STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055142	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0559 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform in writing of a room change one of three sample residents. (Resident 1). This deficient practice resulted in violating Resident 1's right to be informed. Findings: A review of Resident 1's Admission Record (Face Sheet) indicated an admission to the facility dated 10/31/2019, with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set - (standardized assessment and care-screening tool) dated 3/7/2020 indicated Resident 1 was able to understand and make decisions, and required limited assistance with dressing, eating, personal hygiene, and toilet use. On 7/29/2020, at 2:53 p.m., during a telephone interview and concurrent record review, Social Services Director (SSD) stated Resident 1 had a room change on 5/17/2020. SSD was not able to find documented evidence of the reason of Resident 1's room change or documentation of Resident 1 was informed in writing prior to the room change. The policy and procedure titled Room or Roommate Changes- Notification, undated, indicated the facility will provide notice to resident prior to any room change or roommate change.

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