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 _____	08/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RINALDI CONVALESCENT HOSPITAL	16553 RINALDI ST GRANADA HILLS, CA 91344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a Recertification Survey. Representing the Department of Public Health: Surveyor Federal ID No. 14065, RN, HFEN Surveyor Federal ID No. 18038, RN, HFEN Surveyor Federal ID No. 36203, RN, HFEN Resident Census: : 99 Resident Sample: 19	F 000	2016 SEP 23 AM 10: 31 LOS ANGELES COUNTY HEALTH ASSETS DIVISION Rinaldi Convalescent Hospital submits this response as part of the requirements under the State and Federal Law. The Plan of Correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders.	
F 241 SS=E	Highest Scope and Severity - E 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility staff failed to ensure that residents were addressed in a manner that enhances the resident's dignity and respect and not be called "Mama, Papa or Honey." The residents expressed concerns about staff members not addressing them properly. This deficient practice had a negative impact of the resident's dignity and respect that may affect their quality of life.	F 241	**F-241: Dignity and Respect of Individuality** **CORRECTIVE ACTION** It is the policy and practice of Rinaldi Convalescent Hospital to promote care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. There was no identification of the residents affected by the deficient practice from the resident council meeting during the survey, therefore; random interviews were conducted by the Resource Nurse on 8/27/16 for follow-up and there were no complaints or negative findings. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION**	9/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-23-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 Findings: During the group meeting on August 27, 2016, at 10:30 a.m., eight out of 14 alert and oriented residents who attended the Group Meeting/Interviews stated staff members would call them "Mama" or "Papa" while providing care on all shifts. Two of the residents stated they were called "Honey." staff members often used. They stated they stopped complaining about the above issues because staff would tell them "Mama" and "Papa" is used as an expression of affection. However, four of the residents stated it was more out of habit and routine that staff would do so. They stated it would be more respectful to them if they were called by their names. During an interview with the director of nursing on August 27, 2016 at 2 p.m., she stated staff are frequently in-service to treat the residents with dignity and respect by calling them by their names. She stated she was disappointed to hear that some of the facility staff are addressing the residents in that manner. A review of the facility's policy dated 2005, titled "Dignity and Respect", indicates all resident are treated with dignity, kindness, and respect. Staff shall display respect for residents when speaking and caring for them, an affirmation of their individuality and dignity as human beings.	F 241	All residents could potentially be affected by the alleged deficient practice contained herein; the facility initiated systemic changes to prevent reoccurrence. Under the leadership and direction of the Administrator, the "Guardian Angels" satisfaction survey rounds will be routinely conducted daily by the department heads Monday through Friday and the assigned department manager of the day on weekends with emphasis on: dignity and respect of the residents. In conjunction, the licensed nursing staff will conduct routine rounds each shift to ensure staff compliance. Any untoward findings will be reported immediately for corrective action and discussed in the morning stand-up meetings for further follow up. **MEASURES TO PREVENT RECURRENCES** Under the leadership and direction of the Administrator, an in-service was conducted by the Director of Staff Development with the facility staff on 9/3/16, 9/16/16, 9/19/16, and 9/20/16 regarding: resident dignity and respect. **MONITORING PERFORMANCE AND INTEGRATION INTO THE QAA SYSTEM** Findings of the survey results shall be submitted to the Director of Nursing or designee for follow up as needed. The Director of Nursing or designee shall report findings of the resident satisfaction surveys at the monthly Quality Assurance Committee meeting	
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of	F 246		9/22/16

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F 246	Continued From page 2 the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have the call lights answered in a timely manner. Seven of 14 alert and oriented residents attending the Group Interview Meeting expressed concerns and complained about call lights not answered timely. This deficient practice resulted in the residents being dissatisfied frustrated with the services provided and had the potential for loss of dignity due to incontinence and other complications cause due to delayed response for assistance. Findings: On August 27, 2016, at 11 a.m., during the Resident Group Meeting, seven of the 14 residents in attendance indicated staff took a long time, up to 30 minutes and mostly during the 3 p.m. to 11 p.m. shift, to answer their call lights. They stated they were upset when they had to wait a long time and were dissatisfied with the length of time it took the staff to answer their call lights. One of the residents stated she needed pain medication and three other residents stated they needed assistance to use the restroom. One of the residents stated that on many occasions staff would get upset if she kept pushing on the call lights. One of the residents stated she went to the nursing station to request help for her roommate	F 246	for further review times 90 days or until substantial compliance is obtained per consensus of the Quality Assurance Committee. **F-246 Reasonable Accommodation of Needs/Preferences** **CORRECTIVE ACTION** It is the policy and practice of Rinaldi Convalescent Hospital to have resident's call lights answered in a timely manner. After the alleged practice was brought to the attention of the Director of Nursing, an immediate in-service was conducted on 8/27/16 by the Director of Staff Development on Timeliness of Answering Call Lights. Thereafter; call lights were answered timely and there were no adverse effects noted or reported during random checks. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** All residents have the potential to be affected by the alleged deficient practice; therefore, the facility has implemented a response plan to address timeliness of answering the residents' call lights. Under the leadership and direction of the Administrator, the Director of Staff Development, department managers and nursing supervisors were assigned to audit and observe at random intervals staff response time of answering the resident's call lights. The findings of the audit are discussed	

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F 246	Continued From page 3 who had the call light on, but staff told her to be patient as they are short-staffed. She stated it took over 20 minutes before a nurse came in to help her roommate. On August 28, 2016, at 2 p.m., during an interview, the director of nursing stated staff are required to answer the call lights within few (3 to 5) minutes. The facility's policy dated November 2012, on Call Lights indicated all call lights are answered in a timely manner. Staff is to be prompt and courteous in answering call lights.	F 246	and reviewed in stand-up for further analysis. **MEASURES ADOPTED FOR SYSTEMATIC CHANGES** Under the leadership and direction of the Administrator, on 9/16/16, 9/19/16, and 9/20/16, additional in-services were provided to staff by the Director of Staff Development related to staff responsibility of timely response in answering call lights and accommodation of residents' needs.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	The activity staff will discuss "A call light review" during resident council over the next three months for resident feedback. Random interviews will be conducted three (3) times a week for thirty (30) days by assigned interdisciplinary team members to ensure compliance. **MONITORING OF CORRECTIVE ACTION AND QUALITY ASSURANCE** The Director of Nursing shall report findings of the "call light audits" at the monthly Quality Assurance Committee meeting for further review or corrective action until substantial compliance is obtained per consensus of the Quality Assurance Committee. **F279: Develop Comprehensive Care Plans** **CORRECTIVE ACTION** Rinaldi Convalescent Hospital will develop, review, and revise for each resident a comprehensive care plan	9/22/16

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F 279	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a care plan for fluid restrictions with the resident's participation to assure that the resident and the facility staff members providing care for the resident had a common understanding of the volume of fluid the resident is allowed to consume for one one of 19 sample residents (Resident 2). This deficient practice had the potential to violate the physician's instruction for fluid restrictions. Findings: On August 27, 2016, at 8:40 a.m., Resident 2 was observed in the room drinking a jug of water from a plastic container while taking medications. Resident 2 was observed alert and oriented able to make needs known. A review of Resident 2's physician's order dated August 26, 2016, indicated an order for the resident to be on fluid restrictions to 1,800 cubic centimeters (cc) per day. The breakdown of fluids were written as follows: Nursing: On the 7 a.m.-3 p.m. shift = 400 cc On the 3 p.m.-11 p.m. shift= 400 cc On the 11 p.m.-7 a.m. shift = 160 cc Dietary: Breakfast = 280 cc Lunch = 280 cc Diner = 280 cc	F 279	with measurable objectives and timetables to meet the resident needs per policy and procedure. An immediate interdisciplinary team conference was conducted with Resident 2 to ensure the risk and benefits of the resident's medical status were reviewed and interventions were initiated in conjunction with the resident. A comprehensive care plan for Resident 2 was immediately developed to address the resident's fluid restriction status and the resident's current care needs. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** All residents are potentially affected by the alleged deficient practice contained herein, therefore; all residents receiving fluid restriction in the facility have been identified and the resident's comprehensive care plans were reviewed to ensure the plan of care to accurately reflect the resident's status, risk factors, and has measurable goals. There were no negative findings noted. **MEASURES ADOPTED FOR SYSTEMATIC CHANGES** Under the leadership and direction of the MDS Coordinator and Resource Nurse on 9/22/16 the licensed nursing staff was in-serviced and educated on comprehensive care plans and how care plans are developed according to individual resident's needs.	

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F 279	Continued From page 5 On August 27, 2016, at 10 a.m., an interview was conducted with Resident 2 who was unaware the resident was on fluid restriction and asked LVN 1 for more water in the water jug. On August 27, 2016, at 10:40 a.m., a review of Resident 2's clinical record was conducted with RN 1 indicating no documented evidence a care plan was written for the resident's fluid restriction and the breakdown of fluids necessary throughout the day. During an interview conducted on the same date and time RN 1 stated a care plan for fluid restriction should have been developed to ensure all disciplines providing care for the resident would be aware the resident was on fluid restriction and aware of the breakdown of fluids the resident receives in a day.	F 279	**MONITORING OF CORRECTIVE ACTION AND QUALITY ASSURANCE** The Director of Nursing or designee will complete random audits of clinical records for residents with fluid restrictions for four weeks and then monthly for two months thereafter to ensure compliance with the plan of care. Results of the audits will be communicated to the Quality Assurance Committee for further review or corrective action until substantial compliance is obtained. **F 323: Free of Accident Hazards/Supervision/Devices** **CORRECTIVE ACTION** Resident 3's bed was assessed and immediately replaced. Additionally, all beds were checked by the maintenance department to ensure all brakes were functioning properly. There were no other beds affected. The power strips were assessed by the maintenance department and immediately removed from the identified rooms. Under the leadership and direction of the Administrator, an immediate in-service was conducted on 8/27/16 with the maintenance and housekeeping staff regarding room rounds to ensure bed brakes are locked and the use of power strips. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** All residents have a potential to be affected by the alleged deficient	9/22/16
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the resident's environment was free from accidents and hazards. Power strips were found in five rooms with beds and tube feeding machines plugged into them. The facility	F 323		

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F 323	Continued From page 6 also failed to ensure that the bed brakes were applied for one of 19 sample residents (Resident 3). These deficient practices has the potential for electrical fire hazards and injuries from a fall. Findings: a. On August 27, 2016, at 8:50 a.m., during an environmental tour of the facility in the presence of the maintenance supervisor, five beds were observed to be plugged into a power strip. One of the five beds also had a tube feeding machine plugged into the power strip. In an interview on August 27, 2016, at 8:50 a.m., the maintenance supervisor stated no medical devices, including beds, are to be plugged into the power strips. b. According to the Admission Face Sheet, Resident 3 was admitted to the facility on August 14, 2016, with the diagnoses that includes heart failure, diabetes (high blood sugar), and dementia (a wide range of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities). The Minimum Data Set (MDS), an assessment and care screening tool, dated May 26, 2016 indicates Resident 3 is unable to ambulate and is totally dependent on staff for transfers. During a tour on August 28, 2016 at 9 a.m. with the director of nursing (DON), the brakes on Resident 3 bed were not set. The bed moved when the DON pushed it and she stated the brakes were not set. She further stated the brakes should be set for safety of the resident.	F 323	practice, therefore; all rooms were immediately checked by the maintenance department and there were no negative findings noted. **MEASURES ADOPTED FOR SYSTEMATIC CHANGES** Under the leadership and the direction of the administrator, the maintenance and housekeeping departments received additional in-services on 8/28/16, 9/19/16, & 9/20/16 regarding the use of power strips in a medical environment and resident bed checks for safety. Environmental rounds will be conducted daily by maintenance in conjunction with housekeeping to ensure approved electrical outlets are used and the residents' beds will be checked to ensure safety. **MONITORING OF CORRECTIVE ACTION AND QUALITY ASSURANCE** Weekly inspections for compliance will be conducted by the Maintenance Supervisor or designee with findings reported to the QA Committee monthly for further review or corrective action until substantial compliance is obtained per consensus of the Quality Assurance Committee.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	**F 371: Food Procure, Store/Prepare/Serve-Sanitary** **CORRECTIVE ACTION** The ice machine was immediately and thoroughly inspected, sanitized, and cleaned by dietary staff in conjunction with maintenance.	9/22/16

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F 371	Continued From page 7 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility staff failed to keep the ice machine in the kitchen in clean sanitary condition. This deficient practice has the potential to cause contamination in the ice that may cause food bore illness. Findings: On September 25, 2016, at 5:30 p.m., a tour of the kitchen was conducted with the dietary supervisor. During the tour, the stand alone ice machine was observed with thick rust yellow, white and green stains along the back panel. On September 25, 2016, at 5:45 p.m., an interview was conducted with the dietary supervisor who stated the ice machine is cleaned every day and was unable to explain why the steel panel was rusted.	F 371	**IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** All residents could potentially be affected by the alleged deficient practice contained herein; the facility initiated weekly systemic changes to prevent reoccurrence. **MEASURES ADOPTED FOR SYSTEMATIC CHANGES** Under the leadership and direction of the Administrator; a preventative maintenance and cleaning schedule for the ice machine will be conducted weekly. The dietary and maintenance staff was in-serviced by Director of Staff Development and Maintenance Supervisor on 9/19/16 for proper cleaning and maintenance of the ice machine. **MONITORING OF CORRECTIVE ACTION AND QUALITY ASSURANCE** The Administrator and/or designee and maintenance supervisor and the infection control nurse will monitor corrective action and ensure compliance. Any concerns will be reported to administration immediately and findings will be discussed monthly with the Quality Assurance Committee for further review and recommendations until compliance is sustained.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425		

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F 425	Continued From page 8 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to administer medication in accordance with physician's order for one of 19 sample residents (Resident 2). This deficient practice has the potential to cause a side effect in medication. Findings: On August 27, 2016, at 8:45 a.m., a medication pass observation was conducted with LVN 1 in Station 2. During the medication pass, LVN 2 prepared and administered a multi-vitamin with mineral tablet to Resident 2. On August 27, 2016, at 10 a.m., following the medication pass during reconciliation of the	F 425	**F425: Pharmaceutical SVC-Accurate Procedures, RPH** **CORRECTIVE ACTION** It is the policy and practice of Rinaldi Convalescent Hospital to administer medication in accordance to the physician's order. Resident 2 was assessed and monitored after receiving the Multivitamins with Minerals and there was no negative findings reported. The licensed nurse was immediately in-serviced by the Director of Nursing on the Five Rights of Medication Administration. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION** This practice has the potential to affect all residents receiving medication in the facility. As all residents are potentially affected by the cited deficiency, the facility will take corrective action as needed in relation to all residents per occurrence. **MEASURES ADOPTED FOR SYSTEMATIC CHANGES** Under the leadership and direction of the Administrator, a medication in-service was given by the MDS Coordinator and Resource Nurse on 9/21/16 for licensed nursing on Safe Practice during Medication Administration. A medication pass competency was conducted with the involved nurse on 9/21/16. All newly hired nurses will receive a medication review and competency upon	9/22/16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 425	Continued From page 9 medication pass with the physician's order it was noted that physician's order for Resident 2 was to administer multi-vitamin tablet one tablet once a day. But, the resident received multi-vitamin with mineral On August 27, 2016, at 10:30 a.m., an interview was conducted with LVN 1 who stated she did not know she administer the incorrect multi-vitamin tablet.	F 425	orientation. Other licensed nurses will receive a medication competency review by pharmacy pending available date and quarterly thereafter by the Director of Staff Development in conjunction with the Resource Nurse. **MONITORING OF CORRECTIVE ACTION AND QUALITY ASSURANCE** A spot check audit will be conducted by the Director of Nursing or designee for increased monitoring. Results of the medication competencies will be submitted to the Director of Nursing for review and follow-up action as needed. The Director of Nursing shall report findings of the medication quality-assurance checks and submit findings monthly to the Quality Assurance Committee meeting for further review of corrective action until substantial compliance is obtained per consensus of the Quality Assurance Committee.	
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and record review and interview, the facility failed to provide at least 80 square feet per resident in multiple resident bedrooms. Findings: The following rooms provided less than 80 square feet per resident: Rooms Beds Area SqFt SqFt/Resident 1 2 148 74.25 2 2 148.5 74.25 4 3 214 71.33 The space available for the residents was	F 458	**F 458 Bedrooms Measure at Least 80 SQ FT/Resident** **CORRECTIVE ACTION** Rooms 1, 2, and 4 were checked on 8/28/16 to be free and clear of clutter to ensure adequate space for nursing care and wheelchair access. **IDENTIFICATION OF OTHER RESIDENTS AND CORRECTIVE ACTION**	9/22/1

PRINTED: 09/15/2
FORM APPROV
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RINALDI CONVALESCENT HOSPITAL	16553 RINALDI ST GRANADA HILLS, CA 91344

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 458	Continued From page 10 observed to be sufficient to provide freedom of movement for the residents with wheelchairs and geri-chair access and staff members. The facility submitted a written request for continued waivers.	F 458	All residents residing in rooms 1, 2, and 4 during their stay have the potential to be affected by the alleged deficient practice. There were none noted to be affected. **MEASURES ADOPTED FOR SYSTEMATIC CHANGES** Random daily checks will be conducted on all three rooms by maintenance department to ensure adequate space and comfort for residents occupying these rooms. I respectfully request this waiver be granted in conjunction with the recertification survey conducted 8/25/16 - 8/28/2016. Yearly waiver will be requested from administration to the Department of Health as per past years. **MONITORING OF CORRECTIVE ACTION AND QUALITY ASSURANCE** The Administrator and/or designee and maintenance supervisor will monitor corrective action and ensure compliance. Any concerns will be reported to administration and the Quality Assurance Committee for further review and recommendations until compliance is sustained.	