STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056084	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Nursing and Rehab Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42311 Based on observation, interview, and record review, the facility failed to implement a person-centered care plan for one of three sampled residents (Resident 1) by failing to ensure Resident 1's bed alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) was functioning as indicated in Resident 1's Care Plan for fall. This failure had the potential for Resident 1 to fall and placed Resident 1 at risk for injury. Cross reference F689. Findings: During a review of Resident 1's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted Resident 1 on 4/22/2025, with diagnoses that included unspecified (unconfirmed) fracture of the ninth and tenth thoracic vertebrae (a break in the bone of the spine, specifically in the middle back), history of fall, and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) Examination, dated 4/25/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Care Plan, dated 4/23/2025, about status post (after) fall, the Care Plan indicated an intervention initiated on 4/25/2025 for Resident 1 to have a bed alarm while Resident 1 was in bed. During a review of Resident 1's Care Plan Review, dated 4/25/2025, the Care Plan Review indicated an Interdisciplinary Team (IDT-a coordinated group of experts from several different fields who work together) meeting was done with Family member 1 (FM 1) about Resident 1's fall incident on 4/23/2025. The Care Plan Review indicated FM 1 agreed for Resident 1's use of bed alarm. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, and interview on 4/29/2025, at 8:15 a.m., with Resident 1, at Resident 1's bedside. Observed Resident 1 raised her buttocks and waist from her (Resident 1) bed and heard no sound of an alarm. Resident 1 stated she (Resident 1) had a bed alarm, but it was off today (4/29/2025) and was not working. During an interview on 4/29/2025, at 8:35 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 was not on bed alarm. During an interview on 4/29/2025, at 8:46 a.m., with Certified nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 had no bed alarm. During a concurrent observation, and interview on 4/29/2025, at 9 a.m., with the Director of Staff Development (DSD), in Resident 1's right side of the bed. Observed a blue machine box hanging on the right side of the bed with no light on. The DSD stated the bed alarm was not turned on. The DSD stated the wire from the sensor pad was not connected to the bed alarm machine. Observed the DSD connected the wire to the bed alarm machine and a small light on the machine turned green and heard a beeping sound. During an interview on 4/29/2025, at 9:33 a.m., with LVN 1, LVN 1 stated he (LVN 1) should have checked and made sure that Resident 1's bed alarm was turned on and functioning. LVN 1 stated the importance of care plan was it guides the nurses on Resident 1's care, how to manage and treat Resident 1 to achieve Resident 1's goal and for Resident 1's safety. During an interview on 4/29/2025, at 9:40 a.m., with the DSD, the DSD stated CNAs, LVNs and nurses are responsible for making sure bed alarm are functioning for Resident 1's to prevent fall. During a concurrent interview, and record review on 4/29/2025, at 10:36 a.m., with the Director of Nursing (DON), facility's policy and procedure (P&P) titled, Comprehensive Care Plan undated and last reviewed on 1/16/2025, the P&P indicated, 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or Care Area Triggers in isolation may have little, if any, benefit for the resident. 6. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making. No single discipline can manage the task in isolation. The resident's physician (or primary healthcare provider) is integral to this process. The DON stated Resident 1's care plan for use of bed alarm should be followed. The DON stated care plans are guides on how to render necessary care to Resident 1 and bed alarm was one of the intervention to prevent Resident 1's fall.

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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** 42311 Based on observation, interview, and record review, the facility failed to follow its policy on fall prevention for one of three sampled residents (Resident 1) who had a history of fall and had an incident of fall on 4/23/2025 while admitted at the facility by: 1. Failing to ensure Resident 1's bed alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) was turned on and functioning. 2. Failing to accurately assess Resident 1's Fall Risk Assessment after incident of fall on 4/23/2025. These failures can potentially place Resident 1 at risk for further injury, fall, and accidents. Cross reference F656. Findings: a. During a review of Resident 1's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted Resident 1 on 4/22/2025, with diagnoses that included unspecified (unconfirmed) fracture of the ninth and tenth thoracic vertebrae (a break in the bone of the spine, specifically in the middle back), history of fall, and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR) Communication Tool (a technique that provides a framework for communication between members of the health care team about a resident's condition), dated 4/23/2025, the SBAR indicated on 4/23/2025 at 6:45 a.m., Resident 1 was found sitting on her (Resident 1) bedside floor with a pain level of 10 out of 10 (zero-no pain, 10-severe pain) right shoulder and right arm pain. During a review of Resident 1's Patient Report (Radiology Report-a detailed report that describes the results of an imaging test), dated 4/23/2025, the Patient Report indicated Resident 1 had acute mildly displaced fracture (a bone break that occurred recently within the first few days and where the broken pieces of bone are slightly out of alignment) involving the proximal humerus (the upper, shoulder end of the humerus bone, which is the long bone in the upper arm). During a review of Resident 1's Care Plan, dated 4/23/2025, about status post (after) fall, the Care Plan indicated an intervention initiated on 4/25/2025 for Resident 1 to have a bed alarm while Resident 1 was in bed. During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) Examination, dated 4/25/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. (continued on next page)

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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	During a review of Resident 1's Care Plan Review, dated 4/25/2025, the Care Plan Review indicated an Interdisciplinary Team (IDT-a coordinated group of experts from several different fields who work together) meeting was done with Family member 1 (FM 1) about Resident 1's fall incident on 4/23/2025. The Care Plan Review indicated FM 1 agreed for Resident 1's use of bed alarm. During a concurrent observation, and interview on 4/29/2025, at 8:15 a.m., with Resident 1, at Resident 1's bedside. Observed Resident 1 raised her buttocks and waist from her (Resident 1) bed and heard no sound of an alarm. Resident 1 stated she (Resident 1) had a bed alarm, but it was off today (4/29/2025) and was not working. Resident 1 stated she did not remember where she (Resident 1) fell but knows it was on her right side because she (Resident 1) had a broken right shoulder. During an interview on 4/29/2025, at 8:35 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 1 did not have a bed alarm. During an interview on 4/29/2025, at 8:46 a.m., with Certified nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 had no bed alarm. During a concurrent observation and interview on 4/29/2025, at 9 a.m., with the Director of Staff Development (DSD), in Resident 1's right side of the bed. Observed a blue machine box hanging on the right side of the bed with no light on. The DSD stated the bed alarm was not turned on. The DSD stated the wire from the sensor pad (pressure-sensitive devices designed to detect weight, that is placed under a mattress or a chair. When pressure is removed or when someone gets up from a bed, the pad sends an alert), was not connected to the bed alarm machine. Observed the DSD connected the sensor pad wire to the bed alarm machine and a small light on the bed alarm machine turned green and made a beeping sound. During an interview on 4/29/2025, at 9:33 a.m., with LVN 1, LVN 1 stated he (LVN 1) should have checked and made sure that Resident 1's bed alarm was turned on and functioning. LVN 1 stated the importance of bed alarm was for Resident 1's safety, to prevent another fall. During an interview on 4/29/2025, at 9:40 a.m., with the DSD, the DSD stated CNAs, LVNs and nurses are responsible for making sure bed alarm are functioning to prevent Resident 1's fall. During an interview on 4/29/2025, at 10:36 a.m., with the Director of nursing (DON), the DON stated bed alarm alerts the staff for any unsupervised attempts of Resident 1 to get up from the bed to prevent fall. The DON stated if bed alarm was not turned on and not working the risk of Resident 1 falling again can happen. The DON stated nurse should check the bed alarm if its working. During a review of facility's policy and procedure (P&P) titled, Using Devices as Nursing Intervention, undated and last reviewed on 1/16/2025, the P&P indicated, It is the policy of this facility to use device(s) to remind resident to call for assistance when needed and not to get up from bed or wheelchair unassisted. Some devices are being used as enabler or intervention to protect resident from sustaining major injury. Devices are defined as a manual method or physical or mechanical device material, or equipment attached or adjacent to the resident 's body that the resident can remove easily by merely asking to avoid restriction of movements. Some devices are placed around resident's bed or wheelchair as a nursing intervention to protect resident for possible injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 1's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated Resident 1 had a total score of eight (low risk for fall, 10 represents high risk for fall). The Fall Risk Assessment indicated Resident 1 had one or two of the condition listed was present and scored two points on predisposing diseases (a condition that increases a person's risk of developing another, related disease). The Fall Risk Assessment indicated the following predisposing conditions: 1. hypertension (HTN-high blood pressure), 2. vertigo (a sensation of spinning or movement), 3. cardiovascular accident (CVA- stroke, loss of blood flow to a part of the brain), 4. Parkinson's diseases (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), 5. loss of limbs, 6. seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), 7. arthritis (inflammation or swelling of one or more joints) 8. osteoporosis weak and brittle bones due to lack of calcium and Vitamin D) and 9. fractures. During a concurrent interview and review on 4/29/2025 at 9:40 a.m., with the DSD, Resident 1's Fall Risk assessment dated [DATE] was reviewed. The DSD stated Resident 1 was not a high risk for fall because Resident 1's total score was below 10. The DSD stated Resident 1's Fall Risk assessment dated [DATE] should be high risk for fall. During an interview on 4/29/2025, at 10:36 a.m., with the DON, the DON stated Resident 1's Fall Risk Assessment should be high risk for fall because Resident 1 had history of fall, HTN, osteoporosis and fracture. The DON stated Resident 1 had four predisposing condition for fall. The DON stated the Fall Risk Assessment, dated 4/23/2025 was incorrect. The DON stated because of incorrect Fall Risk Assessment, intervention was inaccurate, and the facility will not be able to implement necessary intervention specific to Resident 1. The DON stated safety measure will not be implemented that can jeopardize (place in danger) resident safety. The DON stated the Registered Nurse (RN) should have assess Resident 1 thoroughly and review the H&P and diagnoses of Resident 1 before completing the Fall Risk Assessment. During a review of facility's policy and procedure (P&P) titled, Falls-Clinical Protocol, dated 3/2018, and last reviewed on 1/16/2025, the P&P indicated, Assessment and Recognition: 1. The physician will help identify individuals with a history of falls and risk factors for falling. a. Staff will ask the resident and the caregiver or family about a history of falling. (continued on next page)

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