

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/20/2025
NAME OF PROVIDER OR SUPPLIER  Astoria Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  14040 Astoria Street Sylmar, CA 91342	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42311</p> <p>Based on interview and record review, the facility failed to report injury of unknown origin within 24 hours to the State Survey Agency (SSA- the agency that inspects long-term care facilities for the purposes of survey and certification) and the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), as per its policies and procedures on abuse for one of three sampled residents (Resident 1).</p> <p>This deficient practice had the potential to place Resident 1 at risk for an unidentified abuse while under the care of the facility.</p> <p>Findings:</p> <p>During a review of Resident 1's Face Sheet (Admission Record), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included inflammatory polyarthorpathy (a condition characterized by inflammation in multiple joints), other low back pain, and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 1's History and Physical (H&amp;P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 2/27/2025, the H&amp;P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 3/5/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 needed maximum assistance from staff for toileting, dressing, and personal hygiene.</p> <p>(continued on next page)</p>

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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Situation Background Assessment Recommendation (SBAR, technique that provides a framework for communication between members of the health care team about a resident 's condition) Communication Tool dated 3/5/2025, timed at approximately 5 a.m., the SBAR indicated Certified Nursing Assistant (CNA ) 1 notified Registered Nurse (RN) 1 that Resident 1's right hand was swollen, red, skin was warm to touch and with pain level of three out of ten (numerical scale used to measure pain with 0 being no pain and 10 being the worst pain). The SBAR indicated at 7 a.m. on 3/5/2025, the physician was notified with orders for Xray (a medical imaging technique that uses a special type of radiation to create pictures of the inside of your body, allowing doctors to see bones and other structures) of right hand, right wrist, and left ankle. The SBAR also indicated an order to give acetaminophen (medication used to treat pain) 650 milligrams (mg- metric unit of measurement) one time.</p> <p>During a review of Resident 1's Progress Notes dated 3/5/2025, timed at 10:29 a.m., the Progress Notes indicated orders received from the physician for acetaminophen 650 mg by mouth one time and Xray of right hand, right wrist, and left ankle.</p> <p>During a review of Resident 1's Patient Report (Xray result) dated 3/5/2025, timed at 1:26 p.m., the Patient Report for right hand Xray indicated acute fracture (fresh, newly formed bone breaks that occur as a result of sudden trauma or injury) fifth metacarpal (connecting the pinky finger to the wrist).</p> <p>During a review of Resident 1's Physician Order dated 3/5/2025, timed at 3:30 p.m., the Physician Order indicated to transfer Resident 1 to General Acute Care Hospital (GACH) for evaluation and splinting (application of a device, either rigid or flexible, used to protect, immobilize, or restrict motion of an injured body part, like a bone or joint, to promote healing and prevent further damage) of right fifth metacarpal fracture.</p> <p>During a review of Resident 1's Progress Notes dated 3/5/2025, timed at 4:06 p.m., the Progress notes indicated Resident 1 still had right hand swelling and pain with touch and movement. The Progress Notes indicated Resident 1 normally takes medication one tablet at a time using her (Resident 1) right hand but that day (3/5/2025) was unable to take her medication and Licensed Vocational Nurse (LVN ) 1 had to assists Resident 1.</p> <p>During an interview on 3/19/2025, at 3:34 p.m., with LVN 1, LVN 1 stated she (LVN 1) worked on 3/5/2025 from 7 a.m. to 3 p.m. LVN 1 stated when she (LVN 1) came to work, RN 1 notified her (LVN 1) that Resident 1 had redness and swelling on the right hand. LVN 1 stated she (LVN 1) went to Resident 1's room and observed Resident 1's right hand red and swollen. LVN 1 stated before Resident 1's right hand swelling, Resident 1 liked to take her (Resident 1) own medication one tablet at a time using her (Resident 1) right hand but on 3/5/2025, LVN 1 had to assist Resident 1 with medication administration.</p> <p>During an interview on 3/19/2025, at 4:19 p.m., with CNA 1, CNA 1 stated on 3/5/2025 at 4 a.m., she (CNA1) was doing her (CNA 1) second rounds (process of checking each residents) to check on her residents, when RN 1 notified her (CNA 1) that RN 1 had spilled water on Resident 1 after medication administration. CNA 1 stated she (CNA 1) went inside Resident 1's room and observed Resident 1 unable to move and complained of righthand pain. CNA 1 stated she (CNA 1) notified RN 1 and showed Resident 1's swollen right hand.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/19/2025, at 4:33 p.m., with the Director of Nursing (DON), the DON stated on 3/5/2025 morning, RN 1 notified her (DON) of Resident 1's red and swollen right hand. The DON stated Resident 1 unable to state how the incident happen. The DON stated the incident was an injury of unknown origin. The DON stated the incident was reported to SSA and Ombudsman on 3/6/2025 because they wanted to confirm there was an injury first before reporting to SSA and Ombudsman. The DON stated the report to SSA and Ombudsman was within 24 hours from the time they received the Xray result that Resident 1 had a right fifth metacarpal fracture on 3/5/2025 at 1 p.m.</p> <p>During an interview on 3/19/2025, at 4:47 p.m., with the Administrator (ADM) the ADM stated the facility's policy for abuse reporting was to report injury of unknown origin within 24 hours for any incident that does not result from abuse or with bodily injury.</p> <p>During an interview on 3/20/2025, at 10:24 a.m., with RN 1, RN 1 stated he (RN 1) notified the DON on 3/5/2025 at around 7 a.m., of Resident 1's right hand swelling.</p> <p>During an interview on 3/20/2025, at 3:13 p.m., with the DON, the DON stated RN 1 notified her (DON) of Resident 1's right hand swelling on 3/5/2025 between 7 a.m. to 7:30 a.m. The DON stated the facility fax the report to SSA and Ombudsman on 3/6/2025 at 9:36 a.m. The DON stated the Nurse Practitioner (NP) wanted to transfer Resident 1 to the GACH to make the Xray result was the same as the GACH result. The DON stated sometimes the GACH result for fracture are negative (no fracture). The DON stated the facility should have reported injury of unknown origin within 24 hours from the time the change of condition happen not from the time the Xray result of the fracture was identified.</p> <p>During a concurrent interview and record review on 3/20/2025, at 3:45 p.m., with the ADM, facility's policy and procedure (P&amp;P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 9/2022 and last reviewed on 1/16/2025, the P&amp;P indicated, Reporting Allegations to the Administrator and Authorities</p> <ol style="list-style-type: none"> <li>1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.</li> <li>2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: <ol style="list-style-type: none"> <li>a. The state licensing/certification agency responsible for surveying/licensing the facility;</li> <li>b. The local/state ombudsman;</li> <li>c. The resident's representative;</li> <li>d. Adult protective services (where state law provides jurisdiction in long-term care);</li> <li>e. Law enforcement officials;</li> <li>f. The resident's attending physician; and</li> <li>g. The facility medical director.</li> </ol> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Immediately is defined as:</p> <ul style="list-style-type: none"> <li>a. within two hours of an allegation involving abuse or result in serious bodily injury; or</li> <li>b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</li> </ul> <p>4. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone.</p> <p>The ADM stated the facility should report injury of unknown origin within 24 hours upon knowledge of the swelling or change in condition. The ADM stated the importance of reporting within 24 hours to SSA and Ombudsman was for SSA to assist with the investigation and for Resident 1's safety.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42311</p> <p>Based on interview and record review, the facility failed to maintain accurate and complete medical records for one of three sampled residents (Resident 1).</p> <p>This failure had the potential to cause confusion in care and the medical records containing inaccurate documentation</p> <p>Findings:</p> <p>During a review of Resident 1's Face Sheet, the Face Sheet indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included inflammatory polyarthoropathy (a condition characterized by inflammation in multiple joints), other low back pain, and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 1's History and Physical (H&amp;P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) dated 2/27/2025, the H&amp;P indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 3/5/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 needed maximum assistance from staff for toileting, dressing and personal hygiene.</p> <p>During a review of Resident 1's Situation Background Assessment Recommendation (SBAR, technique that provides a framework for communication between members of the health care team about a resident's condition) Communication Tool dated 3/5/2025, timed at approximately 5 a.m., the SBAR indicated Certified Nursing Assistant (CNA ) 1 notified Registered Nurse (RN) 1 that Resident 1's right hand was swollen, red, skin was warm to touch with pain level of three out of ten (numerical scale used to measure pain with 0 being no pain and 10 being the worst pain). The SBAR indicated at 7 a.m. the physician was notified with orders for Xray (a medical imaging technique that uses a special type of radiation to create pictures of the inside of your body, allowing doctors to see bones and other structures) of right hand, right wrist, and left ankle. The SBAR also indicated an order to given acetaminophen (mediation used to treat pain) 650 milligrams (mg-metric unit of measurement) one time.</p> <p>During a review of Resident 1's Physician Order dated 3/5/2025, timed at 7:41 a.m., the Physician Order indicated Tylenol (acetaminophen- medication used to treat pain) 650 mg by mouth one time now.</p> <p>During a concurrent interview and record review on 3/19/2025, at 4:43 p.m., with the Medical Records Director (MRD), Resident 1's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 3/5/2025 was reviewed. The MAR indicated acetaminophen 650 mg tablet was given on 3/5/2025 at 5:30 a.m. The MRD stated RN 1 administered acetaminophen 650 mg to Resident 1 on 3/5/2025 at 5:30 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 3/20/2025, at 3:13 p.m., with the Director of Nursing (DON), Resident 1's SBAR dated 3/5/2025 and MAR dated 3/5/2025 were reviewed. The SBAR indicated the physician was notified on 3/5/2025 at 7 a.m. and ordered acetaminophen tablet 650 mg one time dose. The MAR indicated RN 1 administered acetaminophen to Resident 1 on 3/5/2025 at 5:30 a.m. The DON stated RN 1 documented an inaccurate time. The DON stated RN 1 should have documented the exact time medication was given after the physician made the acetaminophen order. The DON stated RN 1 failed to document accurate time acetaminophen was given.</p> <p>During a review of facility's policy and procedure (P&amp;P) titled, Charting and Documentation dated 7/2017 and last reviewed on 1/16/2025, the P&amp;P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.</p> <p>2. The following information is to be documented in the resident medical record:</p> <ul style="list-style-type: none"> <li>a. Objective observations;</li> <li>b. Medications administered;</li> <li>c. Treatments or services performed;</li> <li>d. Changes in the resident's condition;</li> <li>e. Events, incidents or accidents involving the resident; and</li> <li>f. Progress toward or changes in the care plan goals and objectives.</li> </ul> <p>3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.</p>		