

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/04/2024
NAME OF PROVIDER OR SUPPLIER Rinaldi Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 16553 Rinaldi St Granada Hills, CA 91344	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39739</p> <p>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 by one resident towards another) for one (1) of four (4) sampled residents (Resident 2) on 10/20/2024, when Resident 1 threw water at Resident 2, wetting Resident 2's face, chest, and clothes.</p> <p>This deficient practice resulted in Resident 2 being subjected to physical abuse by Resident 1 while under the care of the facility and had the potential to cause Resident 2 emotional harm which could result to a feeling of embarrassment, low self-esteem, and self-worth.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the document indicated the facility originally admitted the resident on 2/25/2023, and readmitted the resident on 12/30/2023, with diagnoses that included congestive heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues), ventricular tachycardia (a fast, abnormal heart rhythm), and hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]).</p> <p>During a review of Resident 1's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings) Examination dated 2/3/2024, the document indicated Resident 1 had the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/23/2024, the MDS indicated Resident 1 had fully intact cognition (ability to think and make decisions). Resident 1's MDS further indicated Resident 1 had the ability to express ideas and wants and had the ability to understand others.</p> <p>During a review of Resident 1's Change in Condition (COC - a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) Evaluation dated 10/20/2024, the document indicated that on 10/20/2024, Resident 1 threw water on Resident 2 because she was asked to turn down her television.</p> <p>(continued on next page)</p>

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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Post-Event Review dated 10/22/2024, the document indicated on 10/20/2024 there was a resident-to-resident altercation in which Resident 1 grew frustrated with Resident 2 and decided to throw water at Resident 2. Resident 1's Post-Event Review also indicated Resident 1 was alert and oriented (refers to a person's mental status and level of consciousness) to person, place, and time (knows who they are, where they are, and the time/date).</p> <p>During a review of Resident 2's Admission Record, the document indicated the facility originally admitted the resident on 12/10/2014 and readmitted the resident on 9/25/2024, with diagnoses that included metabolic encephalopathy (brain damage or loss of brain function that is caused by an illness or condition), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized anxiety disorder (a condition where you worry constantly about everyday issues and situations).</p> <p>During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had moderately intact cognition.</p> <p>During a review of Resident 2's Change in Condition Evaluation dated 10/20/2024, the document indicated that on 10/20/2024, Resident 2 was splashed with water by Resident 1.</p> <p>During a review of the facility's Conclusion Letter of Resident-to Resident Altercation between Resident 1 and Resident 2 dated 10/24/2024, the document indicated the allegation of abuse was substantiated (to establish something to be true through proof and evidence) based on Resident 1 admitting to throwing water at Resident 2 and the water making contact with Resident 2.</p> <p>During an interview on 11/4/2024 at 11:00 a.m., with Resident 1, Resident 1 stated she remembered the altercation she had with her old roommate, Resident 2. Resident 1 stated Resident 2 asked her to turn down her TV, so she did, but then Resident 2 started playing something very loudly on her phone. Resident 1 stated that pissed [her] off so she threw her water at Resident 2. Resident 1 stated the water made contact with Resident 2's face, chest and clothes. Resident 1 stated she was angry and frustrated with Resident 2 and intended for the water to make contact with Resident 2.</p> <p>During an interview on 11/4/2024 at 1:10 p.m., with Resident 2, Resident 2 stated she remembered the altercation with her old roommate, Resident 1. Resident 2 stated Resident 1 splashed her with water and pointed to her face and chest to indicate where the water went.</p> <p>During an interview on 11/4/2024 at 2:25 p.m., with the Administrator (ADM), the ADM stated he substantiated the altercation between Resident 1 and Resident 2 but feels that there was nothing the facility could have done to prevent the altercation from happening since it was a spontaneous action from Resident 1. When asked if Resident 1's actions were intentional, the ADM stated yes.</p> <p>During a review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, last revised 4/2023, the policy indicated it is the policy of the facility to uphold a resident's right to be free from abuse, neglect, misappropriation of property and exploitation.</p>		