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	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care in a manner that maintained a resident`s dignity and respect to three of three residents (Resident 8, Resident 11 and Resident 2) by failing to: a. Ensure a Certified Nursing Assistant 1 (CNA 1) was not sitting in a Resident 8's room with her personal belongings while waiting for the end of her shift during a random observation. b. Ensure staff were not standing over Resident 11 whileˆassistingˆwith feeding. c. Ensure a staff member knocked prior to entering a resident`s room observed duringˆresident screening.ˆˆ These deficient practices violated the resident's right to privacy, to be treated with dignity and had the potential to affect the residents' sense of self-worth and self-esteem.ˆ Findings:ˆ a. During a review of Resident 8's admission Record, the admission Record indicated the facility admitted Resident 8 on 4/16/2020 with diagnoses including dysphagia (difficulty swallowing) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 8's Minimum Date Set (MDS- a standardized assessment and care screening tool), dated 11/5/2025, the MDS indicated Resident 13 could sometimes make himself understood and sometimes understand others and required substantial assistance (helper dose more than half the effort) for oral hygiene, upper body dressing and personal hygiene and was dependent (helper does all the work) on staff for toileting, showering, lower body dressing and putting off/on footwear. During an initial pool interview on 3/28/2026 at 9:42 A.M. in Resident 8's room with Resident 8, Resident 8 was lying in bed and unable to respond to questions. Resident 8 responded with one or two words and nonsensical (having no meaning; making no sense) phrases. During an observation on 3/28/2026 at 2:22 P.M., in Resident 8's room, Resident 8 was lying in bed asleep in the bed nearest to the door and Certified Nursing Assistant 1 (CNA 1) was sitting between the wall with the entrance door and the left side of Resident 8's bed. In front of CNA 1 was Resident 8's bedside table and on top of the bedside table was CNA 1's personal purse and her personal cell phone. During an interview on 3/28/2026 at 2:24 P.M. with CNA 1, CNA 1 stated the purse on Resident 8's bedside table belonged to her, that her shift was almost over and she was in Resident 8's room to wait for the time to wind down till she is off the clock. CNA 1 stated she did not ask before she sat down in Resident 8's room, that Resident 8 was confused, and most likely not be able to consent or deny her sitting in his room. CNA 1 stated she should have used the break room, and her actions did (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not respect Resident 8's dignity and privacy. During an interview on 3/29/2026 at 11:41 A.M. with the Assistant Director of Nursing (ADON), the ADON stated staff may not bring personal items into resident rooms, nor can they use resident rooms for breaks. The ADON stated CNA 1's actions were not acceptable, and she did not provide dignity to Resident 8 that the facility strive to give to each resident. During a review of the facility's policy and procedure (P&P) titled, Dignity, last reviewed and revised on 1/29/2026, the P&P indicated the facility must care for each resident in a manner that promotes and enhances his or her sense of well-being.and feelings of self-worth and self-esteem. The P&P indicates the resident's private space and property are respected at all times; staff do not handle or move resident's belongings without the resident's permission. During a review of the facility's P&P titled, Resident Rights, last reviewed and revised on 1/29/2026, the P&P indicated employees must treat all residents with kindness, respect and dignity. b. During a review of Residentˆ11's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE]ˆwith diagnoses that includedˆmetabolic encephalopathy (a temporary, reversible brain dysfunction caused by chemical imbalances in the body),ˆmuscle weakness,ˆdysphagia (difficulty swallowing), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity).ˆ During a review of Residentˆ11's MDSˆdated 1/1/2026, the MDS indicated Residentˆ11's cognitionˆ(a mental process ofˆacquiringˆknowledge and understanding through thoughtˆexperience and the sense)ˆwasˆmoderatelyˆimpaired. The MDS indicated Residentˆ11ˆrequiredˆsubstantial/maximalˆassistanceˆ(staff does more thanˆhalf the effort)ˆwith eating and personal hygieneˆandˆwasˆdependent (staff doesˆall ofˆthe effort) on staff with oral careˆand toileting hygiene.ˆ During an observation onˆ3/28/2026ˆat 1:30ˆp.m., inˆResident 11'sˆroom,ˆobservedˆCertified Nursing Assistant 3 assisting Residentˆ11 with feeding, standing over and hovering over Resident 11. Observedˆa folding chair next toˆCNA 3.ˆˆ During a concurrent observation and interview on 3/28/2026 at 1:31 pm with the Desk Nurse (DN),ˆin Resident 11'sˆroom, theˆDNˆstatedˆthat CNA 3 is standing over Resident 11 whileˆassistingˆwith feeding. The DNˆstatedˆthat CNA 3ˆshould be sitting down and should be at eye levelˆwhile feeding Resident 11 so CNA 3 staff can properlyˆobserveˆthe resident while eatingˆto ensure safety while maintaining the resident's dignity and respect. The DN stated that CNA 3 should have sat down on theˆchair since the chairˆisˆnext to CNA 3.ˆ During an interview onˆ3/28/2026 at 2:47 p.m. with CNA 3, CNA 3 stated thatˆshe would feed Resident 11 and wipe her mouth, after which t CNA 3 would sit down. CNA 3 stated that she is unable toˆsit in the chairˆbecause theˆrolling bedside table does not roll under Resident 11's bed, preventing CNA 3 from positioning herself comfortably.ˆˆˆ During an interview on 3/29/2026ˆatˆ4:34ˆp.m., with the Director of Staff Development (DSD), the DSDˆstatedˆthat all staff should respect residentsˆwhileˆassistingˆwith feeding by sitting down on a chair.ˆThe DSD continued toˆstateˆthat staff should be at eye level with the residentˆto make meals (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pleasant and to be able to interact with residentsˆwithin eye level.ˆThe DSDˆstatedˆnursing staff should be sitting at eye level with the resident during meals to facilitate proper observation of chewing and swallowing.ˆ ˆ During aˆreview of the facility'sˆpolicy and procedureˆ(P&P)ˆtitled Dignity,ˆwith review dateˆ1/29/2026,ˆthe P&P indicatedˆeach resident shall be cared for in a manner that promotes and enhances his or her sense of well-being,ˆlevel of satisfaction with life,ˆand feeling ofˆself-worthˆandˆself-steam.ˆ b. During a review of Residentˆ11's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE]ˆwith diagnoses that includedˆmetabolic encephalopathy (a temporary, reversible brain dysfunction caused by chemical imbalances in the body),ˆmuscle weakness,ˆdysphagia (difficulty swallowing), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity).ˆ During a review of Residentˆ11's MDSˆdated 1/1/2026, the MDS indicated Residentˆ11's cognitionˆ(a mental process ofˆacquiringˆknowledge and understanding through thoughtˆexperience and the sense)ˆwasˆmoderatelyˆimpaired. The MDS indicated Residentˆ11ˆrequiredˆsubstantial/maximalˆassistanceˆ(staff does more thanˆhalf the effort)ˆwith eating and personal hygieneˆandˆwasˆdependent (staff doesˆall ofˆthe effort) on staff with oral careˆand toileting hygiene.ˆ During an observation onˆ3/28/2026ˆat 1:30ˆp.m., inˆResident 11'sˆroom,ˆobservedˆCertified Nursing Assistant 3 assisting Residentˆ11 with feeding, standing over and hovering over Resident 11. Observedˆa folding chair next toˆCNA 3.ˆˆ During a concurrent observation and interview on 3/28/2026 at 1:31 pm with the Desk Nurse (DN),ˆin Resident 11'sˆroom, theˆDNˆstatedˆthat CNA 3 is standing over Resident 11 whileˆassistingˆwith feeding. The DNˆstatedˆthat CNA 3ˆshould be sitting down and should be at eye levelˆwhile feeding Resident 11 so CNA 3 can properlyˆobserveˆthe resident while eatingˆto ensure safety while maintaining the resident's dignity and respect. The DN stated that CNA 3 should have sat down on theˆchair since the chairˆisˆnext to CNA 3.ˆ During an interview onˆ3/28/2026 at 2:47 p.m. with CNA 3, CNA 3 stated thatˆshe would feed Resident 11 and wipe her mouth, after which t CNA 3 would sit down. CNA 3 stated that she is unable toˆsit in the chairˆbecause theˆrolling bedside table does not roll under Resident 11's bed, preventing CNA 3 from positioning herself comfortably.ˆˆˆ During an interview on 3/29/2026ˆatˆ4:34ˆp.m., with the Director of Staff Development (DSD), the DSDˆstatedˆthat all staff should respect residentsˆwhileˆassistingˆwith feeding by sitting down on a chair.ˆThe DSD continued toˆstateˆthat staff should be at eye level with the residentˆto make meals pleasant and to be able to interact with residentsˆwithin eye level.ˆThe DSDˆstatedˆnursing staff should be sitting at eye level with the resident during meals to facilitate proper observation of chewing and swallowing.ˆ ˆ (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During aˆreview of the facility'sˆpolicy and procedureˆ(P&P)ˆtitled Dignity,ˆwith review dateˆ1/29/2026,ˆthe P&P indicatedˆeach resident shall be cared for in a manner that promotes and enhances his or her sense of well-being,ˆlevel of satisfaction with life,ˆand feeling ofˆself-worthˆandˆself-steam.ˆ

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to promote the resident's right to be informed of and participate in their treatment for three of six (Resident 71, 102, and 75) residents observed for medication administration by failing to provide the name of medications and their indication (reason for the use of the medication) prior to administration of the medications. This deficient practice violated Resident 71, 102, and 75`s rights to make decisions regarding their medication regimen and to refuse any or all the medications. Findings: a. During a review of Resident 71's admission Record, the admission Record indicated the facility admitted the resident on 8/25/2020 with diagnosis including, hypertension (high-blood pressure) and chronic kidney disease (a serious, long-term condition where kidneys are damaged and cannot properly filter blood, often leading to waste buildup). During a review of Resident 71's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 2/23/2026, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 71 required substantial/maximal assistance (helper does more than half the effort) from staff for toileting hygiene, shower, upper body dressing, personal hygiene and totally dependent on staff for lower body dressing and putting on/taking off footwear. During an observation on 3/28/2026 at 4:22 p.m., in Resident 71's room observed Licensed Vocational Nurse 1 (LVN 1) administering docusate sodium (stool softener used to treat occasional constipation [infrequent bowel movement]) 10 milligrams (mg-unit of measurement) tablet and amlodipine besylate (a medication to treat high blood pressure) 4 mg tablet orally to Resident 71. LVN 1 was not observed informing Resident 70 of the name of each medication and its indication during administration of the medications. During a review of Resident 71`s Order Summary Report (OSR) as of 3/28/2026, the OSR indicated the following prescribed medications administered by LVN 1 to Resident 70. 1.Docusate Sodium 100 milligram (mg) tablet, 1 tablet by mouth for bowel management. 2. Amlodipine Besylate Tablet 5 mg, give 1 tablet by mouth two times a day for hypertension. b. During a review of Resident 102's admission Record the admission Record indicated the facility admitted the resident on 3/22/2026 with diagnosis including muscle weakness and chronic kidney disease (a serious, long-term condition where kidneys are damaged and cannot properly filter blood, often leading to waste buildup). During a review of Resident 102's History and Physical (H&P- a foundational medical document and examination performed by a clinician to assess a patient's condition, documenting their story [history] and physical findings to guide diagnosis and treatment) dated 3/23/2026, the H&P indicated that the resident has decision making capacity at the time of admission. During an observation and interview on 3/28/2026 at 4:36 p.m., in Resident 102's room, observed Licensed Vocational Nurse 1 (LVN 1) administering gabapentin (a medication used to treat nerve pain) 100 mg capsule and furosemide (a medication used to treat fluid retention) tablet 40 mg orally to Resident 102. LVN 1 was not observed informing Resident 102 of the name of each medication and its indication during administration of the medications. During an interview with LVN 1, on 3/28/2026 at 4:41 p.m., LVN 1 stated the residents have the right to be informed of and participate in decisions regarding their care and treatment. LVN 1 stated she forgot to inform Resident 71 and Resident 102 the name of the medications and their indications and asked for their consent to administer the medications prior to medication administration. During a review of Resident 102`s Order Summary Report (OSR) as of 3/28/2026, the OSR indicated the following prescribed medications orders that were administered by LVN 1 to Resident 102: 1.Gabapentin 100 mg oral capsule, 1 capsule by mouth two times a day for Neuropathy (nerve damage causing numbness, tingling, burning pain, or weakness, usually starting in the hands or feet). 2. Furosemide Oral Tablet 40 mg, 1 tablet by mouth two times a day for edema. c. During a review of Resident 75's admission Record the, admission Record indicated the facility admitted the resident on 1/23/2026 with diagnosis including, hypertension (high-blood pressure) and muscle weakness. During a review of (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 75's MDS dated [DATE], the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 75 required partial/moderate assistance (helper does more than half the effort) from staff for toileting hygiene, shower, lower body dressing, and putting off footwear. During a concurrent observation and interview on 3/29/2026 at 4:11 p.m., in Resident 75's room, observed Licensed Vocational Nurse 6 (LVN 6) administering metoclopramide (medication used to treat gastroesophageal reflux disease [GERD-a chronic condition where stomach acid frequently flows back into the esophagus, causing irritation, heartburn, and potential damage])tablet 5 mg, omeprazole (used to treat conditions where there is too much acid in the stomach) 20 mg capsule, Creon (digestive enzyme medication) capsule 24000 units orally to Resident 75. LVN 1 was not observed informing Resident 102 of the name of each medication and its indication during administration of the medications. LVN 6 stated she did not inform Resident 75 the name of the medications and their indications and asked for Resident 75's consent to administer the medications prior to medication administration. LVN 6 stated that it a violation of the resident's right to participate in their care and make decisions regarding their care if the resident was not informed of their treatment and medication regimen. During a review of Resident 75`s Order Summary Report (OSR) as of 3/29/26, the OSR indicated the following prescribed medications that were administered by LVN 6 to Resident 75: 1.Metoclopramide Oral Tablet 5 mg, give 1 tablet by mouth before meals for nausea and vomiting. 2. Omeprazole 20 mg cap, give 1 capsule by mouth two times a day for gastroesophageal reflux disease (GERD). 3. Creon Oral Capsule 24000-76000 Unit, give 24000 unit by mouth with meals for pancreatic enzyme replacement therapy give with meals. 4. Famotidine Oral Tablet 20 mg, give 1 tablet by mouth two times a day for GERD. During a review of the facility`s Policy and Procedure (P&P) titled Resident Rights, last reviewed on 1/29/2026, the P&P indicated that Employees shall treat all residents with kindness, respect, and dignity.be informed of, and participate in, his or her care planning and treatment.

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	055906	A. Building B. Wing	03/29/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide) for two of 19 sampled residents (Resident 40, Resident 5) by: a. Failing toˆimplementˆinterventionsˆfor Resident 40 to help prevent and treat constipation. This deficient practice had the potential toˆnegatively affect the delivery of care and services to Resident 40ˆ b. Failing to develop a care plan that specifically address Residentˆ5's diet.ˆ This deficient practice had the potential to negatively affect the delivery of care and services to Residentˆ5.ˆ a. During a review of Residentˆ40's admission Record, the admission Record indicated the facilityˆadmitted ˆResidentˆ40ˆonˆ1/10/2026ˆwith diagnoses includingˆintercerebral hemorrhage (CVA -ˆstroke, loss of blood flow to a part of the brainˆby a brokenˆblood vessel causingˆbleeding into the brain), dysphagiaˆ(difficulty swallowing)ˆand muscle weakness.ˆˆ During a review of Residentˆ40's MDS dated [DATE], the MDS indicated Residentˆ40ˆcould make himself understood andˆunderstand others and requiredˆpartialˆassistance (helper doseˆlessˆthan half the effort) for oral hygieneˆand personal hygiene and was dependent (helper does all the work) on staff for toileting, showering, lower body dressing and putting off/on footwear.ˆˆ Duringˆa concurrent observation and interview on 3/28/2026 atˆ8:37ˆA.M. in Residentˆ40's room with Residentˆ40ˆandˆfamily member 1 (FM 1), Residentˆ40ˆwasˆsitting upˆin bedˆwith FM 1 next to him.ˆˆFM 1 stated Residentˆ40 had not had a bowel movementˆ(BM)ˆfor several days and it happens often.ˆResident 40ˆstatedˆhe was constipated,ˆfelt uncomfortableˆand has told staff in the past but could not remember who he told.ˆ During a review ofˆResident 40'sˆPotential for Constipation Care Plan (CP)ˆwith a goal to pass soft formed stoolˆat the preferred frequency of every three days. The CPˆindicatedˆinterventionsˆto administer medications and treatments as ordered by the physician and monitor for effectiveness,ˆand for the certified nursing assistant (CNA) toˆrecordˆBMˆpattern each day.ˆˆ During a review of Resident 40'sˆBMˆTask filled out by CNAs, theˆtaskˆindicated:ˆ 3/11/2026ˆ–ˆNoneˆ 3/12/2026 – Noneˆ 3/13/2026 – Noneˆˆ 3/14/2026 – Noneˆ 3/15/2026 – Noneˆ 3/16/2026 – Noneˆ 3/18/2026 – Noneˆ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/192026 – Noneˆ 3/20/2026 – Noneˆ 3/21/2026 – Noneˆ 3/22/2026 – Noneˆ During a review ofˆResident 40's Order Summary Report with activeˆorders as of 3/29/2026 included:ˆ -1/10/2026 – Docusate Sodium (stool softener)ˆ100 MG (milligrams – unit of measurement) Give one capsuleˆby mouth two times a day for constipation.ˆˆ -ˆ2/3/2026 – Sennaˆ(medicine used to stimulate the colon causing contractions to relieve constipation) 8.6 MG. Give 1 tablet by mouth as needed for constipation every bedtime as neededˆ(PRN). Give if docusate sodium is ineffective.ˆˆ -ˆ2/9/2026 -ˆDocusate Sodium Oral Capsule 100 MG (Docusate Sodium) Give 2ˆcapsulesˆby mouthˆPRNˆfor constipation twice dailyˆ During a review of Resident 40's electronic medication administration record (eMAR)ˆfor 3/2026,ˆthe eMAR did not have documented evidence that PRNˆDocusate Sodium and Senna were administeredˆfor the month of 3/2026. Duringˆaˆconcurrent interview and record reviewˆonˆ3/29/2026 atˆ10:22ˆA.M.ˆwith CNA 2, CNA 2 reviewed Resident 40'sˆBMˆtaskˆonline. CNA 2 explained every shift (7:00 A.M. – 3:00 P.M., 3:00 P.M. – 11:00 P.M, 11:00P.M. -7:00 A.M.), Resident 40's CNAˆmustˆindicateˆif and how much his BM is. CNA 2 explained:ˆ Noneˆ– no BMˆ Small – small BMˆˆ Medium – medium BMˆ Large – Large BMˆˆ Resident Refused - theˆresidentˆrefusedˆto be checkedˆ Not Applicable – if the residentˆis out of the building for that shift.ˆ CNA 2ˆstated, according to the documentation, Resident 40 did notˆhave a bowel movement from 3/11/2026 – 3/16/2026ˆ(6 days) and from 3/18/2026 – 3/22/2026 (5 days) and a couple other instances of no BMs for 3 daysˆplus.ˆCNAˆ2ˆstatedˆshe was not aware that she had to notify the charge nurse if the resident did not have a BM for several daysˆand that Resident 40 neverˆnotified herˆspecifically that he was constipated.ˆCNA 2ˆstatedˆmore that 3 days isˆway tooˆlong for a resident to go without a BMˆand the charge nurse should have been notified to give more medication or call the doctor.ˆˆ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During aˆconcurrentˆinterviewˆand record reviewˆon 3/29/2026 at 11:18ˆA.M.ˆwith the Assistant Director of Nursing (ADON), the ADONˆreviewed Resident 40'sˆConstipation CP,ˆBMˆTaskˆand 3/2026 MAR. The ADON stated it was unacceptable for Resident 40 to be constipated for more than six daysˆwithout the certified nursing assistants notifying the charge nurse so they can call the doctor or at the very least give a PRN medication for constipation.ˆThe ADON stated the Constipation CP clearlyˆstatesˆthe goal is to not go for moreˆthanˆ3 days without a BMˆwas not met by the licensed staff.ˆ During a review of the facility's policy and procedure (P&P)ˆtitled, Care Plans,ˆComprehensive Person Centered, last reviewed and revised on 1/29/2026, the P&P indicatedˆCPsˆinclude measurable objectives and timetables to meet the resident's physical, psychological and functional needsˆis developed and implemented for each resident.ˆˆ b. During a review of Residentˆ5's admission Record, the admission Record indicated the resident wasˆreadmitted to the facility on ˆˆ3/9/2026ˆwith diagnoses that includedˆend stage renal disease (ESRD-ˆirreversible kidney failure)ˆand dependence on renal dialysisˆ(a life-sustaining medical treatment that filters waste products, toxins, and excess fluids from the blood when the kidneys are failing).ˆ During a review of Residentˆ5's MDS dated [DATE], the MDS indicated Residentˆ5's cognition (a mental process ofˆacquiringˆknowledge and understanding through thought experience and the sense) was moderately impaired. The MDS indicated Residentˆ5ˆrequiredˆsupervision or touchingˆassistanceˆ(helperˆprovides cuesˆand/or touching/steadyingˆassistance)ˆwith eating and oral hygiene,ˆrequiredˆ partial/moderateˆassistanceˆ(helper does less than half the effort) with personalˆhygiene andˆrequiredˆsubstantial/maximalˆassistanceˆ(helper does more than half the effort)ˆwith toileting.ˆˆ During a review ofˆResident 5's Order SummaryˆReport, the Order Summary Report indicated an order dated 3/9/2026 for ˆLiberal Renal (a specialized eating plan for people with kidney disease that limits specific minerals and fluidsˆto reduce strain on the kidneys and prevent waste buildup)- No Added Salt (NAS) dietˆfor ESRD.ˆˆ During an interview and concurrent record review onˆ3/29/2026, at 9:50ˆa.m. with theˆDesk Nurse (DN), theˆDNˆreviewed Residentˆ5'sˆcare plansˆandˆstatedˆthat there was no care planˆcreatedˆaddressingˆResident 5'sˆrenal diet. TheˆDNˆstatedˆthatˆResident 5 should have aˆspecificˆcare planˆfor Resident 5'sˆrenal diet because a care planˆwill provide interventionsˆfor Resident 5 specific to a renal diet. The DNˆstatedˆthat all staffˆare responsible forˆinitiatingˆdiet care plans. The DN furtherˆstatedˆthat care plans are important because care plans are a form of communicationˆfor the interdisciplinary team to help provide quality of care.ˆˆ During a review of the facility's policy and procedure (P&P)ˆtitled, Care Plans,ˆComprehensive Person Centered, last reviewed and revised on 1/29/2026, the P&P indicatedˆCPsˆinclude measurable objectives and timetables to meet the resident's physical, psychological and functional needsˆis developed and implemented for each resident.ˆˆ

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	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a call light (a device used by a patient to signal his or her need for assistance) within reach for one of three residents reviewed under the environment task (Resident 11). This deficient practice had the potential to result in Resident 11 not being able to call for facility staff assistance and delay in the provision of necessary care and services that can negatively affect the residents' comfort and well-being. Findings: During a review of Resident 11's admission Record, the admission Record indicated the facility admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a temporary, reversible brain dysfunction caused by chemical imbalances in the body), muscle weakness, dysphagia (difficulty swallowing), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 11's Minimum Date Set (MDS- a standardized assessment and care screening tool) dated 1/1/2026, the MDS indicated Resident 11's cognition (a mental process involved in knowing, learning, and understanding things) was moderately impaired. The MDS indicated Resident 11 required substantial/maximal assistance (staff does more than half the effort) with eating and personal hygiene and was dependent (staff does all of the effort) on staff with oral care and toileting hygiene. During an observation on 3/28/2026 at 8:30 a.m., in Resident 11's room, observed Resident 11 in bed, with the call light not within the resident's reach. Observed Resident 11's call light tucked in between Resident 11's mattress and pillow. During a concurrent observation and interview on 3/28/2026 at 8:48 a.m., with the RN Case Manager (RNCM), in Resident 11's room, observed Resident 11 in bed with the call light not within the resident's reach. Observed Resident 11's call light tucked in between Resident 11's mattress and pillow. Observed RNCM place the call light within Resident 11' s reach, next to Resident 11's right hand and stated Resident 11' s call light was not within reach. The RNCM continued to state that the call light should always be next to the resident so that the resident can call for assistance and for Resident 11's safety. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, last reviewed on 1/29/2026, the P&P indicated the purpose of this procedure is to ensure timely responses to the resident's request and needs. The P&P further indicated staff must ensure the call light is accessible to the resident when in bed.

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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 ensure one of eight sampled residents (Resident 12) was provided written information regarding their rights to refuse or accept medical or surgical treatment and to formulate an Advanced Directive (AD- a written instruction, recognized under State law, relating to the provision of health care when an individual is unable to make decisions for themselves).This deficient practice had the potential to result in the facility not honoring the residents' medical decisions regarding end-of-life care. Findings:During a review of Resident 12's admission Record (face sheet), the admission Record indicated that the facility originally admitted the resident on 12/3/2025, and readmitted on [DATE], with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), nondisplaced fracture of base of neck of femur (a hip fracture where the thigh bone is broken at its lowest point near the hip joint, but the bone pieces remain in their normal position), and dysphagia (difficulty swallowing).During a review of Resident 12's Minimum Data Set (MDS- a resident assessment tool) dated 2/5/2026, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making were severely impaired, as the resident rarely or never made decisions. The MDS further indicated that Resident 12 was dependent (helper does all of the effort) on staff for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene. During a review of Resident 12's Advance Healthcare Directive Acknowledgement form (ADA- a document provided by the facility that indicates whether a resident has an AD, would like information regarding creation of an AD, or refusal to create an AD) dated 12/3/2025, the ADA form indicated that Resident 12`s representative signed the form on 12/3/2025. The ADA form further indicated that Resident 12 did not have an AD.During a review of Resident 12's Social Service Review form dated 3/6/2026, the Social Service Review form indicated that Resident 12 has not issued an AD about his care and treatment. The social service review form further indicated that the resident and/or Resident 12's representative were not provided with written information regarding AD, and that the facility representative did not offer assistance in formulating an AD.During a concurrent interview and record review on 3/28/2026 at 3:02 p.m., with Social Service Assistant (SSA), Resident 12's ADA form dated 12/3/2025 and Social Service Review form were reviewed. SSA stated that Resident 12`s ADA form completed on 12/3/2025 indicated the resident did not have an AD. However, the resident`s ADA form did not indicate whether the resident or their representative wished to receive additional information regarding AD. SSA stated Resident 12`s ADA form was not completed thoroughly. SSA further stated that Resident 12`s Social Service Review form dated 3/6/2026 indicated that the resident or their representative was not provided with written information about ADs, and the facility staff did not offer assistance in formulating one. SSA stated facility policy requires that residents or their representatives be provided with written information regarding AD and be offered assistance in completing the AD. SSA stated that failure to provide this information and support may result in the resident's wishes not being known or honored. During a concurrent interview and record review on 3/11/2025 at 5:10 p.m., with the Director of Nursing (DON), Resident 12`s ADA form dated 12/3/2025 and Social Service Review form dated 3/6/2026 were reviewed. The DON stated it is the policy of the facility to provide written information regarding formulating AD to residents or their representatives and offer assistance to formulate AD. The DON stated Resident 12`s ADA form dated 12/3/2025, did not indicate whether the resident or their representative wished to receive information regarding AD. The DON stated Resident 12`s Social Service Review form dated 3/6/2026 indicated that the resident or their representative was not provided with written information about ADs and facility representative did not offer assistance to formulate an AD. The DON stated the potential outcome of not offering information and assistance to (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	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	formulate AD to residents or their representative is that the residents` wishes may not be honored.During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, last reviewed on 1/29/2026, the P&P indicated that the resident has the right to formulate an AD, including the right to accept or refuse medical or surgical treatment. Advanced directives are honored in accordance with state law and facility policy. Prior to or upon admission of a resident the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advanced directives. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an AD if he or she chooses to do so. If the resident is incapacitated and unable to receive information about his or her right to formulate an AD, the information may be provided to the resident`s legal representative. Nursing staff will document in the medical record the offer to assist and the resident`s decision to accept or decline assistance.

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	055906	A. Building B. Wing	03/29/2026

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facilityˆfailed to maintain a homelike environment for two of two residents (Resident 15 and 82) by failing to ensure the window screen was in good repair and did not have a tear which created an opening measuring approximately 24 inches from top to bottom. This deficient practiceˆhadˆthe potentialˆto allow insects, dirt, and outside debris to enter the room, placing the residents at increased risk for infection and compromising their safety.Findings:ˆ a. During a review of Resident 15's admission Record, the admission Record indicated the facility originally admitted the resident on 7/01/2025 and readmitted the resident on 12/17/2025 with diagnosis including, muscle weakness and hypertension (high-blood pressure). During a review of Resident 15's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 3/02/2026, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 15 required partial/moderate assistance (helper does more than half the effort) from staff for oral hygiene, upper body dressing and substantial/maximal assistance (helper does more than half the effort) with toileting, shower and personal hygiene. b. During a review of Resident 82's admission Record, the admission Record, indicated the facility originally admitted the resident on 8/23/2023 with diagnosis including history of falling and hypertension (high-blood pressure). During a review of Resident 82's MDS dated [DATE], the MDS indicated the resident had the ability to sometimes make self-understood and the ability to sometimes understand others. The MDS indicated that Resident 82 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower, upper body dressing, lower body dressing and personal hygiene. During an observation onˆ3/28/2026 at 9:01 a.m., in Resident 15 and Resident 82's room, observed both residents sleeping in their bed. Observed the room's sliding door screen with a tear measuring approximately 24 inches.During a concurrent observation and interview on 03/28/2026 at 9:35ˆa.m. with the Director of Nursing (DON) in Resident 15 and 82`s room, the DON confirmed the observation of the torn screen door. The DON stated that the resident`s room must be sealed from the outside by a screen to prevent small insects from entering the room. The DON stated the torn screen posed a health and safety risk to residents, as it had the potential to allow entry of insects that may transmit infection. During a review of the facility`s policy and procedures (P&P) titled, Homelike Environment,, the P&P indicated that Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.clean, sanitary and orderly environment. ˆˆˆˆˆˆˆˆˆˆˆˆˆ

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	055906	A. Building B. Wing	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to review, and update a care plan (a document outlining a detailed approach to care customized to an individual resident's need) after a resident`s Change of Condition (COC- an improvement or worsening of a resident`s condition which was not anticipated) for one of 19 sampled residents (Resident 12) by failing to review and revise the resident`s CP after his fall on 1/29/2026.This deficient practice had the potential to result in Resident 12 receiving inadequate care and supervision at the facility and an increased risk of recurrent falls. Findings: During a review of Resident 12's admission Record (face sheet), the admission Record indicated that the facility originally admitted the resident on 12/3/2025, and readmitted on [DATE], with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), nondisplaced fracture of base of neck of femur (a hip fracture where the thigh bone is broken at its lowest point near the hip joint, but the bone pieces remain in their normal position), and dysphagia (difficulty swallowing).During a review of Resident 12's Minimum Data Set (MDS- a resident assessment tool) dated 2/5/2026, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making were severely impaired, as the resident rarely or never made decisions. The MDS further indicated that Resident 12 was dependent (helper does all of the effort) on staff for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene. During a review of Resident 12's Post Fall Review form dated 1/29/2026, the Post Fall Review form indicated that on 1/29/2026 at 4:00 a.m., the resident was observed lying on the floor on the left side of the bed. The form indicated that Resident 12`s fall was unwitnessed and the resident denied hitting his head during the fall. The Interdisciplinary Team (IDT- a group of professionals from different disciplines such as physicians, nurses, social workers, and therapists who work together to develop and implement a comprehensive care plan for a resident) Review Summary of Root Cause section of the form indicated that IDT recommended to apply bilateral (both) landing pads (a floor pad designed to help prevent injury should a person fall) at the resident`s bedside to mitigate the risk of injury related to falls.During a review of Resident 12's COC Evaluation form dated 1/29/2026, timed at 4:00 a.m., the COC Evaluation form indicated that on 1/29/2026 at 4:00 a.m. Resident 12 had an unwitnessed fall.During a review of Resident 12's Physician Order Summary Report (physician order) dated 1/29/2026, the Order Summary Report indicated to apply landing pads on both sides of the resident`s bed.During a review of Resident 12`s Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated that Resident 12 had one to two falls within the last six months. The Fall Risk Assessment indicated that Resident 12 was assessed as being at high risk for falls.During a review of Resident 12's Safety and Fall Prevention care plan initiated on 12/19/2025, and last revised on 2/12/2026, the care plan indicated a goal for the resident to remain free from any injuries. The care plan interventions included providing supervision as needed, removing tripping hazards (any obstruction, uneven surface, or irregularity in a walking path that causes a person's foot to strike it, leading to a loss of balance and a potential fall), and encouraging the use of the call light for assistance.During a review of Resident 12's Risk for Fall and Injuries Related to Limited Mobility care plan initiated on 12/03/2025, the care plan indicated a goal for the resident to have less fall with injuries through next review period. The care plan interventions included maintaining the resident`s bed in a low position, ensuring adequate lighting, placing personal items within the resident`s reach, and providing a safe environment.During an observation on 3/28/2026 at 7:40 a.m., inside Resident 12`s room, the resident was observed in bed, with no landing pads present at the bedside.During a concurrent interview and record review on 3/28/2026 at 6:52 p.m., with the facility`s Assistant Director of Nursing (ADON), Resident 12's Physician Order Summary dated 1/29/2026, COC (continued on next page)

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	055906	A. Building B. Wing	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Evaluation form dated 1/29/2026, Safety and Fall Prevention care plan initiated on 12/19/2025, Risk for Fall and Injuries Related to Limited Mobility care plan initiated on 12/03/2025 and Post Fall Review form dated 1/29/2026 were reviewed. The ADON stated that Resident 12 had a COC due to a fall on 1/29/2026, and one of the IDT recommendations was to apply landing pads at the resident`s bedside. The ADON stated Resident 12`s physician ordered placement of landing pads on both sides of the resident`s bed on 1/29/2026. The ADON stated Resident 12`s Safety and Fall Prevention care plan was initiated on 12/19/2025, and last revised on 2/12/2026. However, the care plan did not include the use of bilateral landing pads as an intervention. The ADON stated Resident 12`s Risk for Fall and Injuries Related to Limited Mobility care plan, initiated on 12/03/2025 was not reviewed or revised following the resident`s fall on 1/29/2026. The ADON stated that licensed staff are required to review and update all fall care plans following a resident fall to ensure that any necessary new interventions are included and implemented. The ADON stated licensed staff did not review and update Resident 12`s care plans following the resident`s fall on 1/29/2026. Consequently, one of the IDT recommendation to place landing pads at the resident`s bedside was not incorporated as an intervention in the care plan. The ADON stated that this failure had the potential to result in inadequate care and an increased risk of injury to the resident.During an interview on 3/29/2026 at 5:06 p.m., with the Director of Nursing (DON), the DON stated licensed staff are required to review and revise residents` care plans following a COC, on a quarterly (every three months) basis, and as needed. The DON stated the purpose of reviewing and re-evaluating care plans is to assess the effectiveness of the care plan interventions and to ensure that all pertinent information and interventions related to the resident's care are accurately included in the care plan. The DON stated that failure to review and revise a resident's care plan after a fall could result in inadequate care and an increased risk of recurrent falls. During a review of the facility`s Policy and Procedure (P&P) titled Care Plans, Comprehensive Person-Centered, last reviewed on 1/29/2026, the P&P indicated assessments of residents are ongoing and care plans are revised as information about the residents and the resident`s conditions changed. The interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident`s condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay, at least quarterly, in conjunction with the quarterly MDS assessments.

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	03/29/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain good grooming and personal hygiene for one of one two residents (Resident 65) reviewed under the Activities of Daily Living care area by failing to ensure Resident 65's nails were trimmed.This deficient practice placed the resident at risk for skin injury and breakdown and infection. Findings: During a review of Resident 65's admission Record, the admission Record indicated the facility admitted the resident to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included severe protein-calorie malnutrition (a life-threatening condition caused by an extreme lack of protein and total calories, leading to severe weight loss, muscle wasting, and fat depletion), lack of coordination, and muscle weakness. During a review of Resident 65's Minimum Date Set (MDS- a standardized assessment and care screening tool) dated 2/11/2026, the MDS indicated Resident 65's cognition (a mental process of acquiring knowledge and understanding through thought experience and senses) was severely impaired. The MDS indicated Resident 65 was independent with eating, required partial/moderate assistance (helper does less than half the effort) with oral hygiene, and required substantial/maximal assistance (helper does more than half the effort) with toileting and personal hygiene. During an observation on 3/28/2026 at 10:05 a.m., in Resident 65's room, observed Resident 65's fingernails to be long, untrimmed, and unkempt. During a concurrent observation and interview on 3/29/2026 at 10:01 a.m. with the Desk Nurse (DN), in Resident 65's room, the DN observed Resident 65's fingernails. The DN stated that Resident 65's fingernails are long and unclean. The DN stated that Resident 65's fingernails should be kept trimmed and clean. During an interview on 3/29/2026 at 10:14 a.m. with the Director of Staff Development Assistant (DSDA), the DSDA stated that Certified Nursing Assistants (CNAs) are responsible for keeping residents' nails clean and trimmed. The DSDA stated that when CNAs see that residents' nails are long it is the CNAs responsibility to trim the residents' fingernails. The DSDA stated that there is no specific schedule for trimming the residents' nails. During a follow up interview on 3/29/2026 at 10:15 a.m. with the DN, the DN stated that residents' nails should be kept short and clean to promote personal hygiene, infection control and dignity. During a review of the facility's policy and procedure (P&P) titled Fingernails/Toenails, Care of, reviewed on 1/29/2026, the P&P indicated the purpose of the procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. The P&P indicated under general guidelines, the P&P indicates nail care includes daily cleaning and regular trimming.

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	055906	A. Building B. Wing	03/29/2026

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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 provide services that promote the prevention of pressure ulcer injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) by failing to ensure that one of four sampled residents (Resident 36) had heel protectors (a specialized medical device or wearable cushion designed to prevent or treat pressure ulcers on the heel) in place as ordered by the physician.This deficient practice placed Resident 36 at risk for developing a new pressure injury.Findings:During a review of Resident 36's admission Record (face sheet), the admission Record indicated that the facility originally admitted the resident on 6/26/2025, and readmitted on [DATE], with diagnoses including encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), pressure ulcer of right buttock stage three (full-thickness loss of skin in which dead and black tissue may be visible), and dysphagia (difficulty swallowing) following cerebral infarction (stroke, loss of blood flow to a part of the brain).During a review of Resident 36's Minimum Data Set (MDS- a resident assessment tool) dated 12/23/2025, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making were severely impaired (never or rarely made decisions). The MDS indicated that Resident 36 was dependent (helper does all of the effort) on staff for showering/bathing, toileting hygiene, and lower body dressing. The MDS indicated that Resident 36 required substantial/maximum assistance (helper does more than half the effort) for oral hygiene, personal hygiene, and upper body dressing. The MDS further indicated that Resident 36 was at risk for developing pressure ulcers and had pressure-reducing devices for both bed and chair.During a review of Resident 36`s Physician Order Summary Report (physician orders) dated 3/27/2026, the Order Summary Report indicated to apply bilateral (both) heel protectors for pressure injury prevention and management during every shift.During a review of Resident 36's Care Plan (CP- a document that outlines how a resident`s health care needs will be met) titled The resident is at risk for pressure sore or potential for pressure ulcer development, initiated on 8/27/2025, the CP indicated that the goal was for the resident to maintain intact skin, free from redness, blister (a painful skin condition where fluid fills a space between layers of skin) or discoloration (any abnormal change in skin color). The CP interventions included monitoring, documenting and reporting any changes in skin condition to the physician, as well as conducting weekly skin checks/assessments.During a concurrent observation, and interview on 3/28/2026 at 10:04 a.m., with Certified Nursing Assistant 1 (CNA 1), inside Resident 36`s room, Resident 36 was observed lying in bed without heel protectors in place. CNA1 stated that Resident 36 was not wearing heel protectors. CNA1 stated that she (CNA 1) was not aware of a physician's order requiring the application of heel protectors for Resident 36. During a concurrent observation, and interview on 3/28/2026 at 10:10 a.m., with Licensed Vocational Nurse 3 (LVN 3), inside Resident 36`s room, LVN3 stated that Resident 36`s was not wearing heel protectors. LVN 3 searched for heel protectors at Resident 36`s bedside and inside the resident`s closet. However, LVN 3 was unable to locate any.During a concurrent interview and record review on 3/28/2026 at 10:14 a.m., with LVN 3, Resident 36`s Physician Order Summary Report dated 3/27/2026 and Treatment Administration Record (TAR- a daily documentation record used by a licensed nurse to document treatments given to a resident) for March 2026 were reviewed. LVN 3 stated that on 3/27/2026, Resident 36`s physician ordered the application of bilateral heel protectors for the prevention of pressure injuries. However, Resident 36 was not wearing heel protectors. LVN 3 further stated that Resident 36`s TAR indicated licensed staff had documented the resident as wearing heel protectors on 3/27/2026 and 3/28/2026; however, LVN 3 stated she (LVN 3) was unable to locate any heel protectors in Resident 36`s room. LVN 3 stated licensed staff are responsible for implementing physician orders. LVN 3 stated Resident (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	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	36 was not wearing heel protectors as ordered by his (Resident 36) physician, placing the resident at risk for developing new pressure injury.During an interview on 3/30/2026 at 4:50 p.m., with the Director of Nursing (DON), the DON stated that licensed staff are required to implement physician orders to prevent pressure injuries in residents. The DON stated Resident 36 was not wearing bilateral heel protectors as ordered by the physician. The DON stated the potential outcome is skin breakdown and an increased risk for the development of pressure ulcers.During 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 that review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the devise, monitor regularly for comfort and signs of pressure related injury. For prevention measures associated with specific devices, consult clinical practice guidelines.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to provide services and treatments to maintain joint range of motion (ROM- full movement potential of a joint) for one of three sampled residents (Resident 10) by failing to follow physician's orders for a Restorative Nursing program (a nursing-driven service in long-term care settings that helps residents maintain or improve their functional abilities to their highest possible level) treatment to apply an inflatable therapy orthosis carrot (a soft, cone-shaped, inflatable hand splint used to treat severe finger contractures [clenched fists]). This deficient practice had the potential to cause further decline in functional mobility, ROM, and quality of life for Resident 10. Findings: During a review of Resident 10's admission Record, the admission Record indicated the facility admitted the resident to the facility on 6/29/2024 with diagnoses that included dementia (a progressive state of decline in mental abilities), lack of coordination, and contracture (a permanent tightening or shortening of muscles, tendons, skin, or tissues that causes joints to become stiff and restricts normal movement) of muscle, multiple sites. During a review of Resident 10's Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 12/24/2025, the MDS indicated Resident 10's cognition (a mental process of acquiring knowledge and understanding through thought experience and senses) was severely impaired. The MDS indicated Resident 10 was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 10's Order Summary Report, the Order Summary Report dated 9/11/2025, indicated an order for RNA: - to apply inflatable therapy Carrot orthosis to Right hand to prevent more fingers flexion contracture every day seven times a week. Seven hours daily as tolerated. Every day shift. Every Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Sunday. During a review of Resident 10's care plan (CP) addressing risk for decline in range of motion and risk of decreased muscle strength, initiated 7/31/2024, the CP indicated an intervention for RNA to apply an inflatable therapy carrot orthosis to the right hand to prevent more fingers flexion contracture every day seven times a week, seven hours daily as tolerated. During an observation on 3/29/2026 at 8:40 a.m., in Resident 10's room, observed Resident 10 in bed, without Resident 10's inflatable therapy carrot orthosis on his right hand. Observed Resident 10's inflatable therapy Carrot orthosis on top of Resident 10's bedside table. During an observation on 3/29/2026 at 10:10 a.m., in Resident 10's room, observed Resident 10 in bed, without Resident 10's inflatable therapy carrot orthosis on his right hand. Observed Resident 10's inflatable therapy Carrot orthosis on top of Resident 10's bedside table. During an observation on 3/29/2026 at 12:30 p.m., in Resident 10's room, observed Resident 10 in bed, without Resident 10's inflatable therapy carrot orthosis on his right hand. Observed Resident 10's inflatable therapy Carrot orthosis on top of Resident 10's bedside table. During a concurrent interview and observation on 3/29/2026 at 2:36 p.m. with the Desk Nurse (DN), in Resident 10's room, observed Resident 10 in bed. The DN stated that Resident 10's inflatable therapy carrot orthosis had not been applied. The DN stated that RNAs are responsible for applying Resident 10's inflatable therapy carrot orthosis. During an interview on 3/29/2026 at 2:37 p.m. with RNA 1, RNA 1 stated that he is assigned to Resident 10 today (3/29/2026), however, RNA 1 stated he did not apply Resident 10's inflatable therapy carrot orthosis. When asked why RNA 1 did not apply Resident 10's inflatable therapy carrot orthosis as ordered by the physician, RNA 1 did not respond. During a follow up interview on 3/29/2026 at 2:50 p.m. with the DN, the DN stated that Resident 10 should have had Resident 10's inflatable therapy Carrot orthosis applied because it is a physician's order. The DN stated that it is important to apply Resident 10's inflatable therapy Carrot orthosis to prevent further decline and worsening of contractures in the resident's right hand. During a review of the facility's policy and procedure titled, Restorative Nursing Services, reviewed on 1/29/2026, the P&P indicated resident will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative goals and objectives are individualized and resident-centered and are (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	03/29/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outlined in the resident's plan of care. During a review of the facility's policy and procedure titled, Assistive Devices and Equipment, reviewed on 1/29/2026, the P&P indicated that the facility maintains and supervises the use of assistive devices and equipment for residents. The P&P indicated certain devices and equipment that assist resident mobility, safety, and independence are provided for residents.

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	055906	A. Building B. Wing	03/29/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an environment that was free from accidents and hazards for two of four sampled residents investigated under accidents (Resident 12 and Resident 20) by failing to: 1.Apply landing pads (a floor pad designed to help prevent injury should a person fall) at Resident 12`s bedside as ordered by the physician. This deficient practice had the potential to place Resident 12 at risk for injuries in the event of a fall. 2. Check for placement and functionality of Resident 20`s wander management system (WMS - a wearable bracelet security technology designed to keep residents with memory issues from wandering away from safe areas) every shift from 3/5/2026 - 3/29/2026. This deficient practice placed Resident 20 at an increased risk for injuries and elopement (when a resident who is incapable of adequately protecting himself, and who departs the health care facility unsupervised and undetected)). 2. During a review of Resident 20's admission Record, the admission Record indicated the facility admitted Resident 20 on 3/27/2021 with diagnoses including diabetes type 2 (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and peripheral vascular disease (a narrowing of blood vessels that slows down the movement of blood in the body). During of review of Resident 20's History and Physical (H&P), the H&P indicated Resident 20 can make his needs known but cannot make medical decisions. During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20 could sometimes make himself understood and sometimes understand others and required substantial assistance (helper dose more than half the effort) for oral hygiene, upper body dressing and personal hygiene, showering, lower body dressing and putting off/on footwear. During a review of Resident 20's At risk for Elopement Care Plan (CP) initiated on 2/16/2024, the CP indicated an intervention for Resident 20 to wear a WMS and monitor for placement and function every shift. During a review of Resident 20's March 2026 Medication Administration Record (MAR), the MAR indicated to monitor for WMS placement and function each shift (7:00 A.M. – 3:00 P.M., 3:00 P.M. – 11:00 P.M, 11:00P.M. -7:00 A.M.) until 3/5/2026. Monitoring for placement and function was not completed from 3/5/3036 to 3/29/2026. During an initial pool interview on 3/28/2026 at 8:33 A.M. in Resident 20's room with Resident 20, Resident 20 was lying in bed and was unable to answer some questions properly and said some nonsensical (having no meaning, making no sense) phrases. Observed the WMS bracelet applied to Resident 20's right wrist. During a concurrent interview and record review on 3/29/2026 at 11:56 A.M., with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 20's March 2026 MAR and elopement CP. The ADON stated monitoring of placement and function of the WMS should be ongoing and not have ended on 3/5/2026. The ADON stated Resident 20 can get confused and has had an elopement attempt in the past and the WMS is important to help prevent any future elopement attempts. During a review of the facility's policy and procedure (P&P) titled, Wandering and Elopement, last (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	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed and revised on 1/29/2026, the P&P indicated the facility will identify residents who are at risk for unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Findings: a.During a review of Resident 12's admission Record (face sheet), the admission Record indicated that the facility originally admitted the resident on 12/3/2025, and readmitted on [DATE], with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), nondisplaced fracture of base of neck of femur (a hip fracture where the thigh bone is broken at its lowest point near the hip joint, but the bone pieces remain in theirˆnormal position), and dysphagia (difficulty swallowing). During a review of Resident 12's Minimum Data Set (MDS- a resident assessment tool) dated 2/5/2026, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 12 was dependent on staff (helper does all of the effort) for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, and personal hygiene. During a review of Resident 12's Post Fall Review form dated 1/29/2026, the Post Fall Review form indicated that on 1/29/2026 at 4:00 a.m., the resident was observed on the floor lying on the left side of the bed. The form indicated that Resident 12`s fall was unwitnessed and the resident denied hitting his head during the fall. The Interdisciplinary (IDT-a group of professionals from different disciplines such as physicians, nurses, social workers, and therapists who work together to develop and implement a comprehensive care plan for a patient) Review Summary of Root Cause section indicated that IDT recommended to apply bilateral (both) landing pads at the resident`s bedside.  During a review of Resident 12's Change in Condition Evaluation form (COC-an improvement or worsening of a patient`s condition which was not anticipated) dated 1/29/2026 at 4:00 a.m., the COC evaluation form indicated that on 1/29/2026 at 4:00 a.m. Resident 12 had an unwitnessed fall. During a review of Resident 12's physician Order Summary Report (physician order) dated 1/29/2026, the order summary report indicated to apply landing pad on both sides of the resident`s bed.  During a review of Resident 12`s Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated that Resident 12 had one-two falls within the last six months. The fall risk assessment indicated that Resident 12 was at high risk for falls. During an observation on 3/28/2026 at 7:40 a.m., inside Resident 12`s room, the resident was observed in bed, and no landing pads were present at the bedside.  During a concurrent interview and record review on 3/28/2026 at 8:06 a.m. with Registered Nurse 1 (RN 1), Resident 12's Physician Order Summary Report was reviewed. RN 1 stated that on 1/29/2026, Resident 12`s physician ordered to apply landing pads on both sides of the resident`s bed. During a concurrent observation and interview on 3/28/2026 at 8:10 a.m. with RN 1, inside Resident (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	03/29/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12`s room, RN 1 stated there are no landing pads placed at the resident`s bedside. RN 1 stated there should be landing pads placed at Resident 12`s bedside as ordered by his physician to protect the resident from injuries if fall occurs.  During a concurrent interview and record review on 3/28/2026 at 6:52 p.m. with the facility`s Assistant Director of Nursing (ADON), Resident 12's physician order summary report, COC and post fall review forms dated 1/29/2026 were reviewed. The ADON stated That Resident 12 had a fall on 1/29/2026, and one of the IDT recommendations was to apply landing pads at the resident`s bedside. The ADON stated Resident 12`s physician ordered to apply landing pads on both sides of the resident`s bedside on 1/29/2026, however, staff failed to place landing pads at Resident 12`s bedside. The ADON stated the potential outcome is increased risk of injury if fall occurs. During an interview on 3/29/2026 at 5:04 p.m. with the Director of Nursing (DON), the DON stated that staff are required to implement physician orders for fall precautions. The DON stated Resident 12 had a physician order for landing pads on both sides of the bed, which was not implemented by staff. The DON stated the potential outcome is increased risk of injuries in the event of a fall. During a review of the facility's policy and procedure(P&P) titled, Falls and Fall Risk, Managing, last reviewed on 1/19/2026,the P&P indicated that the IDT team with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) for falls for each resident at risk or with a history of falls. In conjunction with the attending physician, licensed staff will identify and implement relevant interventions (e.g., low bed position, floor pad) to try to minimize serious consequences of falling.

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	055906	A. Building B. Wing	03/29/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review the facility failed to: a. Ensure a resident who had a diagnosis of obstructive and reflux uropathy (a blockage in the urinary system that prevents urine from flowing freely, causing it to back up and potentially damage the kidneys. Reflux uropathy is the backward flow of urine from the bladder to the kidneys) receives appropriate treatment and services to prevent recurring urinary tract infections (UTI, common infections that happen when bacteria infect the urinary tract) by failing to keep urinary catheter (a tube that is inserted into the bladder, allowing urine to drain) tubing from forming a dependent loop (a urinary catheter dependent loop isˆa U-shaped sag in the drainage tubing that falls below the collection bag, creating a low point that disrupts gravity drainage. It causes urine to pool, leading to bacteria growth, reduced bladder drainage, and a high risk of catheter-associated urinary tract infections) and allowing the contents to flow freely into the urinary catheter bag (container that connects to a urinary catheter and collects urine) for one of four residents (Resident 2) investigated under the care area Bowel and Bladder Incontinence. This deficient practice had the potential to result in ineffective treatment and management of Resident 2`s current diagnosis of UTI. b. Ensureˆoneˆofˆfourˆsampled resident (Residentˆ99) with an indwelling catheter received proper care and services by failing toˆprovideˆmonitoringˆasˆindicated in the resident`s care planˆ(CP-a document that outlines how a patient`s health care needs will be met).ˆ ˆThisˆdeficient practice had the potential to result in Residentˆ99ˆreceiving inadequate care andˆmonitoringˆat the facility.ˆˆ Findings: a. During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted the resident on 6/29/2021 and readmitted the resident on 2/27/2026 with diagnosis including, muscle weakness, urinary tract infection and obstructive uropathy (a blockage in the urinary tract that prevents urine from flowing properly, causing it to back up and potentially damage the kidneys). During a review of Resident 2's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 3/02/2026, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 2 required partial/moderate assistance (helper does more than half the effort) from staff for eating, oral hygiene, upper body dressing, personal hygiene and dependent (helper does all the effort) on staff for toileting hygiene, shower, lower body dressing and putting on/taking off footwear. During a review of Resident 2` Order Summary Report (OSR) as of 3/28/2026, the OSR indicated an order for Foley ˆ(a type of indwelling urinary catheter) Catheter (a flexible, indwelling tube inserted through the urethra into the bladder to continuously drain urine into a bag) French #16/5 cc (French;ˆ16ˆinches in length;ˆ5ccˆballon secures catheter in place) to bedside drainage due to diagnosis of obstructive uropathy dated 2/27/2026. The OSR also included an order for Daptomycin (an antibiotic used intravenously to treat severe infections of the skin, bloodstream [bacteremia]) Intravenous (IV therapy is a medical process that administers fluids, medications and nutrients directly into a person's vein) Solution Reconstituted Use 325 milligram (mg) intravenously every 24 hours for Bacteremia/Sepsis (a life-threatening reaction to an infection) for 5 weeks dose to start on 2/27/2026 at the facility. During an observation on 03/28/2026 at 5:52 p.m. in Resident 2`s room, with Licensed Vocational Nurse 2 (LVN 2) observed Resident 2 lying on her bed with the indwelling urinary catheter tubing visible below the side of the mattress. The catheter tubing formed a U shaped loop with the end of the (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	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	loop pointing downwards to the urine collection bag. The portion of the tubing where the loop started contained light yellow urine that was pooling in the loop and was not draining to the urine collection bag. During an interview on 3/28/2026 at 5:58 p.m. with LVN 2, LVN2 stated that the indwelling urinary catheter tubing should not form a loop to ensure there is no pooling of urine which can potentially cause the urine to flow back to the bladder. LVN 2 stated that urine backflow can cause urinary tract infection. During a review of the facility`s policy and procedure (PP) titled Catheter Care, Urinary, last reviewed on 1/29/2026, the PP indicated that The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections.check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks.position the drainage bag lower than the bladder at all time to prevent urine from flowing back into the urinary bladder.,. b. During a review of Resident 99's admission Record (face sheet), the admission Record indicated that the facility admitted the resident on 3/25/2026, with diagnoses includingˆurinary tract infection (UTI),ˆdysphagia (difficulty swallowing), andˆobstructive and reflux uropathyˆ(when the urine instead of flowing from your kidneys to your bladder, flows backward, or refluxes, into your kidneys because of an obstruction).ˆ During a review of Resident 99`s physician History and Physical (H&P) dated 3/27/2026, the H&Pˆindicatedˆthatˆthe resident did not have the capacity for medical decision making.ˆˆ During a review of Residentˆ99's Physician Order Summary Report datedˆ3/25/2026, the Order Summary Reportˆindicatedˆtoˆprovide indwelling catheter care:ˆwash with soap and water, and pat dryˆduring every shift.ˆThe order summaryˆreport indicated to change theˆfoley catheter (a type of indwelling catheter)ˆand the bagˆif leaking, pluggedˆ(block or fill in)ˆor pulled out, obstructed,ˆwithˆexcessive sedimentationˆ(when there is a significant buildup of mineral crystals, bacteria, and on the inner or outer surface of the catheter),ˆor whenˆthe closed system is compromisedˆ(damaged).ˆ During a review of Residentˆ99's care planˆtitled At risk for infection due toˆindwelling catheter,ˆinitiatedˆonˆ3/26/2026, the care planˆindicatedˆa goal that the resident willˆremain freeˆfromˆcatheter-relatedˆtrauma through the next review.ˆThe care plan interventions were toˆposition catheter bag and tubing below the level of the bladderˆand away from the entrance room door, check the tubing for kinks, monitor/document for pain/discomfort due to catheter, monitor/recordˆand report signsˆand symptoms ofˆUTI, pain, burning, blood tinged urineˆ(presence of blood inˆthe urine), cloudiness, no output, foul smellingˆ(having a very bad smell)ˆurine, fever, chills, altered mental status, change in behavior and eating pattern to the physician.ˆ During a review of Residentˆ99's Treatment Administration Record (TAR- a daily documentation record used by a licensed nurse to document treatments given to a resident)ˆand Medication Administration Recordˆ(MAR - a daily documentation record used by a licensed nurse to document medications given to a resident)ˆforˆMarch 2026,ˆthe TARˆand MARˆdid not indicateˆanyˆdocumentedˆevidenceˆthatˆlicensed staffˆprovidedˆmonitoringˆfor Resident 99`sˆindwelling catheter.ˆˆ (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	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review onˆ3/28/2026ˆatˆ7:00 p.m., withˆthe Assistant Director of Nursingˆ(ADON), Residentˆ99`sˆphysician orders, care plans,ˆandˆTAR and MARˆfor Marchˆ2026ˆwere reviewed.ˆThe ADONˆstatedˆthat Residentˆ29`sˆindwelling catheterˆcare plan interventions were to position catheter bag and tubing below the level of the bladder and away from the entrance room door, check the tubing for kinks, monitor/document for pain/discomfort due to catheter, monitor/record and report sign and symptoms of UTI, pain, burning, blood tinged urine, cloudiness, no output, foul smelling urine, fever, chills, altered mental status, change in behavior and eating pattern to the physician.ˆHowever,ˆthere is no documented evidence in the resident`s MAR or TAR that licensed staff orˆCertified Nursing Assistants (CNA)ˆimplemented these interventions andˆprovided monitoring for theˆresident.ˆTheˆADONˆstatedˆthatˆthe potential outcome of notˆprovidingˆappropriateˆmonitoringˆfor a resident withˆanˆindwellingˆcatheterˆisˆlack of care,ˆincreased risk ofˆUTI,ˆand inability toˆidentifyˆand reportˆcomplications toˆthe physician.ˆ During an interview onˆ3/29/2026ˆatˆ5:11ˆp.m., with theˆDirector of Nursing (DON), the DONˆstatedˆthatˆlicensed staffˆare requiredˆtoˆimplement residents` care plan interventionsˆand monitor for effectiveness of the interventions. The DONˆstatedˆlicensed staffˆare required toˆmonitorˆtheˆresidentsˆwithˆanˆindwelling catheterˆfor sign and symptoms of infection,ˆprovide indwelling catheter care,ˆandˆdocument their monitoringˆand careˆin the residents` medical record.ˆThe DONˆstatedˆthat licensed staff did notˆimplementˆResident 99`s care plan interventions for the indwelling catheterˆandˆfailed toˆmonitorˆthe residentˆforˆside effectsˆassociated with having anˆindwelling catheter. The DONˆstatedˆthe potential outcome is increased risk of UTI and inability toˆidentifyˆand report complications to the physician.ˆ Duringˆaˆreview of the facility`s Policy and Procedure (P&P) titled CatheterˆCare,ˆUrinary last reviewed on 1/29/2026, the P&Pˆindicatedˆthatˆthe purpose of this policy is toˆpreventˆcatheter-associated urinaryˆtract infections.ˆReview the resident`s care plan toˆassessˆany special needs of the resident.ˆObserved the resident for complications associated with urinary catheters. Report unusual findings to the physician or supervisorˆimmediately.ˆThe following information should be recorded in the resident`s medical record: the date and time that catheter care was given, the name and title of the individual giving the catheter care, all assessment data obtained when giving catheter care,ˆcharacter of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood) and odor,ˆhow the resident tolerated the procedure and if the resident refused the procedure, the reason why and the interventions taken.ˆ

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	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and record review, the facility failed to ensure the enteral feeding (delivers liquid nutrition directly to the stomach or small intestine via a tube for individuals unable to meet nutrient needs orally) rate was transcribed (written) on the enteral feeding formula bottle for one of one sampled resident (Resident 43). This deficient practice had the potential to place Resident 43 at risk for not receiving the correct amount of feeding formula per physician's order which could result in unintended weight loss.Findings: During a review of Resident 43's admission Record, the admission Record indicated that the facility admitted the resident on 9/29/2025 with diagnoses including muscle weakness and encounter for attention to gastrostomy (G-tube, a tube inserted through the belly that brings nutrition directly to the stomach). During a review of Resident 43's Minimum Data Set (MDS-a resident assessment tool) dated 12/23/2025, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 43 required substantial/maximal assistance (helper does more than half the effort) from staff for oral hygiene, toileting hygiene, upper body dressing, lower body dressing, and personal hygiene. During an observation on 3/28/2026 at 9:05 a.m., observed Resident 43 in her room sleeping. Upon checking the resident`s environment, observed a G-tube feeding pump turned off at the time and the feeding bottle formula (Isosource 1.5 calories) hanging on the G-tube pole had no written tube feeding order in the label. During a concurrent observation and interview on 3/28/2026 at 9:32 a.m., with Licensed Vocational Nurse 7 (LVN 7), in Resident 43`s room, observed Resident 43's G-tube feeding pump turned off at this time and the feeding bottle formula (Isosource 1.5 calories) hanging on the G-tube pole with no written tube feeding order on the label. LVN 7 stated that the nurse that hung the feeding formula bottle should have transcribed on the label the rate of infusion or feeding rate order in order to ensure the physician`s ordered rate is accurately reflected in the label. LVN 7 stated if there is no feeding rate on the label, it may result in inaccurate delivery of the amount of formula the resident will receive which could result in unintended weight loss. During a concurrent interview and record review on 3/28/2026 at 10:00 a.m., with LVN 7, reviewed Resident 43's physician`s order dated 3/25/2026 for enteral feeding Isosource 1.5 via G-tube at 50 milliliter/hour (ml- [unit of measurement]/hr) for 20 hrs., off at 8 a.m. and on at 12 noon or until dose is met to provide 1000 ml volume/1500 kilocalories (kcal- a unit of energy). During a review of the facility's policy and procedure (P&P) titled, Enteral Tube Feedings via Continuous Pump Gastrostomy Tube., last reviewed on 1/29/2026, the P&P indicated, The purpose of this procedure is to provide a guideline for the use of a pump for enteral feedings .check the enteral nutrition label against the order before administration, check the following information:A. Resident name, ID and room number;B. Type of formula;C. Date and time formula was prepared;D. Route of delivery;E. Access site;F. Method (pump, gravity, syringe) andG. Rate of administration (mL/hr.).

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	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to: 1. Obtain a physician's order prior to administering oxygen for one of two sampled residents (Resident 99). 2. Ensure a resident's nasal canula (NC- a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) oxygen tubing was labeled with the date and time it was last changed for one of two sampled residents (Resident 99). These deficient practices had the potential to place Resident 99 at increased risk of infection, and cause complications associated with oxygen therapy. 3. Ensure a resident received continuous oxygen as ordered by the physician for one of two sampled residents (Resident 11). This deficient practice had the potential to cause Resident 11 to have shortness of breath that could lead to hypoxemia (a low level of oxygen in the blood).Findings: a. During a review of Resident 99's admission Record, the admission Record indicated that the facility admitted the resident on 3/25/2026, with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), dysphagia (difficulty swallowing), and lack of coordination. During a review of Resident 99`s History and Physical (H&P) dated 3/27/2026, the H&P indicated that the resident did not have the capacity for medical decision making.  During an observation on 3/28/2025 at 8:00 a.m., inside Resident 99`s room, observed Resident 99 lying in bed receiving oxygen at two liters per minute (LPM- unit of measurement for oxygen) via nasal cannula. Resident 99`s oxygen tubing was not labeled with the date and time it was last changed.  During a concurrent observation and interview on 3/28/2026 at 8:04 a.m., inside Resident 99`s room with Registered Nurse 1 (RN 1), observed Resident 99 lying in bed receiving oxygen at two LPM via nasal cannula. RN 1 stated that Resident 99`s oxygen tubing did not have a label with the date and time of when it was last changed. RN 1 stated that the facility staff are required to change oxygen tubing once a week on Saturdays and as needed and label the tubing with the date it was last changed. RN 1 stated the potential outcome of not labeling a resident`s oxygen tubing is an inability to determine when the tubing was last changed, which could place the resident at risk for infection.  During a concurrent interview and record review on 3/28/2026 at 8:10 a.m., with RN 1, reviewed Resident 99`s physician orders. RN 1 stated that there was no physician order for the administration of oxygen for Resident 99. RN 1 stated that oxygen administration to residents requires a physician order prior to use. During a concurrent interview and record review on 3/28/2026 at 8:20 a.m., with the Director of Nursing (DON), reviewed Resident 99`s physician orders. The DON confirmed by stating that there was no physician order to administer oxygen to Resident 99. The DON stated a physician order is required for administering oxygen to residents. The DON stated the potential outcome of administering oxygen without a physician order is exposing the resident to complication of oxygen therapy such as shortness of breath. The DON further stated that the facility staff are required to change the oxygen tubing once per week and as needed and label the tubing with the date and time it was last changed. The DON stated the potential outcome of not changing and labeling oxygen tubing is the increased risk of infection for the residents. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, reviewed on (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	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/29/2026, the P&P indicated that verify that there is a physician`s order for this procedure. Review the physician`s order or facility protocol for oxygen administration. b. During a review of Resident 11's admission Record, the admission Record indicated the facility admitted the resident on 12/28/2024 with diagnoses that included metabolic encephalopathy (underlying systemic conditions or substances that disrupt the brain's chemical balance, leading to brain dysfunction), muscle weakness, dysphagia (difficulty swallowing), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 11's Minimum Data Set (MDS- a resident assessment tool) dated 1/1/2026, the MDS indicated Resident 11's cognition (a mental process of acquiring knowledge and understanding through thought experience and the sense) was moderately impaired. The MDS indicated Resident 11 required substantial/maximal assistance (staff does more than half the effort) with eating and personal hygiene and was dependent (staff does all of the effort) on staff with oral care and toileting hygiene. During a review of Resident 11's Order Summary Report, the Order Summary Report indicated an order to administer oxygen at two (2) LPM via nasal canula continuously to keep oxygen saturation (a measure of how much oxygen is in your blood) >90%, dated 10/28/2025. During an observation on 3/28/2026 at 8:40 a.m., in Resident 11's room, observed Resident 11 in bed with their mouth open with the oxygen nasal canula in Resident 11's mouth. During a concurrent observation and interview on 3/28/2026 at 8:46 a.m., with the Registered Nurse Case manager (RNCM) in Resident 11's room, observed Resident 11's mouth open with the oxygen nasal canula in Resident 11's mouth. Observed the RNCM fix Resident 11's nasal cannula and placed Resident 11's nasal canula prongs into Resident 11's nostrils. The RNCM stated that Resident 11's nasal canula was not in place and should not be in Resident 11's mouth. The RNCM stated the nasal canula prongs should be in Resident 11's nostrils. During an interview on 3/28/2026 at 5:12 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that it is important for the nasal canula to be properly placed in resident's nostrils to ensure residents are getting the oxygen per facility policy and per physician's order. The ADON stated that potential negative outcomes that a resident may experience if not getting the ordered oxygen could be dizziness, tachycardia (increase heart rate), and shortness of breath. During a review of the facility's P&P titled, Oxygen Administration, reviewed on 1/29/2026, the P&P indicated oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose.

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	03/29/2026

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview, and record review, the facility failed to ensure a resident's drug regimen was free from unnecessary medications (any medication in excessive dose, excessive duration, without adequate monitoring) for one of one sampled residents (Resident 99) by failing to monitor Resident 99 for sign and symptoms of bleeding for the use of enoxaparin sodium (an anticoagulant [blood thinner] used to prevent and treat harmful blood clots) in accordance with the facility's policy and procedure on Anticoagulation-Clinical Protocol. This deficient practice had the potential for Residents 99 to receive suboptimal (less than the highest standard or quality) care, and experience serious adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) possibly resulting in bleeding, hospitalization, or death. Findings: During a review of Resident 99's admission Record (face sheet), the admission Record indicated that the facility admitted the resident on 3/25/2026, with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), dysphagia (difficulty swallowing), and obstructive and reflux uropathy (when the urine instead of flowing from your kidneys to your bladder, flows backward, or refluxes, into your kidneys because of an obstruction). During a review of Resident 99`s physician History and Physical (H&P) dated 3/27/2026, the H&P indicated that the resident did not have the capacity for medical decision making. During a review of Resident 99's Physician Order Summary Report dated 3/25/2025, the Order Summary Report indicated that Resident 99 was prescribed Enoxaparin Sodium injection solution 40 milligrams (mg- a unit of measure of mass)/0.4 milliliters (ml- a unit of measure of volume), inject one dose subcutaneously (applied under the skin) every 24 hours for Deep Vein Thrombosis (DVT- when a blood clot forms in one or more of the deep veins in the body, usually in the legs) prophylaxis (preventive treatment). During a review of Resident 99's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications given to a resident) for March 2026, the MAR indicated that Resident 99 was administered enoxaparin sodium injections on 3/26/2026 and 3/27/2026. The MAR contained no documentation of monitoring for signs and symptoms of bleeding or bruising related to the use enoxaparin sodium. During a concurrent interview and record review on 3/28/2026 at 6:40 p.m., with Assistant Director of Nursing (ADON), Resident 99`s Physician Order Summary report and MAR for March 2026 were reviewed. The ADON stated Resident 99's order summary report did not include any physician order for monitoring the side effects (unwanted or dangerous medication effects) of enoxaparin sodium such as bleeding and bruising. The ADON stated licensed staff did not obtain physician order to monitor Resident 99 for side effects of Enoxaparin Sodium. The ADON stated licensed staff are required to obtain a physician order to monitor residents on anticoagulants for side effects, ensuring the residents do not experience bleeding. The ADON stated licensed staff did not monitor Resident 99 for the side effects of enoxaparin sodium and the potential outcome is to cause bleeding of the resident. During an interview on 3/29/2026 at 5:15 p.m., with the Director of Nursing (DON), the DON stated residents receiving anticoagulants should be monitored for bleeding, as it is a known side effect of these medications. The DON stated Resident 99 was prescribed enoxaparin and that monitoring for bleeding during its use was important to ensure any bleeding would be identified and addressed. During a review of the facility's policy and procedures (P&P) titled, Anticoagulation-Clinical Protocol, last reviewed on 1/29/2026, the P&P indicated that assess for any signs and symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. The staff and physicians will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria (blood in urine), or any other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.

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	03/29/2026

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors by failing to rotate clonidine patch (medication patch used to treat hypertension [high blood pressure- the force of the blood pushing on the blood vessel walls is too high]) administration sites for one of one sampled resident (Resident 40). This deficient practice had the potential for skin irritation and for the medication to not work as intended.Findings: During a review of Resident 40's admission Record, the admission Record indicated the facility admitted Resident 40 on 1/10/2026 with diagnoses including intercerebral hemorrhage (stroke, loss of blood flow to a part of the brain by a broken blood vessel causing bleeding into the brain), dysphagia (difficulty swallowing), and hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]). During a review of Resident 40's Minimum Data Set (MDS- a resident assessment tool) dated 1/15/2026, the MDS indicated Resident 40 could make himself understood and understand others and required partial assistance (helper dose less than half the effort) for oral hygiene and personal hygiene and was dependent (helper does all the work) on staff for toileting, showering, lower body dressing and putting off/on footwear. During a review of Resident 40's Order Summary Report, the Order Summary Report indicated an order for clonidine transdermal (on the skin) patch weekly 0.2 milligram (mg- unit of measurement)/24 hour. Apply one patch transdermally every Saturday for hypertension. Please alternate/rotate site. Ordered 1/11/2026. During a review of Resident 40's Medication Administration Record (MAR, a report detailing the medications administered to a resident by the licensed nurse in the facility) from 2/1/2026 to 3/29/2026, the MAR indicated the following for clonidine transdermal patch:- On 2/14/2026 removed from right arm- On 2/14/2026 placed on right arm- On 2/21/2026 removed from left arm- On 2/21/2026 placed on left arm- On 3/14/2026 removed from right arm- On 3/14/2026 placed on right arm During a concurrent interview and record review on 3/29/2026 at 9:40 a.m., with Licensed Vocational Nurse 4 (LVN 4), reviewed Resident 40's MAR from 2/1/2026 to 3/29/2026. LVN 4 stated on 2/14/2026, 2/21/2026, and 3/14/2026, Resident 40's clonidine transdermal patch should have been rotated, and it was not. LVN 4 stated it is important to rotate the site because licensed nurses should follow the doctors' orders and it could irritate the resident's skin. During a concurrent interview and record review on 3/29/2026 at 11:06 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 40's MAR from 2/1/2026 to 3/29/2026. The ADON stated clonidine patches must be rotated to avoid harm to the skin. During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, last reviewed and revised on 1/29/2026, the P&P indicated medications are administered as prescribed in accordance with good nursing principles and practice. During a review of the facility-provided manufacturer's guideline on the use of Catapres (brand name for clonidine) patch patient instructions, undated, the guideline indicated after one week, remove the old patch and discard it and after choosing a different site, place the new patch.

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	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure temperatures were checked and documented for one of two refrigerators (Refrigerator 1) in Medication room [ROOM NUMBER]. This deficient practice had the potential to compromise integrity of the medications stored in medication room one refrigerator.Findings: During a concurrent observation, interview, and record review on 3/28/2026 at 12:35 p.m., in Medication room [ROOM NUMBER] with Licensed Vocational Nurse 3 (LVN 3), observed and reviewed Refrigerator 1's temperature log. LVN 3 stated there were no documented temperatures on:- 3/8/2026 at 7:00 a.m.- 3/8/2026 at 11:00 p.m.- 3/15/2026 at 7:00 a.m.LVN 3 stated the medication refrigerator must be checked and documented twice a day, once on day shift (7:00 a.m. - 3:00 p.m.) and once on night shift (11:00 p.m. - 7:00 a.m.) to make sure the medications are the correct temperature and safe to give to the residents. During an interview on 3/29/2026 at 12:16 p.m., with the Assistant Director of Nursing (ADON), the ADON stated correct temperature is very important to the integrity of medication, especially those that require refrigeration. The ADON stated licensed nurses must check and record the temperature of each refrigerator twice a day to ensure they are in good working order to keep the medications safe for use on the residents. During a review of the facility's P&P titled, Medication Labeling and Storage, reviewed on 1/29/2026, the P&P indicated the facility must store all medications and biologicals in locked compartments under proper temperature, humidity and light controls. The P&P indicated medications requiring refrigeration are to be stored in a refrigerator located in the medication room.

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	055906	A. Building B. Wing	03/29/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for one of two sampled residents (Resident 36) by failing to include the resident`s diagnosis of anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life) on the current diagnoses list. This deficient practice placed Resident 36 at risk of not receiving appropriate care due to inaccurate medical care information. Findings: During a review of Resident 36's admission Record, the admission Record indicated that the facility originally admitted the resident on 6/26/2025 and readmitted on [DATE], with diagnoses including encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), pressure ulcer of right buttock stage three (full-thickness loss of skin, dead and black tissue may be visible), and dysphagia (difficulty swallowing) following cerebral infarction (stroke, loss of blood flow to a part of the brain). The admission record did not indicate that Resident 36 had a diagnosis of anxiety disorder. During a review of Resident 36's Minimum Data Set (MDS- a resident assessment tool) dated 12/23/2025, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 36 was dependent on staff (helper does all of the effort) for showering/bathing, toileting hygiene, and lower body dressing. The MDS indicated that Resident 36 required substantial/maximum assistance (helper does more than half the effort) for oral hygiene, personal hygiene, and upper body dressing. The MDS did not indicate that Resident 36 had a diagnosis of anxiety disorder. The MDS further indicated that Resident 36 was taking anti-anxiety medication (a medication used to treat symptoms of anxiety). During a review of Resident 36`s Psychoactive and Sedative/Hypnotic Assessment form dated 8/27/2025, the form indicated that the resident`s physician ordered clonazepam (a medication to treat anxiety) 0.5 milligrams (mg- a unit of measure for mass), one tablet via gastrostomy tube (G-Tube- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) two times a day for diagnosis of anxiety manifested by restlessness with episode of pulling out G-Tube. During a review of Resident 36's Care Plan (CP-a document that outlines how a patient`s health care needs will be met) titled Resident 36 has anxiety related to anxiety disorder as manifested by restlessness, initiated on 10/09/2025, the care plan indicated a goal that the resident will show decreased episodes of sign and symptoms of anxiety through the next review. The care plan interventions were to administer anti-anxiety medications ordered by the physician, and to monitor and document side effects and effectiveness of the medication. During a review of Resident 36`s physician Order Summary Report (physician orders) dated 3/27/2026, the Order Summary Report indicated to administer clonazepam oral tablet 0.5 mg one tablet via G-Tube two times a day for anxiety manifested by restlessness with episode of pulling out G-Tube. During a review of Resident 36`s Psychiatric Note completed by Nurse Practitioner 1 (NP 1) on 11/04/2025, the psychiatric note indicated that the resident had a diagnosis of generalized anxiety disorder. During a review of Resident 36`s Psychiatric Note completed by NP 1 on 1/12/2026, the psychiatric note indicated that the resident had a diagnosis of generalized anxiety disorder. During a concurrent interview and record review on 3/29/2026 at 11:10 a.m., with the Assistant Director of Nursing (ADON), Resident 36`s physician order summery report, MDS, psychiatric notes, and admission records were reviewed. The ADON stated on 8/27/2025, Resident 36 physician ordered clonazepam 0.5 mg two times a day via G-Tube for diagnosis of anxiety disorder. The ADON stated on 10/09/2025, licensed staff developed a CP for the resident`s anxiety related to his anxiety disorder (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	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnosis. The ADON stated Resident 36`s psychiatric notes dated 11/4/2025 and 1/12/2026 indicated that the resident had a diagnosis of anxiety disorder. However, licensed staff failed to include the resident`s anxiety disorder diagnosis on the current diagnoses list. The ADON stated residents` medical record should be complete, accurately documented, including all the residents` current diagnoses. The ADON stated that the potential outcome of not including Resident 36`s anxiety disorder in the current diagnoses list is an increased risk of the resident not receiving appropriate care due to an inaccurate medical record. During an interview on 3/30/2026 at 5:00 p.m., with the Director of Nursing (DON), the DON stated that the facility is responsible for ensuring that residents` medical record were complete and accurate, including documentation of all current diagnoses. The DON stated that the potential outcome of not including Resident 36`s anxiety disorder in the current diagnoses list is an increased risk of the resident not receiving appropriate care due to an inaccurate medical record. During review of facility`s Policy and Procedure (P&P) titled Charting and Documentation, last reviewed on 1/29/2026, the P&P indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident`s medical, physical, functional, or psychosocial condition shall be documented in the resident`s medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident`s condition and response to care.

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	03/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rinaldi Convalescent Hospital	16553 Rinaldi St Granada Hills, CA 91344

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review, the facility failed to ensure the facility arranged provisions of hospice services for one of one sampled residents (Resident 11) by failing to: 1.Ensure the hospice attending physician assessed and completed a history and physical (H&P- a comprehensive, structured evaluation performed by a clinician, combining subjective patient-reported history with objective physical exam findings to guide diagnosis and treatment). 2. Ensure the hospice agency provided training programs in hospice care for facility staff per contractual agreement. These deficient practices had the potential to negatively affect Resident 11's physical comfort, psychosocial (state of mental, emotional, and social health of an individual) well-being, and had the potential to delay or have a lack of necessary care and services.Findings: a. During a review of Resident 11's admission Record, the admission Record indicated the facility admitted the resident on 12/28/2024 with diagnoses that included metabolic encephalopathy (underlying systemic conditions or substances that disrupt the brain's chemical balance, leading to brain dysfunction), muscle weakness, dysphagia (difficulty swallowing), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 11's Minimum Data Set (MDS- a resident assessment tool) dated 1/1/2026, the MDS indicated Resident 11's cognition (a mental process of acquiring knowledge and understanding through thought experience and the senses) was moderately impaired. The MDS indicated Resident 11 required substantial/maximal assistance (staff does more than half the effort) with eating and personal hygiene and was dependent (staff does all of the effort) on staff with oral care and toileting hygiene. During a concurrent interview and record review on 3/28/2026 at 5:25 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 11's medical records for a hospice H&P. The ADON stated she was unable to locate a hospice H&P. The ADON stated that when hospice staff come to the facility, hospice staff sign-in in the hospice binder. The ADON stated that signing in the hospice binder ensures that the hospice staff was physically in the facility. The ADON reviewed the hospice sign-in sheets from 12/23/2025- 3/27/2026 and stated that there is no documented evidence that the hospice physician was in the facility to evaluate Resident 11. During a concurrent interview and record review on 3/29/2026 at 1:09 p.m., with the Medical Records Assistant (MRA), the MRA stated that there was no documented hospice H&P for Resident 11. During an interview on 3/29/2026 at 5:13 p.m., with the Director of Nursing (DON), the DON stated that Resident 11 should have a hospice H&P because hospice is another level of care that the resident is being placed on. The DON stated the hospice H&P will reflect the current level Resident 11 is on and is a formal endorsement of care to confirm terminal illness. The DON continued to state that the hospice H&P will assist facility staff in formulating a comfort focused plan of care. During a review of the facility's policy and procedure (P&P) titled, Hospice Program, reviewed on 1/26/2026, the P&P indicated hospice providers who contract with this facility are held responsible for meeting the same professional standards and timelines of service as any contracted individual or agency associated with the facility. During a review of the facility's hospice contract titled, Hospice- Skilled Nursing Facility Agreement, undated, the facility's hospice contract indicated under hospice physician services: Hospice physicians and/or the medical director shall evaluate each Hospice patient in the nursing facility as necessary and in accordance with applicable federal and state laws, and the Hospice plan of care for each patient. The services of Hospice Physicians shall relate solely to the Hospice Patient's terminal illness and, therefore, shall not duplicate or replace the surfaces of the attending physician. b. During an interview on 3/28/2026 at 5:40 p.m., with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated that she provides care to Resident 11. LVN 5 stated she has not been provided with education or in-service training by Resident 11's hospice agency. During an interview on 3/28/2026 at 5:44 p.m., with Registered Nurse 2 (RN 2), RN 2 stated that she provides care to (continued on next page)

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	055906	A. Building B. Wing	03/29/2026

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 11. RN 2 stated she has not been provided with education or in-service training by Resident 11's hospice agency.During an interview on 3/29/2026 at 3:45 p.m., with the Director of Staff Development (DSD), the DSD stated that Resident 11's hospice agency has not provided in-service training to the facility staff. During a concurrent interview and record review on 3/29/2026 at 4:51 p.m., with the Administrator (ADM), the ADM stated that Resident 11's hospice agency is contractual to the facility and that the ADM is responsible for the contract. The ADM reviewed the hospice contract and stated that Resident 11's hospice agency should have provided in-service training to the facility staff per the contract. The ADM further stated that it is important for the hospice agency to provide in-service training to facility staff so that facility staff are aware of any specific documentation or specific policies of the hospice company. During a review of the facility's hospice contract titled, Hospice- Skilled Nursing Facility Agreement, undated, the facility's hospice contract indicated under training, education and assessment: Hospice shall provide orientation and training for all personnel, including but not limited to the staff specific job duties, and hospice's philosophy, policies and procedures regarding methods of comfort, pain control, and symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements. In addition, hospice shall assess the skills and competence of all personnel, and, as necessary, provide in service training and education programs where required. Hospice shall have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 month period.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure medications are administered in a safe manner by failing to perform hand hygiene before and after medication administration for two of six sampled residents (Resident 71 and 102) observed during medication administration. 2. Ensure Certified Nursing Assistant 1 (CNA 1) did not place her personal purse and cell phone on the bedside table belonging to one of one sampled resident (Resident 8). These deficient practices had the potential to spread infection and cross contamination (the physical movement or transfer of harmful bacteria [germs] from one person, object, or place to another) among staff and other residents.Findings: 1.a. During a review of Resident 71's admission Record, the admission Record indicated the facility admitted the resident on 8/25/2020 with diagnosis including, hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and chronic kidney disease (a serious, long-term condition where kidneys are damaged and cannot properly filter blood, often leading to waste buildup). During a review of Resident 71's Minimum Data Set (MDS- a resident assessment tool) dated 2/23/2026, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 71 required substantial/maximal assistance (helper does more than half the effort) from staff for toileting hygiene, shower, upper body dressing, personal hygiene and totally dependent on staff for lower body dressing and putting on/taking off footwear. During a review of Resident 71's Order Summary Report (OSR), the OSR indicated the following medications: 1. Docusate sodium (stool softener) 100 milligram (mg – unit of measurement) tablet, one tablet by mouth for bowel management, ordered 8/25/2020. 2. Amlodipine besylate (used to treat hypertension) tablet five (5) mg, give one tablet by mouth two times a day for hypertension, ordered 2/19/2026. During an observation on 3/28/2026 at 4:22 p.m., observed Licensed Vocational Nurse 1 (LVN 1) preparing and administering medications to Resident 71. LVN 1 did not perform hand hygiene prior to preparing the medications and after administering the medications. 1.b. During a review of Resident 102's admission Record, the admission Record indicated the facility admitted the resident on 3/22/2026 with diagnosis including muscle weakness and chronic kidney disease. During a review of Resident 102's History and Physical (H&P) dated 3/23/2026, the H&P indicated that the resident had decision making capacity at the time of admission. During a review of Resident 102's OSR, the OSR indicated the following medications: 1. Gabapentin (used to treat neuropathy [nerve damage causing numbness, tingling, burning pain, or weakness, usually starting in the hands or feet]) 100 mg oral capsule, one capsule by mouth two (continued on next page)

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	055906	A. Building B. Wing	03/29/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times a day for neuropathy, ordered 3/23/2026. 2. Furosemide (used to treat edema [fluid retention]) oral tablet 40 mg, one tablet by mouth two times a day for edema, ordered 3/23/2026. During a concurrent observation and interview on 3/28/2026 at 4:36 p.m., observed LVN 1 preparing and administering medications to Resident 102. LVN 1 did not perform hand hygiene prior to preparing the medications and after administering the medications. LVN 1 stated she was tense and stressed and forgot to wash her hands. LVN 1 stated that she should have washed her hands before and after administering medications to Resident 71 and 102 to prevent cross contamination and for infection prevention. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, last reviewed on 1/29/2026, the P&P indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infection.all personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.hand hygiene is indicated immediately after touching the resident`s environment. During a review of the facility's P&P titled, Administering Medications, last reviewed on 1/29/2026, the P&P indicated, Staff follows established facility infection control procedures (e.g., handwashing, antiseptic techniques, gloves, isolation precautions, etc.) for the administration of medications, as applicable. 2. During a review of Resident 8's admission Record, the admission Record indicated the facility admitted Resident 8 on 4/16/2020 with diagnoses including dysphagia (difficulty swallowing) and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 could sometimes make himself understood and sometimes understand others and required substantial assistance (helper dose more than half the effort) for oral hygiene, upper body dressing and personal hygiene and was dependent (helper does all the work) on staff for toileting, showering, lower body dressing and putting off/on footwear. During an interview on 3/28/2026 at 9:42 a.m., with Resident 8, Resident 8 was lying in bed and unable to answer my questions. Resident 8 responded with one or two words and nonsensical (having no meaning; making no sense) phrases. During an observation on 3/28/2026 at 2:22 p.m., in Resident 8's room, observed Resident 8 lying in bed asleep in the bed nearest to the door and CNA 1 sitting between the wall with the entrance door and the left side of Resident 8's bed. In front of CNA 1 was Resident 8's bedside table and on top of Resident 8's bedside table was CNA 1's personal purse made of a fuzzy material and her personal cell phone. During an interview on 3/28/2026 at 2:24 p.m., with CNA 1, CNA 1 stated the fuzzy purse on Resident 8's bedside table belonged to her, that her shift was almost over, and she was in Resident 8's room to wait for the time to wind down until she was off the clock. CNA 1 stated she was using her personal cell phone because she was finished with her resident charting. CNA 1 stated she should never bring her personal items in resident rooms to prevent the spread of germs and infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/29/2026 at 11:41 a.m., with the Assistant Director of Nursing (ADON), the ADON stated staff may not bring personal items into resident rooms and CNA 1 should not have used Resident 8's room or furniture to store personal items. The ADON stated staff must keep their belongings in the designated staff break room. The ADON further stated staff cannot bring personal items into resident rooms for infection control and to prevent the spread of germs to vulnerable residents. During a review of the facility's P&P titled, Infection Control, last reviewed and revised on 1/29/2026, the P&P indicated the facility must maintain practices to facilitate a safe, sanitary and comfortable environment to help prevent and manage transmission of disease and infections.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide at least 80 square feet (sq. ft. - unit of measurement) per resident in multiple resident bedrooms for five of 36 resident rooms (Rooms 101,102,104,105, and 107). rooms [ROOM NUMBERS] had two beds in each room. Rooms 104,105, and 107 had 3 beds in each room. This deficient practice had the potential to result in inadequate useable living space for all the residents and inadequate working space for the health caregivers.Findings: During a review of the Request for Room Size Waiver letter dated 3/29/2026, submitted by the Administrator (ADM), the Request for Room Size Waiver letter indicated the rooms (Rooms 101,102,104,105, and 107) did not meet the 80 square feet requirement per federal regulation. The letter indicated the residents' beds were in accordance with the special needs of the residents and will not adversely affect the residents' health and safety and do not impede the ability of the residents in that room to obtain their highest practicable well-being. The following rooms provided less than 80 square feet per resident:Rooms # Beds Floor Area Sq. Ft. Sq. Ft/Resident101 2 149.6 74.8102 2 149.6 74.8103 3 214.5 71.5104 3 220 73.3105 3 220 73.3The minimum square footage for a 2-bed room should be 160 sq. ft. The minimum square footage for a 3-bed room should be 240 sq. ft During the Resident Council meeting on 3/28/2026 at 2:00 p.m., no concerns were brought up by the residents regarding the size of the rooms. During the general observation of the residents' rooms on 3/28/2026 and 3/29/2026, the residents had ample space to move freely inside the rooms. There was sufficient space to provide freedom of movement for the residents and for nursing staff to provide care for the residents. There was also sufficient space for beds, side tables, and resident care equipment. During interviews with staff on 3/29/2026 at 2:36 p.m., there were no concerns regarding the size of rooms 101, 102, 103, 104, and 105. The facility submitted a written request for continued waiver. During a review of the facility-provided policy and procedure (P&P) titled, Bedrooms, last reviewed on 1/29/2026, the P&P indicated that all residents are provided with clean, comfortable, and safe bedrooms that meet federal and state requirements. Bedrooms measure at least 80 square feet of space per resident in double rooms, and at least 100 square feet of space in single room.