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	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Gardens Convalescent Hospital	17922 San Fernando Mission Rd Granada Hills, CA 91344

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 accurate and complete medical records in accordance with accepted professional standards for one of three sampled residents (Resident 1) by: 1. Failing to document the correct time on Resident 1's Resident Transfer Record. 2. Failing to ensure Resident 1's Resident Transfer Record was complete. These deficient practices had the potential to result in confusion regarding Resident 1's health status at the time of transfer and placed Resident 1 at risk of not receiving appropriate care due to inaccurate and incomplete resident medical care information. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE] with diagnoses that included Parkinson's disease (brain disorder that leads to shaking, stiffness, and difficulty with walking, balance, and coordination), anxiety disorder (mental health condition characterized by persistent and excessive worry, fear, and nervousness that can interfere with daily life), spinal stenosis (when the space inside the backbone is too small, putting pressure on the spinal cord and nerves, causing pain, numbness and weakness in the neck, back, arms and legs). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 11/16/2024, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience and the senses) was moderately impaired. The MDS further indicated Resident 1 needed partial/moderate assistance from staff for toileting hygiene, bathing, lower body dressing and putting on/taking off footwear. During a review of Resident 1's COC (Change of Condition - when a resident's physical or cognitive status suddenly changes, placing them at risk)/Interact Assessment Form (SBAR - situation, background, assessment, recommendation, a communication tool used by healthcare workers when there is a change of condition among the residents) dated 2/14/2025, the SBAR indicated Resident 1 was having lower abdominal pain and had a physician's order to transfer to the hospital via ambulance (a vehicle, often a specially equipped, used to transport sick or injured people, usually to a hospital, especially in emergency situations). Resident 1's SBAR indicated Resident 1 had the following vital signs (measurements of the body's most basic functions), timed at 10:45 a.m.: (continued on next page)

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

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

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	06/18/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Blood Pressure: 128/70 millimeters of mercury (mmHg - unit used to measure the pressure of blood, normal reading 120/80 mmHg) - Pulse: 70 beats per minute (also known as heart rate, normal range 60 to 100) - Respiration: 18 breaths per minute (normal range 12 to 20 breaths per minute) - Temperature (the measurement of the body's internal heat): 97.8 Fahrenheit (°F- scale of temperature, normal range between 97°F and 99°F) During a review of Resident 1's Resident Transfer Record dated 2/14/2025, the Resident Transfer Record indicated Resident 1 had the following vital signs at 10:45 a.m.: - Blood Pressure: 190/110 mmHg - Pulse: 90 beats per minute - Respiration: 20 breaths per minute - Temperature: 97°F Further review of Resident 1's Resident Transfer Record also indicated the following sections were left blank: - Social Security Number - Medicare/Medi-Cal/HMO Numbers - Date and Time symptoms were first noted - Current Diet Order - Baseline Mental Status - Possessions Transferred (continued on next page)

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	055142	A. Building B. Wing	06/18/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/2025 at 2:10 p.m., with Registered Nurse 1 (RN 1), RN 1 stated she was responsible for completing both Resident 1's SBAR and Resident 1's Transfer Record. RN 1 stated she completed Resident 1's SBAR at 10:45 a.m. and Resident 1's Resident Transfer Record about one hour later, closer to the time that the ambulance arrived to take Resident 1 to the hospital. RN 1 stated she (RN 1) took Resident 1's vital signs at 10:45 a.m. and documented them on Resident 1's SBAR. RN 1 added that she (RN 1) obtained a new set of vital signs at around 11:45 a.m. and recorded those vital signs on Resident 1's Resident Transfer Record in preparation for the arrival of the ambulance. RN 1 stated she mistakenly used the same time of 10:45 a.m. for both Resident 1's SBAR and Resident 1's Resident Transfer Record. RN 1 stated Resident 1's Resident Transfer Record should have indicated a time of 11:45 a.m. and not 10:45 a.m. RN 1 also stated she did not realize that there were blank areas and information missing on Resident 1's Resident Transfer Record. RN 1 stated it is important to ensure all resident health records are complete and accurate, so it does not create any confusion. During an interview on 6/18/2025 at 2:45 p.m., with the Director of Nursing (DON), the DON stated he (DON) looked over Resident 1's Resident Transfer Record and spoke with RN 1. The DON confirmed that Resident 1's Resident Transfer Record was incomplete and there was a discrepancy regarding time. The DON stated all resident health records should be complete and accurate. The DON stated inaccuracies and lack of information in resident health records could lead to confusion about a resident's health status, possibly even affecting the care and services for the residents. During a review of the facility's policy and procedure titled, Documentation Principles, dated 01/04 indicated it is the policy of the facility to ensure health records be kept for each resident. The policy and procedure further indicated resident health records must be complete entries that are: a. Accurate; b. Timely - recorded within the required time period; c. Objective - record facts and what it is, do not assume; d. Specific - definite; e. Concise - to the point; f. Legible - written clearly; g. Clear - easily understood; h. Descriptive - adequately explained.