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	05/26/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 honor a resident's right to refuse the use of a floor mat (a cushioned floor pad designed to help prevent injury should a person fall) on the right side of the bed for one of two sampled residents (Resident 1). This deficient practice had the potential to limit the resident's right to make choices regarding care and treatment and negatively affect the resident's dignity, autonomy, and quality of life.Findings: During a review of Resident 1's Face Sheet (FS), the FS indicated that Resident 1 was initially admitted to the facility on [DATE], with diagnoses including malignant neoplasm of right kidney (a disease in which cancer cells form in the tissue of the kidney) with secondary malignant neoplasm of bone, history of falling, low back pain, and pathological fracture of the left femur (a break, crack or crush injury of the thigh bone). During a review of Resident 1's Minimum Data Set (MDS -ˆa resident assessmentˆtool) datedˆ4/30/2026, the MDS indicated that Resident 1's cognition (mental action or process ofˆacquiringˆknowledge and understanding) was intact. Resident 1 required moderate (helper does less than half the effort) to maximal (helper does more than half the effort) physical assistanceˆfrom staff for activities of daily living (ADLs - eating, toileting, hygiene, shower/bathing).ˆˆ During a review of History and Physical (H&P) dated 5/18/2026, the H&P indicated that Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Order Summary Report, dated 5/26/2026, the Order Summary Report indicated the following physician's order dated 5/17/2026: -Support and Safety Device - Low bed with floor mat to decrease potential injury every shift. During a review of Resident 1's Care Plan Report titled At risk for unavoidable declines revised on 5/06/2026, the care plan interventions were to allow the resident to participate in decisions about their care while ensuring their privacy and respecting their rights. During a concurrent observation and interview on 5/26/2026 at 09:15 a.m. with Resident 1, Resident 1 was alert, oriented and able to respond to questions. One floor mat was placed on each side of Resident 1's bedside. The wheel of Resident 1's over-bed table was observed to be caught in the mat. Resident 1 stated that he used to move the over-bed table easily, but now his belongings frequently fall onto the floor. Resident 1 stated, leave it the way things are, I am not walking, I cannot even stand up. Resident 1 added that his right arm hurts from having to pull the bedside table forcefully when the wheels get stuck in the mat. Resident 1 also stated that he should not have to repeatedly ask the staff for the floor mat on his right side to be removed. During a concurrent observation and interview on 5/26/2026 at 09:35 a.m. with Licensed Vocational Nurse (LVN) 1, observed the floor mats had been positioned on both the left and right sides of Resident 1's bed. LVN 1 stated she was aware that Resident 1 had declined the use of the floor mat on the right side of the bed. During an interview on 5/26/2026 at 1:00 p.m. with Assistant Director of Nursing (ADON), the ADON stated that residents retain the right to refuse the placement of floor mats. The ADON also stated that is it important to allow Resident 1 to exercise his right and that respecting the resident's preferences is essential, particularly when the resident is able to make informed decisions regarding their care. During an interview on 5/26/2026 at 3:25 p.m. with Director of Nursing (DON), the DON stated that residents are entitled to refuse the use of a floor mat. The DON also stated it is (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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	important to respect Resident 1's wishes and preferences as part of their care. The DON further stated that residents have the right to decline interventions. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights dated 5/26/2026, the P&P indicated that residents are entitled to be treated with respect, kindness, dignity, and allowed self-determination. During a review of the facility's P&P titled, Lowbed-Floor Mat, Not a Restraint, undated, the P&P indicated that using a low bed and floor mat as a non-restraint required a physician order, restraint assessment, informed consent, Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) and 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 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 ensure the resident environment was free of accident hazards for two of two sampled residents (Resident 1 and Resident 2) by failing to ensure:ˆ 1. Resident 1 did not have an over- bed table on top of the floor mat (a cushioned floor pad designed to help prevent injury should a person fall) on the right side of the bed and a trash can on top of the floor mat on the left side of the bed. 2. Resident 2 did not have an over-bed table, and trash can on top of the floor mat on the left side. This deficient practice increased the risk of accidents such as slips, trips, and falls with injuries for Resident 1 and Resident 2. Findings: 1. During a review of Resident 1's Face Sheet (FS), the FS indicated that the facility initially admitted Resident 1 to the facility on 4/24/2026, with diagnoses including malignant neoplasm of right kidney (a disease in which cancer cells form in the tissue of the kidney) with secondary malignant neoplasm of bone, history of falling, low back pain, and pathological fracture of the left femur (a break, crack or crush injury of the thigh bone). During a review of Resident 1's Minimum Data Set (MDS -ˆa resident assessmentˆtool) datedˆ4/30/2026, the MDS indicated that Resident 1's cognition (mental action or process ofˆacquiringˆknowledge and understanding) was intact. The MDS indicated Residentˆ1ˆrequired ranging from moderate (helper does less than half the effort) to maximal (helper does more than half the effort) physical assistanceˆfrom staff for activities of daily living (ADLs - eating, toileting, hygiene, shower/bathing).ˆˆ During a review of History and Physical (H&P) dated 5/18/2026, the H&P indicated that Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Order Summary Report, dated 5/26/2026, the Order Summary Report indicated the following physician's order dated 5/17/2026: -Support and Safety Device - Low bed with floor mat to decrease potential injury every shift. During a review of Resident 1's Care Plan Report titled at risk for falls/injury related to generalized weakness, history of falls, poor body balance/control, initiated on 4/27/2026, it indicated an objective to reduce the risk of falls and injury. The care plan included an intervention to provide the resident with a safe and clutter-free environment. During a review of Resident 1's Care Plan Report titled low bed with floor mat to decrease potential injury, revised on 5/06/2026, the care plan indicated a goal to reduce incident of injury. During a concurrent observation and interview on 5/26/2026 at 09:35 a.m. with Licensed Vocational Nurse (LVN) 1 inside Resident 1's room, observed a trash can on top of the floor mat on the left side of the bed and an over-bed table on top of the floor mat on the right side of the bed. LVN 1 stated that placing objects on top of the floor mats poses a safety hazard, as the floor mats are intended to provide a soft, safe landing if the resident falls from the bed. LVN 1 further stated that objects on top of the floor mats could potentially cause injury if Resident 1 fell onto them. 2. During a review of Resident 2's FS, the FS indicated that the facility admitted Resident 2 to the facility on 1/04/2026, with diagnoses including heart failure, hypertension (commonly known as high blood pressure), polyneuropathy (damaged or malfunctioning multiple peripheral nerves) and chronic kidney disease (kidneys are damaged and cannot filter blood as well as they should causing waste and fluid to build up in the body). During a review of Resident 2's MDS dated [DATE], the MDS indicated that Resident 2's cognition wasˆintact. The MDS indicated Residentˆ2ˆrequired supervision to maximal physical assistanceˆfrom staff for ADLs. During a review of H&P dated 2/05/2026, the H&P indicated that Resident 2 had partial decision-making capacity and ability to participate in care. During a review of Resident 2's Order Summary Report, dated 5/26/2026, the Order Summary Report indicated the following physician's order dated 2/5/2026: -Support and Safety Device - Low bed with floor mat to decrease potential injury every shift. During a review of Resident 2's Care Plan Report titled at risk for falls/injury related to difficulty walking, poor body balance/control, use of medications, initiated on 1/19/2026, it indicated an objective to reduce the risk of falls and injury. The care plan included an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention to provide the resident with a safe and clutter-free environment. During a review of Resident 2's Care Plan Report titled low bed with floor mat to prevent injuries, revised on 2/11/2026, the care plan indicated a goal to prevent or reduce incident of injury/fall. During a concurrent observation and interview on 5/26/2026 at 10:10 a.m. with LVN 1 in Resident 2's room, observed a trash can and an over-bed on top of the floor mats. LVN 1 stated that these items should not be on top of the floor mat because the floor mat was intended to reduce injury if a fall occurs. During an interview on 5/26/2026 at 1:00 p.m. with Assistant Director of Nursing (ADON), ADON stated that floor mats are used for residents that are at high risk of falling. ADON added that when a fall occurs, floor mats help reduce the chance of injury. ADON further stated that it is important that nothing is placed on top of the mat, as doing so undermines its effectiveness and may even cause harm. During an interview on 5/26/2026 at 3:25 p.m. with Director of Nursing (DON), the DON stated that floor mats are utilized to reduce the risk of injury should a resident experience a fall, thereby enhancing resident safety. The DON added that bedside tables or any unstable items were not acceptable to be on top of the floor mat, as it could potentially fall onto a resident or a resident can fall over it and cause harm. The DON further stated that the presence of unsteady objects on top of the floor mat increases the risk of injury. During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated 5/26/2026, the P&P indicated, environmental factors that elevate the risk of falls include obstructions present in walkways. The P&P also indicated that resident-centered approaches to managing falls and fall risk include staff members, in collaboration with the attending physician, will implement an individualized fall prevention plan aimed at mitigating the specific risk factors for each resident identified as being at risk or with a documented history of falls.

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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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review, the facility failed to provide radiology services to meet the need of one of two sample residents (Resident 1) by failing to: 1. Notify the physician of the delay of the physician's order for Bilateral (both sides) Hip X-ray (type of medical imaging test that captures images of the structures inside the body) STAT (immediate action required). 2. Ensure that Bilateral Hip X-ray STAT was provided within the timeframe specified in the physician's order. These deficient practices resulted in a delay in care and treatment and had the potential to result in worsening clinical conditions. Findings: During a review of Resident 1's Face Sheet (FS), the FS indicated that the facility admitted Resident 1 to the facility on 4/24/2026, with diagnoses including malignant neoplasm of right kidney (a disease in which cancer cells form in the tissue of the kidney) with secondary malignant neoplasm of bone, history of falling, low back pain, and pathological fracture of the left femur (a break, crack or crush injury of the thigh bone). During a review of Resident 1's Minimum Data Set (MDS -ˆa resident assessmentˆtool) datedˆ4/30/2026, the MDS indicated that Resident 1's cognition (mental action or process ofˆacquiringˆknowledge and understanding) was intact. The MDS indicated Residentˆ1ˆrequired moderate (helper does less than half the effort) to maximal (helper does more than half the effort) physical assistanceˆfrom staff for activities of daily living (ADLs - eating, toileting, hygiene, shower/bathing).ˆˆ During a review of Resident 1's Order Summary, dated 5/26/2026, the Order Summary Report indicated a physician order of Bilateral Hip X-ray STAT dated on 5/11/2026 at 6:00 p.m. During a telephone interview on 5/26/2026 at 2:32 p.m. with Registered Nurse 1 (RN 1), RN 1 stated that after receiving the physician's order for a STAT Bilateral Hip X-ray for Resident 1, she contacted the designated diagnostic provider (DDP) to inform the STAT order. RN 1 stated that the DDP staff informed her that they would not be able to arrive until early morning the next day. RN 1 stated that she did not notify the physician about the delay of the completion of bilateral hip X-ray. RN 1 further stated that informing the physician of the delay in X-ray was important, as it could further delay the resident's care and potentially worsen Resident 1's injury. During a concurrent interview and record review on 5/26/2026 at 1:00 p.m. with the Assistant Director of Nursing (ADON), Resident 1's order summary report and DDP's website were reviewed. The ADON stated that the STAT physician order for a bilateral hip X-ray was placed on 5/11/2026 at 5:58 p.m. on the DDP's website, and STAT orders are expected to be completed within four hours. The ADON added that if the delay exceeds four hours, the staff should notify the physician. The ADON stated that the X-ray was performed on 5/12/2026 at 12:25 a.m. The ADON further stated that there was no documentation of staff notifying the physician about the delay and that the staff failed to inform the physician. The ADON stated that failing to notify the physician can worsen the situation, delay care and treatment, and extend Resident 1's discomfort. During an interview on 5/26/2026 at 3:25 p.m. with Director of Nursing (DON), the DON stated that the facility did not follow the time frame for the physician order of bilateral hips X-ray STAT for Resident 1. The DON further stated that when there is a delay of the STAT order, it could lead to complications for the residents. During a review of the facility's Policy and Procedure (P&P) titled, Change in a Resident's Condition or Status, revised 2/2021, the P&P indicated that nursing staff are required to notify the resident's attending physician when a significant change in medical treatment is necessary, when a transfer to a hospital is needed, and when there are specific instructions regarding notification of changes in the resident's condition.