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	08/06/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1) received quality of care in accordance with professional standards of practice to meet Resident 1's physical, mental, and/or psychosocial needs (consists of the emotional and social requirements that individuals have to feel safe, supported, and function effectively in their environment), when an interdisciplinary (IDT) meeting did not timely occur after Resident 1's fall on 8/2/2025 and in compliance with the facility's own policy and procedure. This failure had the potential to result in a delay in investigating and determining the causative factors that resulted in Resident 1's fall on 8/2/2025. Findings: During a review of Resident 1's admission Record, dated 7/6/2025, the admission Record indicated Resident 1's diagnoses included atrial fibrillation (a condition where the heart's upper chambers beat irregularly and too fast, instead of in a coordinated way), congestive heart failure (a condition in which the heart is unable to pump enough blood throughout the body), and diabetes mellitus type 2 (a condition where the body does not properly use insulin, which is a hormone that helps adjust the blood sugar levels in the body). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/19/2025, the MDS indicated Resident 1 needs set up or clean up assistance with eating, personal hygiene, and dressing the upper body parts (resident completes the activity and the helper only needs to set up the activity or clean up after it). The MDS indicated Resident 1 needs supervision or touching assistance with toileting hygiene (resident completes the activity and the helper provides assistance throughout the activity or intermittently).During a review of Resident 1's care plan, dated 8/6/2025, the care plan indicated Resident 1 had an actual fall [related] to poor balance, unsteady gait and poor safety awareness. The care plan indicated nursing interventions included having the call light within reach, frequent visual checks, and keeping the bed in the lowest position.During a concurrent observation and interview on 8/5/2025 at 11:46 a.m. with Resident 1 inside her room, Resident 1 stated that approximately a few days ago, Resident 1 was walking out of the bathroom and tried to grab the handle of the wheelchair that was nearby to steady herself. Resident 1 pointed at the wheelchair which was observed to be approximately 2 feet from the bathroom door. Resident 1 stated that she couldn't reach it and then fell. Resident 1 stated she landed on the right side of her face and her right shoulder. Resident 1 stated that her roommate called the staff for help. During an interview on 8/6/2025 at 12:04 p.m. with Resident 2 sitting on her bed, Resident 2 stated she saw Resident 1 on the floor so she went out [of the room] to get help. Resident 2 stated she wanted to make sure someone came to help Resident 1. Resident 2 could not recall and provide any other additional information. During a phone interview on 8/6/2025 at 12:48 p.m. with LVN 1, LVN 1 stated that after Resident 2 informed her that Resident 1 needed help, LVN 1 went to Resident 1's room and saw her lying on the floor on her right side. LVN 1 stated per facility's policy and procedure, a resident who falls must be physically assessed and the findings must be documented. LVN 1 stated an incident report, care plan, and neurology check (an examination of a person's nervous system, consisting of the brain, spinal cord, and nerves, to assess how well they are functioning) must also be completed and documented after a resident fall. LVN 1 stated she think[s] IDT must meet post fall to discuss what happened and why a resident fell. During a concurrent interview and record review on 8/6/2025 at 2:49 p.m. with the Assistant Director of Nursing (ADON), Resident 1's electronic medical record was reviewed. ADON stated an IDT meeting is part of the protocol after a resident has fallen. ADON stated, we have a meeting because we try to find a solution so that it will not happen anymore. When asked if an IDT meeting occurred after Resident 1 fell on 8/2/2025, ADON stated she was unsure. ADON reviewed Resident 1's electronic medical record but could not provide documented evidence that confirmed an IDT meeting occurred after Resident 1 had fallen on 8/2/2025.During an interview on 8/6/2025 at 3:47 p.m. with the Director of Nursing (DON), the DON stated it is a standard of practice to investigate whenever a resident falls. The DON stated it is the facility's policy to have an IDT meeting within 72 hours of the fall incident, in which the interdisciplinary team will discuss and determine the cause of the fall. The DON stated an IDT meeting was not done within 72 hours of Resident 1's fall in accordance with the facility's policy and procedure. The DON stated the consequence of failing to have an IDT meeting post fall is the potential of additional injury to the resident if causative factors are not identified and addressed. During a review of the facility's policy and procedure titled, Fall Management Program, undated, the policy and procedure indicated the IDT-Falls Committee will meet within 72 hours of a fall. The P&P indicated the IDT-Falls Committee will review and document the [s]ummary of event following a fall; [r]oot cause analysis; [r]eferrals, as necessary; and [i]nterventions to

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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. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure the medical record of one of two sampled residents (Resident 1) was complete and accurately documented when Resident 1's medical record did not contain a Post-Fall Assessment & Investigation that was required by the facility's own policy and procedure. This failure resulted in an incomplete medical record as the facility's policy and procedure mandates the completion of a Post-Fall Assessment & Investigation after a resident is discovered to have fallen.Findings: During a review of Resident 1's admission Record, dated 7/6/2025, the admission Record indicated Resident 1's diagnoses included atrial fibrillation (a condition where the heart's upper chambers beat irregularly and too fast, instead of in a coordinated way), congestive heart failure (a condition in which the heart is unable to pump enough blood throughout the body), and diabetes mellitus type 2 (a condition where the body does not properly use insulin, which is a hormone that helps adjust the blood sugar levels in the body). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/19/2025, the MDS indicated Resident 1 needs set up or clean up assistance with eating, personal hygiene, and dressing the upper body parts (resident completes the activity and the helper only needs to set up the activity or clean up after it). The MDS indicated Resident 1 needs supervision or touching assistance with toileting hygiene (resident completes the activity and the helper provides assistance throughout the activity or intermittently).During a review of Resident 1's care plan, dated 8/6/2025, the care plan indicated Resident had an actual fall [related] to poor balance, unsteady gait and poor safety awareness. The care plan indicated nursing interventions include having the call light within reach, frequent visual checks, and keeping the bed in the lowest position.During a concurrent observation and interview on 8/5/2025 at 11:46 a.m. with Resident 1 inside her room, Resident 1 stated that approximately few days ago, Resident 1 was walking out of the bathroom and tried to grab the handle of the wheelchair that was nearby to steady herself. Resident 1 pointed at the wheelchair which was observed to be approximately 2 feet from the bathroom door. Resident 1 stated that she couldn't reach it and then fell. Resident 1 stated she landed on the right side of her face and her right shoulder. Resident 1 stated that her roommate called the staff for help. During an interview on 8/6/2025 at 12:04 p.m. with Resident 2 sitting on her bed, Resident 2 stated she saw Resident 1 on the floor so she went out [of the room] to get help. Resident 2 stated she wanted to make sure someone came to help Resident 1. Resident 2 could not recall and provide any other additional information.During a phone interview on 8/6/2025 at 12:48 p.m. with LVN 1, LVN 1 stated that after Resident 2 informed her that Resident 1 needed help, LVN 1 went to Resident 1's room and saw her lying on the floor on her right side. LVN 1 stated per facility's policy & procedure, a resident who falls must be physically assessed and the findings must be documented. LVN 1 stated an incident report, care plan, and neurology check (an examination of a person's nervous system, consisting of the brain, spinal cord, and nerves, to assess how well they are functioning) must also be completed and documented after a resident fall. When asked about the Post-Fall Assessment & Investigation, LVN 1 could not recall if she had completed that specific assessment and stated that it used to be done by the Assistant Director of Nursing or the Director of Nursing.During a concurrent interview and record review on 8/6/2025 at 2:49 p.m. with the Assistant Director of Nursing (ADON), Resident 1's electronic medical record was reviewed. The ADON stated the Post-Fall Assessment & Investigation is a facility requirement after a resident fall, and it should be completed by a RN (registered nurse). The ADON stated the Post-Fall Assessment & Investigation template document was created by the Director of Nursing in Resident 1's electronic record, as evidenced by DON's name listed, however the document was incomplete. ADON stated no one filled it out. During an interview on 8/6/2025 at 3:47 p.m. with the Director of Nursing (DON), the DON stated the facility's policy requires the completion of the Post-Fall Assessment & Investigation after a resident has fallen. DON stated the Post-Fall Assessment & Investigation for Resident 1 should have been completed after calling the doctor, but it didn't happen. DON stated the consequence of not completing the Post-Fall Assessment & Investigation is the facility is not able to re-assess Resident 1 because days have already passed since the fall incident. DON stated the Post-Fall Assessment & Investigation needs to be completed near the time of the incident in order to identify accurately why the resident fell. DON stated the importance of identifying causative factors is to avoid additional falls in the future and harm to the resident. During a review of the facility's policy and procedure (P&P) titled, Fall Management Program, undated, the P&P indicated [f]ollowing a resident's fall, the licensed nurse will complete an incident report and a Post-Fall Assessment & Investigation. The P&P stated the Fall Risk