Printed: 12/22/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056367	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2023	
NAME OF PROVIDER OR SUPPLIER  The Rehabilitation Center of North Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  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			

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 056367

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056367	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2023	
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The Rehabilitation Center of North Hills		9655 Sepulveda Boulevard North Hills, CA 91343	FCODE	
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(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)			on)	
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.			
	actions:	M provided an IJ Removal Plan which i  per chest (RUC) was assessed for com-		
	I. Resident 1's CVC to his right upper chest (RUC) was assessed for complications, patency (the line is oper and not blocked) and dressing change by the RN Supervisor on 4/11/2023.			
		sident 1's primary care physician of the ntral line dressing changes and monitor		
	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 an 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, o the facility policy and procedures Abuse Prohibition/Neglect to include providing necessary care and servic 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.			
		ent 1 was in-serviced on 4/17/23 on per ing the resident's body) upon admission	,	
		ole for assessing Resident 1 was in-ser ssions and indicate any lines such as l		
	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.			
	weekly dressing changes and routi	sed nurses on 4/17/2023 regarding cer ne assessments for any complications lents and documentation in the medical	and patency, full body	
	(continued on next page)			

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	DER/SUPPLIER/CLIA TION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2023
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The Rehabilitation Center of North Hills		9655 Sepulveda Boulevard North Hills, CA 91343	. 6052
For information on the nursing home's plan to correct the	nis deficiency, please con	tact the nursing home or the state survey	agency.
	PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		
Evel of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some  IX. The DOI set of guide patency.  X. On 4/17/facility's polifluids includ the physicial On 4/19/202 plan, the SS Findings:  1. A review readmitted to (BKA-remove renal diseased dialysis (a pworking)).  A review of understand  A review of indicated the The MDS further review 4/13/2023, if understood, dressing, are a review of 3/31/2022, if an	In-serviced each licer ines) for assessment of 2023, the DON/ Design by and procedures for ng assessment and min.  If at 2:03 p.m., while of A accepted the IJ Remonth of Resident 1's Admissible resident on 5/28/20 all by surgery of a limble (ESRD, a medical corocedure to remove was and make decisions.  Resident 1's Minimum by resident had the ability of the resident had the ability of the resident had the resident.  Bewoof Resident 1's Minimum by resident had the resident had the resident had the resident had the resident had personal hygiene.  Resident 1's General Andicated that the resident had the resident had the resident had personal hygiene.  Resident 1's General Andicated that the resident had the resident had the resident had the resident had personal hygiene.  Resident 1's Physician ck upon returning to fand discontinued on 5/2 and discontinued on 5	nsed nurse on 4/17/23 regarding unders of central lines and all other intravenous on the parenteral (describes any drug administic on the parenteral (describes any drug administic on the line and after verifying the facility's full moval Plan and removed the IJ in the present of the line and plan and removed the IJ in the present of the line and plan and removed the line and line inserted of the line and	standing the standard of practice (a access sites for complications and rvisors and LVNs) regarding the tration other than by mouth) IV by and complications as ordered by implementation of the IJ removal esence of the ADM and DON.  But the resident on 4/5/2022 and left leg below the knee amputation is of injury or disease), end stage oning) and dependence on renal blood when the kidneys stop one resident had the capacity to the resident had the capacity to be resident had the capacity to be resident had the capacity to real and screening too) dated 4/12/2022, lity to make himself understood. In and screening too dated had the ability to make himself aff assistance with transfers, defined that the ability to make himself aff assistance with transfers, and Diagnostic Imaging report dated in 3/30/2022:  In in the internal jugular vein [IJV-ing:  19. Wednesday, and Friday, dated

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	030307	B. Wing	04/19/2023	
NAME OF PROVIDER OR SUPPLI	NAME OF PROVIDER OR SUPPLIER		P CODE	
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F 0600  Level of Harm - Immediate jeopardy to resident health or safety	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.			
Residents Affected - Some	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.			
	Resident 1's medical records included notes, care plans and skin assess documented evidence that the facilities are considered to the constant of the constant	view and record review on 4/14/2023 at 4:40 p.m., Registered Nurse 1 (RN 1) reviewed edical records including all face sheets, history and physical, physician orders, progress ns and skin assessments from 4/5/2022 to 4/14/2023. RN 1 stated that there was no vidence that the facility was aware or treated Resident 1's CVC prior to 4/11/2023. RN 1 stated vare of Resident 1's CVC until 4/10/2023. RN 1 stated that Resident 1 had informed her that C for over a year.		
	1's Wound Weekly Monitoring Asserviewed. TN 1 stated that when rebody skin assessment to identify a completes her full body assessmer reviewed Resident 1's Wound Weethere was no documented evidence completed a body check for Reside 1's CVC until 4/11/2023.	ecord review on 4/17/2023 at 9:00 a.m. with Treatment Nurse 1 (TN 1), Resident oring Assessments, dated 4/6/2022 and 5/30/2023 documented by TN 1 were at when residents are admitted to the facility, the admitting nurse completes a full identify any catheter lines such as CVCs. TN 1 stated that after the admitting nurse assessment, the treatment nurse is to complete another full body assessment. TN 1 bund Weekly Monitoring Assessments, dated 4/6/2022 and 5/30/2022 and stated devidence that indicated Resident 1 had a RUC CVC. TN 1 stated that she for Resident 1 on 4/6/2022 and 5/30/2022 but stated that she never saw Resident		
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F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Resident 1 had the CVC until the maye potentially developed an infection) from prevent infection such as applying infection.  During a concurrent interview and Wound and Weekly Monitoring Assisted that there was no document Monitoring Assessment forms. The licensed nurses either did not asse had a CVC to his RUC, or the licenstated if the licensed nurses were in nurses would have identified Resid a thorough body assessment on R for over one year could be conside treatment for Resident 1's CVC plate. A review of the facility policy and p licensed nursing staff will complete. The comprehensive assessment with the resident. The assessment proof the residents, as well as communic shifts. Assessment findings may neorders.  A review of the facility policy and p purpose of the policy was to provide integrity and promote healing in achead-to-toe skin assessment (proof the admission process. The license for therapeutic purposes. The license for the facility policy and p indicated the facility ensures each	at 10:10 a.m. with the DON, DON stated esident informed her on 4/11/2023. The ction and become septic (a life-threater of the CVC on his RUC that was not produced by the CVC and monitoring the record review on 4/17/2023 at 12:00 p. sessment forms dated 4/6/2022 and 5/3 ed evidence of Resident 1's RUC CVC at DON stated the licensed nurses were seally conducting a full body assessment ent 1's CVC. The DON stated that the esident 1 resulting in the resident's CVC and reglect because the facility failed the incing the resident at continued risk for it is an admission assessment for resident and admission assessment for resident eas must include direct and indirect obtaction with licensed and non-licensed decessitate communication with attending to conduct titled, Skin Assessment, last be guidelines for routine assessment of cordance with standard of care practice ess of examining entire skin for abnormed nurse completes routine weekly assoloration or breakdown from positioning sed nurse documents assessment find a of the skin assessment. Injurious or at the dother titled, Accuracy of Assessment recedure titled, Accuracy of Assessment recedure titled, Accuracy of Assessment resident receives an accurate assessment, by staff qualified to assess relevant strengths, and areas of decline.	e DON stated that Resident 1 could hing condition that arises with the rovided the necessary care to e CVC for signs and symptoms of e CVC for signs and weekly not doing their job because the he nurses did not know the resident ence of the RUC CVC. The DON into on Resident 1, then the licenses licenses nurse's failure to conduct C being untreated and monitored to provide the needed care and infection.  It, last reviewed 1/18/2023, indicated the supon admission to the facility. It is also behavioral, and social needs of servation and communication with irrect care staff members on all ing physician for treatment or care revised 3/2023, indicated the resident's skin to maintain skin es. The licensed nurse completes a nalities) of the resident's skin during egsments. Skin integrity should be gor use of medical devices applied lings in the resident's medical t-risk areas are documented on a instruction.

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NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
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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 property of the facility policy and property identification, investigation, and reproduced in accordance with federal at mistreatment, neglect, and abuse. In must not permit anyone to engage attain or maintain physical, mental, residents from abuse by anyone incovered individuals with training to physical neglect: poor hygiene, inacare and needs.  2. During an interview on 4/17/2023 RUC when she first started caring funcovered without a dressing durin During an interview and record revirecords from 4/5/2022 to 4/17/2023 physician orders for Resident 1's Cline flushing, or monitoring for signs assessed Resident 1's CVC on 4/1  During an interview and on 4/17/20 concerning that Resident 1 had a Cresident 1 at increased risk for infeassessment of Resident 1 upon ad should have been able to identify Funding an interview on 4/17/2023 and admission to the facility on [DATE], chest without a dressing for a coup	rocedure titled, Abuse Prevention and was designed to ensure a standardized porting of abuse, neglect, mistreatment and state requirements. Each resident has the requirements. Each resident has zero tolerance for abusin abuse, neglect, and mistreatment, of and psychosocial well-being. The faciliculating staff from other agencies servire enable the identification of the followind dequate provision of care and caregive as at 9:45 a.m., CNA 1 stated that Reside for him six months ago. CNA 1 stated to get the time she cared for the resident. However, and symptoms of infection prior to 4/1/2023 at 10:45 a.m., the Nurse Practitione of the cared for the time it was not cover and symptoms of infection prior to 4/1/2023 and at the time it was not cover that should have included certs and symptoms of infection prior to 4/1/2023 and at the time it was not cover that should a full skin check. Resident 1's CVC during their full skin central that included a full skin check. Resident 1's CVC during their full skin central that the has seen Residule of months. LVN 1 stated she notified that the cord of the resident of the resident of the same residuation.	Prohibition Program, last reviewed methodology for the prevention, misappropriation of property, and as the right to be free from the endience, and mistreatment. Staffor deprivation of goods necessary to ity is committed to protecting the residents. The facility provides going residents. The facility provides going and symptoms of potential the rindifference to resident's personal the endience of the endience of the endience of a strail line dressing changes, central endience of the endien

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Wound and Weekly Monitoring Ass stated that there was no document Monitoring Assessment forms. The done by a licensed nurse and document important to find wounds or anythir because the nurses either did not a CVC to his RUC, or the nurses did licensed nurses should have done again on 5/30/2022 which was thre machine filters the waste from your the licensed nurses were really doi nurses would have detected Residand conduct a thorough body asse failed to provide the needed care a for infection.  During an interview on 4/17/2023 a monitored, flushed, and have week because the resident's CVC could During a concurrent interview and reviewed Resident 1's GACH Disct 4/5/2022 and stated that the summ RUC in place. RN 2 stated that the admission on 4/5/22 and 5/28/22 to summary provided to the facility incadmitting nurses of the presence on head-to-toe assessment on Reside Resident 1's CVC. RN 2 stated TN had multiple opportunities to identifithem covered, secure, and safe. Ri and bacteria getting in there due to central line and should notify the R assessed the resident, looked for de 2 stated there were multiple missed nurse on 4/5/2022 and 5/28/2022, conducting weekly skin assessment skin assessments. RN 2 stated that the resident telling facility staff of its	record review on 4/17/2023 at 12:00 p. sessment forms from 4/6/2022 to 4/12/2 ed evidence of Resident 1's RUC CVC in DON stated the facility's procedure for immented on a resident's admissions and gnew on the skin. The DON stated the assess Resident 1's skin since nurses of not document the presence of the RUG a full body assessment as ordered by the times a week after Resident 1's hem or body because your kidneys have failed in gResident 1's full body assessment as ent 1's CVC. The DON stated that the lassment on Resident 1 could be considered in the factor of the resident 1's CVC place at 12:28 p.m., LVN 1 stated that a resident distribution of the factor of the f	2023 were reviewed. The DON on the Wound and Weekly r skin assessments is that they are d weekly forms because it is enurses were not doing their job did not know the resident had a C CVC. The DON stated that the physician on 4/28/2022 and odialysis (HD- a process where a d) treatments. The DON stated if as ordered, then the licenses iccenses nurse's failure to identify ered neglect because the facility cing the resident at continued risk ent's central lines needed to be sident 1 could have been harmed  m., Registered Nurse 2 (RN 2) ary and Transfer Orders dated to the facility with the CVC on his kin assessment on Resident 1 upon ident 1's CVC. RN 2 stated that the blace should have alerted the should have also performed a d should have been able to identify assessments on Resident 1 and tral lines need dressings to keep neart and you do not want germs /N should be able to identify a of a CVC, she should have am for clarification and orders. RN CVC that included the admitting 5/28/2022, treatment nurses and as ordered by the physician at identify Resident 1's CVC despite

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F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Access Devices (devices that are in 1/18/2023, indicated an occlusive of maintained over the central venous surrounding area of central venous dressing that allows visualization of microorganisms) are the dressing of initial dressing application at the tin central catheter dressing changes dressing. During every dressing chof the catheter out of the skin befor cap change. To be considered qual another qualified RN. If a chlorhexist the day it was placed. Label with a initials of the RN performing the proflush and suture stability. Documer securement device change, cap cheskin before the insertion site and the notification of the MD. Check the program of the inside of your body.  A review of the facility policy and performing the condition of the resident's skin, of any redness, edema (swelling), record the number of lumens, the featheter.  A review of the facility policy and performer in accordance with federal and mistreatment, neglect, and abuse. must not permit anyone to engage attain or maintain physical, mental, residents from abuse by anyone in covered individuals with training to	rocedure titled, Dressing and Injection inserted into the body through a vein, a dressing (an air- and water-tight medical access site to reduce the risk of infect access devices. Transparent Semiper of the insertion site, and provides stability of choice for all central catheters. Gauzine of catheter insertion and needs to be shall be done every seven days and as ange, facility staff is to document concerned the insertion into the skin. Only qualified, the RN or IV certified LVN shall he dine gluconate protective disk was used dressing to indicate the type of device, coedure. Document the site appearance in the IV Medication Administration R ange for all lumens, flush for all lumente arm circumference. Notify the MD of attent's chart to confirm the insertion report confirm tip placement are there. Trocedure titled, Flushing of Central Vernitral venous access devices shall be publicable or as ordered by the attending the presence of any sutures or type of drainage, or unusual complaints of pair lushing, arm circumference, site check to cedure titled, Abuse Prevention and was designed to ensure a standardized porting of abuse, neglect, mistreatment and state requirements. Each resident he The facility has zero tolerance for abusin abuse, neglect, and mistreatment, of and psychosocial well-being. The faciliculary staff from other agencies serving enable the identification of the following dequate provision of care and caregive	Iso known as CVC), last reviewed al dressing ) shall always be tion to the insertion or exit site and meable Membrane (TSM, a zation and protection from the dressings are only used with the ended using a TSM type terns, site problems or any amount fied staff shall do a dressing and have return demonstrated skills with the ended date of dressing than the ended date of dressing change, the ended deterior that the ended deterior date is and document the ended deterior deterior deterior devices, last reviewed deterior device, the presence of the ended device, the

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The Rehabilitation Center of North Hills  STREET ADDRESS, CITY, STATE, ZIP CODE  9655 Sepulveda Boulevard  North Hills, CA 91343		PCODE	
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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 register 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 about his CVC and that it needed to be covered, to which LVN 1 informed the resident that she would spe		
	records from 4/5/2022 to 4/19/2023 CVC had been identified in the resi evidence in Resident 1's medical re RN regarding Resident 1's CVC. LY informing the RNs, it means that it During an interview on 4/19/2023 a on his RUC, and during the times h not inform any other facility staff of checked Resident 1's physician or CVC when he observed the line un not inform an RN regarding Reside facility was already aware that Res Resident 1's CVC would be uncover command (reporting to your supervoluting an interview with the DON of because LVN 1 was aware of Resident 1's Resident 1	record review with LVN 1 on 4/19/2023 be were reviewed. LVN 1 stated that she dent's medical records. LVN 1 stated the records from 4/5/2022 to 4/19/2023 to in VN 1 stated that since there was no do was not done, and she had not informed to 10:38 a.m., LVN 2 stated that he was not expressed the CVC, it was not covered the presences of Resident 1's CVC. LY lers to ensure there were orders for trecovered without a dressing. LVN 2 stated that he was not done to the covered without a dressing. LVN 2 stated that he was not expressed that he was not covered without a dressing. LVN 2 stated that he was not covered withou	e did not document that Resident 1's hat there was no documented adicate that LVN 1 had notified an cumented evidence of her ed the RNs of Resident 1's CVC.  So aware that Resident 1 had a CVC ed or dressed. LVN 2 stated he did VN 2 stated he should have eatment and care for Resident 1's ted he could not recall why he did under the impression that the hould have questioned why his findings up the chain of that LVN 1 acted negligently atted with having a CVC such as

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056367	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER  The Rehabilitation Center of North Hills		STREET ADDRESS, CITY, STATE, ZI 9655 Sepulveda Boulevard North Hills, CA 91343	P CODE
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			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 - Some	A review of the facility policy and p Access Devices (devices that are in 1/18/2023, indicated an occlusive of maintained over the central venous surrounding area of central venous dressing that allows visualization of from microorganisms) are the dress the initial dressing application at the Routine central catheter dressing of dressing. During every dressing chof the catheter out of the skin befor cap change. To be considered qual another qualified RN. If a chlorhexist the day it was placed. Label with a initials of the RN performing the proflush and suture stability. Documer securement device change, cap cheskin before the insertion site and the and document notification of the M report confirm tip placement are the A review of the facility policy and p 1/18/2023, indicated the program videntification, investigation, and recrime in accordance with federal and mistreatment, neglect, and abuse. must not permit anyone to engage attain or maintain physical, mental, residents from abuse by anyone in covered individuals with training to physical neglect: poor hygiene, ina care and needs.  4. During an interview on 4/17/202: admission to the facility on [DATE] end of 2022. LVN 1 stated that she dressing for a couple of months. Ly asked her on multiple occasions with a sked her on multiple occasions with a s	rocedure titled, Dressing and Injection inserted into the body through a vein, all dressing (an air- and water-tight medical seaccess site to reduce the risk of infects access devices. Transparent Semiper of the insertion site, is breathable, and pusing of choice for all central catheters. The etime of catheter insertion and needs thanges shall be done every seven day ange, facility staff is to document concrete the insertion into the skin. Only qualified, the RN or IV certified LVN shall be dine gluconate protective disk was used dressing to indicate the type of device, ocedure. Document the site appearance in the IV Medication Administration Range for all lumens, flush for all luments arm circumference. Notify the Medical D. Check the patient's chart to confirm	Cap Change of Central Venous Iso known as CVC), last reviewed al dressing ) shall always be ion to the insertion or exit site and meable Membrane (TSM, a provides stabilization and protection Gauze dressings are only used with the bechanged within 24 hours. It is and as needed using a TSM type terns, site problems or any amount fied staff shall do a dressing and prove return demonstrated skills with doto, remove after seven days from the time and date of dressing change, the ease of blood return, ease of the dressing change, any amount of catheter out of the last Doctor (MD) of any complications the insertion report and chest X-ray as the right to be free from the provides and stream to be free from the provides of signs and symptoms of potential are indifference to resident's personal cared for Resident 1 since his the insight upper chest without a portion of January 2023, Resident 1 had removed.

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F 0694	Provide for the safe, appropriate administration of IV fluids for a resident when needed.			
Level of Harm - Immediate jeopardy to resident health or	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 44244	
Residents Affected - Some	Based on observation, interview, and record review the facility failed to monitor and provide central vecatheter (CVC-a tube placed in a large vein [blood vessel that carries blood to the heart] also known a central line, to give fluids, blood, medications or to do medical tests) line care for one of three sampled residents (Resident 1) by:			
	Failing to ensure that facility staf 4/5/2022 and readmission on 5/28/	f identified Resident 1's central venous 2022.	catheter upon admission on	
	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.			
	Failing to ensure Licensed Voca     Registered Nurse (RN) supervisor	tional Nurse 1 (LVN 1) and Licensed Vor of Resident 1's CVC	ocational Nurse 2 (LVN 2) notified	
	when the line was first identified.			
	Failing to ensure LVN 1 acted or resident's CVC being left without a	n and reported Resident 1's concerns a dressing.	nd requests regarding the	
		tified Nursing Assistant 1 (CNA) 1 did r l 1 and CNA 1 applied dressings to Res		
	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] 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 which the facility's noncompliance with one or more requirements of participation has caused, or is likely cause, serious injury, harm, impairment, or death to a resident) in the presence of the Administrator (ADI 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 ADI actions:	M provided an IJ Removal Plan which i	ncluded the following summarized	
		er chest (RUC) was assessed for com nge 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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The Kenabilitation Center of North	The Rehabilitation Center of North Hills		
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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 inserted into a vein using a needle) Peripherally Inserted Central Cathe guided (threaded) into a large vein placed through the skin into a vein, admitted on [DATE], was identified orders were obtained from Resider PICC line for Resident 2.  IV. DON in-serviced nursing staff, i the facility policy and procedures in who receive intravenous (IV- within blood directly into the blood stream and complications.  V. The Admission Nurse for Reside (examining, measuring, or monitori VI. The Treatment Nurse responsite full body assessment for new admi VII. Resident 1's care plan was reveare professionals from diverse fiel resident) to reflect Resident 1's cur VIII. The DON in-serviced the licen weekly dressing changes and routing assessments, completion of treatm residents with intravenous lines.  IX. The DON in-serviced each licer set of guidelines) for assessment of patency.  X. On 4/17/2023, the DON/ Design facility's policy and procedures for pluids including assessment and method the physician.  On 4/19/2023 at 2:03 p.m., while on plan, the SSA accepted the IJ Rem	the facility for intravenous catheters (I in There were two (2) residents with cereter lines (PICC lines- tube that is insertable above the heart) and one (1) resident in usually in the hand, elbow, or foot) idea with no orders for PICC line use/maint at 2's physician. A care plan was initiated including licensed nurses and certified including providing the necessary care at a vein) therapy (IV therapy- a way to go in through a vein) are assessed and more that 1 was in-serviced on 4/17/23 on pering the resident's body) upon admissional place for assessing Resident 1 was in-sersisions and indicate any lines such as I is liewed and revised by the Interdisciplinated who work in a coordinated fashion to the rent care and service interventions for sed nurses on 4/17/2023 regarding cere assessments for any complications ents and documentation in the medical insed nurse on 4/17/23 regarding under a from the certification of the central lines and all other intravenous the inserviced licensed staff (RN Superporter) and after verifying the facility's full and Plan and removed the IJ in the principal control of the provided licensed staff (RN Superporter) and after verifying the facility's full and Plan and removed the IJ in the principal control of the provided licensed the IJ in the principal control of the provided licensed the IJ in the principal control of the IJ i	V catheter- a thin plastic tube intral lines, two (2) residents with ted into a vein in the upper arm and with a peripheral line (a tube that is entified. Resident 2, who was enance. On 4/17/23, PICC line ed on 4/17/23 for management of ed on 4/17/2023, on end services to ensure residents give fluids, medicine, nutrition, or nitored for intravenous line patency efforming a full body assessment in.  Eviced on 4/17/23 on performing a V lines.  Early Team (IDT- a group of health oward a common goal for the his CVC on 4/17/2023.  Entral line access care including and patency, full body and patency, full body access sites for complications and excess sites for complications and excess sites for complications and excess sites for complications and complications as ordered by a limplementation of the IJ removal
	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 Admiss readmitted the resident on 5/28/202 (BKA-removal by surgery of a limb renal disease (ESRD, a medical codialysis (a procedure to remove was working).  A review of Resident 1's History and understand and make decisions.  A review of Resident 1's Minimum indicated the resident had the abilit The MDS further indicated the resident Personal hygiene.  Further review of Resident 1's Minident 4/13/2023, indicated the resident hunderstood. The MDS further indicates dressing, and personal hygiene.  A review of Resident 1's General A 3/31/2022, indicated that the resident a) Right intrajugular (in the internal portion of the central line goes under A review of Resident 1's Physician a) Body check upon returning to far 4/28/2022 and discontinued on 5/2 b) Body check to be performed upon Wednesday, and Friday, dated 5/30 c) IV central line active therapy ord dressing, using sterile technique (to preventing infection), site cleanse welliminate germs and bacteria) or poinfection) as needed, every day shid IV central lines: flush each lumer with normal saline (solution used to administration every shift, dated 4/4 administration every shift.	ion Record indicated the facility admitted 22 with diagnoses that included sepsis, (arm or leg) or other body part because indition in which the kidneys stop functions the products and excess fluid from the diagnoses. Indicated the products and excess fluid from the diagnoses are products and excess fluid from the diagnoses. Indicated the products and excess fluid from the diagnoses are products and excess fluid from the diagnoses. In the products and excess fluid from the diagnoses are producted at the product of the product	ed the resident on 4/5/2022 and pleft leg below the knee amputation e of injury or disease), end stage ioning) and dependence on renal blood when the kidneys stop  the resident had the capacity to creening too) dated 4/12/2022, illity to make himself understood. The with transfers, dressing, and and screening too) dated had the ability to make himself aff assistance with transfers, do Diagnostic Imaging report dated and on 3/30/2022:  The bone of the with microbes (bacteria), which is and as needed, remove old in of a site with microbes [bacteria], (a cleaning product that helps skin to treat or prevent skin unit of measurement for liquids) after and after medication
	During a review of Resident 1's GA	CH Discharge to Skilled Nursing Facilitesident 1 with a five (5) french (fr- unit	

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F 0694  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	in bed inside his room. Resident 1 care of. Resident 1 pull up the right CVC sutured (held in place with stiguluconate protective disk (a small clocal infections) with a transparent his CVC was the first dressing the been asking the facility nurses to codone. Resident 1 stated that facility shower times, but all other times the goes to his heart and he is worried.  During an interview and record reving an interview and record reving an interview and record reving as no documented evidence that 1 stated she was not aware of Resident 1's Wound Weekly Monitoring Asserviewed. TN 1 stated that after the is to complete another full body asserviewed. TN 1 stated that after the is to complete another full body asserviewed. That a RUC CVC. TN 1 and 5/30/2022 but stated that she in During an interview on 4/17/2023 at Resident 1 had a RUC CVC until the rehave potentially developed an infection.  During a concurrent interview and wound and Weekly Monitoring Assand surveyor. The DON stated that the Wound and Weekly Monitoring Assand surveyor. The DON stated that the Wound and Weekly Monitoring Assand surveyor. The DON stated if the life Resident 1, then the license nurse licenses nurse's failure to conduct and CVC being untreated and monitore	iew on 4/14/2023 at 4:40 p.m., Registe ding face sheet, history and physical, a sments, and care plans from 4/5/2022 t the facility was aware or treated Residi ident 1's CVC until 4/10/2023. RN 1 sta	C that the facility was not taking veyor was a purple, single lumen was covered with a chlorhexidine on site of a CVC to help reduce stated that the dressing currently on 4/5/2022. Resident 1 stated he had /5/2022, but nothing was being or a plastic bag over his CVC during 1 stated his CVC line on his RUC ared Nurse 1 (RN 1) reviewed dission assessment, physician to 4/14/2023. RN 1 stated that there ent 1's CVC prior to 4/11/2023. RN atted that Resident 1 had informed attent Nurse 1 (TN 1), Resident 23 documented by TN 1 were dry assessment, the treatment nurse Wound Weekly Monitoring cumented evidence that indicated assment for Resident 1 on 4/6/2022 (2023). The DON stated that Resident 1 could hing condition that arises with the rovided the necessary care to be CVC for signs and symptoms of the licensed nurses were not doing kin thoroughly since the nurses did not document the presence of the a full body assessment on VC. The DON stated that the ent 1 resulting in the resident's at at continued risk for infection due

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F 0694  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	licensed nursing staff will complete The comprehensive assessment with the resident. The assessment procitive residents, as well as communiciantifications as well as communiciantifications. A review of the facility policy and producers.  A review of the facility policy and property and promote healing in acceptable admission process. The license assessed for pressure related disceptation for the facility policy and property and property and property and property and process. The license assessed for pressure related disceptation for the facility policy and property and the facility ensures each assessment about the facility ensures each assessment about the resident's status, needs,  2. During an interview on 4/17/2023 and property assessed Resident 1's CVC on 4/11.  During an interview and on 4/17/2023 and property and prope	3 at 9:45 a.m., CNA 1 stated that Reside for him six months ago. CNA 1 stated to get the time she cared for the resident. Siew on 4/17/2023 at 10:10 a.m. with the swere reviewed. DON stated there was even and symptoms of infection prior to 4/1/2023 and at the time it was not cover at 10:45 a.m., the Nurse Practitione cover without a dressing or monitoring beactions. NP stated that the facility shour mission that included a full skin check. Resident 1's CVC during their full skin country at 11:20 a.m., LVN 1 stated she had can LVN 1 stated she notified the restated there were no orders for dressing their full skin contact.	s upon admission to the facility.  al, behavioral, and social needs of servation and communication with irect care staff members on all g physician for treatment or care  revised 3/2023, indicated the resident's skin to maintain skin es. The licensed nurse completes a nalities) of the resident's skin during essments. Skin integrity should be g or use of medical devices applied ings in the resident's medical erisk areas are documented on a instruction.  Ints, last reviewed 1/18/2023, lent, reflective of the resident's care areas and are knowledgeable dent 1 already had his CVC to his hat Resident 1's CVC was left  B DON, Resident 1's medical in a no documented evidence of a stral line dressing changes, central l1/2023. The DON stated she red.  B C (NP) stated that it was eling done because the CVC places and have conducted a full physical The NP stated that the facility heck.  The d for Resident 1 since his 1's CVC on his right upper chest egistered nurse to assess and

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F 0694  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Wound and Weekly Monitoring Ass stated that there was no document Monitoring Assessment forms. The done by a licensed nurse and document important to find wounds or anythin because the nurses either did not a CVC to his RUC, or the nurses did licensed nurses should have done again on 5/30/2022 which was thre machine filters the waste from your the licensed nurses were really doi nurses would have detected Reside conduct a thorough body assessment to provide the needed care and treatinfection.  During an interview on 4/17/2023 a monitored, flushed, and have week because the resident's CVC could During a concurrent interview and reviewed Resident 1's GACH Disch 4/5/2022 and stated that the summ RUC in place. RN 2 stated that the admission on 4/5/22 and 5/28/22 to summary provided to the facility she CVC. RN 2 stated TN 1 should have and readmission and should have I weekly skin assessments on Resid stated central lines need dressings into the heart and you do not want stated an LVN should be able to idnotified of a CVC, an RN should hap hysician for clarification and order Resident 1's CVC that included the	record review on 4/18/2023 at 11:12 a. narge to Skilled Nursing Facility Summary indicated Resident 1 was admitted admitting nurse should have done a slo identify any central lines such as Resould have alerted the admitting nurses the also performed a head-to-toe assess been able to identify the CVC. RN 2 statement 1 and had multiple opportunities to to keep them covered, secure, and sate germs and bacteria getting in there due tentify a central line and should notify the assessed the resident, looked for district RN 2 stated there were multiple mister admitting nurse on 4/5/2022 and 5/28, nurses conducting weekly skin assess	2023 were reviewed. The DON on the Wound and Weekly on the Wound and Weekly skin assessments is that they are diversely forms because it is a nurses were not doing their job did not know the resident had a CCVC. The DON stated that the physician on 4/28/2022 and odialysis (HD- a process where a d) treatments. The DON stated if as ordered, then the licenses icenses nurse's failure to identify or neglect because the facility failed are resident at continued risk for ent's central lines needed to be sident 1 could have been harmed  The presence of Resident 1 upon ident 1's CVC. RN 2 stated that the of the presence of Resident 1's sment on Resident 1 on admission ated TN 1 should have performed identify the resident's CVC. RN 2 fe. RN 2 stated a central line goes at the risk of infection. RN 2 fe. RNs. RN 2 stated if an RN was ocumentation, then notified the sed opportunities to identify (2022, TN 1 upon admission on

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F 0694  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Access Devices (devices that are in 1/18/2023, indicated an occlusive of maintained over the central venous surrounding area of central venous dressing that allows visualization of microorganisms) are the dressing of initial dressing application at the tin central catheter dressing changes in dressing. During every dressing chof the catheter out of the skin befor cap change. To be considered qual another qualified RN. If a chlorhexing the day it was placed. Label with a initials of the RN performing the proflush and suture stability. Document securement device change, capich skin before the insertion site and the notification of the MD. Check the projectures of the inside of your body)  A review of the facility policy and provided the prosence of any redness, eden treatment record the number of lume exposed catheter.  3. During an interview on 4/17/2023 admission to the facility on [DATE]. 2022. LVN 1 stated licensed vocation registered nurse's responsibility to nurse to assess and monitor Residisaid.	rocedure titled, Dressing and Injection inserted into the body through a vein, all dressing (an air- and water-tight medical access site to reduce the risk of infect access devices. Transparent Semiper of the insertion site, and provides stability of choice for all central catheters. Gauzine of catheter insertion and needs to be shall be done every seven days and as ange, facility staff is to document concernation into the skin. Only qualified, the RN or IV certified LVN shall he dine gluconate protective disk was used dressing to indicate the type of device, ocedure. Document the site appearance of the IV Medication Administration R ange for all lumens, flush for all lumens are arm circumference. Notify the MD of attent's chart to confirm the insertion report confirm tip placement are there. To cedure titled, Flushing of Central Vernitral venous access devices shall be per flushing guidelines, or as ordered by or flushing shall be ordered by the attent of the skin, the presence of any suturnal (swelling), drainage, or unusual compens, the flushing, arm circumference, and at 11:20 a.m., LVN 1 stated she had. LVN 1 stated she did not know Reside onal nurses do not provide care for cerprovide care for the central lines. LVN ent 1's CVC, but she does not remember the contral speak with the RN Supervisors, but it 1:00 p.m., Resident 1 stated that the RN 1 about his CVC and that it needed the speak with the RN Supervisors, but it 1:00 p.m., Resident 1 stated that the RN 1 about his CVC and that it needed the speak with the RN Supervisors, but it	so known as CVC), last reviewed al dressing ) shall always be ion to the insertion or exit site and meable Membrane (TSM, a zation and protection from e dressings are only used with the e changed within 24 hours. Routine reded using a TSM type erns, site problems or any amount fied staff shall do a dressing and lave return demonstrated skills with d, remove after seven days from time and date of dressing change, e, ease of blood return, ease of ecord the dressing change, s, any amount of catheter out of the any complications and document port and chest X-ray (special cous Access Devices, last reviewed erformed by an RN after each the attending physician. The inding physician. Document in the ures or type of securement device, plaints of pain. Document on the site checks and any amount of cared for Resident 1 since his ent 1 had a CVC until the end of intral lines, and that it was the 1 stated she notified the registered er who she notified or what they

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For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey	agency.
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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	records including face sheet, histor skin assessments, and care plans for document that Resident 1's CVC has there was no documented evidence that LVN 1 had notified an RN regard documented evidence of her inform RNs of Resident 1's CVC.  During an interview on 4/19/2023 at on his RUC, and during the times have not inform any other facility staff of checked Resident 1's physician or CVC when he observed the line under not inform an RN regarding Reside facility was already aware that Resignesident 1's CVC would be uncovered to command (reporting to your supervoice). A review of the facility policy and proposed facility and command (reporting to your supervoice). A review of the facility policy and proposed facility and command in the central venous surrounding area of central venous surrounding area of central venous dressing that allows visualization of from microorganisms) are the dress the initial dressing application at the Routine central catheter dressing change. To be considered qual another qualified RN. If a chlorhexist the day it was placed. Label with a initials of the RN performing the proflush and suture stability. Document securement device change, cap change have securement device change, cap change have securement device change, cap change have the insertion site and the and document notification of the MI report confirm tip placement are the 4. During an interview on 4/17/2023 admission to the facility on [DATE], end of 2022. LVN 1 stated that she dressing for a couple of months. LV	rocedure titled, Dressing and Injection inserted into the body through a vein, a liressing (an air- and water-tight medical access site to reduce the risk of infect access devices. Transparent Semiper of the insertion site, is breathable, and pusing of choice for all central catheters. The etime of catheter insertion and needs hanges shall be done every seven day ange, facility staff is to document conce the insertion into the skin. Only qualified, the RN or IV certified LVN shall I dine gluconate protective disk was used dressing to indicate the type of device pocedure. Document the site appearance it in the IV Medication Administration Frange for all lumens, flush for all lumene arm circumference. Notify the Medical C. Check the patient's chart to confirm	t, physician orders, progress notes, wed. LVN 1 stated that she did not dical records. LVN 1 stated that 4/5/2022 to 4/19/2023 to indicate that since there was no done, and she had not informed the done, and she had not informed the saware that Resident 1 had a CVC and or dressed. LVN 2 stated he did vN 2 stated he should have stated he could not recall why he did under the impression that the hould have questioned why his findings up the chain of  Cap Change of Central Venous also known as CVC), last reviewed al dressing) shall always be tion to the insertion or exit site and meable Membrane (TSM, a provides stabilization and protection Gauze dressings are only used with to be changed within 24 hours. As and as needed using a TSM type terns, site problems or any amount fied staff shall do a dressing and have return demonstrated skills with add, remove after seven days from the time and date of dressing change, the, ease of blood return, ease of the dressing change, so, any amount of catheter out of the all Doctor (MD) of any complications the insertion report and chest X-ray cared for Resident 1 since his tent 1 had a CVC until around the his right upper chest without a for January 2023, Resident 1 had

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 056367

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056367	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
The Rehabilitation Center of North Hills		9655 Sepulveda Boulevard North Hills, CA 91343	. 6052
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.		agency.	
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0694  Level of Harm - Immediate jeopardy to resident health or safety	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.		
Residents Affected - Some	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.		
	purpose of the policy was to provid integrity and promote healing in ac head-to-toe skin assessment (proc the admission process. The license assessed for pressure related disc for therapeutic purposes. The licen record weekly following completion	rocedure titled, Skin Assessment, last reguidelines for routine assessment of cordance with standard of care practice ess of examining entire skin for abnormed nurse completes routine weekly asseptionation or breakdown from positioning sed nurse documents assessment find to fithe skin assessment. Injurious or at ted to the primary physician for further	resident's skin to maintain skin es. The licensed nurse completes a nalities) of the resident's skin during essments. Skin integrity should be g or use of medical devices applied ings in the resident's medical -risk areas are documented on a
	once a week and covered the resic with LVN 1 regarding Resident 1's shower. CNA 1 stated that she info LVN 1 instructed her to cover Resident knew she should not cover Resident Resident 1's CVC because LVN 1	3 at 8:58 a.m., CNA 1 stated she gave lent's CVC on his RUC herself. CNA 1 CVC and how she was worried that the rmed LVN 1 that Resident 1 wanted his dent 1's CVC with the dressings provident 1's CVC herself as it is outside her so did not do it. CNA 1 stated she had spore his CVC covered during his shower.	stated she had previously spoken e CVC was uncovered during his s CVC covered. CNA 1 stated that ed by the family. CNA 1 stated she cope of practice, but she covered
	(continued on next page)		

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056367	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 04/19/2023
NAME OF PROVIDER OR SUPPLIER  The Rehabilitation Center of North Hills		STREET ADDRESS, CITY, STATE, ZIP CODE  9655 Sepulveda Boulevard North Hills, CA 91343	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)
F 0694  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	During an interview on 4/19/2023 a RN Supervisor but was unable to re assess Resident 1 CVC. LVN 1 sta cover the resident's CVC with a ga	at 9:11 a.m., LVN 1 stated that she had ecall who. LVN 1 stated that to her kno ated that when the RN did not assess Fuze dressing. LVN 1 stated covering a fact when she covered Resident 1's C	reported Resident 1's CVC to an wledge, the RN Supervisors did not Resident 1's CVC, LVN 1 would CVC was not within her scope of