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	11/20/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement infection control practices by failing to:1. Ensure Restorative Nursing Assistant 1 [RNA 1]) had not worn long artificial fingernails according to facility policy while providing direct resident care for one of five sampled residents (Resident 1).2. Ensure one of 12 sampled staff (Janitor 1) wore gloves while collecting and discarding trash bags and performed hand hygiene (cleaning hands by either washing with soap and water, or by using a hand sanitizing gel) after handling and discarding trash bags.3. Ensure two of 12 sampled staff (Certified Occupational Therapy Assistant 1 [COTA 1] and RNA 2) wore N95 masks (a disposable face mask that covers the user's nose and mouth which offers protection from small solid or liquid droplets found in the air) properly, covering their nose and mouth while in resident care areas during a Coronavirus disease-2019 (COVID-19, a highly contagious viral infection that can trigger respiratory tract infection) outbreak (OB - when more people than usual get sick with a particular disease in a specific area over a certain time period).These deficient practices had the potential to result in the spread of infection placing residents, staff, and visitors at risk of being infected with germs including COVID-19.Findings:1. During a review of Resident 1's admission Record, the admission Record indicated that the facility admitted Resident 1 on 7/29/2024 with diagnoses including cerebral infarction (a serious medical condition that occurs when blood flow to the brain is blocked, leading to brain cell death) and tracheostomy (a surgical procedure that creates an opening in the trachea [windpipe] to allow air to enter the lungs when the natural airway is blocked) status. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 7/25/2025, the MDS indicated that Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was severely impaired. The MDS further indicated that Resident 1 was dependent on staff with activities of daily living (ADLs-activities related to personal care).During a concurrent observation and interview on 9/26/2025 at 2:55 p.m., with RNA 1 and Resident 1, observed RNA 1 reposition Resident 1's body and brought Resident 1 to the lobby area. Observed that RNA 1 did not wear gloves while repositioning and assisting Resident 1. Observed that RNA 1 wore long artificial nails.During a concurrent observation and interview on 9/26/2025 at 3:05 p.m., with RNA 1, the Infection Control Preventionist (ICP), and the Director of Nursing (DON), when asked why health care workers who provide direct care to the residents should not wear artificial nails, RNA 1 stated that there were germs under the fingernails and it was against infection control. The DON stated that nursing staff were not permitted to wear artificial nails or have long fingernails due to safety reasons that included infection control prevention. The DON stated it was hard to remove and disinfect germs underneath artificial nails or long fingernails. The ICP measured RNA 1's fingernails from the tip of RNA 1's finger, and was observed with a length of 0.8 centimeters (cm - a unit of length measurement).During a review of the facility's policy and procedure (P&P) titled, Artificial Nails, revised 9/17/2025, the P&P indicated, To provide guidelines to minimize the risk of infection transmission by nails. Nail Length: The facility prefers fingernails to be maintained clean, healthy, and no longer than approximately a quarter inch (=0.635 cm) or less beyond the tip of the finger. Long nails, both artificial and natural, harbor more microorganism than short nails. Numerous studies validate the increased number of bacteria cultured (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

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	11/20/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from the fingertips of persons wearing artificial nails, both before and after hand washing. Outbreaks of infections have been traced to the artificial fingernails of healthcare workers. 2. During an observation on 9/26/2025 at 3:44 p.m., observed Janitor 1 handling trash bags by collecting the trash bags from the hamper to the transport cart without using gloves in Hallway 1 and discarded the trash bags with bare hands into the trash bin placed outside the facility building. Janitor 1 came into the building without performing hand hygiene then went to Hallway 2 and touched the trash hamper to collect a trash bag with his bare hands.During an interview on 9/26/2025 at 4:15 p.m., with the ICP, the ICP stated that Janitor 1 should have worn gloves when handling the trash bags and should have done hand hygiene in between his activities while handling the trash bags and before touching other objects.During a concurrent interview on 9/30/2025 at 11:55 a.m., with the ICP and the DON, the ICP stated that the facility provided a one-on-one in-service (training intended for those actively engaged in a profession or activity) already to Janitor 1 for infection control. The DON stated that staff should prevent cross contamination (the transfer of harmful germs or other microorganisms from one substance to another) while providing resident care or services.During a review of the facility's P&P titled, Infection Prevention and Control Program, revised 9/17/2025, the P&P indicated, The ensure the facility has establishes and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with federal and state requirements.During a review of the facility's P&P titled, Hand Hygiene, revised 9/17/2025, the P&P indicated, The Facility considers hand hygiene the primary means to prevent the spread of infections.3. During an interview on 9/26/2025 at 2:17 p.m., with the ICP, the ICP stated that as of 9/26/2025, there were a total of 17 residents and one staff with confirmed COVID-19 and the OB was still ongoing.a. During a concurrent observation and interview on 9/26/2025 at 2:48 p.m., in the rehabilitation room, observed COTA 1 sitting at the table and documenting with her (COTA 1) N95 mask hanging under her chin. COTA 1 was asked if she (COTA 1) was aware of an ongoing COVID-19 OB in the facility and COTA 1 stated that she was not with any resident at that moment and she just finished drinking and about to wear her N95 mask. When COTA 1 was informed that she was not drinking and documenting at the table without wearing a N95 properly in the resident care area, COTA 1 stated that she should have worn the N95 properly.b. During a concurrent observation and interview on 9/26/2025 at 2:51 p.m., in the ADL Therapy room, observed RNA 2 sitting at the table and documenting and with her (RNA 2) N95 mask hanging under her chin. RNA 2 was asked if she was aware of an ongoing COVID-19 OB in the facility and RNA 2 stated that she was aware and received instructions to wear the N95 mask at all times. RNA 2 stated RNA 2 forgot to put on the N95 mask after drinking water. When RNA 2 was asked why staff should wear a N95 mask while staying in the resident care area, RNA 2 stated it was to protect her and the residents from COVID-19.During an interview on 9/26/2025 at 5:10 p.m., with the Administrator (ADM), the ADM stated that during a COVID-19 OB, all facility staff should wear well-fitting N95 masks in the resident care areas to prevent the spread of germs.During an interview on 9/30/2025 at 11:50 a.m., with the DON, the DON stated that staff should wear well-fitted masks that cover their nose and mouth and completely cover their chin with N95 masks in the resident care areas because the facility has an ongoing COVID-19 OB.During a review of the facility's P&P titled, Communicable Disease - Outbreak, revised 9/17/2025, the P&P indicated, To ensure that outbreaks of communicable disease are identified and handled as required. Outbreaks of communicable diseases within the facility are promptly identified and appropriately treated and reported.During a review of the Centers for Disease Control and Prevention (CDC) Guidelines titled, Infection Control Guidance: SARS-CoV-2, dated 6/24/2024, it indicated, This guidance applies to all United States settings where healthcare is delivered, including nursing homes and home health. The recommendations in this guidance continue to apply after the expiration of the federal COVID-19 Public Health Emergency (PHE - a crisis that threatens the health of many people, like a new disease outbreak) . Source control options for Health care personnel included a well-fitting facemask.