10 a.m. with the DON, Resident 1's medical records from 4/5/2022 to 4/17/2023 were reviewed. DON stated there was no documented evidence of a physician orders for Resident 1's CVC care that should have included central line dressing changes, central line flushing, or monitoring for signs and symptoms of infection prior to 4/11/2023. The DON stated she assessed Resident 1's CVC on 4/11/2023 and at the time it was not covered. During an interview and on 4/17/2023 at 10:45 a.m., the Nurse Practitioner (NP) stated that it was concerning that Resident 1 had a CVC without a dressing or monitoring being done because the CVC places Resident 1 at increased risk for infections. NP stated that the facility should have conducted a full physical assessment of Resident 1 upon admission that included a full skin check. The NP stated that the facility should have been able to identify Resident 1's CVC during their full skin check. During an interview on 4/17/2023 at 11:20 a.m., LVN 1 stated she had cared for Resident 1 since his admission to the facility on [DATE]. LVN 1 stated she has seen Resident 1's CVC on his right upper chest without a dressing for a couple of months. LVN 1 stated she notified the registered nurse to assess and monitor Resident 1's CVC. LVN 1 stated there were no orders for dressing changes or monitoring for Resident 1's CVC to his RUC prior to 4/11/2023. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent interview and record review on 4/17/2023 at 12:00 p.m. with the DON, Resident 1's Wound and Weekly Monitoring Assessment forms from 4/6/2022 to 4/12/2023 were reviewed. The DON stated that there was no documented evidence of Resident 1's RUC CVC on the Wound and Weekly Monitoring Assessment forms. The DON stated the facility's procedure for skin assessments is that they are done by a licensed nurse and documented on a resident's admissions and weekly forms because it is important to find wounds or anything new on the skin. The DON stated the nurses were not doing their job because the nurses either did not assess Resident 1's skin since nurses did not know the resident had a CVC to his RUC, or the nurses did not document the presence of the RUC CVC. The DON stated that licensed nurses should have done a full body assessment as ordered by the physician on 4/28/2022 and again on 5/30/2022 which was three times a week after Resident 1's hemodialysis (HD- a process where a machine filters the waste from your body because your kidneys have failed) treatments. The DON stated if the licensed nurses were really doing Resident 1's full body assessment as ordered, then the licenses nurses would have detected Resident 1's CVC. The DON stated that the licenses nurse's failure to identify or conduct a thorough body assessment on Resident 1 could be considered neglect because the facility failed to provide the needed care and treatment for Resident 1's CVC placing the resident at continued risk for infection. During an interview on 4/17/2023 at 12:28 p.m., LVN 1 stated that a resident's central lines needed to be monitored, flushed, and have weekly dressing changes. LVN 1 stated Resident 1 could have been harmed because the resident's CVC could have gotten infected. During a concurrent interview and record review on 4/18/2023 at 11:12 a.m., Registered Nurse 2 (RN 2) reviewed Resident 1's GACH Discharge to Skilled Nursing Facility Summary and Transfer Orders dated 4/5/2022 and stated that the summary indicated Resident 1 was admitted to the facility with the CVC on his RUC in place. RN 2 stated that the admitting nurse should have done a skin assessment on Resident 1 upon admission on 4/5/22 and 5/28/22 to identify any central lines such as Resident 1's CVC. RN 2 stated that the summary provided to the facility should have alerted the admitting nurses of the presence of Resident 1's CVC. RN 2 stated TN 1 should have also performed a head-to-toe assessment on Resident 1 on admission and readmission and should have been able to identify the CVC. RN 2 stated TN 1 should have performed weekly skin assessments on Resident 1 and had multiple opportunities to identify the resident's CVC. RN 2 stated central lines need dressings to keep them covered, secure, and safe. RN 2 stated a central line goes into the heart and you do not want germs and bacteria getting in there due to the risk of infection. RN 2 stated an LVN should be able to identify a central line and should notify the RNs. RN 2 stated if an RN was notified of a CVC, an RN should have assessed the resident, looked for documentation, then notified the physician for clarification and orders. RN 2 stated there were multiple missed opportunities to identify Resident 1's CVC that included the admitting nurse on 4/5/2022 and 5/28/2022, TN 1 upon admission on 4/5/2022 and 5/28/2022, treatment nurses conducting weekly skin assessments, and licensed nurses doing weekly and as ordered by the physician skin assessments. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility policy and procedure titled, Dressing and Injection Cap Change of Central Venous Access Devices (devices that are inserted into the body through a vein, also known as CVC), last reviewed 1/18/2023, indicated an occlusive dressing (an air- and water-tight medical dressing) shall always be maintained over the central venous access site to reduce the risk of infection to the insertion or exit site and surrounding area of central venous access devices. Transparent Semipermeable Membrane (TSM, a dressing that allows visualization of the insertion site, and provides stabilization and protection from microorganisms) are the dressing of choice for all central catheters. Gauze dressings are only used with the initial dressing application at the time of catheter insertion and needs to be changed within 24 hours. Routine central catheter dressing changes shall be done every seven days and as needed using a TSM type dressing. During every dressing change, facility staff is to document concerns, site problems or any amount of the catheter out of the skin before the insertion into the skin. Only qualified staff shall do a dressing and cap change. To be considered qualified, the RN or IV certified LVN shall have return demonstrated skills with another qualified RN. If a chlorhexidine gluconate protective disk was used, remove after seven days from the day it was placed. Label with a dressing to indicate the type of device, time and date of dressing change, initials of the RN performing the procedure. Document the site appearance, ease of blood return, ease of flush and suture stability. Document in the IV Medication Administration Record the dressing change, securement device change, cap change for all lumens, flush for all lumens, any amount of catheter out of the skin before the insertion site and the arm circumference. Notify the MD of any complications and document notification of the MD. Check the patient's chart to confirm the insertion report and chest X-ray (special pictures of the inside of your body) report confirm tip placement are there. A review of the facility policy and procedure titled, Flushing of Central Venous Access Devices, last reviewed 1/18/2023, indicated flushing of central venous access devices shall be performed by an RN after each intermittent infusion, blood draw, per flushing guidelines, or as ordered by the attending physician. The solutions and volumes to be used for flushing shall be ordered by the attending physician. Document in the nurse's notes the condition of the resident's skin, the presence of any sutures or type of securement device, the presence of any redness, edema (swelling), drainage, or unusual complaints of pain. Document on the treatment record the number of lumens, the flushing, arm circumference, site checks and any amount of exposed catheter. 3. During an interview on 4/17/2023 at 11:20 a.m., LVN 1 stated she had cared for Resident 1 since his admission to the facility on [DATE]. LVN 1 stated she did not know Resident 1 had a CVC until the end of 2022. LVN 1 stated licensed vocational nurses do not provide care for central lines, and that it was the registered nurse's responsibility to provide care for the central lines. LVN 1 stated she notified the registered nurse to assess and monitor Resident 1's CVC, but she does not remember who she notified or what they said. During an interview on 4/17/2023 at 1:00 p.m., Resident 1 stated that there was a day (resident unable to recall exact date) he spoke with LVN 1 about his CVC and that it needed to be covered, to which LVN 1 informed the resident that she would speak with the RN Supervisors, but nobody came. (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	04/19/2023

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 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent interview and record review with LVN 1 on 4/19/2023 at 9:11 a.m., Resident 1's medical records including face sheet, history and physical, admission assessment, physician orders, progress notes, skin assessments, and care plans from 4/5/2022 to 4/19/2023 were reviewed. LVN 1 stated that she did not document that Resident 1's CVC had been identified in the resident's medical records. LVN 1 stated that there was no documented evidence in Resident 1's medical records from 4/5/2022 to 4/19/2023 to indicate that LVN 1 had notified an RN regarding Resident 1's CVC. LVN 1 stated that since there was no documented evidence of her informing the RNs, it means that it was not done, and she had not informed the RNs of Resident 1's CVC. During an interview on 4/19/2023 at 10:38 a.m., LVN 2 stated that he was aware that Resident 1 had a CVC on his RUC, and during the times he observed the CVC, it was not covered or dressed. LVN 2 stated he did not inform any other facility staff of the presences of Resident 1's CVC. LVN 2 stated he should have checked Resident 1's physician orders to ensure there were orders for treatment and care for Resident 1's CVC when he observed the line uncovered without a dressing. LVN 2 stated he could not recall why he did not inform an RN regarding Resident 1's CVC. LVN 2 stated that he was under the impression that the facility was already aware that Resident 1 had a CVC. LVN 2 stated he should have questioned why Resident 1's CVC would be uncovered and that he should have reported his findings up the chain of command (reporting to your supervisor). A review of the facility policy and procedure titled, Dressing and Injection Cap Change of Central Venous Access Devices (devices that are inserted into the body through a vein, also known as CVC), last reviewed 1/18/2023, indicated an occlusive dressing (an air- and water-tight medical dressing) shall always be maintained over the central venous access site to reduce the risk of infection to the insertion or exit site and surrounding area of central venous access devices. Transparent Semipermeable Membrane (TSM, a dressing that allows visualization of the insertion site, is breathable, and provides stabilization and protection from microorganisms) are the dressing of choice for all central catheters. Gauze dressings are only used with the initial dressing application at the time of catheter insertion and needs to be changed within 24 hours. Routine central catheter dressing changes shall be done every seven days and as needed using a TSM type dressing. During every dressing change, facility staff is to document concerns, site problems or any amount of the catheter out of the skin before the insertion into the skin. Only qualified staff shall do a dressing and cap change. To be considered qualified, the RN or IV certified LVN shall have return demonstrated skills with another qualified RN. If a chlorhexidine gluconate protective disk was used, remove after seven days from the day it was placed. Label with a dressing to indicate the type of device, time and date of dressing change, initials of the RN performing the procedure. Document the site appearance, ease of blood return, ease of flush and suture stability. Document in the IV Medication Administration Record the dressing change, securement device change, cap change for all lumens, flush for all lumens, any amount of catheter out of the skin before the insertion site and the arm circumference. Notify the Medical Doctor (MD) of any complications and document notification of the MD. Check the patient's chart to confirm the insertion report and chest X-ray report confirm tip placement are there. 4. During an interview on 4/17/2023 at 11:20 a.m., LVN 1 stated she had cared for Resident 1 since his admission to the facility on [DATE]. LVN 1 stated she did not know Resident 1 had a CVC until around the end of 2022. LVN 1 stated that she continued to see Resident 1's CVC on his right upper chest without a dressing for a couple of months. LVN 1 stated that around the beginning of January 2023, Resident 1 had asked her on multiple occasions why he had the CVC and why was it not removed. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/17/2023 at 12:00 p.m., the DON stated that when Resident 1 complained to LVN 1 that the facility was not treating or caring for his CVC, LVN 1 should have notified the RN Supervisor. The DON stated LVN 1 did not provide the care Resident 1 needed because she left the resident's CVC uncovered and did not notify the RN Supervisors. During an interview on 4/17/2023 at 1 p.m., Resident 1 stated that he spoke with LVN 1 about his CVC and that it needed to be covered. Resident 1 stated that LVN 1 informed him that she would speak with the supervisors, but nobody came back. Resident 1 stated the facility absolutely did not provide good care and it made him feel scared because they were supposed to know how to take care of his CVC. During an interview on 4/19/2023 at 8:58 a.m., CNA 1 stated she talked with LVN 1 regarding Resident 1's CVC and how she was worried that the line was uncovered during his showers and that the resident wanted it covered. CNA 1 stated she spoke with LVN 1 on multiple occasions regarding covering Resident 1's CVC. During an interview 4/19/2023 at 9:12 a.m., LVN 1 stated she thought about Resident 1's CVC every day that she worked. yet she did not follow up with the RN Supervisors when Resident 1's CVC remained uncovered and untreated. During an interview on 4/19/2023 at 11:25 a.m. the DON stated LVN 1 should have addressed Resident 1's concerns and complaints regarding his CVC. The DON stated if LVN 1 knew about the CVC, LVN 1 should have followed up with the RN supervisor. DON stated that because LVN 1 did not follow up with an RN, no monitoring or treatment was done for Resident 1's CVC. The DON stated LVN 1 knew the adverse effects associated with having a CVC and she should have followed up with Resident 1's concerns of having his CVC left untreated. DON stated that LVN 1 did not follow up with an RN Supervisors or the DON so that orders to monitor and provide the necessary treatment to Resident 1's CVC could be obtained. A review of the facility policy and procedure titled, Skin Assessment, last revised 3/2023, indicated the purpose of the policy was to provide guidelines for routine assessment of resident's skin to maintain skin integrity and promote healing in accordance with standard of care practices. The licensed nurse completes a head-to-toe skin assessment (process of examining entire skin for abnormalities) of the resident's skin during the admission process. The licensed nurse completes routine weekly assessments. Skin integrity should be assessed for pressure related discoloration or breakdown from positioning or use of medical devices applied for therapeutic purposes. The licensed nurse documents assessment findings in the resident's medical record weekly following completion of the skin assessment. Injurious or at-risk areas are documented on a change in condition form and reported to the primary physician for further instruction. 5. During an interview on 4/19/2023 at 8:58 a.m., CNA 1 stated she gave Resident 1 a shower approximately once a week and covered the resident's CVC on his RUC herself. CNA 1 stated she had previously spoken with LVN 1 regarding Resident 1's CVC and how she was worried that the CVC was uncovered during his shower. CNA 1 stated that she informed LVN 1 that Resident 1 wanted his CVC covered. CNA 1 stated that LVN 1 instructed her to cover Resident 1's CVC with the dressings provided by the family. CNA 1 stated she knew she should not cover Resident 1's CVC herself as it is outside her scope of practice, but she covered Resident 1's CVC because LVN 1 did not do it. CNA 1 stated she had spoken with LVN 1 a couple of times regarding Resident 1's need to have his CVC covered during his shower. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/19/2023 at 9:11 a.m., LVN 1 stated that she had reported Resident 1's CVC to an RN Supervisor but was unable to recall who. LVN 1 stated that to her knowledge, the RN Supervisors did not assess Resident 1 CVC. LVN 1 stated that when the RN did not assess Resident 1's CVC, LVN 1 would cover the resident's CVC with a gauze dressing. LVN 1 stated covering a CVC was not within her scope of practice and she was aware of this fact when she covered Resident 1's CVC. LVN 1 stated she covered Resi[TRUNCATED]