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	02/19/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) by Resident 2 for one of two sampled residents (Resident 1). On 2/2/2025, Certified Nursing Assistant 1 (CNA 1) witnessed Resident 2 punch Resident 1 with a closed fist, three times on the left side of Resident 1's chest. This deficient practice resulted in Resident 1 being subjected to physical abuse by Resident 2 while under the care of the facility. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 1/9/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), chronic respiratory failure (condition in which not enough oxygen passes from your lungs into your blood), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/8/2025, the MDS indicated Resident 1 had intact cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS also indicated Resident 1 required set up or clean up assistance with eating, and is dependent with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 1's Change of Condition (COC- a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) Evaluation dated 2/2/2025, the COC indicated the resident (Resident 1) was going to the kitchen, another resident (Resident 2) was passing by, and hit her (Resident 1) three times on her left upper chest area and immediately separated by Certified Nursing Assistant (CNA). The COC indicated Resident 1 complained of pain to area (left upper chest) due to hit. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted the resident on 5/13/2022 and readmitted the resident on 8/5/2023 with diagnoses that included bipolar disorder (mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks), paranoid personality disorder (mental health condition marked by a long-term pattern of distrust and suspicion of others without adequate reason), and schizoaffective disorder (a mental health condition that includes features of both schizophrenia [serious mental illness that affects how a person thinks, feels, and behaves] and a mood disorder [marked disruptions in emotions]). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had severely impaired cognition. The MDS also indicated Resident 2 required supervision or touching assistance with eating and oral hygiene, dependent with toileting hygiene, and required substantial/maximal assistance (helper does more than half the effort) with personal hygiene. During a review of Resident 2's COC Evaluation dated 2/2/2015, the COC indicated the resident (Resident 2) was passing by another resident (Resident 1) and hit the other resident (Resident 1) three (3) times on the left upper chest. During an interview on 2/18/2025 at 10:53 a.m., with CNA 1, CNA 1 stated that on Sunday 2/2/2025 around lunch time, CNA 1 was near Station 2's restroom when CNA 1 heard Resident 1 yell, No, no, no. When CNA 1 turned around, CNA 1 witnessed Resident 1 covering herself while Resident 2 punched Resident 1 with Resident 2's closed fist three times on Resident 1's left chest. During an interview on 2/18/2025 at 11:22 a.m., with the Activities Director (AD), the AD stated that on 2/2/2025 at around lunch time, the AD was informed by CNA 1 that CNA 1 witnessed Resident 1 covering herself while Resident 2 punched Resident 1 with Resident 2's closed fist three times to Resident 1's left chest. The AD continued to state that she reported the incident to the Administrator and Resident 2 was placed on a one-to-one monitoring (situation where a healthcare worker is assigned to constantly observe and monitor a single resident, maintaining close proximity at all times) for other residents' safety. During a follow-up interview on 2/18/2025 at 2:12 p.m., with CNA 1, CNA 1 stated that Resident 2 was angry on 2/2/2025 while Resident 2 was hitting Resident 1. CNA 1 stated that Resident 2's face looked angry because her forehead was wrinkled, and her face was red while hitting Resident 1 with a closed fist. CNA 1 further stated that she reported Resident 2's aggression to the AD because residents are not supposed to hit another resident. CNA 1 stated that she reported Resident 2 hitting Resident 1 to the AD because it was physical abuse. During an interview on 2/18/2025 at 2:57 p.m., with Resident 1, Resident 1 stated that Resident 2 and Resident 1 were facing the opposite side in the hallway near Station 2. Resident 1 stated as Resident 2 was passing Resident 1, Resident 2 started to punch Resident 1's left chest three times. Resident 1 stated the punches were painful. During an interview on 2/18/2025 at 3:39 p.m., with Registered Nurse 2 (RN 2), RN 2 stated that Resident 2 punching Resident 1 is physical abuse because there should not be any resident-to-resident punching in the facility. During an interview on 2/19/2025 at 11:54 a.m., with the Assistant Director of (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (ADON), the ADON stated that the incident between Resident 1 and Resident 2 is physical abuse because of Resident 2's aggressive behavior of punching Resident 1. The ADON stated hitting of any kind is unacceptable in the facility. The ADON stated that Resident 2's behavior is assault. The ADON continued to state that the incident was avoidable if Resident 2's aggressive behavior was addressed and/or monitored. During a review of the facility's policy and procedure titled, Abuse, Neglect (fail to care properly), and Exploitation (taking advantage of a resident) of Residents & Property, reviewed in 3/2023, the policy indicated the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Physical abuse: Includes hitting slapping, punching, and kicking.

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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. 39550 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a written course of action that helps a resident achieve outcomes that improve their quality of life) for one of two sampled residents (Resident 1), who had a new onset of pain on 2/2/2025. 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 admitted Resident 1 on 1/9/2024 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), chronic respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in the body), unspecified severe protein-calorie malnutrition, major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/8/2025, the MDS indicated Resident 1 had intact cognition. The MDS also indicated Resident 1 required set up or clean up assistance with eating, and is dependent with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 1 ' s Change in Condition (COC- a significant change in resident ' s health status) Evaluation, dated 2/2/2025, timed at 1:11 p.m., the COC indicated as Resident 1 was heading to the kitchen, another resident passed by, and hit Resident 1 three times on the left upper chest area. The residents were immediately separated by CNA (Certified Nursing Assistant). Resident 1 reported pain level of 8, due to being hit by another resident. During a review and concurrent record review on 2/18/2025 at 11:03 a.m. with Registered Nurse 1 (RN 1), RN 1 reviewed Resident 1 ' s care plans and stated that there was no care plan created addressing Resident 1 ' s new onset of left chest pain. RN 1 stated that Resident 1 should have a specific care plan for Resident 1 ' s new onset of left chest pain so that the facility staff can monitor Resident 1 ' s pain to make sure the pain does not get worse. During a review of the facility ' s policy and procedure titled Develop-Implement Comprehensive Care Plans, revised 3/2023, the policy and procedure indicated the facility develops a person-centered comprehensive care plan 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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 39550 Based on interview and record review, the facility failed to monitor a resident for 72 hours after a Change of Condition (COC- sudden deviation from a resident ' s baseline in physical, cognitive [involving the processes of thinking and reasoning], behavioral, or functional domains) for one of two sampled residents (Resident 1) as indicated in the facility policy. This deficient practice had the potential to place the resident at risk of not receiving appropriate care due to the lack of monitoring and had the potential to negatively affect the resident ' s psychosocial (the mental, emotional, social, and spiritual effects of a disease) well-being and delay in attaining the resident ' s highest practicable mental and psychosocial well-being. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 1/9/2024 with diagnoses that including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), chronic respiratory failure (a condition where there's not enough oxygen or too much carbon dioxide in the body), unspecified severe protein-calorie malnutrition, major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/8/2025, the MDS indicated Resident 1 had intact cognition. The MDS also indicated Resident 1 required set up or clean up assistance with eating, and is dependent with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 1 ' s Change in Condition (COC- a significant change in resident ' s health status) Evaluation, dated 2/2/2025, timed at 1:11 p.m., the COC indicated as Resident 1 was heading to the kitchen, another resident passed by, and hit Resident 1 three times on the left upper chest area. The residents were immediately separated by CNA (Certified Nursing Assistant). Resident 1 reported pain level of 8, due to being hit by another resident. During a review and concurrent record review on 2/18/2025 at 11:11 a.m. with Registered Nurse 1 (RN 1), RN 1 stated that after a COC licensed nurses are to monitor residents every shift for 72 hours. RN 1 reviewed Resident 1 ' s nursing progress notes from 2/2/2025-2/5/2025. RN 1 stated that there is no documented evidence of licensed nurses monitoring of Resident 1 ' s COC from 2/3/2025-2/5/2025. RN 1 stated that nursing staff should have documented monitoring for Resident 1 ' s COC to ensure Resident 1 ' s safety and to ensure Resident 1 ' s psychosocial wellbeing. During an interview on 2/19/2025 at 11:13 a.m., with the Assistant Director of Nursing (ADON), the ADON stated that after a resident ' s COC licensed nurses should monitor the resident every shift for 72 hours. The ADON stated that monitoring should been done and documented for Resident 1 to make sure that Resident 1 felt safe with no further injuries. The ADON stated that it is traumatizing to be hit by someone. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure titled, Documentation Policy, revision date 11/2024, the policy indicated it is the policy of this facility to document relevant findings in the clinical record. The policy further indicated 72-hour charting shall be initiated at the following times: a. a significant change in physical, mental, or psychosocial status of the resident. 72-hour charting shall be once daily and me completed more frequently at the nurses ' discretion.

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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 0697 Level of Harm - Minimal harm or potential for 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** 39550 Based on interview and record review, the facility failed to implement the facility's policy on pain assessments as evidenced by failing to ensure a pain assessment was completed quarterly (every three months) and for new onset of pain on 2/2/2025 for one of two sampled residents (Resident 1). This deficient practice had the potential to result in Resident 1 not maintaining Resident 1's highest possible level of comfort. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 1/9/2024 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), chronic respiratory failure (condition in which not enough oxygen passes from your lungs into your blood), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/8/2025, the MDS indicated Resident 1 had intact cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS also indicated Resident 1 required set up or clean up assistance with eating, and is dependent with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 1's Change of Condition (COC- a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) Evaluation dated 2/2/2025, the COC indicated the resident (Resident 1) was going to the kitchen, another resident (Resident 2) was passing by, and hit her (Resident 1) three times on her left upper chest area and immediately separated by Certified Nursing Assistant (CNA). The COC indicated Resident 1 complained of pain to area (left upper chest) due to hit. The COC indicated Resident 1 had a pain level of eight (8) out of 10 (numerical scale used to measure pain with 0 being no pain and 10 being the worst pain). During a concurrent interview and record review on 2/19/2025 at 11:00 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 1's pain assessments from 10/8/2024 to 2/19/2025. The ADON stated that pain assessments should be done upon admission, quarterly, annually, and during a change of condition. The ADON reviewed Resident 1's pain assessments and stated that the last pain assessment documented was on 10/8/2024 at 11:45 a.m. The ADON stated that Resident 1's pain assessment should have been done four (4) months after 10/2024 and on the day of the COC, 2/2/2025. The ADON further stated that the MDS nurse is responsible for the quarterly and annual pain assessments while the assigned charge nurse is responsible for the pain assessment during a COC. The ADON continued to state that a pain assessment should have done on 2/2/2025 for Resident 1's new onset of pain to Resident 1's left chest. The ADON stated pain assessments are important to be done to make sure Resident 1's new onset of pain is monitored. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/19/2025 at 12:33 p.m., with the MDS Nurse (MDSN), reviewed Resident 1's pain assessments from 10/8/2024 to 2/19/2025. The MDSN stated that pain assessments are done by the Registered Nurse Supervisor upon admission and for a COC and the MDSN is responsible to conduct pain assessments quarterly and annually during residents' comprehensive assessments. The MDSN reviewed Resident 1's pain assessments and stated that Resident 1 has a quarterly pain assessment dated [DATE] and Resident 1 should have had an annual pain assessment completed on 1/8/2025. The MDS continued to state that the MDSN missed the annual comprehensive pain assessment due on 1/8/2025 and it should have been done. During a review of the facility's policy and procedure titled, Pain Assessment and Management, revised date 3/2023, the policy indicated the purposes of this procedure are to help the staff identify pain in the resident and develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. The policy further indicated to conduct a comprehensive pain assessment upon admission to the facility, at the quarterly review, whenever there is a significant change in condition and when there is onset of new pain or worsening of existing pain.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 39550 Based on interview and record review, the facility failed to ensure a resident's attending physician documented a resident's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) annually for one of two sampled residents (Resident 2). This deficient practice had the potential for inconsistent care coordination due to incomplete records for Resident 2. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted the resident on 5/13/2022 and readmitted the resident on 8/5/2023 with diagnoses that included bipolar disorder (mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks), paranoid personality disorder (mental health condition marked by a long-term pattern of distrust and suspicion of others without adequate reason), and schizoaffective disorder (a mental health condition that includes features of both schizophrenia [serious mental illness that affects how a person thinks, feels, and behaves] and a mood disorder [marked disruptions in emotions]). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 11/14/2024, the MDS indicated Resident 2 had severely impaired cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS also indicated Resident 2 required supervision or touching assistance with eating and oral hygiene, dependent with toileting hygiene, and required substantial/maximal assistance (helper does more than half the effort) with personal hygiene. During a concurrent interview and record review on 2/18/2025 at 3:56 p.m., with the Medical Records Director (MRD), reviewed Resident 2's medical records in regard to H&Ps. The MRD stated that residents' H&Ps should be completed and documented within 72 hours of admission and annually. The MRD reviewed Resident 2's medical records and stated that the latest H&P is dated 8/7/2023 at 11:19 a.m. and stated that Resident 2 does not have an updated H&P. During an interview on 2/19/2025 at 11:15 a.m., with the Assistant Director of Nursing (ADON), the ADON stated that it is important for the physician to document a current H&P within 72 hours of a new admission and annually so that the facility has updated interventions needed to be addressed for each resident. The ADON stated that Resident 2's physician has been in the facility however does not know why Resident 2 does not have an updated H&P. During a review of the facility's policy and procedure titled, Physician's Visits, revised date 3/2023, the policy indicated the physician must review the resident's total program of care, including medications and treatments during each required visit. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Documentation Policy, revised date 11/2024, the policy indicated it is the policy of this facility to document relevant findings in the clinical record.