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	06/23/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a follow-up process to ensure the formulation of the resident's Advance Directive (AD - a written document that states a resident's wishes regarding medical care if the resident is no longer able to make medical decisions due to a serious illness or injury) for one of six sampled residents (Resident 3). This deficient practice had the potential to result in uncertainty regarding the resident's healthcare preferences, which could lead to decisions that are inconsistent with the resident's expressed wishes. During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted the resident (Resident 3) on 10/25/2021 and readmitted on [DATE] with diagnoses that included pressure ulcers (PU -localized damage to the skin and underlying tissue, usually occurring over a bony prominence as a result of pressure, friction or shear) of right buttock stage IV (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), PU of right hip unstageable (a severe wound with full-thickness tissue loss where the true depth and damage cannot be assessed), diabetes mellitus (DM - disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcers (an open sore or lesion [any area of abnormal or damaged tissue in the body, caused by injury, infection or diseases] on the skin of the foot that fails to heal or keeps returning), dementia (a progressive state of decline in mental abilities that is severe enough to interfere with daily life), depression (a serious mood disorder characterized by a persistent feeling of sadness, emptiness, and a prolonged loss of interest in daily activities), and bipolar disorder (a lifelong mental health condition that causes extreme shifts in mood, energy, activity levels, and concentration). During a review of Resident 3's AD Acknowledgement dated 11/4/2021, signed by Resident 3, the AD Acknowledgement indicated the following: The box stating, I have not executed an AD was marked with an ?X'. The box for Yes under tube feeding (a medical way to deliver liquid food and medications directly into the stomach or small intestine) was marked with an ?X'. Resident 3's initials were documented in the section indicating the resident was capable of making decisions regarding the preferred intensity of medical treatment. During a review of Resident 3's History and Physical (H&P - document created when a resident is admitted , consists of a resident's medical history and a physical examination) note dated 1/19/2026, the H&P note indicated Resident 3 did not have capacity to understand and make decisions. During a review of Resident 3's Psychiatric (anything related to diagnosing, treating, and preventing mental, emotional, and behavioral disorders) Note dated 5/25/2026, the Psychiatric Note indicated that Resident 3's mental status could not be fully assessed due to dementia, the resident's condition, and lack of cooperative with the examination. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 6/15/2026, the MDS indicated Resident 3 had severely impaired cognition (mental process of acquiring, processing, and storing information). The MDS indicated Resident 3 was dependent on staff for Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 3's Multidisciplinary Care Conference note dated 6/10/2026, the Multidisciplinary Care Conference note indicated that the Interdisciplinary Team (IDT - the group of different healthcare (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	professionals who work together to create and manage the residents' overall care, therapy, and recovery plan) conducted the quarterly care plan review with Resident 3's friend (Friend 1). The IDT discussion included the resident's current plan of care, diagnoses, medication regimen, discharge planning, and the Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end of life). During a concurrent interview and record review on 6/23/2026 at 3:06 p.m., with Social Services Assistant 1 (SSA 1), SSA 1 reviewed Resident 3's AD Acknowledgment dated 11/4/2021 and the Multidisciplinary Care Conference note dated 6/10/2026. When SSA 1 was asked whether the IDT discussed or offered to formulate and AD with Friend 1 after Resident 3 lost decision-making capacity, SSA 1 stated the IDT reviewed the POLST with Friend 1 and confirmed there were no changes but did not address or formulate an AD. When SSA 1 was asked who made Resident 3's healthcare decisions, SSA 1 stated Resident 3 was not alert or oriented and was unable to make healthcare decisions, then referred the issue to the Social Services Director (SSD). During a concurrent interview and record review on 6/23/2026 at 3:43 p.m., with the Administrator (ADM) and the Acting Director of Nursing (Acting DON), reviewed Resident 3's AD Acknowledgment dated 11/4/2021 and the facility's policy and procedure (P&P) for AD. The ADM stated that when a resident does not have an AD, the facility should approach the resident or the resident's responsible party during quarterly reviews or at least annually, to offer the opportunity to formulate an AD and document if the offer is declined. The Acting DON stated Friend 1 did not always wish to make healthcare decisions for Resident 3 depending on the situation and confirmed the facility had only one AD acknowledgement dated 11/4/2021, in Resident 3's medical record. During an interview on 6/23/2026 at 4:40 p.m., with the ADM and the Acting DON, the ADM stated that Resident 3 no longer had decision-making capacity and stated that the facility's Ethics Committee (an advisory group that helps resolve medical, legal, and ethical dilemmas) should have assisted in facilitating the formulation of an AD including clarifying Resident 3's wishes regarding tube feeding based on Resident 3's current clinical condition, including weight loss. During a review of the facility's P&P titled, Advance Directives last reviewed on 1/29/2026, the P&P indicated, The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Advance Directive - a written instruction, such as a living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated. Legal Representative (i.e., substitute decision-maker, proxy, agent) - a person designated and authorized by an advance directive or state law to make treatment decisions for another person in the event the other person becomes unable to make necessary health care decisions. POLST paradigm form - a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patients current medical condition into consideration. A POLST paradigm form is not an advance directive.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policies and procedures (P&P) for ensuring the reporting of a reasonable suspicion of a crime in accordance with Section 1150B of the Act by failing to report the results of its investigation of an allegation of neglect (failure to provide necessary goods or services required to maintain a resident's physical or mental health) to the State Survey Agency (SSA) within five (5) working days of the incident for one of six sampled residents (Resident 1). This deficient practice had the potential to delay the SSA's oversight of measures necessary to ensure the protection of residents. During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted the resident (Resident 1) on 8/26/2022 and readmitted on [DATE] with diagnoses that included paraplegia (loss of movement and/or sensation, to some degree, of the legs), bullous pemphigoid (a disease that causes large, fluid-filled blisters [small, fluid-filled sac that develops under the outer layers of the skin] on the skin), diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/4/2026, the MDS indicated Resident 1's cognition (ability to think and make decisions) was moderately impaired. The MDS further indicated that Resident 1 was dependent on staff for toileting hygiene, lower body dressing and showering, and required moderate assistance from staff with upper body dressing, personal hygiene and bed mobility (movement) including rolling left and right. The MDS further indicated that Resident 1 was at risk for developing pressure ulcers/pressure injuries (PUs/PIs -localized damage to the skin and underlying tissue, usually occurring over a bony prominence as a result of pressure, friction or shear). During a review of the facility's initial report verification for Resident 1's allegation of neglect, the email verification indicated that the facility submitted the initial report to the SSA on 6/8/2026 at 5:58 p.m.During a review of the facility's follow-up investigation report verification for Resident 1's neglect allegation, the email verification indicated that the facility submitted the follow-up investigation report to the SSA on 6/18/2026 at 10:39 p.m. During a review of the undated facility's Resident Abuse Investigation Report Form regarding Resident 1's neglect allegation, the investigation report form indicated the following: Date Incident Occurred: 6/8/2026 Date Incident Reported: 6/8/2026 at 4:50 p.m. Summary of Interview with Person(s) Reporting the Incident: During a conversation with Resident 1's family member 1 (FM 1) on 6/08/2026 at around 4:50 p.m., FM 1 stated that they believed Resident 1 had been subjected to neglect and abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish) at the facility. Results of Findings and Corrective Action taken reported to: State Licensing Agency on 6/18/2026 at 10 p.m. by the Administrator (ADM). During a concurrent interview and record review on 6/23/2026 at 3:31 p.m., with the ADM, the ADM reviewed the facility's reporting verification for both the initial and follow-up reports related to Resident 1's neglect allegation. The ADM stated that no staff were found to have committed abuse or neglect. The ADM stated that FM 1 became upset after Resident 1 missed a scheduled dermatology (the medical study and treatment of the skin, hair, and nails) appointment on 6/8/2026 and alleged that the missed appointment constituted abuse and neglect related to Resident 1's skin condition. The ADM stated that the facility submitted the initial report to the SSA on 6/8/2026 at 5:58 p.m., approximately two hours after the allegation was reported and immediately initiated an investigation however, the ADM was unable to identify the exact date the investigation was completed. The ADM stated that although the final investigation report was submitted on 6/18/2026, it should have been submitted/reported by 6/15/2026. The ADM stated the facility failed to submit the follow-up investigation report within the required timeframe. During a review of the facility's P&P titled, Abuse, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Neglect, Exploitation (illegal or improper act of using a resident's funds, property, or assets for another person's profit or advantage, often involving coercion, manipulation, or fraud) and Misappropriation (deliberate misplacement, exploitation, or wrongful temporary/permanent use of a resident's belongings or money without their consent) Prevention Program last reviewed on 1/29/2026, the P&P indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Investigate and report any allegations within timeframes required by federal requirements.

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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 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 the proper use of low air loss mattress (LALM - a specialty bed that alternates pressure to help heal and prevent pressure ulcers/injuries [PU/PI- injuries that break down the skin and underlying tissue when an area of skin is placed under pressure]) by placing multiple layers of linens over the LALM for two of two sampled residents (Resident 1 and Resident 3), which had the potential to interfere with the pressure-redistribution function of the LALMs. These failures had the potential to reduce the therapeutic effectiveness of the LALMs, increasing the residents' risk for skin breakdown and/or delaying the healing of existing PU/PI.During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted the resident (Resident 1) on 8/26/2022 and readmitted on [DATE] with diagnoses that included paraplegia (loss of movement and/or sensation, to some degree, of the legs), bullous pemphigoid (a disease that causes large, fluid-filled blisters [small, fluid-filled sac that develops under the outer layers of the skin] on the skin), diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/4/2026, the MDS indicated Resident 1's cognition (ability to think and make decisions) was moderately impaired. The MDS further indicated that Resident 1 was dependent on staff for toileting hygiene, lower body dressing and showering, and required moderate assistance from staff with upper body dressing, personal hygiene and bed mobility (movement) including rolling left and right. The MDS further indicated that Resident 1 was at risk for developing pressure ulcers/pressure injuries (PUs/PIs -localized damage to the skin and underlying tissue, usually occurring over a bony prominence as a result of pressure, friction or shear). During a review of Resident 1's Order Summary Report dated 4/30/2026, the Order Summary Report indicated Resident 1's physician ordered a LALM for Resident 1 for skin maintenance and PU prevention. During a review of Resident 1's Surgical Consult Notes, dated 6/9/2026, the Surgical Consult Notes indicated that Resident 1 had skin lesions (any distinct area of skin that differs from its surrounding tissue in color, texture, shape or size) on the right lower leg, left lower leg. The Surgical Consult Notes further indicated that Resident 1 was at risk for developing a PI due to the following risk factors: a history of healed stage III (full-thickness skin loss where the underlying subcutaneous fat [soft, jiggly layer of fat stored directly beneath the skin and above the muscle] is visible), or stage IV (involves full-thickness skin and tissue loss where bone, muscle, tendon, or joint structures are directly exposed), DM, and limited mobility. During a review of Resident 3's admission Record, the admission Record indicated the facility originally admitted the resident (Resident 3) on 10/25/2021 and readmitted on [DATE] with diagnoses that included pressure ulcers (PU -localized damage to the skin and underlying tissue, usually occurring over a bony prominence as a result of pressure, friction or shear) of right buttock stage IV (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), PU of right hip unstageable (a severe wound with full-thickness tissue loss where the true depth and damage cannot be assessed), diabetes mellitus (DM - disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcers (an open sore or lesion [any area of abnormal or damaged tissue in the body, caused by injury, infection or diseases] on the skin of the foot that fails to heal or keeps returning), dementia (a progressive state of decline in mental abilities that is severe enough to interfere with daily life), depression (a serious mood disorder characterized by a persistent feeling of sadness, emptiness, and a prolonged loss of interest in daily activities), and bipolar disorder (a lifelong mental health condition that causes extreme shifts in mood, energy, activity levels, and concentration). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 6/15/2026, the MDS indicated Resident 3 had severely impaired (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognition (mental process of acquiring, processing, and storing information). The MDS indicated Resident 3 was dependent on staff for Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS further indicated that Resident 3 was at risk for developing PUs/PIs. During a review of Resident 3's Order Summary Report dated 1/18/2026, the Order Summary Report indicated Resident 3's physician ordered a LALM for Resident 3 for wound management and PI prevention. During a review of Resident 3's Surgical Consult Notes dated 6/9/2026, the Surgical Consult Notes indicated that Resident 3 had the following wounds: Right buttock: Stage IV PU/PI Right trochanter (the bony prominence on the upper part of the thigh bone): Unstageable PU/PI Left lateral malleolus (the bony prominence on the outside of the ankle): Diabetic wound 1. During a concurrent observation and interview on 6/23/2026 at 10:51 a.m., in Resident 1's room, with Treatment Nurse 1 (TN 1), observed Resident 1 lying in bed on a LALM. Resident 1 had a spread sheet with two cloth incontinence (loss of bowel or bladder control) pads made of two different layers of cloth, and the two cloth incontinence pads overlapped by approximately 10 centimeters (cm - a unit of measurement). TN 1 stated that the overlapping pads extended from Resident 1's mid-back to the feet and overlapped in the upper thigh area, resulting in a total of three layers of linen in the non-overlapping areas and five layers of linen in the overlapping areas beneath Resident 1. TN 1 further stated that the purpose of using the LALM was for skin management to prevent PU, and that staff should use only one layer of linen because multiple layers would prevent the LALM from functioning effectively to prevent PUs. 2. During a concurrent observation and interview on 6/23/2026 at 11:16 a.m., in Resident 3's room, with TN 1, and Certified Nursing Assistant 1 (CNA 1), observed Resident 3 lying on a LALM while wearing an incontinence brief over a total of five layers of linen (one spread sheet and four layers of linen by folding a spread sheet twice) resulting in six total layers of linen between the resident and the mattress surface. CNA 1 stated that Resident 3 had multiple wounds on his body and that only one layer of linen should be used with the LALM. CNA 1 further stated that using multiple layers would prevent the LALM from functioning effectively to promote wound healing and stated the extra linens would be removed. During a concurrent interview and record review on 6/23/2026 at 4:44 p.m., with the Acting Director of Nursing (Acting DON) and the Administrator (ADM), the Acting DON reviewed the LALM manual and stated that the minimal padding meant using one spread sheet and one incontinent barrier pad if needed. The Acting ADON further stated that using multiple layers of linen would defeat the purpose of the LALM and impair its ability to promote wound healing. The ADM stated that using multiple layers of linen with a LALM could trap moisture and heat, negatively affecting the mattress's performance and increasing the resident's risk of developing a new PU. During a review of the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries last reviewed on 1/29/2026, the P&P indicated, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Support Surfaces and Pressure Redistribution. 1. Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice. During a review of the LALM's manual provided by the facility, titled, User-Service Manual copyrighted 2024, the LALM manual indicated, Recommended Linen. Based upon the patient's specific needs, the following may be utilized: Draw or slide sheet to aid in positioning and to further minimize friction and shearing. Incontinence barrier pad for urine and/or stool and patients with heavily draining wounds. Minimal padding between the patient and the surface to provide optimum performance.