STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055142	A. Building B. Wing	12/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Gardens Convalescent Hospital	17922 San Fernando Mission Rd 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** 42275 Based on observation, interview, and record review, the facility failed to ensure a resident's call light (a device used by a resident to signal his/her need for assistance from staff) was within reach for two of six sampled residents (Resident 1 and 2). This deficient practice had the potential to delay the provision of services and residents' needs not being met. Findings: a. During a review of Resident 1's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 7/17/2023 and readmitted the resident on 12/25/2024 with diagnoses that included acquired absence of left leg above knee and right leg above knee, pressure ulcer/injury (PU/PI) stage IV (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of sacral (the bony region at the very base of your spine and just above the tailbone) region, obstructive uropathy (a condition in which the flow of urine is blocked), and reflux uropathy (a condition that occurs when urine flows back up into the kidneys from the bladder damaging the kidneys over time). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 11/28/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired, and the resident needed total assistance from staff with toileting hygiene, upper/lower body dressing, and bed mobility (movement). During a review of Resident 1's untitled care plan (a document that summarizes a resident's needs, goals, and care/treatment) initiated on 7/30/2023 and last revised on 10/21/2024, the care plan indicated Resident 1 had actual fall related to Resident 1's cognitive impairment and poor safety awareness/judgement. The care plan indicated an intervention to attach Resident 1's call light to bed within access of resident. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/27/2024 at 10:50 a.m., with Licensed Vocational Nurse 1 (LVN 1), observed Resident 1 lying in bed. When asked for Resident 1's call light placement, LVN 1 found Resident 1's call light was out of reach and stated that Resident 1's call light was stuck on the left side of bed frame and Resident 1 was not able to use it if needed. LVN 1 then placed the call light within reach. LVN 1 stated that the residents' call lights should be always within reach. b. During a review of Resident 2's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 8/26/2018 and readmitted the resident on 12/15/2024 with diagnoses that included Parkinson's disease (a movement disorder of the nervous system that worsens over time). During a review of Resident 2's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was severely impaired, and the resident needed total assistance from staff with oral hygiene, toileting hygiene, upper/lower body dressing and transfer, and needed maximum assistance with bed mobility (movement). During a review of Resident 2's untitled care plan initiated on 8/12/2024, the care plan indicated Resident 2 had activities of daily living (ADL- activities related to personal care) self-care performance deficit (an inability to perform certain daily functions related to health and well-being) related to Resident 2's cognitive deficits and poor safety awareness. The care plan indicated an intervention to place Resident 2's call light within reach and attend needs promptly. During a concurrent observation and interview on 12/27/2024 at 11:28 a.m., with Certified Nursing Assistant 2 (CNA 2), observed that Resident 2 was sitting on the geriatric chair (a large, padded, reclining chair that provides support and comfort for people with limited mobility) next to Resident 2's bed. CNA 2 stated that Resident 2 was not able to reach the call light if needed to use. During a concurrent observation and interview on 12/27/2024 at 11:33 a.m., with LVN 3 in Resident 2's room, observed that Resident 2's call light was tangled with the bed frame. LVN 3 stated that Resident 2's call light was not placed within reach. LVN 3 untangled Resident 2's call light and placed within reach and stated that the residents' call lights should be always within reach for all residents regardless of their ability to use it or not, just in case of emergency. During a concurrent interview and record review on 12/27/2024 at 3:14 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 2's care plan for ADL self-care performance deficit. The ADON stated that the call lights should be within reach for all the residents and staff should always check the call light placement when leaving the resident's rooms. The ADON stated that Resident 2's care plan indicated to place Resident 2's call light within reach and attend needs promptly. During a review of the facility's policy and procedure (P&P) titled, Call System, Resident, last reviewed on 4/9/2024, the P&P indicated, Resident are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42275 Based on observation, interview, and record review, the facility failed to ensure no more than two layers of linen were used with the use of a low air loss mattress (LALM - a specialty bed that alternates pressure to help heal and prevent pressure ulcer/injuries [PU/PI - injuries that break down the skin and underlying tissue when an area of skin is placed under pressure]) for one of two sampled residents (Resident 1). This deficient practice had the potential to increase the resident's risk of skin breakdown. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 7/17/2023 and readmitted the resident on 12/25/2024 with diagnoses that included acquired absence of left leg above knee and right leg above knee, pressure ulcer/injury (PU/PI) stage IV (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of sacral (the bony region at the very base of your spine and just above the tailbone) region, obstructive uropathy (a condition in which the flow of urine is blocked), and reflux uropathy (a condition that occurs when urine flows back up into the kidneys from the bladder damaging the kidneys over time). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 11/28/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired, and the resident needed total assistance from staff with toileting hygiene, upper/lower body dressing, bed mobility (movement). During a review of Resident 1's physician orders (Order Listing Report), the physician ordered to apply LALM for wound care and management: Order Status: Active, and Revision Date: 12/27/2024. During a concurrent observation and interview on 12/27/2024 at 10:40 a.m., with Licensed Vocational Nurse 1 (LVN 1) and LVN 2, observed Resident 1 in bed on a LALM. LVN 1 stated that Resident 1 had a stage IV PU on the buttock area. LVN 1 and LVN 2 counted the linen layers placed between Resident 1' skin and the LALM surface. LVN 1 stated there was one cloth incontinence (loss of bowel or bladder control) pad made of two different textures of linen, Resident 1 was wearing an adult brief, and there was one bed sheet folded twice. LVN 1 stated there was four layers of linen placed between Resident 1's upper back and the surface of the LALM. LVN 1 stated that the nursing staff should not use multiple layers of linen and should use only a single layer of linen with the LALM if the resident was wearing an adult brief, otherwise, the LALM was not going to help the wound healing process. During a concurrent observation and interview on 12/27/2024 at 11:05 a.m., with Certified Nursing Assistant 1 (CNA 1), observed Resident 1 in bed on a LALM. CNA 1 stated that CNA 1 thought that the cloth incontinent pad was just one layer even though it was made with two different textures. CNA 1 further stated that only one bed sheet was used but it was folded twice and there were four layers of linen placed under Resident 1's upper parts of body. CNA 1 stated that only one or two layers of linen should be used with the LALM. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/27/2024 at 3:40 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that Resident 1 had a stage IV PU on the buttock. The ADON stated if staff placed multiple layers of linen between the resident's skin and the LALM surfaces, then that would defeat the purpose of the LALM use to promote the wound healing process. The ADON stated staff should not use more than two layers of linen, and an adult brief would be considered as one layer of linen. During a review of the facility's policy and procedure (P&P) titled, Support Surface Guidelines, last reviewed on 4/9/2024, the P&P indicated, Element of support surfaces that are critical to pressure ulcer prevention and general safety include pressure redistribution, moisture control, shear (to cut or slide something apart by applying force in opposite directions) reduction . and the life expectancy. During a review of the facility's P&P titled, Pressure-Reducing Mattresses, last reviewed on 4/9/2024, the P&P indicated, To provide the mattresses that will prevent and/or minimize pressure on the skin Place flat sheet over mattress, while ensuring that no more than two layers of linen are between resident and pressure-reducing mattress (this excludes the thin mattress cover from manufacturer). If resident is incontinent, place protective pad in center of bed (Remember, this will count as one layer of linen. So, do not exceed two layers) Key Points: Check to ensure that only two layers of linen are between the resident and mattress.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42275 Based on interview and record review, the facility failed to ensure licensed nurse staff completed reconciliation (a process that validates the controlled substance [medication with a high potential for abuse] amount at the end of a shift is the amount expected) of controlled medications for one of four medication carts (Medication Cart A). This deficient practice had the potential to result in inaccurate reconciliation of controlled medication and placed the facility at risk for the inability to readily identify loss and drug diversion (the illegal distribution of prescription drugs for unintended purposes) of controlled medications. Findings: During a concurrent interview and record review on 12/27/2024 at 11:09 a.m., with Licensed Vocational Nurse 2 (LVN 2) for Medication Cart A, reviewed the Controlled Drugs Accountability Sheet (CDAS) for the month of 11/2024 and 12/2024. LVN 2 stated there were gaps not signed by two licensed nurses on the following dates: - On 11/5/2024: 3 p.m.-11 p.m. shift - On 11/9/2024: 7 a.m.-3 p.m. shift and 3 p.m.-11 p.m. shift - On 11/16/2024: 7 a.m.-3 p.m. shift and 3 p.m.-11 p.m. shift - On 11/19/2024: 3 p.m.-11 p.m. shift - On 11/20/2024: 7 a.m.-3 p.m. shift and 3 p.m.-11 p.m. shift - On 12/1/2024: 7 a.m.-3 p.m. shift and 3 p.m.-11 p.m. shift LVN 2 stated that LVN 2 always counted the controlled medications with another licensed nurse when changing shifts, then any discrepancies of controlled medications would be reported to the Director of Nursing (DON) immediately. LVN 2 stated that could not say if two licensed nurses counted the controlled medications but forgot to sign on the form or did not count. LVN 2 further stated that the facility protocol was that both the outgoing and the incoming licensed nurses are to sign on the CDAS together after counting the controlled medications and ensuring the quantity of the controlled medications matches. During a concurrent interview and record review on 12/27/2024 at 5:01 p.m., with the DON, the DON reviewed the CDAS for the month of 11/2024 and 12/2024 for Medication Cart A. The DON stated that the two licensed nurses who were incoming and outgoing to change shifts should count together then sign together on the CDAS form after counting the controlled medications, The DON stated the two licensed nurses should report to the DON immediately for any discrepancies of controlled medications, then the facility would start an investigation right away if necessary. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Controlled Substances, last reviewed on 4/9/2024, the P&P indicated, The facility complies with all laws, regulations, and other requirements related to admission, handling, storage, disposure, and documentation of controlled medications Controlled substances are reconciled upon receipt, administration, disposition, and at the end of shift At the End of Each Shift: a. The medications are counted at the end of each shift the nurse coming on duty and the nurse going off duty determine the count together. b. Any discrepancies in the controlled substance count are documented and reported to the director of nursing services immediately.

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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. 42275 Based on observation, interview, and record review, the facility failed to implement infection control practices by failing to ensure a resident's indwelling urinary catheter (a flexible tube inserted into the bladder and left in place to continuously drain urine) tubing was not touching the floor for one of two sampled residents (Resident 1). This deficient practice had the potential to result in the spread of germs placing the resident with an indwelling urinary catheter at risk for infection. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 7/17/2023 and readmitted the resident on 12/25/2024 with diagnoses that included acquired absence of left leg above knee and right leg above knee, pressure ulcer/injury (PU/PI) stage IV (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of sacral (the bony region at the very base of your spine and just above the tailbone) region, obstructive uropathy (a condition in which the flow of urine is blocked), and reflux uropathy (a condition that occurs when urine flows back up into the kidneys from the bladder damaging the kidneys over time). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 11/28/2024, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired, and the resident needed total assistance from staff with toileting hygiene, upper/lower body dressing, bed mobility (movement). During a review of Resident 1's physician orders (Order Listing Report), the physician ordered to secure indwelling urinary catheter tubing with anchor every day shift (To minimize dislodging of catheter): Order Status: Active, and Revision Date: 12/26/2024. During a concurrent observation and interview on 12/27/2024 at 10:45 a.m., with Licensed Vocational Nurse 1 (LVN 1) and LVN 2, observed Resident 1's indwelling urinary catheter tubing was touching the floor. LVN 1 stated that staff should monitor and make sure the indwelling urinary catheter tubing was off the floor, otherwise, there would be a possibility of the germs entering into the resident's body through the urine tubing and cause a urinary tract infection (UTI - an infection in the bladder/urinary tract). During an interview on 12/27/2024 at 10:59 a.m., in Resident 1's room with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated that CNA 1 provided the morning care for Resident 1 at around 9 a.m. on that morning, but CNA 1 forgot to place the urine collection bag (attached to the catheter tube for the purpose of collecting urine) and indwelling urinary catheter tubing inside a basin to not touch the floor. CNA 1 stated if the indwelling urinary catheter tubing was touching the floor, the germs could go upward and enter the body through the indwelling urinary catheter and was against infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program (IPCP), last reviewed on 4/9/2024, the P&P indicated, An IPCP is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections Prevention of Infection (3) educating staff and ensuring that they adhere to proper techniques and procedures. During a review of the facility's P&P titled, Catheter Care, Urinary, last reviewed on 4/9/2024, the P&P indicated, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections Be sure the catheter tubing and the drainage bag are kept off the floor.