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	12/05/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident assessment accurately reflected the residents' status for one (1) out of three (3) sampled residents (Resident 1).This deficient practice had the potential to lead to a delay or lack of delivery of care and services for Resident 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD - a lung disease that causes obstructed airflow from the lungs, making it hard to breathe), type 2 diabetes mellitus (condition in which the body doesn't use insulin properly, resulting in unusual blood sugar levels), and urinary tract infection (UTI - an infection in the bladder [muscular organ that stores urine] or urinary tract [refers to the system of organs that produce, store, and excrete urine]). During a review of Resident 1's Skilled Nursing Facility admission History and Physical, dated 9/22/2025, the Skilled Nursing Facility admission History and Physical indicated Resident 1 can make needs known, but does not have full capacity to make complex medical decisions. Resident 1's Skilled Nursing Facility admission History and Physical also indicated Resident 1 had a deep tissue injury (DTI- a pressure-related injury to underlying soft tissues that starts with discoloration, such as a deep red, maroon, or purple area under intact skin, often described as looking like a bruise) on his (Resident 1) right heel. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/26/2025, the MDS indicated Resident 1 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS also indicated Resident 1 had adequate hearing and no deep tissue injuries. During a review of Resident 1's Wound Weekly Monitoring Assessment, dated 9/21/2025, the Wound Weekly Monitoring Assessment indicated Resident 1 had a suspected deep tissue injury to the right heel. During an interview on 10/15/2025 at 3:50 p.m. with the Assistant Administrator (AADM), the AADM stated Resident 1 was very hard of hearing and had recently lost his hearing aids which the facility was in the process of having replaced. The AADM stated in order for Resident 1 to hear you, you had to speak closely into his (Resident 1) left ear. During an interview on 10/15/2025 at 4:03 p.m. with Resident 1, Resident 1 stated, I can't hear you unless you speak into this (left) ear. Resident 1 stated he has hearing aids but has not been able to find them. During an interview on 10/16/2025 at 3:30 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated she was the treatment nurse for Resident 1. LVN 1 stated Resident 1 was currently being treated for two main skin conditions that he was admitted with: a stage 4 pressure ulcer (a severe form of pressure injury [area of skin damage that develops when prolonged pressure is applied to the same spot on the body] that involves full-thickness tissue loss, exposing muscle, tendon, or bone) to the sacrum (large, triangular bone at the base of the spine, located between the two hip bones) and a DTI to the right heel. During a concurrent interview and record review on 10/16/2024 at 4:05 p.m. with the Director of Nursing (DON), Resident 1's MDS dated [DATE] was reviewed. The DON stated the MDS was inaccurate for the following sections:Section B - Hearing, Speech and Vision: The MDS indicated Resident 1 had adequate hearing when Resident 1 was actually hard of hearing and uses a hearing aid.Section M - Skin Conditions: The MDS indicated Resident 1 did not have any deep tissue injuries when Resident 1 was actually being treated for DTI to the right heel that was present upon admission.The DON stated it is important to have an accurate MDS because resident care plans are based on the information in the MDS. If a resident has an issue that is not identified in the MDS, it is likely that the issue might not be identified within the care plans as well. In order to create appropriate goals for the residents, the resident assessments have to be accurate. During a review of the facility's policy and procedure titled, Accuracy of Assessments, last revised January 2025, indicated it is the policy of the facility to ensure each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment.

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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 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. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop 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 three sampled residents (Resident 1) that addressed:1. Resident 1's hearing difficulty; 2. Resident 1's wounds; and 3. Resident 1's indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine). This deficient practice had the potential to negatively affect the delivery of care and services to Resident 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD - a lung disease that causes obstructed airflow from the lungs, making it hard to breathe), type 2 diabetes mellitus (condition in which the body doesn't use insulin properly, resulting in unusual blood sugar levels), and urinary tract infection (UTI - an infection in the bladder or urinary tract [refers to the system of organs that produce, store, and excrete urine]). During a review of Resident 1's Skilled Nursing Facility admission History and Physical, dated 9/22/2025, the Skilled Nursing Facility admission History and Physical indicated Resident 1 can make needs known, but does not have full capacity to make complex medical decisions. Resident 1's Skilled Nursing Facility admission History and Physical also indicated Resident 1 had a Stage 4 pressure ulcer (a severe form of pressure injury [area of skin damage that develops when prolonged pressure is applied to the same spot on the body] that involves full-thickness tissue loss, exposing muscle, tendon, or bone) of the coccyx (last bone at the bottom of the spine, also known as the tailbone) and a deep tissue injury (DTI- a pressure-related injury to underlying soft tissues that starts with discoloration, such as a deep red, maroon, or purple area under intact skin, often described as looking like a bruise) on his (Resident 1) right heel. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/26/2025, the MDS indicated Resident 1 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS also indicated Resident 1 had one (1) Stage 4 pressure ulcer present upon admission. During a review of Resident 1's Treatment Administration Record (TAR) for October 2025, the TAR indicated Resident 1 was receiving treatments for an indwelling catheter, a right heel DTI and a Stage 4 sacrum (large, triangular bone at the base of the spine, located between the two hip bones) pressure injury. During a review of Resident 1's Wound Weekly Monitoring Assessment, dated 9/21/2025, the Wound Weekly Monitoring Assessment indicated Resident 1 had a Stage IV (4) pressure ulcer to the sacrum and a suspected deep tissue injury to the right heel. During a review of Resident 1's Progress Notes dated 10/14/25 at 4:14 p.m. by the Social Services Director (SSD), the progress notes indicated that an audiology appointment was scheduled for Resident 1 to address Resident 1's misplaced hearing aids. During an interview on 10/15/2025 at 3:50 p.m. with the Assistant Administrator (AADM), the AADM stated Resident 1 was very hard of hearing and had recently lost his hearing aids which the facility was in the process of having replaced. The AADM stated in order for Resident 1 to hear you, you had to speak closely into his (Resident 1) left ear. During a concurrent observation and interview on 10/15/2025 at 4:03 p.m. with Resident 1, Resident 1 was observed lying in bed with a drainage bag hanging from the right side of his (Resident 1) bed, draining clear yellow urine. When speaking to Resident 1, Resident 1 stated, I can't hear you unless you speak into this (left) ear. Resident 1 stated he has hearing aids but has not been able to find them. During an interview on 10/16/2025 at 3:30 p. m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated she was the treatment nurse for Resident 1. LVN 1 stated Resident 1 was currently being treated for two main skin conditions that he was admitted with: a stage 4 pressure ulcer to the sacrum and a DTI to the right heel. During a concurrent interview and record review on 10/16/2025 at 3:44 p.m., with the Medical Records Assistant (MRA), Resident 1's care plans from 9/20/2025 to 10/16/2025 were reviewed. The MRA stated the care plans reviewed were all the care plans that were in Resident 1's medical records. The MRA stated there were no care plans that addressed Resident 1's hearing difficulty, Resident 1's wounds and Resident 1's indwelling urinary catheter. During a concurrent interview and record review on 10/16/2024 at 4:05 p.m., with the Director of Nursing (DON), Resident 1's care plans from 9/20/2025 to 10/16/2025 were reviewed. The DON stated there was no care plan developed for Resident 1's hearing difficulty, Resident 1's wounds and Resident 1's indwelling catheter. The DON stated there should have been a care place for Resident 1's hearing difficulty, Resident 1's wounds and Resident 1's indwelling catheter. The DON stated any staff that was aware of the issues could have