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	02/18/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 42275 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 28) were provided in advance information of treatment risk and benefits, options, and alternatives. Director of Staff Development (DSD) did not sign as obtaining a telephone informed consent (the resident or family was provided information regarding the side effects of a vaccine or any treatment before making a medical decision to either agree or refuse a vaccine or treatment) from Family Member 1 (FM 1). This deficient practice may result to inaccuracy of resident's medical record and violated resident rights for informed consent. Findings: A review of Resident 28's Admission Record (Face Sheet) indicated the facility admitted the resident on 06/06/2021 with diagnoses included diabetes (a disorder in which the body does not produce enough or respond normally to insulin, causing blood sugar [glucose] levels to be abnormally high), hypertension (uncontrolled elevated blood pressure) and dementia (a decline in memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities). A review of Resident 28's History and Physical exam, dated 06/07/2021, indicated the resident could make needs known but could not make medical decisions. A review of Resident 28's Physician's Order, dated 09/09/2021, indicated an order for Influenza vaccine (flu shot - medication given to prevent getting a respiratory infection) 0.5 milliliter (ml - unit of measure) intramuscular (IM- injected to the muscle) one dose. A review of Resident 28's Medication Administration Record (MAR - flowsheet to record medications given to a resident), dated 09/09/2021, indicated influenza vaccine was given at 02:30 p.m. A review of Resident 28's Influenza Vaccination - Informed Consent form (form where the resident or responsible party signs when they were provided education and information regarding the side effects of a vaccine before making a medical decision to either agree or refuse a vaccine or treatment) dated 08/24/2021 indicated a telephone consent was obtained from Family Member 1 (FM1). The form did not have a license nurse signature. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/06/2021 at 01:37 p.m., DSD stated she called FM 1 to get an informed consent for influenza vaccine. DSD stated she forgot to have a witness when she called and forgot to sign the informed consent form. DSD stated after obtaining consent she gave the form to the Director of Nursing (DON) to order the vaccine. DSD stated Licensed Vocational Nurse 10 (LVN 10) administered the medication should have checked the consent before administering the vaccine. During an interview on 04/06/2022 at 2 p.m., LVN 10 stated DON gave her the consent and the vaccine on 09/09/2021 and she called FM 1 that vaccine will be given to Resident 28. LVN 10 stated she did not read the consent form. LVN 10 stated consent should always have two licensed nurses' signatures. During an interview on 04/06/2022 at 03:55 p.m., DON stated LVN 10 should have first checked the consent before the vaccine administration. DON stated the telephone informed consent needed two witness signatures for accuracy of informed consent. A review of facility's policy and procedure titled Influenza Prevention & Control dated 11/10/2021 indicated the resident or resident representative was provided education regarding the benefits and potential side effects of influenza vaccination.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 43988 Based on observation, interview, and record review, the facility failed to ensure residents' call lights (bedside button tethered into the wall in a patient's room which directs signals to the nursing station; a call light usually indicates that the patient has a need requiring attention from the nurse on duty) were within reach for two (Residents 163 and 14) out of four sample residents investigated for call lights. This deficient practice had the potential to result in residents' needs not being met. Findings: a. A review of the admission record indicated Resident 163 was admitted to the facility, on 02/13/2022, with diagnoses that included bacterial pneumonia (an infection in the lungs caused by certain bacteria), shortness of breath, and congestive heart failure (CHF - occurs when the heart muscle does not pump as well as it should). A review of the History and Physical, dated 02/15/2022, indicated Resident 163 had the capacity to understand and make decisions. During an observation, on 02/15/2022 at 10:58 a.m., Resident 163 was awake in bed with the resident's call light on the floor. During a concurrent observation and interview, on 02/15/2022 at 11:09 a.m., Certified Nursing Assistant 4 (CNA 4) confirmed the resident's call light was on the floor and stated it should have been within the resident's reach. During an interview, on 02/18/2022 at 9:08 a.m., the Staffing Coordinator (SC) stated the staff was to make sure the call lights were within the resident's reach before leaving the room. The SC stated it was important to have the call light within the resident's reach in case they needed something. During an interview, on 02/18/2022 at 9:12 a.m., the Director of Nursing (DON) stated the staff was to ensure that call lights were within reach. The DON stated it was important for the staff to leave the resident's call light within reach to ensure that the resident was able to call for assistance when needed so their needs could be attended to. A review of the facility's policy and procedure titled, Communication - Call System, revised on 01/22/2016, indicated the purpose of the policy was to provide a mechanism for residents to promptly communicate with nursing staff. The policy indicated that the facility will provide a call system to enable residents to alert the nursing staff from their rooms and toilet/bathing facilities. Call cords will be placed within the resident's reach in the resident's room. 38549 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. A review of admission record indicated Resident 14 was admitted to the facility, on 05/14/2021, with diagnoses that included heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), morbid (severe) obesity due to excess calories, muscle weakness (generalized), and difficulty in walking. A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 02/12/2022, indicated Resident 14 had moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS indicated Resident 14 was totally dependent on staff for transfers and locomotion on and off the unit and required extensive assistance for bed mobility, dressing, toilet use, and personal hygiene. A review of Resident 14's care plan (contains all of the relevant information about a patient's diagnoses, the goals of treatment, the specific nursing orders [including what observations are needed and what actions must be performed], and a plan for evaluation) for risk for falls related to generalized muscle weakness, poor balance, and unsteady gait, initiated on 05/22/2021, indicated the following goals: (1) The resident would be free of minor injury through the review date and (2) The resident would not sustain serious injury through the review date. Among some of the interventions listed was to have the resident's call light (a bedside button tethered to the wall in a patient's room, which directs signals to the nursing station; a call light usually indicates that the patient has a need or perceived need requiring attention from the nurse on duty) within reach and to encourage the resident to use it for assistance as needed. During an observation, on 02/15/2022 at 9:39 a.m., Resident 14 was asleep in bed with the resident's call light hanging on the side of her bed near the floor. The call light was oberved not within reach and not clipped to the resident's bedsheet. During an concurrent observation and interview, on 02/15/2022 at 9:50 a.m., the Assistant Administrator (AA) confirmed the resident's call light was hanging off the side of her bed and was not within reach. During an interview, on 02/17/2022 at 4:02 p.m., Certified Nursing Assistant 2 (CNA 2) stated staff were to make sure to leave the call light within the resident's reach before leaving the room so the resident was able to use it. CNA 2 stated the call light should be clipped to the resident's bed. During an interview, on 02/18/2022 at 9:08 a.m., the SC stated the staff was to make sure the call light was within the resident's reach before leaving the room. The SC stated it was important to have the call light within the resident's reach in case they needed something. During an interview, on 02/18/2022 at 9:12 a.m., the DON stated it was important for the staff to leave the resident's call light within reach to ensure that the resident was able to call for assistance when needed so their needs could be attended to. A review of the facility's policy titled, Communication - Call System, revised on 01/22/2016, indicated the purpose of the policy was to provide a mechanism for residents to promptly communicate with nursing staff. The policy indicated that the facility will provide a call system to enable residents to alert the nursing staff from their rooms and toilet/bathing facilities. Call cords will be placed within the resident's reach in the resident's room.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36500 Based on interview and record review, the facility failed to ensure staff informed and provided residents and/or their responsible party with written information in regard to the right to formulate an advance directive (a written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) for four (Resident 25, 57, 62 and 78) of nine sampled residents. This deficient practice violated residents' and/or their representatives' right to be fully informed of the option to formulate an advance directive and had the potential to cause conflict due to lack of communication regarding residents' wishes about their medical treatment. Findings: a. A review of the admission record indicated Resident 25 was admitted to the facility, on 11/16/2021, with diagnoses including sepsis (potentially life threatening condition that occurs when the body's response to an infection damages its own tissues), type 2 diabetes mellitus (condition that affects the way the body processes blood sugar), and peripheral vascular disease (PVA, a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). A review of the Minimum Data Set (MDS- a standardized assessment and screening tool), dated 11/23/2021, indicated Resident 25's cognition (mental action or process of acquiring knowledge and understanding) was intact. A review of the History and Physical, dated 11/17/2021, indicated Resident 25 had the capacity to understand and make decisions. During a concurrent interview and record review, on 02/17/2022, at 09:22 a.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 25's Advance Directive and Psychosocial assessment dated [DATE] was reviewed. LVN 1 stated the Advance Directive was not in the resident's chart. LVN 1 stated the Psychosocial Assessment indicated an Advance Directive was not offered to the resident on admission. During an interview with the Social Services Director (SSD), on 02/17/2022 at 03:30 p.m., the SSD stated it was the facility's policy to ask the resident on admission about the existence of an Advance Directive. The SSD stated if the resident did not have an Advance Directive, the facility would provide information on how to formulate one. A review of the facility's policy titled, Advance Directive, revised on 08/01/2019, indicated at the time of the admission, Admission Staff or designee will inquire about the existence of an Advance Directive. If no Advance Directive exists, the facility provides the resident with an opportunity to complete the Advance Directive form upon resident request. Assistance is provided as necessary to execute an Advance Directive. 38549 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. A review of the admission record indicated Resident 57 was admitted to the facility, on 12/23/2021, with diagnoses that included fracture (break in the bone) of the left and right femur (thigh bone). A review of the MDS, dated [DATE], indicated Resident 57 had intact cognition and required extensive assistance from staff for bed mobility, transfers, walking in the room and in the corridor, dressing, toilet use, and personal hygiene. During a concurrent interview and record review, on 02/17/2022 at 1:47 p.m., Licensed Vocational Nurse 1 (LVN 1) confirmed that, per the Psychosocial assessment dated [DATE], assistance with formulating an Advance Directive was not offered. LVN 1 stated the Social Services department was responsible for offering residents assistance with formulating an Advance Directive upon admission. During an interview, on 02/17/2022 at 1:54 p.m., Receptionist 1 (RCPTN 1) stated the Social Services Director (SSD) was the one responsible for offering residents assistance with formulating an Advance Directive. During an interview, on 02/17/2022 at 2 p.m., the SSD stated she did not document anywhere that the resident was offered assistance with formulating an Advance Directive. During an interview, on 02/18/2022 at 9 a.m., the SSD stated it was part of their department's duties to offer an Advance Directive to residents upon admission, especially if the resident was alert and oriented, so they would know who could make decisions for the resident in the event they lost the capacity. The SSD stated for Resident 57, who is alert and oriented, the Social Services department should have offered her assistance with formulating an Advance Directive upon admission. During an interview, on 02/18/2022 at 9:12 a.m., the DON stated the facility should offer residents assistance with formulating an Advance Directive upon admission. The DON stated it was important for them to do this to ensure that the facility knew how to care for the resident in the event the resident could not make their own decisions. A review of the facility's policy titled, Advance Directives, revised on 08/01/2019, indicated the purpose of the policy was to provide residents with the opportunity to make decisions regarding their health care. The policy indicated that at the time of admission, Admission Staff or designee will inquire about the existence of an Advance Directive, including whether the resident has requested or is in possession of an aid-in-dying drug. The Admission Staff will inform and provide written information to all adult residents concerning the right to accept or refuse medical treatment. The facility will honor resident's Advance Directives and will provide the resident with information related to Advance Directives upon admission. Assistance is provided as necessary to execute an Advance Directive. 43988 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. A review of the admission record indicated Resident 62 was admitted to the facility, on 12/25/2021 and was readmitted on [DATE], with diagnosis including chronic respiratory failure (a long-term condition in which your lungs have a hard time loading your blood with oxygen and can leave you with low oxygen),with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), tracheostomy status (a hole that surgeons makes through the front of the neck and into the windpipe to relieve an obstruction to breathing), cerebral infarction (also called ischemic stroke and it occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), hemiplegia (a severe or complete loss of strength or paralysis on one side of the body)and hemiparesis (a mild or partial weakness or loss of strength on one side of the body), gastrostomy status (a procedure in which a gastrostomy tube is placed into your stomach for nutritional support). A review of the History and Physical, dated 1/19/2022, indicated Resident 62 did not have the capacity to understand and make decisions. A review of the MDS, dated [DATE], indicated Resident 62's cognition was severely impaired. During a concurrent interview and record review, on 02/17/2022, at 09:22 a.m., with Minimum Data Set Coordinator (MDSN), Resident 62's Advance Directive and Psychosocial assessment dated [DATE] was reviewed. MDSN stated the Advance Directive was not in the resident's chart. MDSN stated the Psychosocial Assessment indicated an Advance Directive was not offered to the resident or resident representative on admission. During an interview, on 02/17/2022 at 9:50 a.m., the SSD stated Resident 62 did not have an Advance Directive on file. SSD stated Advance Directive information was not provided to resident representative. SSD stated that from her understanding Advance Directive had to come from the resident or their representatives. SSD stated an Advance Directive was important to coordinate resident's care with all members of the interdisciplinary team. A review of the facility policy titled, Advance Directive, revised on 08/01/2019, indicated at the time of the admission, Admission Staff or designee will inquire about the existence of an Advance Directive. If no Advance Directive exists, the facility provides the resident with an opportunity to complete the Advance Directive form upon resident request. Assistance is provided as necessary to execute an Advance Directive. 38469 d. A review of the admission record indicated Resident 78 was admitted to the facility, on 02/07/2021 and readmitted on [DATE], with diagnoses including heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), muscle weakness, and diabetes mellitus (a group of diseases that result in too much sugar in the blood). A review of the MDS, dated [DATE], indicated Resident 78's cognition was severely impaired. The MDS indicated the resident was totally dependent on staff with activities of daily living. A review of the History and Physical, dated 01/06/2022, indicated Resident 78 did not have the capacity to make decisions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 02/18/2022 at 10:05 a.m., the SSD stated there was no Advanced Directive on file. The SSD stated upon admission the residents and/or their responsible party was provided with an Advance Directive acknowledgment form to complete and information on how to formulate Advance Directive was also provided if there was not one in place. The SSD stated the Advance Directive would give the facility information of the residents' choices regarding his or her care and treatment decisions and indicate if they had appointed someone else to make healthcare decisions for them. A review of the facility's policy titled, Advance Directive, revised on 08/01/2019, indicated at the time of the admission, Admission Staff or designee will inquire about the existence of an Advance Directive. If no Advance Directive exists, the facility provides the resident with an opportunity to complete the Advance Directive form upon resident request. Assistance is provided as necessary to execute an Advance Directive.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36500 Based on observation, interview, and record review, the facility failed to provide a restraint (device that limits ones' movements) -free environment which provided the least restrictive measures as indicated in the facility's policy for one (Resident 105) of two residents reviewed for restraints by: 1. Failing to ensure an assessment was completed by a licensed nurse prior to the application of hand mitten (soft device that covers the hands to prevent residents from pulling out anything) and to ensure the restraining device was used to treat a medical condition. 2. Failing to document frequent observations of the condition of the skin and the release of the restraint every two hours for toileting and/or repositioning. These deficient practices had the potential to violate the resident's right to be free from any restraints that were imposed for reasons other than of treatment of the resident's medical symptoms. Findings: A review of the admission record indicated Resident 105 was admitted to the facility, on 01/13/2022 and readmitted on [DATE], with diagnoses including acute respiratory failure (condition causing breathing problems), dependence on ventilator (machine that assists with breathing), and benign prostatic hyperplasia (BPH-a condition in which the prostate gland [a part of the male reproductive] is enlarged). A review of the Minimum Data Set (MDS- a standardized assessment and screening tool), dated 02/03/2022, indicated Resident 105's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 105 was totally dependent on staff in all areas of activities of daily living (ADLs). The MDS indicated Resident 105 had a limb restraint that was used less than daily. During an observation, on 02/15/2022 at 10:52 a.m., Resident 105 was wearing a mitten on his left hand. Resident 105's bed had padded side rails (padding used to prevent from injury). A review of the Order Summary Report, dated 02/07/2022, indicated Resident 105 was to use a left hand mitten to prevent accidental pulling out of invasive tubings and for staff to monitor skin breakdown and impaired condition. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 105's care plan on physical restraints, initiated on 02/07/2022, indicated the resident used hand mittens secondary to attempting to pull out tubes. The care plan indicated Resident 105's goals included the resident would be free of complications related to restraint use, including contractures (stiff joints), skin breakdown, altered mental status, isolation or withdrawal. The care plan's interventions indicated to evaluate the resident's restraint use, evaluate/record continuing risks/benefits of restraints, alternatives to restraints, need for ongoing use, reason for restraint use, the resident needs to have restraint applied and release for repositioning, and document restraint use and release. During a concurrent interview and record review, on 02/16/2022 at 11:24 a.m., Licensed Vocational Nurse (LVN 1) stated the resident's care plan indicated to document use and release of hand mitten. LVN 1 stated there was no documentation in the resident's medical records that indicated the restraint release and skin condition monitoring every two hours was documented. LVN 1 stated restraint should be released every two hours so staff could monitor the resident's skin circulation and integrity. During a concurrent interview and record review, on 02/17/2022 at 10:50 a.m. LVN 1 stated there was no Device/Physical Restraint Assessment for the use of hand mitten. LVN 1 stated there should be an assessment prior to the use of hand mitten. LVN 1 stated the Licensed Nurse who received the order from the physician should have completed the assessment. During an interview, on 02/17/2022 at 11:03 a.m., the Registered Nurse 2 (RN 2) stated she did not conduct an assessment prior to the use the hand mitten. RN 2 stated Resident 105's assessment should have been done to document the need for the restraint. RN 2 stated the licensed nurse should assess Resident 105's behavior, alternative interventions implemented, monitor the use and release of the restraint including skin monitoring and assessment. RN 2 stated hand mitten use and release of the restraint every two hours for at least ten minutes should be documented by licensed nurses. A review of facility's policy titled, Devices and Physical Restraints, revised on 07/01/2018, indicated restraints may only be used if/when the resident has a specific, medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to treat the medical symptom; protect the resident's safety; and help the resident attain the highest level of his/her physical and psychological well-being. An assessment will be completed by a Licensed Nurse prior to the application of any device that restricts movement or access to one's body. The assessment will be repeated quarterly and as needed. Care plans for residents with restraints will reflect including systematic and gradual approached for minimizing or eliminating the concerning behavior and restraint use; and frequent observation and release every 2 hours for toileting and/or repositioning and checking the condition of skin and impaired circulation if indicated. Residents with restraints shall have documentation including the least restrictive alternatives attempted, a plan for gradually reducing or eliminating restraint; resident's response to restraint application, reduction, or elimination; and observation, range of motion and repositioning.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to transmit the Minimum Data Set (MDS- an assessment and care screening tool) within 14 days of the completion of a resident's assessment for one out of one resident (Resident 3) investigated under the facility task Resident Assessment. This deficient practice had the potential to delay care and services for Resident 3. Findings: A review of the admission record indicated Resident 3 was admitted to the facility, on 08/16/2021 and readmitted on [DATE], with diagnoses including heart failure, hypertension (elevated blood pressure) and diabetes mellitus ((a group of diseases that result in too much sugar in the blood). During a concurrent interview and record review, on 2/18/20 at 11:28 a.m., the Centers for Medicare and Medicaid Services (CMS) Submission Reports were reviewed with the Minimum Data Set Coordinator Nurse (MDSCN). The CMS Submission Reports indicated the submission date was more than 14 days after assessment. The MDSCN stated this was a late submission and should be transmitted within 14 days of the completion of a resident's assessment. A review of the facility-provided CMS Resident Assessment Instrument (RAI) Version 3.0 Manual, dated 10/2019, indicated the Quarterly MDS Assessment transmission date should be no later than the MDS completion date + 14 days.

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	056367	A. Building B. Wing	02/18/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 36500 Based on observation, interview, and record review, the facility failed to develop a comprehensive plan of care that addressed the resident's left heel diabetic ulcer (open sore or wound) with measurable objectives and interventions for one (Resident 25) of 24 sampled residents. This deficient practice placed Resident 25 at risk for not receiving the necessary services and treatment which may subsequently worsen or delay the healing of Resident 25's left foot diabetic ulcer. Findings: A review of the admission record indicated Resident 25 was admitted to the facility, on 11/16/2021, with diagnoses including sepsis (a potentially life threatening condition that occurs when the body's response to an infection damages its own tissues), type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar), and peripheral vascular disease (PVA, a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). A review of the Minimum Data Set (MDS- a standardized assessment and screening tool), dated 11/23/2021, indicated Resident 25's cognition (mental action or process of acquiring knowledge and understanding) was intact. The MDS indicated Resident 25 required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene; and was totally dependent with staff with and bathing. A review of the History and Physical, dated 11/17/2021, indicated Resident 25 had the capacity to understand and make decisions. A review of the Physician's Wound Assessment and Plan, dated 01/13/2022, indicated Resident 25 had a diabetic wound on the left heel measuring 3 centimeter (cm) length x 3 cm width x 0.2 cm depth. A review of the Order Summary Report, dated 02/14/2022, indicated Resident 25's left heel diabetic wound was to be cleansed with normal saline, pat dry, paint with betadine (anti-infective), apply dressing and wrap with kerlix (dressing) daily and as needed for 14 days. During an observation, on 02/15/2022 at 11:04 a.m., Resident 25 was in bed. Resident 25 was observed to have a heel protector (device used to protect boney heel of the foot)to her left foot. The resident's left foot was wrapped in gauze bandage. During a concurrent interview and record review, on 02/17/2022 at 09:50 a.m., with Registered Nurse 1 (RN 1) and Licensed Vocational Nurse 1 (LVN 1), Resident 25's care plan was reviewed. RN 1 stated Resident 25 did not have a care plan that addressed the left heel diabetic ulcer. RN 1 stated there should have been a care plan for left heel diabetic ulcer to ensure staff were aware of the resident's plan of care and the specific goals and treatment. LVN 1 stated without a care plan there was potential for the resident's wound to worsen if treatments were not implemented by staff. LVN 1 stated the care plan should have been initiated on 01/13/2022 when the physician identified the wound as a diabetic wound. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Wound Management, revised 11/01/2017, indicated the licensed nurse will develop a care plan for the resident based on recommendations from Dietary, Rehabilitation and the attending physician. A review of the facility policy titled Care Planning, revised on 11/01/2017, indicated a comprehensive care plan will be developed for each resident. The care plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs; each resident's comprehensive care plan will describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 38469 Based on observation, interview, and record review, the facility failed to ensure one out of one resident (Resident 262) was provided care and services to maintain good grooming and personal hygiene. This deficient practice resulted in Resident 262 having long and untrimmed fingernails that had the potential to result in a negative impact on the resident`s self-esteem and self-worth. Findings: A review of the admission record indicated Resident 262 was admitted to the facility, on 01/21/2022, with diagnoses including muscle weakness, benign prostatic hyperplasia- prostate gland enlargement), and diabetes mellitus (a group of diseases that result in too much sugar in the blood). A review of the Minimum Data Set (MDS- a standardized assessment and screening tool), dated 01/28/2022, indicated Resident 262's cognitive skills (cognition refers to conscious mental activities, and include thinking, reasoning, understanding, learning, and remembering) for daily decision making was moderately impaired. The MDS indicated Resident 262 required extensive assistance with transfer, dressing, eating, toilet use, personal hygiene, and bathing. A review of Resident 262`s Care Plan addressing the potential for impairment to skin integrity, created on 01/24/2022, indicated staff's interventions to keep fingernails short, to avoid scratching and to keep the resident's hands and body parts from excessive moisture. During a concurrent observation and interview, on 02/15/22 at 03:43 p.m., Resident 262 was observed the room, awake and in bed. Resident 262`s fingernails were long and jagged on the edges. Resident 262 stated he repeatedly asked the staff to trim his fingernails and that they never did. Resident 262 stated that it bothered him that it was too long and that it did not look good. During a concurrent observation and interview, on 02/15/22 at 03:45 p.m., Licensed Vocational Nurse 9 (LVN 9) stated Certified Nurse Assistants (CNA) were assigned to trim the residents` fingernails and were supervised by charge nurses. LVN 9 confirmed Resident 262's fingernails required trimming and the resident's edges of the fingernails were jagged. LVN 6 stated that the resident could accidentally scratch himself and could lead to skin breakdown. During an interview, on 02/18/22 at 08:25 a.m., the Infection Preventionist stated that CNAs were responsible for cutting the residents` fingernails to prevent residents from injuring themselves which may result in skin infection.  A review of the facility`s undated policy titled Grooming Care of the Fingernails and Toenails, indicated that nail care is given to clean and keep the nails trimmed.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 43988 Based on interview and record review, the facility failed to ensure the needed care and services were resident centered as evidenced by: 1. The interventions for Resident 56's agitation and crying were ineffective and the physician was not notified with lack of an assessment from the licensed nurse for one of two sampled residents. This deficient practice had the potential to affect Resident 56's well-being. Findings: A review of admission record indicated Resident 56 was admitted to the facility, on 9/19/2020, with diagnoses that included intracerebral hemorrhage (a common subtype of stroke which refers to bleeding into the substance of the brain in the absence of trauma or surgery), metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood and can lead to personality changes), dementia with behavioral disturbance (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), Alzheimer's Disease (a brain disorder that slowly destroys memory and other important mental functions), and hypertension (high blood pressure). A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 12/28/2021, indicated Resident 56 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and required extensive assistance from staff for bed mobility, transfers, walking in the room and in the corridor, locomotion on and off the unit, dressing, toilet use, and personal hygiene. A review of the Skilled Nursing Facility Admission History and Physical, dated 9/21/2020, indicated Resident 56 did not have the capacity to understand and make decisions. A review of Resident 56's Care Plan, initiated on 8/2/2021, for the resident's use of antidepressant medication manifested by constant crying, indicated the following interventions: 1. Monitor, document, or report to physician as needed ongoing signs and symptoms of depression unaltered by antidepressant medications. 2. Use of non-pharmacological approaches such as encourage to verbalize feelings, encourage family to participate in care, provide a quiet and calm environment with diversion, relaxation techniques, and redirect and provide reality orientation. A review of the Order Summary Report indicated the following physician's orders, dated 12/29/2021: 1. Resident 56 was to receive Citalopram Hydrobromide 10 milligrams (mg - a unit of measurement of mass) give 1 tablet by mouth one time a day for depression manifested by constant crying. 2. To monitor episodes of depression manifested by constant crying every shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. To monitor side effects of anti-depressant agent every shift. During an interview, on 2/18/2022 at 2:25 p.m., Licensed Vocational Nurse 5 (LVN 5) stated Resident 56 had tendencies to resist care and screamed non-stop. LVN 5 stated non-pharmacological interventions and routine medications administered were ineffective. LVN 5 stated she should have called Registered Nurse 1 (RN 1) to assess the resident. LVN 5 stated the physician should have been notified and a Situation-Background-Analysis-Recommendation Communication Form (SBAR - communication information to physicians and other health care professionals) should have been initiated. During an interview, on 2/18/2022 at 2:35 p.m., RN 1 stated she was not aware of Resident 56's screaming and constant crying despite non-pharmacological intervention and routine medications. RN 1 stated LVN 5 should have reported this to her and the behavior. RN 1 stated it was mportant to properly assess Resident 56, notify physician, and initiate the SBAR to help maintain the resident's well-being. A review of facility's policy titled Change of Condition Notification, revised on 1/1/2017, indicated a purpose of informing the physician of changes in the resident's condition in a timely manner. The policy also indicated the licensed nurse will assess the resident's change of condition and document the observations and symptoms in the Nursing notes.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36500 Based on observation, interview, and record review, the facility failed to ensure the residents' low air loss mattresses (LALM - a pressure-relieving mattress used to prevent and treat pressure ulcers [a wound that occurs as a result of prolonged pressure on a specific area of the body]) was set according to the resident's weight per manufacturer's guidelines, for two (Resident 25 and 80) out of four sampled residents investigated for pressure ulcer/injury. This deficient practice placed the resident at risk for discomfort and development of pressure ulcers. Findings: a. A review of the admission record indicated Resident 25 was admitted to the facility, on 11/16/2021, with diagnoses including sepsis (a potentially life threatening condition that occurs when the body's response to an infection damages its own tissues), type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar), and peripheral vascular disease (PVA, a circulatory condition in which blood vessels reduce blood flow to the limbs). A review of the Minimum Data Set (MDS- a standardized assessment and screening tool), dated 11/23/2021, indicated Resident 25's cognition (mental action or process of acquiring knowledge and understanding) was intact. The MDS indicated the resident required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene and was totally dependent with staff with and bathing. The MDS indicated Resident 25 had three unstageable (full thickness wound covered) pressure ulcers present at admission. The MDS also indicated Resident 25 was at risk for developing pressure sores/injuries. A review of the Wound Weekly Monitoring Assessment, dated 02/10/2022, indicated Resident 25 had a left heel diabetic wound (open area). A review of the Order Summary Report, dated 12/01/2021, indicated Resident 25 was to receive a LALM set to #4 for wound healing every day shift. During a concurrent observation and interview, on 02/15/2022 at 11:04 a.m., Resident 25 was in bed with LAL mattress. The mattress machine's setting was set at #10 (400 pounds [lbs.]). Resident 25 stated she weighed about 170 lbs. During an interview, on 02/16/2022 at 09:50a.m., Licensed Vocational Nurse (LVN 2) stated the LALM was provided for residents who had pressure ulcers and at risk for developing pressure ulcers. LVN 2 stated the LALM setting was set according to the resident's weight. LVN 1 stated Resident 25 weighed 171 lbs and the setting should be at #4. LVN 1 stated the setting should be followed in order for the resident to get the maximum benefit of the LALM. A review of the facility's policy titled, Wound Management, revised 11/01/2017, indicated per attending physician order, the nursing staff will initiate treatment and utilize interventions for pressure redistribution and wound management. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Pressure Ulcer Prevention, revised on 08/13/2019, indicated the facility will identify residents at risk for skin breakdown, implement measures to prevent and/or manage pressure ulcers and minimize complications. 38549 b. A review of the admission record indicated Resident 80 was admitted to the facility, on 06/15/2007 and readmitted on [DATE], with diagnoses that included hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke), pressure ulcer of the left ankle, and generalized muscle weakness. A review of the MDS, dated [DATE], indicated Resident 80 was moderately impaired in cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS indicated Resident 80 was totally dependent on staff for transfers and toilet use and required extensive assistance with bed mobility, dressing, and personal hygiene. A review of the Order Summary Report, dated 02/18/2022, indicated Resident 80 was to receive a LALM for wound management set to #4 every shift. A review of Resident 80's Care Plan for risk for pressure ulcer development, initiated on 03/30/2021, indicated the following goals: (1) The resident's pressure ulcer would show signs of healing and remain free from infection by/through next review and (2) The resident would have intact skin, free of redness, blisters, or discoloration by/through review date. Among some of the interventions listed was to ensure the resident's LALM for wound management was set to 4. During an observation, on 02/15/2022 at 11:20 a.m., Resident 80 was awake in bed. Resident 80's LAL mattress was observed to be on and set to 8/300 pounds (lbs). During a concurrent observation and interview, on 02/16/2022 at 10:09 a.m., Resident 80 was asleep in bed. Resident 80's LAL mattress was observed on and set to 8/300 lbs. LVN 7 verified that the resident's LAL mattress was set to 8 and stated it should have been set to 4 in accordance with the resident's weight. LVN 7 also pointed out that there was a sticker on the machine with a number 4 indicating that was the setting number. During a concurrent interview and record review, on 02/17/2022 at 1:53 p.m., LVN 1 verified Resident 80 currently had a physician's order for his LALM to be set to 4. During an interview, on 02/18/2022 at 9:12 a.m., the Director of Nursing (DON) stated charge nurses were responsible for ensuring that residents' LAL mattresses were on the correct setting. The DON stated the LAL mattress should be set according to the resident's weight. During an interview, on 02/18/2022 at 9:22 a.m., Licensed Vocational Nurse 2 (LVN 2) stated the resident currently had an open wound on his left amputated (cut off limb) leg. LVN 2 stated the resident was on a LALM because he was considered at high risk of developing pressure sores. LVN 2 stated his LALM should be set to 4 or 5 in accordance with his weight. LVN 2 stated it was important for the resident to have his LALM at the correct setting in order to prevent the development and reopening of his pressure sores. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Wound Management, revised on 11/01/2017, indicated the purpose of the policy was to provide a system for the treatment and management of residents with wounds including pressure and non-pressure ulcers. The policy indicated that a resident who has a wound will receive necessary treatment and services to promote healing, prevent infection, and prevent new pressure ulcers from developing.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36500 Based on observation, interview, and record review the facility failed to provide appropriate treatment and services for two of two sampled residents (Residents 105 and 211) investigated for urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) or urinary tract infection (UTI- an infection in any part of the urinary system, bladder, or urethra [the tube through which urine leaves the body]) care area by: 1. Failing to promptly assess changes in the characteristics in the Resident 105's urine and by failing to notify the physician of the change of condition (COC). This deficient practice had the potential to result in a delay of care and services and had the potential to cause discomfort to the resident. 2. Failing to ensure Resident 211's indwelling urinary catheter drainage tubing was kept off the floor. This deficient practice had the potential to cause increased risk of infection from cross contamination (unintentional transfer of bacteria/germs or other contaminants from one surface or substance to another) to facility residents. Findings: a. A review of Resident 105's Admission Record indicated the resident was initially admitted to the facility on [DATE], and was most recently admitted on [DATE], with diagnoses including acute respiratory failure (condition when not enough oxygen passes from the lungs to the blood), dependence on ventilator (a life support device that breathes for individuals who lost all ability to breathe on their own), and benign prostatic hyperplasia (BPH-a condition in which the prostate gland [a part of the male reproductive] is enlarged). A review of Resident 105's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 02/03/2022, indicated the resident's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision-making was severely impaired. The resident was totally dependent on staff in all areas of activities of daily living (ADLs). The MDS also indicated the resident had an indwelling catheter (urinary catheter - a flexible tube used to empty the bladder and collect urine in a drainage bag). A review of Resident 105's Order Summary Report indicated an order dated 01/27/2022, to monitor every shift for change in urine character; document 0=None; C=Cloudiness; S=Sediments; FS=Foul smelling; B=Blood in urine; DC=deepening or concentrating urine output every shift; flush catheter with 50 cubic centimeters (cc-unit of measurement) of normal saline (NS - a solution) every day as needed for sedimentation and cloudiness. During an observation on 02/16/2022 at 09:20 a.m., observed presence of blood and sediments in Resident 105's urine in the indwelling catheter drainage tubing. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 02/16/2022 at 09:40 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 verified presence of blood and sediments in Resident 105's urine. LVN 1 stated there is a physician order to monitor change in urine characteristic and to flush the indwelling catheter with 50 cc of NS for sedimentation and cloudiness and monitor for foul smell and blood in the urine to ensure the resident does not develop urinary tract infection. LVN 1 also stated the physician should be notified so the physician is aware and can order laboratory tests including urine culture (test to identify germs) and sensitivity (to check what kind of medicine will work best to treat the germs). LVN 1 stated the physician may order an antibiotic based on the laboratory test results. During an interview on 02/16/2022 at 10:03 a.m., Licensed Vocational Nurse 2 (LVN 2) stated if there is presence of hematuria (presence of blood or blood cells in the urine), the physician should be notified because it could be a sign of infection. A review of facility policy and procedures titled, Catheter-Care of, revised on 07/01/2015, indicated to report to the attending physician signs and symptoms of urinary tract infection including change in urine, such as foul odor or bloody/cloudy appearance, hematuria. b. A review of Resident 211's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including urinary tract infection (UTI- an infection in any part of the urinary system, bladder, or urethra [the tube through which urine leaves the body]), acute kidney failure (when the kidneys suddenly become unable to filter waste products from the blood), and type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar). A review of Resident 211's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 02/17/2022, indicated the resident's cognition (mental action or process of acquiring knowledge and understanding) was severely impaired. The MDS indicated the resident had an indwelling catheter (urinary catheter - a flexible tube used to empty the bladder and collect urine in a drainage bag). A review of Resident 211's Physician Order dated 02/15/2022, indicated an order for indwelling catheter French 16/10 (size of catheter) to drainage bag due to diagnosis of obstructive uropathy (condition in which the flow of urine is blocked). A review of Resident 211's care plan on indwelling catheter, addressing risk for UTI dated 02/15/2022, indicated a goal of the resident will have minimized risk for complications from indwelling catheter. During a concurrent observation and interview on 02/15/2022 at 10:10 a.m., with Registered Nurse 1 (RN 1), in Resident 211's room, the resident's indwelling urinary catheter drainage tubing was touching the floor. RN 1 stated to ensure infection control, the tubing should not be touching the floor because the floor is considered dirty and contaminated. A review of the facility policy and procedures titled, Catheter-Care of, revised on 07/01/2015, indicated a resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review the facility failed to ensure one of two sampled residents (Resident 97) with peripheral intravenous (IV) catheter (an intravenous catheter that is threaded into a peripheral vein) was provided safe care to prevent complications. This deficient practice had the potential to place Resident 97 at risk for developing complications such as inflammation of the vein and infection. Findings: A review of Resident 97's Admission Record indicated the resident was admitted on [DATE] with diagnoses including but not limited to acute respiratory failure (occurs when the respiratory system is unable to either adequately absorb oxygen) with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) tracheostomy status (a hole that surgeons makes through the front of the neck and into the windpipe to relieve an obstruction to breathing), gastrostomy status (a surgical opening into the stomach used for feeding usually thru a feeding tube), and dysphagia (difficulty swallowing foods or liquids). A review of History and Physical dated 1/14/2022 indicated Resident 97 did not have the capacity to understand and make decisions. A review of Resident 97's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 1/20/2022, indicated the resident's cognition (mental action or process of acquiring knowledge and understanding) is severely impaired and is totally dependent on staff with activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). A review of Resident 97's Order Summary Report active as of 2/1/2022 indicated a physician's order dated 1/25/2022 to start IV, change site every 72 hours and as needed infiltration or soiling. A review of Resident 97's completed or discontinued Order Summary Report indicated a physician's order dated 2/8/2022 for ceftazidime solution reconstituted (antibiotic medication used to treat bacterial infections) use 2 grams (gm - unit of measurement of mass) intravenously two times a day for pneumonia (lung inflammation caused by infection) until 2/11/2022. A review of the IV Administration Treatment Record for 2/2022 indicated to start IV, change site every 72 hours and as needed infiltration or soiling. May extend beyond 72 hours due to poor venous access, every day shift every 3 days. During an observation on 2/15/2022 at 4:05 p.m., a yellow peripheral IV catheter was observed on the Resident 97's right inner forearm secured in place with transparent tape, with dried, crusty material underneath the tape, and was undated. (continued on next page)

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	056367	A. Building B. Wing	02/18/2022

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 2/15/2022 at 4:06 p.m., Licensed Vocational Nurse 3 (LVN 3) validated that Resident 97's peripheral IV catheter did not indicate the date it was changed and there was presence of dried, crusty material underneath the tape. LVN 3 stated the date should have been indicated on the tape. LVN 3 stated it had the potential for complications such as infection if the date is not known. LVN 3 stated peripheral IV catheter should have been removed if the IV therapy has been completed. During a concurrent interview and record review on 02/16/2022 at 12:31 p.m., the Sub-Acute Coordinator (SAC) stated that ceftazidime 2 gm intravenously every 12 hours for 7 days was completed on 2/11/2022. SAC validated there was no physician order to maintain peripheral IV catheter. SAC stated peripheral IV access are usually changed after 7 days or as needed if leaking, infiltrated, or soiled. SAC stated the peripheral IV access should have been dated to know when the next due date is to be changed and should have been removed after completion of antibiotic therapy especially if soiled per facility policy. SAC stated it had the potential for development of complications such as infection on the insertion site During a concurrent interview and record review on 2/18/2022 at 2:05 p.m., the Infection Control Preventionist (IP) stated that the peripheral IV catheter should have been discontinued after completion of antibiotic therapy unless there's an order from the physician. IP validated and stated that the peripheral IV catheter should have been discontinued on 2/15/2022 at 7:00 a.m. and it had the potential to be a source of infection. A review of the facility's undated policy and procedures titled, Universal Precautions, indicated all personnel involved with administering intravenous therapy will comply with universal precautions and all peripheral IV sites will be rotated (changed sites) every 72 hours or sooner unless otherwise ordered.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42275 Based on observation, interview and record review, the facility failed to ensure a resident received the volume of oxygen ordered by the physician for one of four sampled residents (Resident 91). Resident was given instead of This deficient practice resulted in Resident 91 receiving more oxygen than required and can negatively impact Resident 91's well-being. Findings: A review of Resident 91's Admission Record indicated the facility admitted the resident on 01/12/2022 with diagnoses including chronic respiratory failure (a group of lung diseases that block airflow and make it difficult to breathe). A review of Resident 91's History and Physical exam dated 01/12/2022, indicated the resident had the capacity to understand and make decisions. A review of Resident 91's Minimum Data Set (MDS - a standardized assessment and screening tool) dated on 01/19/2022 indicated, Resident 91's cognition (thought process) for daily decision making was intact. The MDS also indicated, Resident 91 needed extensive assistance for bed mobility, transfer, toilet use, and personal hygiene. A record review of the physician's order dated 01/27/2022, indicated an order for continuous oxygen two liters per minute (L/min) via nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a patient in need of respiratory help) to maintain oxygen level greater than 93% every shift. During a concurrent observation and interview on 04/05/2022, at 4:04 pm, Licensed Vocational Nurse 7 (LVN 7) was in Resident 91's room setting the oxygen setting level from 4.5 L/min to 2L/min. LVN 7 stated is not to change the oxygen inhalation rate without a doctor's order. LVN 7 checked the oxygen saturation rate (refers to the percentage of oxygen in a person's blood, and normal range considering greater than 92%) via pulse oximeter (a small clip device placed on the tip of a finger to measure blood oxygen saturation levels), indicated 93% then the resident was not needed to have more than 2 LPM at that moment. On 04/06/2022, at 4:10 p.m., during an interview with Director of Nursing (DON), DON stated, staff should follow the physician's order to administer oxygen to the resident, and they should call the physician to obtain the orders for the continuous oxygen therapy. A review of the undated facility's policy and procedures titled, Oxygen Administration, the policy indicated that A physician's order is required to initiate oxygen therapy, except in an emergency situation A physician is to be contacted as soon as possible after initiation of oxygen therapy in emergency situations for verification and documentation of the order for oxygen therapy consultation, and further orders Turn on the oxygen at the prescribed rate.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38469 Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 261), who was at risk for pain and distress related to osteoarthritis (when the protective cartilage that cushions the ends of the bones wears down over time resulting in pain), received pain management in accordance with professional standards of practice, the facility's policy and the comprehensive person-center care plan by failing to implement the physician's order to administer Hydrocodone-Acetaminophen (Norco - a medication used to relieve moderate to severe pain) 5-325 milligram (mg-unit of measure) as needed for pain. This deficient practice caused Resident 261 to experience severe untreated pain (pain rated at seven [7] or higher out of 10, on a pain scale from zero [0] to 10, where 10 is the worst possible pain) on 2/5/2022 and 2/14/2022 when the pain medication was not administered as ordered. Findings: A. A review of Resident 261's Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including muscle weakness and osteoarthritis. A review of Resident 261`s History and Physical dated 2/6/2022, indicated that the resident had the capacity to understand and make decisions. The History and Physical further indicated diagnoses that included osteoarthritis, and that Resident 261 was able to request pain medications as needed.  A review of Resident 261`s Physician Order dated 2/5/2022 at 10:16 a.m., indicated an order for Norco 5-325 mg, to give one (1) tablet by mouth every six (6) hours as needed for pain management for 14 days. A review of Resident 261's Care Plan titled The resident at risk of pain . dated 2/7/2022 indicated that the resident will display a decrease in behaviors of inadequate pain control. Interventions indicated to administer analgesia (pain medications) as per orders. During an interview on 2/16/22 at 10:29 a.m., Resident 261 stated that she was admitted to the facility on [DATE] at approximately 10:00 a.m. Resident 261 stated that she takes Norco 5/325 mg for her knee pain due to her osteoarthritis. Resident 261 stated that on 2/5/2022 she informed her nurse that she was suffering from pain and requested for her Norco 5-325mg. Resident 261 stated that the nurse informed her that they were awaiting delivery of her Norco 5-325mg. Resident 261 stated she had to wait till the following day on 2/6/2022 before she was given her first dose of Norco 5-325 mg. Resident 261 stated she had to endure pain rated at 10 while she was waiting for her Norco 5-325 mg. Resident 261 stated that she was in tears due to her untreated pain. A review of facility's Pharmacy Delivery Sheet for Resident 261's Norco 5-325 mg dated 2/5/2022, indicated a delivery of 28 tablets which was received by the facility at 11:35 p.m. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 261`s Medication Administration Record (MAR- the report that serves as a legal record of the medications administered to a resident of a facility by a health care professional) for 02/2022 indicated that the resident did not received her first dose of Norco 5-325 mg at the facility until 2/6/2022 at 12:06 a.m. The MAR further indicated that Resident 261's pain level was at a six [6] which meant moderate pain. During an interview on 02/16/22 at 3:37 p.m., the Director of Nursing (DON) stated that if the facility does not currently have a specific medication for a new admission, the staff can call the pharmacy to get authorization to obtain the medication from the facility's automated medication dispensing system (machine that stores medication to be used during emergent situations such as when a significant medication has not yet been delivered to the facility). During an interview on 2/17/2022 at 3:32 p.m. with Licensed Vocational Nurse 8 (LVN 8), LVN 8 stated that on 2/5/2022 Resident 261 had informed him that she was having knee pain. LVN 8 stated that he was unable to administer Norco 5-325 mg to Resident 261 because the resident was a new admission and the pharmacy had not yet delivered their ordered medication. LVN 8 stated that he did not know that the facility utilized an automated medication dispensing system where he could have obtained a dose of Norco 5/325 mg for Resident 261 while the pharmacy had not yet delivered the resident's medication. LVN 8 further stated that if a resident is not medicated for pain, the resident could then suffer. During an interview on 2/18/2022 at 8:15 a.m. with the Assistant Director of Nursing (ADON), ADON stated that the facility does carry doses of Norco 3/325 mg inside their automated medication dispensing system. ADON stated that on 2/5/2022, doses of Norco were available in the automated medication dispensing system. B. A review of Resident 261`s Physician Order dated 2/8/2022 indicated an order for Norco 5-325 mg, to give one (1) tablet by mouth every four (4) hours as needed for severe pain.  A review of Resident 261`s Refill Order Details, dated 2/14/2022 at 10:17 a.m., indicated a request to refill the resident's prescription for Norco 5-325 mg. A review of facility's Pharmacy Delivery Sheet for Resident 261's Norco 5-325 mg dated 2/14/2022, indicated a delivery of 35 tablets which was received by the facility at 7:00 p.m. A review of Resident 261's MAR dated 2/2022 indicated that Resident 261 was administered Norco 5-325mg on 2/14/2022 at 8:00 p.m. for a complaint of pain eight [8-severe pain] out of 10. During an interview on 02/16/22 at 10:29 a.m., Resident 261 stated that on 02/14/2022 sometime before 12:00 p.m., when she asked the nurse for her prescribed Norco 5-325 mg, they informed her that they had ran out of her pain medication. Resident 261 stated that she once again had to wait for pharmacy to deliver her medication. Resident 261 stated that the pharmacy did not deliver the medication until around 8:00 p.m. Resident 261 stated that the prolonged untreated pain caused her to cry out. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/17/2022 at 3:32 p.m. with LVN 8, LVN 8 stated that on 2/14/2022, Resident 261 had informed him that she was having knee pains. LVN 8 stated he was unable to administer Norco 5-325 mg to the resident because the medication was not available. LVN 8 stated that he made sure that Resident 261's Norco 5-325 mg refill was ordered. LVN 8 stated that he did not know that the facility utilized an automated medication dispensing system where he could have obtained a dose of Norco 5/325 mg for Resident 261 while the pharmacy had not yet delivered the refill of the resident's medication. During an interview on 2/18/2022 at 12:46 p.m. with Certified Occupational Therapy Assistant (COTA), COTA stated that she provides physical therapy exercises to Resident 261. COTA stated that on 2/14/2022 at approximately 10:30 a.m., Resident 261 complained to her of knee pain. COTA stated that Resident 261 informed her that the facility had run out of her prescribed pain medication of Norco 5-325 mg. COTA stated she observed Resident 261 breathing heavily, appearing to be overwhelmed by not having any pain medications. COTA stated that she informed the nurses that Resident 261 needed pain medication. A review of Resident 261`s Physical Therapy (PT) Treatment Encounter Notes dated 2/14/2022 indicated that multiple visits had to be made to Resident 261 to initiate therapy treatment due to reports of pain. The note further indicated that the facility was unable to premedicated the resident for pain due to the prescription medication running out. A review of Resident 261's Care Plan titled The resident at risk of pain . dated 2/7/2022 indicated that the resident will not have an interruption in normal activities due to pain. Interventions indicated to administer analgesia (pain medications) as per orders. During an interview on 2/16/22 at 3:37 p.m., the Director of Nursing (DON) stated that medication refills for residents should be placed when there is around three to four days' worth of remaining medication doses. The DON added that if the facility does not currently have the medication, the staff can call the pharmacy to get authorization to obtain the medication from the facility's automated medication dispensing system (machine that stores medication to be used during emergent situations such as when a significant medication has not yet been delivered to the facility). DON stated that residents will suffer in pain if not timely medicated. During an interview on 2/18/2022 at 8:15 a.m. with the Assistant Director of Nursing (ADON), ADON stated that the facility does carry doses of Norco 3/325 mg inside their automated medication dispensing system. ADON stated that on 2/14/2022, doses of Norco were available in the automated medication dispensing system. A review of the facility`s undated policy and procedure, titled Pain Management, indicated that facility staff is responsible for helping the resident attain or maintain their highest level of well-being to prevent or manage the resident`s pain. A review of the facility`s undated policy and procedure, titled Medication-Administration, indicated that medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner. The time and dose of the drug or treatment administered to the resident will be recorded in the resident`s individual medication record by the person who administers the drug or treatment. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A review of the facility`s undated policy and procedure, titled Medication-Administration, indicated that medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner. The time and dose of the drug or treatment administered to the resident will be recorded in the resident`s individual medication record by the person who administers the drug or treatment.  A review of the facility`s undated policy and procedure, titled Medication Ordering and Receiving from Pharmacy, indicated that emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by the facility`s emergency medication supply or by special order from the pharmacy. The pharmacy supplies emergency medications including emergency drugs, antibiotics, controlled substances, products for infusion in limited quantities in portable, sealed containers in compliance with applicable state regulations.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for two out of two sampled residents (Resident 6 and Resident 84) by: 1. Failing to ensure that a licensed nursing staff gave Resident 6 the prescribed amount of calcium carbonate (also known as TUMS - dietary supplement used as an antacid to relieve heartburn, acid indigestion, and upset stomach). 2. Failing to ensure that a licensed nursing staff did not leave the calcium carbonate on top of Resident 6's bedside table without an order for self-administration of oral medications. 3. Failing to ensure that the Catapres patch (medication used to help lower blood pressure to manage hypertension [high blood pressure]) was administered as ordered by the physician to Resident 84. These deficient practices had the potential for causing adverse side effects (any unexpected or dangerous reaction to a drug) such as nausea/vomiting, loss of appetite, mental/mood changes, headache, weakness, and dizziness. Findings: a. A review of Resident 6's Admission Record (a document that gives a patient's information at a quick glance) indicated the resident was admitted to the facility on [DATE] with diagnoses that included but not limited to gastroesophageal reflux disease (GERD - a chronic disease that occurs when stomach acid or bile flows into the food pipe and irritates the lining manifested by burning pain in the chest that usually occurs after eating and worsens when lying down). A review of Resident 6's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 1/29/2022 indicated the resident had intact cognition (mental action or process of acquiring knowledge and understanding). The MDS also indicated the resident required limited to extensive assistance with activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During an observation on 2/15/2022 at 11:35 a.m., observed two tablets of medicine in a medicine cup on top of Resident 6's bedside table. Resident 6 validated that the medicine is TUMS and stated that she takes it after lunch and that she tells the nurses to leave it at the bedside for her to take later. During a concurrent observation and interview on 2/15/2022 at 11:44 a.m., Licensed Vocational Nurse 4 (LVN 4) validated that the tablets in the medicine cup are TUMS. LVN 4 stated that Resident 6 requested that the medicine be left at the bedside for later. LVN 4 stated Resident 6 had an order to self-administer medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview, and record review on 2/15/2022 at 11:47 a.m., Minimum Data Set Coordinator (MDSN) validated two tablets of TUMS in a medicine cup was left on top of Resident 6's bedside table. A review of Resident 6's Order Summary Report indicated a physician's order dated 12/12/2021, that Resident 6 may self-administer and leave at the bedside eye drops, inhalers, and nasal spray. MDSN stated the medicine should not have been left at the resident's bedside table as there was no order for self-administration of oral medications. During an interview on 2/17/2022 at 4 p.m., LVN 4 stated the medicine should not have been left at the bedside. LVN 4 also stated that the physician order should have been checked prior to dispensing and administering the medication. A review of facility's policy and procedure titled, Medication Administration, revised on 12/17/2021, indicated the purpose of ensuring that physician orders are followed and medication orders are administered safely. The procedure indicated that prior to administration, the nurse will verify the medication is correct by comparing physician order with the medication label and it's the correct dose. b. A review of Resident 6's Admission Record (a document that gives a patient's information at a quick glance) indicated the resident was admitted to the facility on [DATE] with diagnoses that included but not limited to gastroesophageal reflux disease (GERD - a chronic disease that occurs when stomach acid or bile flows into the food pipe and irritates the lining manifested by burning pain in the chest that usually occurs after eating and worsens when lying down). A review of Resident 6's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 1/29/2022 indicated the resident had intact cognition (mental action or process of acquiring knowledge and understanding). The MDS also indicated the resident required limited to extensive assistance with activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During an observation on 2/15/2022 at 11:35 a.m., observed two tablets of medicine in a medicine cup on top of Resident 6's bedside table. Resident 6 validated that the medicine is TUMS and stated that she takes it after lunch and that she tells the nurses to leave it at the bedside for her to take later. During a concurrent observation and interview on 2/15/2022 at 11:44 a.m., Licensed Vocational Nurse 4 (LVN 4) validated that the tablets in the medicine cup are TUMS. LVN 4 stated that Resident 6 requested that the medicine be left at the bedside for later. During a concurrent observation, interview, and record review on 2/15/2022 at 11:47 a.m., Minimum Data Set Coordinator (MDSN) validated two tablets of TUMS in a medicine cup was left on top of Resident 6's bedside table. A review of Resident 6's Order Summary Report indicated a physician's order dated 9/14/2016 of calcium carbonate antacid tablet (TUMS) chewable 500 milligrams (mg - unit of measurement of mass) one tablet by mouth every 24 hours as needed for gastrointestinal (GI) upset. MDSN stated that the amount in the medicine cup is more than the amount prescribed by the physician and giving the medicine more than the prescribed amount may cause adverse side effects. A review of the Medication Administration Record indicated calcium carbonate was documented as administered on 2/15/2022 at 9:48 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/17/2022 at 4 p.m., LVN 4 stated the direction in the bottle indicated to give two tablets. LVN 4 stated that the physician order should have been checked prior to dispensing and administering the medication. LVN 4 stated giving more than the prescribed amount may cause adverse side effects. A review of facility's policy and procedure titled, Medication Administration, revised on 12/17/2021, indicated the purpose of ensuring that physician orders are followed and medication orders are administered safely. The procedure indicated that prior to administration, the nurse will verify the medication is correct by comparing physician order with the medication label and it's the correct dose. c. A review of Resident 84's Admission Record (a document that gives a patient's information at a quick glance) indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included but not limited to congestive heart failure (a serious condition in which the heart doesn't pump blood as efficiently as it should), hypertension (high blood pressure), and cardiomyopathy (a disease of the heart muscle that makes it harder for your heart to pump blood to the rest of your body that may lead to heart failure. A review of History and Physical Examination dated 7/2/2021, indicated Resident 84 does not have the capacity to understand and make decisions. A review of Resident 84's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 1/18/2022 indicated the resident had moderately impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS also indicated the resident required limited to extensive assistance with activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During an accompanied Nurses' Station 3 Medication Cart 3 observation (inspection) on 2/18/2022 at 12:44 p.m. with Licensed Vocational Nurse 6 (LVN 6), the box of Catapres patch for Resident 84 contained three clonidine patches (generic form of Catapres patch) and two adhesive cover that came with the patch. The medication label indicated medication was filled on 1/22/2022 and a box contained four patches. The box had an open date of 1/29/2022. A review of pharmacy delivery receipt indicated 4 patches of clonidine patch 0.1 milligram (mg - a unit of measurement of mass) was delivered on 1/22/2022 at 11:47 a.m. During a concurrent interview and record review of Resident 84's Medication Administration Record (MAR) with Licensed Vocational Nurse 3 (LVN 3) on 2/18/2022 at 12:52 p.m., the order indicated Catapres-TTS-1 patch weekly 0.1 mg every 24 hours (clonidine); apply one patch transdermally (through or by way of the skin) one time a day every Saturday, with a start date of 7/3/2021. LVN 6 validated that the medication was documented as administered on the following dates and times: 1. 1/29/2022 at 8:48 a.m. 2. 2/5/2022 at 8:12 a.m. 3. 2/12/2022 at 9:19 a.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/18/2022 at 12:55 p.m., LVN 6 stated the current contents of the box should have been one clonidine patch and one adhesive patch left if medication was administered as prescribed. LVN 6 stated whoever previously administered the medications did not apply the correct patch. During an interview on 2/18/2022 at 1:15 p.m., the Director of Nursing (DON) stated it's possible only the adhesive cover was applied on Resident 84 and the possible outcome is hypertension but resident's vital signs are being monitored. A review of facility's policy and procedure titled, Medication Administration, revised on 12/17/2021, indicated the purpose of ensuring that physician orders are followed and medication orders are administered safely. The procedure indicated that prior to administration, the nurse will verify the medication is correct by comparing physician order with the medication label and it's the correct dose.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility food service staff failed to honor food preferences that had been identified on the diet tray card for one (Resident 95) of six sampled residents. This deficient practice had the potential for the resident to have a lesser food intake during mealtimes which may lead to weight loss. Findings: A review of Resident 95's Admission Record (a document that gives a patient's information at a quick glance) indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included but not limited to acute respiratory failure with hypoxia (means that a person is not exchanging oxygen properly in their lungs due to swelling or damage to the lungs), encephalopathy (brain disease that alters brain function or structure manifested by declining ability to reason and concentrate, memory loss, personality change, seizures, and twitching), and major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 95's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 1/23/2022, indicated the resident usually was able to understand and make herself understood. The MDS also indicated the resident required extensive assistance from staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. A review of Resident 95's Physician's Progress Notes (an ongoing record of a patient's illness and treatment) dated 7/28/2021 indicated the resident had the capacity to understand and make decisions. During a concurrent observation and interview on 2/16/2022 at 12:52 p.m., Resident 95 was eating lunch and stated that her lunch is not bad except that she was served carrots and she does not like carrots. Upon inspection of her lunch tray, resident was served cut up chicken tenders, potatoes, and chopped up carrots. Lunch diet slip on the tray dated 2/16/2022 indicated carrots as one of Resident 95's dislikes. During a concurrent interview and record review on 2/16/2022 at 12:55 p.m., Certified Nursing Assistant 2 (CNA 2) confirmed that Resident 95 was served carrots for lunch and the diet slip indicated that carrots are included in the resident's dislikes. CNA 2 stated that the resident should not have been served carrots as indicated on the resident's dislikes. CNA 2 stated that the resident may not be able to eat well if the food she disliked was in the tray. During a concurrent interview and record review on 2/17/2022 at 1:30 p.m., the Minimum Data Set Coordinator (MDSN) stated that the quarterly Dietary Profile assessment dated [DATE], indicated carrots as of Resident 95's dislikes. MDSN stated resident's dietary preferences should be honored as it will not help the resident to eat well and promote weight gain. (continued on next page)

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	056367	A. Building B. Wing	02/18/2022

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/17/2022 at 2:08 p.m., Registered Dietitian (RD) confirmed that Resident 95 was served carrots for lunch on 2/16/2022. RD stated that she visits the resident almost every day and updates her food preferences accordingly. RD stated resident should not have been served carrots. RD stated it's important that resident preferences are respected and if not honored, resident won't be able to eat well and may lead to unexpected weight loss. A review of Resident 95's care plan on Potential for Nutritional Risks initiated on 7/30/2021 indicated resident with goals to consume 75% to 100% of meals and tolerate prescribed diet without difficulties or gastrointestinal distress (a group of digestive disorders that are associated with lingering symptoms of constipation, bloating, reflux, nausea, vomiting, diarrhea, abdominal pain and cramping). Intervention included honor food preferences and liberalize diet as clinically stable. A review of facility's policy and procedure titled, Resident Preference Interview, revised on 10/1/2019, indicated residents will be provided with meals consistent with their preferences as indicated on the tray card.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36500 Based on observation, interview, and record review, the facility failed to maintain the kitchen in a clean, safe, and sanitary condition in which food was stored, prepared, and served in accordance with professional standards of food service safety by failing to ensure an open bag of uncooked pasta was stored in a container with a tight-fitting lid and labeled with an open date. This deficient practice had the potential to result in harmful bacteria growth that could lead to foodborne illnesses (illness caused by the ingestion of contaminated food or beverages). Findings: During a concurrent observation and interview with the Dietary Services Supervisor (DSS) on [DATE] at 07:45 a.m., observed a bag of opened pasta stored in the kitchen without an open date. There was no expiration date indicated in the bag of pasta. The pasta was not stored in a storage container with tight fitting lid. The DSS stated the bag of pasta should have been labeled with an open date so staff will know when to discard the pasta. During an interview on [DATE] at 07:28 a.m., with the Registered Dietician (RD), the RD stated once the bag of stored pasta was opened it should have been stored in a container with a tight-fitting lid and labeled with open date and use by date, so the staff do not give expired foods to the residents. A review of the facility policy and procedure titled, Food Storage, revised on [DATE], indicated dry storage guidelines should be observed. Any opened products should be placed in storage containers with tight-fitting lids, label and date storage products.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42275 Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards of practices for one of three sampled residents (Resident 58). Director of Staff Development (DSD) did not document Resident 58 had a pad and wheelchair alarm on 04/01/2022 at day shift (between 7 a.m. to 3:30 p.m.) This deficient practice resulted in inaccurate information entered into the resident's clinical record. Findings: A review of Resident 58's Admission Record (Face Sheet) indicated the facility admitted the resident on 12/23/2022 with diagnoses including multiple fractures (broken bones), pneumonia (lung infection) and hypertension (uncontrolled elevated blood pressure). A review of Resident 58's Minimum Data Set (MDS - a comprehensive assessment and care-screening tool) dated 04/02/2022, indicated Resident 58 was unable to comprehend, remember and make decisions. Resident 58 required extensive assistance for activities of daily living (ADLs - personal hygiene, bed mobility, eating and dressing). The MDS also indicated Resident 58 was on trunk restraint and bed alarm. A review of Resident 58's Medication Administration Record (MAR - flowsheet to record all medications given to a resident) dated 04/01/2022, indicated the section to document the use of the pad alarm in bed and the self-release belt with alarm in wheelchair, were left blank on the day shift (7 a.m. to 3 p.m.) A review of Resident 58's care plan on use of physical restraint dated 11/22/2021 indicated an intervention to evaluate the resident's restraint use. During an interview on 04/06/2022 at 11:17 a.m., with Director of Staff Development (DSD), DSD stated she forgot to document that Resident 58 has the pad alarm and self-release belt while on wheelchair on 04/01/2022 at day shift. DSD stated she did monitor the resident and the alarm for functions that day but forgot to document. During an interview on 04/06/2022 at 03:55 p.m., with Director of Nursing (DON), DON stated checking the equipment is important to make sure it is working properly and that alarms is used for Resident 58 to prevent fall and prevent injury. DON stated if left blank it means it was not done. A review of facility's policy and procedure titled Devices and Physical Restraints dated 07/01/2018 indicated position change alarms are any physical or electronic device that monitors resident movement and alert the staff when movement is detected. Types include chair and bed sensor pads. A documentation for resident with restraints shall include restraint information (type and period), observation, range of motion and repositioning.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36500 Based on observation, interview, and record review, the facility failed to: 1. Ensure the Sitter assigned for Resident 211 (looks after the resident at bedside) in the yellow zone (cohort for newly admitted or readmitted residents, residents who leave the facility for 24 hours or longer, residents who have symptoms, close contact to a known coronavirus disease 2019 [COVID-19 - a highly contagious respiratory illness capable of producing severe symptoms] case, all residents on the unit or wing where a case was identified in resident or healthcare personnel, residents with severely immunocompromised conditions/treatments, and residents with indeterminate test results) don (put on) and doff (take off) an isolation gown appropriately and ensure the Sitter did not bring his personal drink inside the yellow zone room. These deficient practices increase the risk of spreading COVID-19 to residents and staff. 2. Ensure the residents' oxygen tubings were labeled with the date of when they were last changed for two (Residents 62 and 68) out of four sampled residents investigated for infection control. This deficient practice had the potential to place the residents at increased risk of infection. Findings: a. During an observation on 02/15/2022 at 10:06 a.m., observed the Sitter entering Resident 211's room and donning an isolation gown that was placed on a chair inside the resident's room. Also observed the Sitter carrying a mug and placed it on top of the resident's overbed table. A review of Resident 211's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including urinary tract infection (UTI - an infection in any part of the urinary system [kidneys, bladder or urethra]), acute kidney failure (when the kidneys suddenly become unable to filter waste products from the blood), and type 2 diabetes mellitus (a condition that affects the way the body processes blood sugar). A review of the Order Summary Report indicated an order dated 02/10/2022, for placing Resident 211 on COVID-19: Contact/Droplet precautions (measures aimed at preventing spread of germs after touching a person or an object the person has touched, and those that are passed through respiratory secretions) for observation of COVID-19 symptoms due to New Admission/Readmission (yellow zone) for 14 days. During an interview on 02/15/2022 at 10:11 a.m., the Sitter stated he went out of Resident 211's room to get hot water. The Sitter stated he used the same isolation gown when he returned to the resident's room because he considered the gown clean. The Sitter also stated he was not aware he cannot bring his drink inside the room. The Sitter stated he should have taken off the gown when he left the room and put on a new when he reentered the room for infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/15/2022 at 10:18 a.m , with the Infection Preventionist (IP), the IP stated the Sitter's agency has been made aware of the facility's policy on infection control and personal protective equipment (PPE - equipment worn to minimize exposure to hazards like infections that cause serious workplace injuries and illnesses) and the Sitter should comply with these policies. The IP stated all staff should not be eating or drinking inside the resident's room and observe proper donning and doffing of PPE to ensure there was no break in infection control practices. A review of facility policy and procedures titled, Infection Control for COVID-19 or Persons/Patient Under Investigation (PUI) of suspected COVID-19, revised on 12/2017. 2021, indicated facility adherence to Centers for Disease Control on proper usage of PPE on different zones. Extended use of gowns in the yellow zone is not recommended. Inservice company staff regarding the handling of patients with infectious disease, with emphasis on isolation precaution, handwashing/hand hygiene, properly putting and removing of PPE. 43988 b. A review of Resident 62's Admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including chronic respiratory failure (a long-term condition in which your lungs have a hard time loading your blood with oxygen and can leave you with low oxygen), with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), tracheostomy status (a hole that surgeons makes through the front of the neck and into the windpipe to relieve an obstruction to breathing). A review of Resident 62's History and Physical dated 1/19/2022, indicated the resident does not have the capacity to understand and make decisions. A review of Resident 62's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 11/23/2021, indicated the resident's cognition (mental action or process of acquiring knowledge and understanding) was severely impaired and the resident was totally dependent on staff with activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During an observation on 2/15/2022 at 4:12 p.m., Resident 62 was lying in bed with tracheostomy connected to oxygen at 4 liters per minute via T-Piece (T-shaped tubing connected to tracheostomy tube used to deliver oxygen to a patient who does not require mechanical ventilation). Upon inspection of the resident`s environment and equipment, it was observed that the oxygen cannula was not labeled with the date it was changed. A review of Resident 62's Order Summary Report with a physician's order date of 2/7/2022 to change oxygen line and oxygen adapter every night shift every Saturday. A review of Respiratory Treatment Administration Record indicated Resident 62's oxygen line was changed on 2/12/2022 evening. During an interview on 2/15/2022 at 4:13 p.m., Licensed Vocational Nurse 3 (LVN 3) validated that the oxygen tubing did not indicate the date it was changed and stated oxygen tubing should be changed once a week. LVN 3 also stated oxygen tubing should be labeled with date for infection control reasons and places a resident at risk for acquiring an infection if date tubing was changed is unknown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/18/2022 at 11:40 a.m., Licensed Vocational Nurse 1 (LVN 1), stated oxygen tubings are supposed to be changed and dated once a week and as needed if soiled. LVN 1 stated it is an infection control issue and places the resident at risk for infection if tubing is used longer than one week. A review of the facility's policy and procedure titled, Oxygen Administration, revised on 07/01/2015, indicated that all oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen will be changed weekly and when visibly soiled. 38549 c. A review of Resident 68's Admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) and chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs). A review of Resident 68's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 12/05/2021, indicated the resident had intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and required extensive assistance from staff for bed mobility, transfers, walking in the room and in the corridor, locomotion on and off the unit, dressing, and toilet use. On 02/15/2022 at 9:54 a.m., during an observation, Resident 68 was awake in bed. The resident was receiving oxygen via nasal cannula (a medical device to provide supplemental oxygen therapy) from an oxygen concentrator (a device that concentrates the oxygen from a gas supply by selectively removing nitrogen to supply an oxygen-enriched product gas stream) set at 2 liters per minute (LPM). The oxygen tubing did not have a label on it indicating the date of when it was last changed. On 02/15/2022 at 10:30 a.m., during a concurrent observation and interview, the Staffing Coordinator (SC) confirmed that the resident's oxygen tubing did not have a label on it with the date indicating when it was last changed. On 02/18/2022 at 9:12 a.m., during an interview, the Director of Nursing (DON) stated that nurses and respiratory therapists (RT) were responsible for changing residents' oxygen tubing weekly. The DON stated they should be labeling the oxygen tubing with the date of when it was last changed for infection control purposes. A review of the facility's policy and procedure titled, Oxygen Administration, revised on 07/01/2015, indicated that all oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen will be changed weekly and when visibly soiled.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 38469 Based on observation, interview, and record review, the facility failed to ensure that 27 out of 55 rooms met the 80 square feet (sq. ft. - unit of measurement) per resident in multiple resident rooms. These 27 rooms consisted of three 2-bed rooms, and twenty four 3-bed rooms. This deficient practice had the potential to result in inadequate useable living space for the residents and working space for the health care givers. Findings: A review of the letter for request of room waiver submitted by the Administrator dated 02/15/2022, indicated 27 resident rooms did not meet the 80 square foot requirement per resident in multiple resident rooms per federal regulation. The letter indicated there was still enough space to provide for each resident's care, dignity, and privacy. The rooms were in accordance with the special needs of the residents, and would not have an adverse effect on the residents' health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. The Administrator submitted to the survey team a letter to request continued permit for the room size waiver for the rooms as indicated below: Rm No. No. of Beds Sq. Ft. Sq.Ft/Res 201 2 159.81 79.91 210 2 156.86 78.43 211 2 156.86 78.43 103 3 215.74 71.91 105 3 219.46 73.15 106 3 211.75 70.58 107 3 213.79 71.26 108 3 212.09 70.69 109 3 212.67 70.89 110 3 224.02 74.67 111 3 211.86 70.62 112 3 219.09 73.03 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	213 3 221.18 73.72 215 3 229.96 76.65 216 3 217.59 72.53 217 3 224.30 74.76 301 3 211.58 70.52 302 3 208.20 69.40 303 3 210.38 70.12 309 3 212.30 70.76 311 3 213.40 71.13 312 3 213.40 71.13 313 3 213.40 71.13 315 3 213.40 71.13 321 3 211.98 70.66 323 3 215.76 71.92 325 3 217.97 72.65 The required minimum square footage for a 2-bedroom is 160 sq. ft. and the minimum square footage for a 3-bedroom is 240 sq. ft. During the initial observation tour on 2/15/2022, from 9:00 a.m. to 2:30 p.m., the evaluators inspected the aforementioned rooms and observed that nursing staff had enough space to provide care to the residents. There were curtains to provide privacy for each resident and the rooms had direct access to the corridors. During an interview with the Resident Council President (Resident 98) on 02/15/2022 at 11:05 a.m., Resident 98 stated that there were no concerns regarding the size of the rooms during the resident council meetings.