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	05/16/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 42275 Based on observation, interview, and record review, the facility failed to provide materials to facilitate communication for a resident with speech disabilities for one of four sampled residents (Resident 1). This deficient practice had the potential to prevent the resident from communicating with the staff and had the potential to delay receiving care/treatment the resident needed. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 5/27/2021 and readmitted the resident on 5/12/2025 with diagnoses including intracerebral (within the brain) hemorrhage (the dramatic and sudden loss of blood), seizure (a sudden, temporary disruption in brain electrical activity that can cause involuntary changes in body movement, behavior, sensation, or awareness), and gastrostomy (the creation of an artificial external opening into the stomach for nutritional support) with dysphagia (difficulty swallowing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/10/2025, the MDS indicated Resident 1's speech was unclear such as slurred or mumbled words and 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 severely impaired. The MDS further indicated that the resident was dependent on staff with oral/toileting/personal hygiene and upper/lower body dressing and needed maximal assistance from staff with bed mobility (movement). During a review of Resident 1's General Acute Care Hospital (GACH) Skilled Nursing Facility Transfer Orders (SNFTO) dated 5/12/2025, the SNFTO indicated dysphasia was included in active problems in the physician report. (continued on next page)

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/16/2025 at 8:38 a.m., with Certified Nursing Assistant 1 (CNA 1) and Registered Nurse 1 (RN 1) in Resident 1's room, observed Resident 1 lying in bed coughing and pointing to his (Resident 1) mouth area but unable to describe what Resident 1 needed. CNA 1 stated that Resident 1 was able to answer 'yes' or 'no' to questions but was unable to request what Resident 1 needed verbally. When CNA 1 was asked if they had a communication board or some tools to communicate with Resident 1, CNA 1 stated that there were no communication boards or tools in Resident 1's room. When RN 1 was asked how RN 1 communicated with Resident 1, RN 1 stated that Resident 1 was not able to talk and state what he needed. RN 1 stated if a communication board was available then it would be helpful to figure out what Resident 1 wanted, but RN 1 could not tell what Resident 1 wanted at that moment. During an interview on 5/16/2025 at 12:57 p.m., with the Director of Nursing (DON), the DON stated that Resident 1's general conditions had been declining including verbal expressions, so, Resident 1 should have a communication board or any written assistive communication tools because Resident 1 was not able to express his needs. The DON further stated that the Social Services Department was informed to assess Resident 1 and place a communication tool in his room. During a review of the facility's policy and procedure (P&P) titled, Communication Barriers, last reviewed on 1/8/2025, the P&P indicated, To facilitate communication and ensure equal opportunity to service and activities for residents with hearing, visual and speech disabilities During admission, Facility Staff will conduct a communication assessment and will notify the Social Services Department of the resident's need for communication assistance services When a resident identifies as a person with a disability that affect the ability to communicate or to access or manipulate written materials . the Facility Staff will collaborate with the resident to determine what aids or services are necessary to provide effective communication.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42275 Based on interview and record review, the facility failed to ensure a licensed nurse documented the administration of levetiracetam (a medication used to treat seizures [a sudden, temporary disruption in brain electrical activity that can cause involuntary changes in body movement, behavior, sensation, or awareness]) on the Medication Administration Record (MAR- a report detailing the medications administered to a resident by a healthcare professional) after administering the medication to one of one sampled resident (Resident 1). This deficient practice had the potential to result in medication errors and had the potential to result in confusion on the delivery of care and services. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 5/27/2021 and readmitted the resident on 5/12/2025 with diagnoses including intracerebral (within the brain) hemorrhage (the dramatic and sudden loss of blood), seizure, and gastrostomy (the creation of an artificial external opening into the stomach for nutritional support) with dysphagia (difficulty swallowing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 3/10/2025, the MDS indicated Resident 1's speech was unclear such as slurred or mumbled words and 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 severely impaired. The MDS further indicated that the resident was dependent on staff with oral/toileting/personal hygiene and upper/lower body dressing and needed maximal assistance from staff with bed mobility (movement). During a review of Resident 1's Order Summary Report dated 4/1/2025, the Order Summary Report indicated an order to give levetiracetam (a medication used to treat seizures) oral solution 100 milligram (mg - a unit of measurement)/milliliter (ml - a unit of measurement) five (5) ml by mouth two times a day for seizure disorder. During a review of Resident 1's Electronic Medication Administration Record (EMAR) Resident Details (MAR audit records) for levetiracetam five (5) ml for the periods of 4/1/2025 to 4/24/2025, the EMAR Resident Details indicated the following: 1. On 4/1/2025, scheduled for 9 a.m., documented at 10:06 a.m. 2. On 4/2/2025, scheduled for 9 a.m., documented at 10:59 a.m. 3. On 4/6/2025, scheduled for 5 p.m., documented at 6:42 p.m. 4. On 4/7/2025, scheduled for 5 p.m., documented at 8:36 p.m. 5. On 4/8/2025, scheduled for 5 p.m., documented at 7:29 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On 4/14/2025, scheduled for 5 p.m., documented at 8:07 p.m. 7. On 4/15/2025, scheduled for 9 a.m., documented at 10:47 a.m. 8. On 4/17/2025, scheduled for 5 p.m., documented at 7:25 p.m. During a concurrent interview and record review on 5/16/2025 at 2:40 p.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 1's EMAR Resident Details for levetiracetam administered by LVN 1 on 4/7/2025 at 8:36 p.m., 4/8/2025 at 7:29 p.m., 4/14/2025 at 8:07 p.m., and 4/17/2025 at 7:25 p.m. LVN 1 stated that LVN 1 should document right after administering medications and LVN 1 was aware that the licensed nurses have a window time of one hour before and after from the scheduled time to administer medications. LVN 1 stated all the medications were given in a timely manner, but some days she (LVN 1) documented later to save time to give the medications on time. LVN 1 further stated that it should not be that way and was not able to prove what time the medications were given because she documented late. During a phone interview on 5/16/2025 at 3:15 p.m., with Registered Nurse 2 (RN 2), RN 2 was informed that Resident 1's EMAR Resident Details indicated that RN 2 administered levetiracetam five (5) ml to Resident 1 on 4/15/2025 at 10:47 a.m. for the 9 a.m. scheduled levetiracetam. RN 2 stated that it was given in the window time of 8 a.m. to 10 a.m., but there was probably something that came up so RN 2 was not able to document right after giving the medication. RN 2 further stated that he (RN 2) should document right after giving the medication. During an interview on 5/16/2025 at 4:12 p.m., with the Director of Nursing (DON), the DON stated that the license nurses should document right after administering medications, otherwise there would be confusion regarding the medication administration time and unable to prove that the medications were given at the right time as scheduled. During a review of the facility's policy and procedure (P&P) titled, Medication Administration-General Guideline, last reviewed 1/8/2025, the P&P indicated, The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions Medications are administered within 60 minutes of scheduled time, except before, with or after meal orders, which are administered based on mealtimes. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility.