STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055906	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the physician was notified for one of three sampled residents (Resident 1), when Resident 1's indwelling catheter (a thin flexible tube that is placed into the bladder [a hollow, muscular organ in the lower abdomen that stores urine] and left in place to continuously drain urine into a collection bag) was observed to have sediments and cloudiness, in accordance with the facility's policy and procedure (P&P). This deficient practice had the potential to result in a delay in treatment for Resident 1 and increase the risk of urinary complications, including catheter obstruction and urinary tract infection (UTI- an infection in the bladder or urinary tract [body's drainage system for filtering blood and removing liquid waste as urine]), that can lead to worsening infection and may result in hospitalization.During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 8/26/2022, with the most recent admission on [DATE] with diagnoses that included but not limited to paraplegia (loss of movement and/or sensation, to some degree, of the legs), neuromuscular dysfunction of bladder (the nerves and muscles that control the bladder are not working properly), and benign prostatic hyperplasia (a condition in which the prostate gland [a small, firm, partly muscular gland that helps make up the male reproductive system] grows larger than normal, blocking the flow of urine) with lower urinary tract symptoms. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 1 had mild cognitive (ability to remember things, solve problems, or make decisions) impairment skills for daily decision making. The MDS further indicated Resident 1 was dependent on toileting hygiene, showering/bathing, lower body dressing and putting on/taking off footwear and was independent in eating. During a review of Resident 1's Order Summary Report dated 5/4/2026, the Order Summary Report indicated an order was noted for an indwelling catheter for neurogenic bladder. During a review of Resident 1's Care Plan (CP), dated 1/22/2026 and revised 3/28/2026, the CP indicated Resident 1 was at risk for urinary retention related to neuromuscular dysfunction of bladder. The CP goal indicated Resident 1 would not exhibit signs and symptoms of urinary retention (inability to completely empty the bladder) and or infection by reporting to physician signs and symptoms of UTI, such as pain, fever (a temporary rise in body temperature, usually signaling that your body's immune system is actively fighting an infection or illness), foul smelling urine, no output, cloudiness, blood-tinged urine and altered mental status (any sudden or gradual change in a person's baseline level of awareness, cognition or consciousness). The CP further indicated that cloudy urine with sediment was identified on 4/3/2026, with the goal that Resident 1 would have no complications related to indwelling catheter drainage. The CP interventions included close monitoring for increased sediments and or cloudiness, notification of the physician if symptoms persisted, and reporting of any further abnormalities. During an observation on 5/12/2026 at 9:20 a.m. in Resident 1's room, Resident 1 was observed with an indwelling catheter draining cloudy yellow urine with whitish and pink-tinged sediment throughout the tubing and drainage bag. During an interview on 5/12/2026 at 11:03 a.m., with Treatment (Tx) Nurse, the Tx Nurse stated the indwelling catheter had sediments and appeared (continued on next page)

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
	055906	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cloudy. The Tx Nurse further stated the physician should have been notified of the cloudy urine and sediment to prevent potential catheter obstruction, UTI, and possible decline in Resident 1's condition. During an interview on 5/12/2026 at 3:56 p.m., with the Director of Nursing (DON), the DON stated it is important to notify the physician of cloudy urine and sediment in accordance with the resident's CP to prevent the development of UTI. During a review of the facility's policy and procedure (P&P) titled, Change in a resident's condition or status, last revised on 1/2026, the P&P indicated, The nurse will notify the resident's attending physician or physician on call when there has been a(an): significant change in the resident's physical/emotional/mental condition; specific instruction to notify the physician of changes in the resident's condition. A significant change of condition is a major decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff or implementing standard disease related clinical interventions (is not self-limiting).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055906	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that refusal of physician-ordered wound treatment was properly documented for one of three sampled residents (Resident 1), in accordance with facility policy and procedure (P&P) and professional standards of practice. This deficient practice had the potential to result in the absence of appropriate follow-up care, delayed physician notification and evaluation of the resident's condition, and may contribute to delayed wound healing, increased risk of infection, and potential decline in the resident's overall condition. During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 8/26/2022, with the most recent admission on [DATE] with diagnoses that included but not limited to paraplegia (loss of movement and/or sensation, to some degree, of the legs), neuromuscular dysfunction of bladder (the nerves and muscles that control the bladder are not working properly), and benign prostatic hyperplasia (a condition in which the prostate gland [a small, firm, partly muscular gland that helps make up the male reproductive system] grows larger than normal, blocking the flow of urine) with lower urinary tract symptoms. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 1 had mild cognitive (ability to remember things, solve problems, or make decisions) impairment skills for daily decision making. The MDS further indicated Resident 1 was dependent on toileting hygiene, showering/bathing, lower body dressing and putting on/taking off footwear and was independent in eating. During a review of Resident 1's Admission/readmission Skin Review dated 4/29/2026, the Admission/readmission Skin Review indicated Resident 1 had skin scabbing (the process where your body creates a protective crust of dried blood over a wound or skin break to stop bleeding and keep out bacteria), plaque with red borders (typically refers to a skin lesion or rash with an elevated, flat-topped surface greater than one centimeter [cm- unit of measure] in diameter, surrounded by an inflamed, reddish ring or margin), white abnormalities over it and lesions (abnormal area of the skin) to the front right lower leg and front right thigh. During a review of Resident 1's Order Summary Report dated 5/1/2026, the Order Summary Report indicated, a physician order for the right lower leg wound to be cleansed with normal saline (NS- a mixture of water and salt), patted dry, to apply Vaseline (a skin protectant used to temporarily protect and relieve minor cuts, scrapes and burns), and cover with a non-adherent dressing (a type of dressing and wrapped with Kerlix (a soft rolled gauze bandage used to secure dressings and absorb wound drainage) daily for 14 days. During a review of Resident 1's Care Plan (CP) dated 4/30/2026, the CP indicated Resident 1 had actual skin issues affecting bilateral lower extremities related to bullous pemphigoid (a rare skin condition that causes large fluid-filled blisters). The goal was for Resident 1 to remain free from signs and symptoms of infection and for wounds to show signs of improvement through administration of treatments as ordered and monitoring for effectiveness. During an observation on 5/12/2026 at 10:55 a.m., in Resident 1's room, the Treatment Nurse (Tx Nurse) cleansed Resident 1's right lower leg wound with NS, patted dry and applied Vaseline, dressing and covered the wound with a two by two dressing with adhesive sides to help keep the dressing in place. During a concurrent interview and record review on 5/12/2026 at 11:03 a.m., with Tx Nurse, Resident 1's Physician Order, dated 5/1/2026 was reviewed. The Tx Nurse stated the order indicated cleansing the right lower leg with NS, patting dry, applying Vaseline, and covering with a non-adherent dressing and wrapping with kerlix daily for 14 days. The Tx Nurse stated kerlix was not applied to Resident 1's right lower leg because Resident 1 refused. The Tx Nurse stated that Resident 1's refusal should have been documented in the Nurse's Progress Notes and that documentation is necessary to ensure proper wound monitoring, physician notification, and follow-up with Resident 1's wound care. During an interview on 5/12/2026 at 3:56 p.m., with the Director of Nursing (DON), the DON stated Resident 1's refusal of kerlix application should have been documented in the Nurse's Progress Notes. The DON (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055906	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further stated that residents have the right to refuse treatment; however, refusals must be documented to ensure the physician is notified and able to reassess and modify the treatment plan as needed. During a review of the facility's policy and procedure (P&P) titled, Wound care, last revised on 1/2026, the P&P indicated, The following information should be recorded in the resident's medical record: . If the resident refused the treatment and the reason(s) why.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055906	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	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)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1), was wearing heel protectors (soft protective devices placed around a person's heels to reduce pressure and friction to the heels) to bilateral heels while positioned in bed. This deficient practice had the potential to increase Resident 1's risk for impaired skin integrity, skin breakdown, and the development of pressure ulcers/injuries (PU/PI- damaged to the skin and underlying tissue resulting from prolonged pressure). During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 8/26/2022, with the most recent admission on [DATE] with diagnoses that included but not limited to paraplegia (loss of movement and/or sensation, to some degree, of the legs), neuromuscular dysfunction of bladder (the nerves and muscles that control the bladder are not working properly), and benign prostatic hyperplasia (a condition in which the prostate gland [a small, firm, partly muscular gland that helps make up the male reproductive system] grows larger than normal, blocking the flow of urine) with lower urinary tract symptoms. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/4/2026, the MDS indicated Resident 1 had mild cognitive (ability to remember things, solve problems, or make decisions) impairment skills for daily decision making. The MDS further indicated Resident 1 was dependent on toileting hygiene, showering/bathing, lower body dressing and putting on/taking off footwear and was independent in eating. During a review of Resident 1's Braden Scale (a tool used to assess a resident's risk for PU/PI development) assessment dated [DATE], the assessment indicated Resident 1 had a score of 12, which indicated Resident 1 as being at high risk for PU/PI development. During a review of Resident 1's Order Summary Report dated 4/29/2026, the Order Summary Report indicated a physician's order to apply heel protectors to bilateral heels for pressure injury prevention and management. During a review of Resident 1's Care Plan (CP) dated 8/8/2024 and revised 12/11/2025, the CP indicated Resident 1 was at risk for unavoidable PU/PI. The CP further indicated the goal for Resident 1 to maintain intact skin free from redness, blisters (a small pocket of fluid that forms within the upper layers of the skin) or discoloration (refers to any change in your natural skin tone) through interventions that included application of heel protectors to bilateral heels. During an observation on 5/12/2026 at 9:20 a.m. in Resident 1's room, Resident 1 was observed lying flat in bed without heel protectors applied to either heel. During an interview on 5/12/2026 at 10:01 a.m., with the Treatment Nurse (Tx Nurse), the Tx Nurse stated Resident 1 should have been wearing heel protectors while in bed. The Tx Nurse further stated heel protectors are important to reduce pressure to the heels and prevent the development of PU/PI. During an interview on 5/12/2026 at 12:10 p.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 1 was not wearing heel protectors because night shift staff may have removed them and failed to reapply them. CNA 2 further stated heel protectors are important to prevent pressure to the heels that could result in PU development. During an interview on 5/12/2026 at 3:56 p.m., with the Director of Nursing (DON), the DON stated heel protectors are required to be applied in accordance with physician orders. The DON further stated heel protectors are important to prevent the development of PU/PI. During a review of the facility's policy and procedure (P&P) titled, Prevention of pressure injuries, last revised on 1/2026, the P&P indicated, Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Provide support devices.