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	01/15/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on observation, interview, and record review, the facility failed to ensure the resident ' s call light (a devices used by a resident to signal his/her need for assistance from staff) was answered promptly for one of four sampled residents (Resident 3). This deficient practice had the potential to delay the provision of services and residents' needs not being met. Findings: During a review of Resident 3 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 4/29/2016 and readmitted on [DATE] with diagnoses including angina pectoris (a severe acute attack of cardiac pain), acute respiratory failure (lungs suddenly cannot provide enough oxygen to your blood, making it difficult to breathe and potentially causing your organs to not function properly due to lack of oxygen), and chronic pain syndrome. During a review of Resident 3 ' s Minimum Data Set (MDS - a resident assessment tool) dated 12/1/2024, the MDS indicated the resident ' s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was moderately impaired, and the resident needed total assistance from staff with toileting hygiene, personal hygiene and transfer, and needed maximal assistance with upper/lower body dressing and bed mobility (movement). During a review of Resident 3 ' s care plan (a document that summarizes a resident ' s needs, goals, and care/treatment) created on 9/25/2023, the care plan indicated Resident 3 had activities of daily living (ADL-activities related to personal care) self-care performance deficit (an inability to perform certain daily functions related to health and well-being) related to Resident 3 ' s impaired cognition and physical mobility. The care plan indicated an intervention to encourage Resident 3 to use bell to call for assistance and keep call lights within reach at all times. During a concurrent observation and interview on 1/14/2025 at 1:50 p.m., with Resident 3 in the resident's room, Resident 3 stated she has concerns with the staff ' s response time in answering call lights. Resident 3 stated at one point, she waited for more than an hour for staff to respond to her call light. At 1:52 p.m., observed Resident 3 pressed the call button, however, after five minutes of waiting, no staff came to answer Resident 3 ' s call light. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 - Few	Observed the call light indicator above the doorway of Resident 3 ' s room was on. At 1:58 p.m., during an observation, in Nurse Station 1 (NS 1), observed Certified Nursing Assistant 1 (CNA 1) was sitting and talking with two other staff. Observed the two staff leave NS 1 and CNA 1 went back to working on the computer. Observed the call light panel at the nurse station with two call lights on and alarming including Resident 3 ' call light. During a concurrent observation and interview on 1/14/2025 at 2 p.m., with CNA 1 in NS 1, CNA 1 stated she was aware that there were two call lights that were on, but CNA 1 was documenting at that time. CNA 1 stated she should have answered the residents ' call lights first. CNA 1 then stood up and went to the residents ' rooms to respond to the call lights. During an interview on 1/15/2025 at 4:09 p.m., with the Administrator (ADM), the ADM stated all staff are responsible in answering the resident ' s call lights. The ADM stated the resident ' s call lights should be answered promptly to check if the resident ' s needs are emergent or not. During a review of the facility ' s policy and procedure (P&P), titled Resident Call System, last reviewed on 1/17/2024, the P&P indicated, The facility is adequately equipped to allow residents to call for staff assistance through a communication system To provide staff with a method to respond to the resident ' s request and needs. Based on observation, interview, and record review, the facility failed to ensure the resident's call light (a devices used by a resident to signal his/her need for assistance from staff) was answered promptly for one of four sampled residents (Resident 3). This deficient practice had the potential to delay the provision of services and residents' needs not being met. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated the facility originally admitted the resident on 4/29/2016 and readmitted on [DATE] with diagnoses including angina pectoris (a severe acute attack of cardiac pain), acute respiratory failure (lungs suddenly cannot provide enough oxygen to your blood, making it difficult to breathe and potentially causing your organs to not function properly due to lack of oxygen), and chronic pain syndrome. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 12/1/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was moderately impaired, and the resident needed total assistance from staff with toileting hygiene, personal hygiene and transfer, and needed maximal assistance with upper/lower body dressing and bed mobility (movement). During a review of Resident 3's care plan (a document that summarizes a resident's needs, goals, and care/treatment) created on 9/25/2023, the care plan indicated Resident 3 had activities of daily living (ADL-activities related to personal care) self-care performance deficit (an inability to perform certain daily functions related to health and well-being) related to Resident 3's impaired cognition and physical mobility. The care plan indicated an intervention to encourage Resident 3 to use bell to call for assistance and keep call lights within reach at all times. (continued on next page)

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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 - Few	During a concurrent observation and interview on 1/14/2025 at 1:50 p.m., with Resident 3 in the resident's room, Resident 3 stated she has concerns with the staff's response time in answering call lights. Resident 3 stated at one point, she waited for more than an hour for staff to respond to her call light. At 1:52 p.m., observed Resident 3 pressed the call button, however, after five minutes of waiting, no staff came to answer Resident 3's call light. Observed the call light indicator above the doorway of Resident 3's room was on. At 1:58 p.m., during an observation, in Nurse Station 1 (NS 1), observed Certified Nursing Assistant 1 (CNA 1) was sitting and talking with two other staff. Observed the two staff leave NS 1 and CNA 1 went back to working on the computer. Observed the call light panel at the nurse station with two call lights on and alarming including Resident 3' call light. During a concurrent observation and interview on 1/14/2025 at 2 p.m., with CNA 1 in NS 1, CNA 1 stated she was aware that there were two call lights that were on, but CNA 1 was documenting at that time. CNA 1 stated she should have answered the residents' call lights first. CNA 1 then stood up and went to the residents' rooms to respond to the call lights. During an interview on 1/15/2025 at 4:09 p.m., with the Administrator (ADM), the ADM stated all staff are responsible in answering the resident's call lights. The ADM stated the resident's call lights should be answered promptly to check if the resident's needs are emergent or not. During a review of the facility's policy and procedure (P&P), titled Resident Call System , last reviewed on 1/17/2024, the P&P indicated, The facility is adequately equipped to allow residents to call for staff assistance through a communication system To provide staff with a method to respond to the resident's request and needs.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42275 Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for two of four sampled residents by failing to: 1. Document Resident 1 and Resident 3 ' s blood sugar readings and or insulin administered in the Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). 2. Document Resident 1's blood sugar (BS) reading accurately in the resident's blood sugar summary records. This deficient practice resulted in incomplete resident medical care information for Resident 1 and Resident 3 and placed the residents at risk for not receiving the appropriate care and treatment related to management of diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). Findings: 1.a. During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/31/2024 and readmitted on [DATE] with diagnoses including diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) and dependence on respirator (also known as ventilator dependence, is a serious medical condition that occurs when someone needs a machine to breathe for part or all of the day). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 12/31/2024, the MDS indicated the resident ' s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was moderately impaired, and the resident needed total assistance from staff with toileting hygiene, lower body dressing and chair/bed to-chair transfer, and needed maximal assistance with oral hygiene, upper body dressing, and moderate assistance with bed mobility (movement). During a review of Resident 1 ' s physician order summary report, the following orders dated 12/26/2024, indicated the following: -Insulin Regular Human (IRH - used to help lower blood sugar levels in people with diabetes) injection solution, inject as per sliding scale (SS - the increasing administration of the pre-meal insulin dose based on the blood sugar level before the meal): -If blood sugar (BS) 70 milligrams per deciliter (mg/dl - a unit of measure) - 200 = O, no action; For BS is lower than 70, give juice/snack/oral glucose (simple sugar- the body ' s primary source of energy from food)gel then recheck; (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For BS 201 - 250 = inject one unit of IRH; For BS 251 - 300 = inject two units of IRH; For BS 301 - 350 = inject three units of IRH; For BS 351 - 400 = inject four units of IRH; and For BS greater than 400, call provider, subcutaneously (used to administer medications between skin and muscle) before meals and at bedtime for DM. During a review of Resident 1 ' s MAR for 01/2025, the MAR indicated there were no documented entries (blank) of Resident 1 ' s blood sugar readings or medications administered to Resident 1 on the following dates and times: On 1/6/2025 at 6:30 a.m. On 1/8/2025 at 6:30 a.m. On 1/14/2025 at 6:30 a.m. 1.b. During a review of Resident 3 ' s Admission Record, the Admission Record indicated the facility originally admitted the resident on 4/29/2016 and readmitted on [DATE] with diagnoses including angina pectoris (a severe acute attack of cardiac pain), acute respiratory failure (lungs suddenly can't provide enough oxygen to your blood, making it difficult to breathe and potentially causing your organs to not function properly due to lack of oxygen), and chronic pain syndrome. During a review of Resident 3 ' s History and Physical (H&P) dated 7/17/2024, the H&P indicated the resident had a history of diabetes mellitus. During a review of Resident 3 ' s MDS dated [DATE], the MDS indicated the resident ' s cognitive skills for daily decision making was moderately impaired, and the resident needed total assistance from staff with toileting hygiene, personal hygiene and transfer, and needed maximal assistance with upper/lower body dressing and bed mobility. During a review of Resident 3 ' s physician order summary report, the following orders dated 6/23/2024, indicated the following: Humalog kwikpen subcutaneous solution pen-injector 100 unit/milliliter (Insulin Lispro - used to treat diabetes), inject three units subcutaneously before meals for DM. Insulin Lispro, inject as per sliding scale: If BS 201 - 250 = inject two units of Insulin Lispro; For BS 251 - 300 = inject four units of Insulin Lispro; For BS 301 - 350 = inject six units of Insulin Lispro; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For BS 351 - 400 = inject eight units of Insulin Lispro; and For BS greater than 400 = inject 10 units of Lispro and call the physician, subcutaneously before meals and at bedtime. For BS is lower than 70 and the resident is awake give orange juice/snack, if the resident is unresponsive, give glucagon one milligram intramuscular injection and call the physician, rotate sites, fingerstick BS monitoring four times a day (before meals and at bedtime). During a review of Resident 3 ' s MAR for 01/2025, the MAR indicated there were no documented entries (blank) of Resident 3 ' s blood sugar readings or medications administered to Resident 3 on the following dates and times: On 1/8/2025 at 6:30 a.m. On 1/14/2025 at 6:30 a.m. During a concurrent interview and record review on 1/15/2025 at 12:50 p.m., with the Assistant of Nursing Director (ADON), reviewed Resident 1 and Resident 3 ' s MAR for 01/2025. The ADON stated that there were missing entries of blood sugar readings and licensed nurses ' initials in the MAR. The ADON stated the MAR did not indicate if the residents ' blood sugars were checked and if there were insulin injections administered to the residents on the dates and times with missing entries. During an interview on 1/15/2025 at 3:56 p.m., with Registered Nurse 3 (RN 3), RN 3 stated that some staff from the registry do not have electronic medical records (EMR) access, so RN 3 printed paper MAR for the registry nurses to use. RN 3 stated registry staff gave the paper MAR to RN 3 but RN 3 was unable to recall which nursing supervisor she (RN 3) submitted the paper MAR to. During a review of the facility ' s policy and procedure (P&P) titled Electronic Medical Records last reviewed on 1/17/2024, indicated, When secure access cannot be created for an authorized user, such as temporary personnel or a power outage, maintain paper documentation of medication and treatment administration, physician orders and activities of daily living, 2.a. During a concurrent interview and record review on 1/15/2025 at 1:15 p.m., with the ADON, reviewed Resident 1's Weights and Vitals Summary/Blood Sugar Summary and progress notes dated 12/27/2024. The ADON stated that the residen's BS reading on 12/27/2024 at 8:32 p.m. was 66 milligrams per deciliter (mg/dl, unit of measurement). The ADON stated there was no documentation in Resident 1 's progress note on 12/27/2024, that Licensed Vocational Nurse 3 (LVN 3) took a nursing action to implement the protocol for low blood sugar or notified the resident ' s physician. The ADON stated that the protocol for low blood sugar was to implement the physician orders and notify the physician. The ADON stated it was important to notify the physician of the resident 's low blood sugar even if the resident 's blood sugar has returned to normal after an intervention, because the physician may change the plan of care by adjusting the resident ' s medication to treat DM. The ADON further stated that if LVN 3 made a mistake in documentation, it should be corrected by documenting the correct BS reading because an incorrect information can affect the resident ' s plan of care related to management of DM. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/15/2025 at 3 p.m., with LVN 3, reviewed Resident 1's Weights and Vitals Summary/Blood Sugar Summary dated 12/27/2024 that indicated the resident's blood sugar reading was 66 mg/dl on 12/27/2024 at 8:32 p.m. LVN 3 stated she made an error in her documentation. LVN 3 stated it was important to document blood sugar readings correctly in order to provide continuity of care and promote resident safety. During a review of the facility ' s P&P, titled Documentation Policy last reviewed on 1/17/2024, indicated, It is the policy of this facility to document relevant findings in the clinical record This facility utilizes assessment sheets, flow sheets, progress notes, care plans and other mandated assessments as required by State and Federal Regulations . Errors in the clinical record shall be made by a single line strikethrough with the individual ' s initials and the word error. Error corrections must never be obliterated. The error must still be legible. Based on interview and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for two of four sampled residents by failing to: 1. Document Resident 1 and Resident 3's blood sugar readings and or insulin administered in the Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). 2. Document Resident 1's blood sugar (BS) reading accurately in the resident's blood sugar summary records. This deficient practice resulted in incomplete resident medical care information for Resident 1 and Resident 3 and placed the residents at risk for not receiving the appropriate care and treatment related to management of diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). Findings: 1.a. During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/31/2024 and readmitted on [DATE] with diagnoses including diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) and dependence on respirator (also known as ventilator dependence, is a serious medical condition that occurs when someone needs a machine to breathe for part or all of the day). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/31/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was moderately impaired, and the resident needed total assistance from staff with toileting hygiene, lower body dressing and chair/bed to-chair transfer, and needed maximal assistance with oral hygiene, upper body dressing, and moderate assistance with bed mobility (movement). During a review of Resident 1's physician order summary report, the following orders dated 12/26/2024, indicated the following: (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Insulin Regular Human (IRH - used to help lower blood sugar levels in people with diabetes) injection solution, inject as per sliding scale (SS - the increasing administration of the pre-meal insulin dose based on the blood sugar level before the meal): -If blood sugar (BS) 70 milligrams per deciliter (mg/dl - a unit of measure) - 200 = O, no action; For BS is lower than 70, give juice/snack/oral glucose (simple sugar- the body's primary source of energy from food)gel then recheck; For BS 201 - 250 = inject one unit of IRH; For BS 251 - 300 = inject two units of IRH; For BS 301 - 350 = inject three units of IRH; For BS 351 - 400 = inject four units of IRH; and For BS greater than 400, call provider, subcutaneously (used to administer medications between skin and muscle) before meals and at bedtime for DM. During a review of Resident 1's MAR for 01/2025, the MAR indicated there were no documented entries (blank) of Resident 1's blood sugar readings or medications administered to Resident 1 on the following dates and times: On 1/6/2025 at 6:30 a.m. On 1/8/2025 at 6:30 a.m. On 1/14/2025 at 6:30 a.m. 1.b. During a review of Resident 3's Admission Record, the Admission Record indicated the facility originally admitted the resident on 4/29/2016 and readmitted on [DATE] with diagnoses including angina pectoris (a severe acute attack of cardiac pain), acute respiratory failure (lungs suddenly can't provide enough oxygen to your blood, making it difficult to breathe and potentially causing your organs to not function properly due to lack of oxygen), and chronic pain syndrome. During a review of Resident 3's History and Physical (H&P) dated 7/17/2024, the H&P indicated the resident had a history of diabetes mellitus. During a review of Resident 3's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was moderately impaired, and the resident needed total assistance from staff with toileting hygiene, personal hygiene and transfer, and needed maximal assistance with upper/lower body dressing and bed mobility. During a review of Resident 3's physician order summary report, the following orders dated 6/23/2024, indicated the following: (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Humalog kwikpen subcutaneous solution pen-injector 100 unit/milliliter (Insulin Lispro - used to treat diabetes), inject three units subcutaneously before meals for DM. Insulin Lispro, inject as per sliding scale: If BS 201 - 250 = inject two units of Insulin Lispro; For BS 251 - 300 = inject four units of Insulin Lispro; For BS 301 - 350 = inject six units of Insulin Lispro; For BS 351 - 400 = inject eight units of Insulin Lispro; and For BS greater than 400 = inject 10 units of Lispro and call the physician, subcutaneously before meals and at bedtime. For BS is lower than 70 and the resident is awake give orange juice/snack, if the resident is unresponsive, give glucagon one milligram intramuscular injection and call the physician, rotate sites, fingerstick BS monitoring four times a day (before meals and at bedtime). During a review of Resident 3's MAR for 01/2025, the MAR indicated there were no documented entries (blank) of Resident 3's blood sugar readings or medications administered to Resident 3 on the following dates and times: On 1/8/2025 at 6:30 a.m. On 1/14/2025 at 6:30 a.m. During a concurrent interview and record review on 1/15/2025 at 12:50 p.m., with the Assistant of Nursing Director (ADON), reviewed Resident 1 and Resident 3's MAR for 01/2025. The ADON stated that there were missing entries of blood sugar readings and licensed nurses' initials in the MAR. The ADON stated the MAR did not indicate if the residents' blood sugars were checked and if there were insulin injections administered to the residents on the dates and times with missing entries. During an interview on 1/15/2025 at 3:56 p.m., with Registered Nurse 3 (RN 3), RN 3 stated that some staff from the registry do not have electronic medical records (EMR) access, so RN 3 printed paper MAR for the registry nurses to use. RN 3 stated registry staff gave the paper MAR to RN 3 but RN 3 was unable to recall which nursing supervisor she (RN 3) submitted the paper MAR to. During a review of the facility's policy and procedure (P&P) titled Electronic Medical Records last reviewed on 1/17/2024, indicated, When secure access cannot be created for an authorized user, such as temporary personnel or a power outage, maintain paper documentation of medication and treatment administration, physician orders and activities of daily living, (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.a. During a concurrent interview and record review on 1/15/2025 at 1:15 p.m., with the ADON, reviewed Resident 1's Weights and Vitals Summary/Blood Sugar Summary and progress notes dated 12/27/2024. The ADON stated that the residen's BS reading on 12/27/2024 at 8:32 p.m. was 66 milligrams per deciliter (mg/dl, unit of measurement). The ADON stated there was no documentation in Resident 1's progress note on 12/27/2024, that Licensed Vocational Nurse 3 (LVN 3) took a nursing action to implement the protocol for low blood sugar or notified the resident's physician. The ADON stated that the protocol for low blood sugar was to implement the physician orders and notify the physician. The ADON stated it was important to notify the physician of the resident's low blood sugar even if the resident's blood sugar has returned to normal after an intervention, because the physician may change the plan of care by adjusting the resident's medication to treat DM. The ADON further stated that if LVN 3 made a mistake in documentation, it should be corrected by documenting the correct BS reading because an incorrect information can affect the resident's plan of care related to management of DM. During a concurrent interview and record review on 1/15/2025 at 3 p.m., with LVN 3, reviewed Resident 1's Weights and Vitals Summary/Blood Sugar Summary dated 12/27/2024 that indicated the resident's blood sugar reading was 66 mg/dl on 12/27/2024 at 8:32 p.m. LVN 3 stated she made an error in her documentation. LVN 3 stated it was important to document blood sugar readings correctly in order to provide continuity of care and promote resident safety. During a review of the facility's P&P, titled Documentation Policy last reviewed on 1/17/2024, indicated, It is the policy of this facility to document relevant findings in the clinical record This facility utilizes assessment sheets, flow sheets, progress notes, care plans and other mandated assessments as required by State and Federal Regulations . Errors in the clinical record shall be made by a single line strikethrough with the individual's initials and the word error. Error corrections must never be obliterated. The error must still be legible.