STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056367	A. Building B. Wing	12/30/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a document that summarizes a resident's needs, goals, and care/treatment) for one of three sampled residents (Resident 1), who was identified to have an amputation (the action of surgically cutting off a limb). This deficient practice had the potential to negatively affect the delivery of care and services to Resident 1. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted Resident 1 on 6/10/2024 and readmitted the resident on 9/5/2024 with diagnoses that included partial traumatic amputation of right mid foot and peripheral vascular disease (PVD - a disorder that reduces blood flow to a body part outside of the brain or heart). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 9/12/2024, the MDS indicated Resident 1's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) for daily decision-making was moderately impaired. The MDS indicated Resident 1 required setup or clean up assistance with eating and partial/moderate assistance with oral hygiene and personal hygiene and was dependent with staff with toileting. During a review of Resident 1's wound weekly monitoring assessment dated [DATE] at 3:50 p.m., the document indicated right foot status post amputation. During a concurrent interview and record review on 12/30/2024 at 3:50 p.m., with the Director of Nursing (DON), reviewed Resident 1's wound weekly monitoring assessment dated [DATE] at 3:30 p.m. and care plans dated 9/5/2024-12/30/2024. The DON stated that Resident 1 had an amputation to Resident 1's right foot. The DON stated there was no documented evidence a comprehensive person-centered care plan was developed to address Resident 1's right foot amputation. The DON stated that a care plan specific to Resident 1's right food amputation is important because a care plan will guide staff to personalized interventions to provide Resident 1. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last revised 10/2023, the policy indicated the facility develops a person-centered comprehensive care plans that are culturally competent and trauma-informed, developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. The interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of the residents' care plan) develops the care plan with corresponding interventions for care that is in accordance with professional standards of practice.

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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** 39550 Based on interview and record review, the facility failed to implement the facility's policy on skin assessment as evidenced by failing to ensure reassessments were done timely using the Braden Scale (a standardized tool used to assess a resident's risk for developing pressure ulcer [injury to skin and underlying tissue resulting from prolonged pressure on the skin]) for two of three sampled residents (Resident 2 and Resident 3). This deficient practice had the potential to negatively affect the delivery of care and services to Resident 2 and Resident 3. Findings: a. During a review of Resident 2's Admission Record, the Admission Record indicated the facility originally admitted Resident 2 on 11/1/2023 with diagnoses that included chronic respiratory failure (condition in which not enough oxygen passes from your lungs into your blood), human immunodeficiency virus (HIV- a virus that attacks and weakens the body's immune system), and personal history of sudden cardiac arrest (sudden, unexpected loss of heart function, breathing, and consciousness [state of being awake and aware of one's surroundings]). During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool) dated 11/7/2024, the MDS indicated Resident 2's cognitive skills (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) for daily decision-making was severely impaired. The MDS indicated Resident 2 was dependent on staff with oral hygiene, toileting, and personal hygiene. During a review of Resident 2's Braden Scale document dated 5/14/2024 at 3:10 p.m., the document indicated Resident 2's Braden Scale score was 11, indicating high risk for developing pressure ulcer. During a concurrent interview and record review on 12/30/2024 at 1:19 p.m., with the Director of Staff Development (DSD), reviewed Resident 2's Braden Scale document dated 5/14/2024 at 3:10 p.m. The DSD stated that Braden Scales are done to assess a resident's risk for pressure injury and should be done upon admission and quarterly (every 3 months). The DSD stated that Resident 2's Braden scale was not up to date. Resident 2's Braden scale should have been updated in 8/2024 and 11/2024. b. During a review of Resident 3's Admission Record, the Admission Record indicated the facility originally admitted Resident 3 on 3/27/2024 and readmitted the resident on 7/8/2024 with diagnoses that included sepsis (a life-threatening complication of an infection), acute (sudden) kidney failure (a condition in which the kidneys suddenly cannot filter waste from the blood), morbid (severe) obesity (disorder that involves having too much body fat, which increases the risk of health problems) due to excess calories. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognitive skills for daily decision-making was intact. The MDS indicated Resident 3 required setup or clean-up assistance with eating and was dependent with toileting. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Braden Scale document dated 7/31/2024 at 5:23 p.m., the document indicated Resident 3's Braden Scale score was 15, indicating low risk for developing pressure ulcer. During a concurrent interview and record review on 12/30/2024 at 1:20 p.m., with the DSD, reviewed Resident 3's Braden Scale document dated 7/31/2024 at 5:23 p.m. The DSD stated that Resident 3's Braden Scale was not up to date. The DSD stated that Resident 3's Braden scale should have been updated in 10/2024. The DSD stated although Resident 3's risk for pressure injury is low, things may change which is why an up-to-date Braden Scale is important. During an interview on 12/20/2024 at 2:30 p.m., with the Director of Nursing (DON), the DON stated that Braden Scale is the standardized tool the facility uses to assess residents' risk for pressure injury and are conducted upon residents' admission and quarterly. The DON stated Braden Scale reassessments are important to help monitor skin integrity and risk for pressure injury. The DON stated Braden Scales assist facility staff in formulating the plan of care of residents. During a review of the facility's policy and procedure titled, Skin Assessment, last revised 10/2023, the policy indicated to provide guidelines for routine assessment of resident's skin to maintain skin integrity and promote healing in accordance with standard of practice guidelines. Under guidelines: The licensed nurse completes a head to toe assessment to the resident's skin during admission process through the use of a standardized tool. Quarterly assessments will be used using the standardized assessment tool in accordance with the Resident Assessment Instrument (RAI- a structured assessment tool used to evaluate nursing home residents) guidelines of completion.