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	05/09/2025

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 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. 43988 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained a resident's dignity for one (1) of 1 sampled resident (Resident 115) reviewed for dignity by failing to ensure Certified Nursing Assistant (CNA) 3 was not standing over the resident while assisting the resident during mealtime. This deficient practice had the potential to negatively affect the residents' psychosocial wellbeing. Findings: During a review of Resident 115's Face Sheet (Admission Record), the Face Sheet indicated the facility originally admitted the resident on 10/22/2023 and readmitted in the facility on 4/2/2025, with diagnoses including pneumonia (an infection/inflammation in the lungs), dementia (a progressive state of decline in mental abilities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 115's History and Physical (H&P), dated 4/9/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 115's Minimum Data Set (MDS - a resident assessment tool), dated 11/29/2024, the MDS indicated Resident 115 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 115 required total assistance from staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview, on 5/7/2025, at 7:20 a.m., inside Resident 115's room, Resident 115 laid in bed with the head of the bed elevated to seat the resident upright. CNA 3 assisted Resident 115 with breakfast while standing over the resident. CNA 3 stated staff should be sitting at eye level while assisting residents with eating to respect the dignity of the residents. CNA 3 stated that she forgot to get a chair and that she should be sitting at eye level while assisting the resident with eating to respect the dignity of Resident 115. (continued on next page)

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
	056084	A. Building B. Wing	05/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 5/7/2025, at 7:23 a.m., outside Resident 115's room, with Registered Nurse (RN) 1, RN 1 stated CNA 3 was standing over the resident while assisting Resident 115 with eating breakfast. RN 1 stated staff should be sitting at eye level while assisting the residents with eating as it was a dignity issue. RN 1 stated CNA 3 should have grabbed a chair and sat at eye level while feeding Resident 115 to preserve the resident's dignity. During an interview, on 5/8/2025, at 3:41 p.m., with the Director of Nursing (DON), the DON stated the staff should be assisting the residents with eating at eye level and sitting down. The DON stated it was important that the staff be sitting at eye level while assisting the residents with eating to preserve the residents' dignity and to observe if the resident was chewing the food properly and/or if there were signs of choking or aspirations. The DON stated CNA 3 should have grabbed a chair and sat down while assisting Resident 115 with eating for safety and dignity. During a review of the facility's policy and procedure (P&P) titled, Assistance with Meals, last reviewed on 1/16/2025, the P&P indicated: - Residents shall receive assistance with meals in a manner that meets the individual. - Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example not standing over residents while assisting them with meals. During a review of the facility's P&P titled, Dignity, last reviewed on 1/16/2025, the P&P indicated: - Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem - When assisting with care, residents are supported in exercising their rights, residents are provided with dignified dining experience.

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	05/09/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 38552 Based on observation, interview, and record review, the facility failed to ensure the resident and/or responsible party (RP) was informed in advance, of the risks and benefits of psychoactive medication (a drug that changes brain function and results in alterations in perception, mood, consciousness or behavior) for one of one sampled resident (Resident 121) reviewed for informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) by failing to ensure Resident 121's Remeron (also known as mirtazapine, a medication used to treat depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]). This deficient practice violated the resident's right to make informed decisions regarding the use of psychoactive medication. Findings: During a review of Resident 121's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted the resident on 2/18/2021 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute (sudden) exacerbation (worsening of the disease), schizophrenia (a mental illness that is characterized by disturbances in thought), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 121's Minimum Data Set (MDS-a resident assessment tool), dated 2/25/2025, the MDS indicated the resident had clear speech, makes self-understood, and had the ability to understand others. During a review of Resident 121's Physician Order, dated 5/2/2025, the Physician Order indicated to administer Remeron 15 milligrams (mg-a unit of measurement) by mouth (PO) every hour of sleep (QHS) for depression manifested by a poor appetite. During a review of Resident 121's History and Physical (H&P), dated 5/8/2025, the H&P indicated the resident can make needs known but cannot make medical decisions. During a concurrent interview and record review on 5/9/2025 at 11:04 a.m. with MDS Nurse (MDSN) 1, Resident 121's informed consents were reviewed. MDSN 1 stated there was no informed consent completed for Resident 121's use of Remeron. During a concurrent interview and record review on 5/9/2025 at 11:13 a.m. with Registered Nurse (RN) 2, Resident 121's informed consents and nursing progress notes were reviewed. RN 2 stated she missed completing the consent for the use of Remeron. RN 2 stated she should have had it done when she got the order on 5/2/2025. RN 2 stated she is still getting used to the process and missed them. RN 2 stated it is important to verify the consent because Remeron is a psychotropic medication, and it is the resident's right to be informed. (continued on next page)

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	05/09/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2025 at 12:35 p.m. with the Director of Nursing (DON), the DON stated the licensed nurse, RN or licensed vocational nurse, are to obtain the informed consent from the resident and/or responsible party before the medication is administered. The DON stated this is to ensure Resident 121 is not being medicated unnecessarily. The DON stated Remeron could potentially cause unnecessary side effects such as nausea, vomiting, hypotension (low blood pressure), and dizziness. During a review of the facility's policy and procedure (P&P) titled, Informed Consent, which had a review and approved date of 1/16/2025, the P&P indicated that it is the facility's policy to facilitate, when necessary, the obtaining of Informed Consent for medical services by verification of the Informed Consent or by the Interdisciplinary Team, comprised at the minimum including the MDS Coordinator, Director of Nursing, Social Services Director, Attending Physician, and any other healthcare members necessary as determined by the resident's need and/or IDT may attend the meeting. The P&P indicated Informed Consent will be verified by the facility with each order.

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	05/09/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 44244 Based on observation, interview, and record review, the facility failed to ensure medication self-administration was clinically appropriate and failed to honor the resident's right to self-administer medications for one of three sampled residents (Resident 96) reviewed under the Accidents care area by failing to perform a medication self-administration assessment when staff had knowledge that the resident kept medication at the bedside for self-administration. This deficient practice violated the residents' right to self-administer medications and had potential for the residents to experience adverse effects (an undesired effect of a drug or other type of treatment) of the medication. Cross-reference F689 Findings: During a review of Resident 96's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted the resident on 8/1/2020 and most recently admitted the resident on 3/24/2025 with diagnoses including polyneuropathy (a disorder of the peripheral nervous system that may result in pain, discomfort, and mobility issues), essential (primary) hypertension (high blood pressure with an unknown cause) major depressive disorder (persistent feelings of sadness and loss of interest that can interfere with daily living), anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), binge eating disorder (a mental illness that causes chronic, compulsive overeating), and unspecified intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently). During a review of Resident 96's Minimum Data Set (MDS - resident assessment tool), dated 4/4/2025, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated that the resident was dependent on staff for toileting and bathing, required substantial / maximal assistance for dressing and moving from lying to sitting, and required partial/moderate assistance for personal hygiene and rolling left and right in the bed. During a review of Resident 96's History and Physical (H&P), dated 3/26/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 96's Physician Order Sheet April 2025, dated 3/28/2025, the Physician Order Sheet indicated the following orders: - On 3/25/2025, bupropion HCL XL (a psychotropic medication [any medication capable of affecting the mind, emotions, and behavior] used to treat depression) 300 milligram (mg - a unit of measurement) 24-hour tablet, extended release, give one tablet daily at the a.m. medication (med) pass by mouth, for major depressive disorder manifested by sad facial expressions. (continued on next page)

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	05/09/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 3/24/2025, buspirone (a psychotropic medication used to treat anxiety) 10 mg tablet, give one tablet two times a day at the a.m. and dinner med pass by mouth for anxiety disorder manifested by repetitive health complaints. - On 3/24/2025, carvedilol (a medication used to treat high blood pressure) 25 mg tablet, one tablet two times daily at the a.m. and dinner med pass by mouth, for essential hypertension, hold (do not give) for systolic blood pressure (SBP - measures the pressure in your arteries [pathway that carries blood away from the heart] less than 110. - On 3/24/2025, lisdexamfetamine (a psychotropic medication used to treat binge eating disorder) 30 mg capsule, give one capsule daily at the a.m. med pass by mouth, for binge-eating disorder. - On 4/3/2024, Vitamin D3 (a supplement) 25 mcg (microgram, a unit of measurement), three tablets daily at the a.m. med pass for supplement. During a review of Resident 96's Self-Administration of Medication Assessment, dated 3/24/2025, the Self-Administration of Medication Assessment indicated the resident did not want to self-administer medication and the resident was not a candidate for safe self-administration of medication. During a review of Resident 96's Care Plan (CP) regarding activities of daily living, self-care deficit, initiated 3/31/2025, the CP indicated to minimize the resident's risk of decline by providing a safe environment, to allow the resident to be active in the decision-making process, and to respect the resident's rights. During a concurrent observation and interview, on 5/6/2025, at 10:50 a.m., with Resident 96, Resident 96 sat up in bed. The bedside rolling table had a clear plastic medicine cup containing two capsules and three tablets. Resident 96 stated the medication belonged to Resident 96 and the Licensed Vocational Nurse (LVN) left the medication on the table because the resident does not like to take all the medication at the same time. Resident 96 stated the resident forgot to take the medication that was left by the LVN. During a concurrent observation and interview, on 5/6/2025, at 11:04 a.m., with LVN 2, LVN 2 entered Resident 96's room and stated LVN 2 left the medication for Resident 96 to self-administer. LVN 2 stated Resident 96 was alert, and it was ok for Resident 96 to self-administer medication. Resident 96 swallowed the five medications in the cup. LVN 2 exited Resident 96's room and stated Resident 96 usually wants LVN 2 to leave the medication in the room to self-administer one at a time. LVN 2 stated because the resident is alert, LVN 2 often leaves medication in Resident 96's room to self-administer. (continued on next page)

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	05/09/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 5/6/2025, at 2:35 p.m., Resident 96's physician orders, Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 5/2025, and Nursing Progress Notes for 5/2025 were reviewed. LVN 2 stated the facility medication administration process is to take the resident's medication to bedside, watch the resident take the medication to make sure the resident safely administers all the medication, then document in the MAR the date and time the resident took the medication. LVN 2 stated the facility process for resident medication self-administration is that the resident should be assessed for the ability to safely self-administer medications and there should be a physician's order indicating what medications the resident may self-administer. LVN 2 stated Resident 96 did not have a physician's order or an assessment indicating the resident was capable of self-administering medication. LVN 2 stated LVN 2 did not do an assessment when Resident 96 requested to self-administered medication or notify anyone of Resident 96's preference to self-administer medications, but LVN 2 should have. LVN 2 stated LVN 2 left lisdexamfetamine, bupropion, buspirone, carvedilol, and one tablet of Vitamin D unattended at Resident 96's bedside for the resident to self-administer but the resident was not assessed and did not have a physician's order for medication self-administration. During a concurrent interview and record review, on 5/6/2025, at 3:01 p.m., with Registered Nurse (RN) 1, Resident 96's Self-Administration of Medication Assessment, dated 3/24/2025, was reviewed. RN 1 stated residents have the right to self-administer medication if they are safely able to. RN 1 stated a medication self-administration assessment is done upon admission and as needed if a resident requests to self-administer medication. RN 1 stated Resident 96's Self-Administration of Medication Assessment indicated the resident did not request to self-administer medication. RN 1 stated when Resident 96 requested to leave medications at bedside to self-administer without the nurse present, there should have been a new self-administration assessment completed because the resident was now requesting self-administration of medication. RN 1 stated there was no documented evidence that Resident 96 was re-assessed, but the resident should have been because it is a resident's right. During an interview, on 5/9/2025, at 9 a.m., with the Director of Nursing (DON), the DON stated residents have a right to self-administer medication, but there is a process to follow. The DON stated that when a resident requests to self-administer medication, there must be an assessment to determine if the resident is capable of safely self-administering medication, the physician is then notified, and if the physician agrees they will write an order for self-administration. The DON stated when LVN 2 left medications at bedside after Resident 96 expressed a desire to self-administer medications, the facility policy was not followed because the resident was not assessed for medication self-administration and medications cannot be left at bedside because the resident may not take the medication as ordered and the unattended medications are a risk to other residents. The DON stated every resident has the right to be assessed for the ability to self-administer medication when they request to. The DON stated when LVN 2 did not follow up with Resident 96's request to self-administer medication, there was a potential that the facility would go against the resident's rights and may result in psychosocial issues in Resident 96. During a review of the facility policy and procedure (P&P) titled, Resident Rights, last reviewed 1/16/2025, the P&P indicated federal and state laws guarantee certain basic rights to all residents of the facility. The rights include the resident's right to self-administer medications, if the interdisciplinary care planning team determines it is safe. (continued on next page)

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	05/09/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility P&P titled, Self-Administration of Medications, last reviewed 1/16/2025, the P&P indicated residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The IDT considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident: a. The medication is appropriate for self-administration. b. The resident is able to read and understand medication labels; c. The resident can follow directions and tell time to know when to take the medication. d. The resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to the staff; e. The resident has the physical capacity to open medication bottles, remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and f. The resident is able to safely and securely store the medication. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and/or decision-making status. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. The IDT evaluates options which allow residents to safely participate in the medication administration process if they wish to do so. Residents who are identified as being able to self-administer medications arc asked whether they wish to do so. For self-administering residents, the nursing staff determines who is responsible (the resident or the nursing staff) for documenting that medications are taken. Self-administered medications are stored in a safe and secure place which is not accessible by other residents. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

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	05/09/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43988 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) was connected to the wall plug for one (1) of 1 sampled resident (Resident 107) reviewed under the Environment task. This deficient practice had the potential to result in the delay of care and services and possible injury to residents when they are unable to call for assistance. Findings: During a review of Resident 107s Face Sheet (Admission Record), the Face Sheet indicated the facility originally admitted the resident on 3/23/2020 and readmitted in the facility on 7/26/2024, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarct (stroke, loss of blood flow to a part of the brain) affecting right dominant side, aphasia (a disorder that makes it difficult to speak), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 107's History and Physical (H&P), dated 7/29/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 107's Minimum Data Set (MDS - a resident assessment tool), dated 3/26/2025, the MDS indicated Resident 107 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 107 required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 107's fall risk assessments, dated 12/24/2025 and 3/25/2025, the fall risk assessments indicated Resident 107 was a risk for falls. During a review of Resident 107's care plan (CP) on potential for falls, initiated on 8/8/2024, the CP indicated to keep call light and frequently used items within as one of the interventions to reduce or minimize risk of falls or injury. During a concurrent observation and interview, on 5/6/2025, at 11:44 a.m., inside Resident 107's room, with Certified Nursing Assistant (CNA) 5, Resident 107 laid in bed asleep with the call light clipped to the resident's sheet and disconnected from the wall. CNA 5 stated all residents' call lights should be plugged to the wall at all times to ensure the call light was functioning properly so the residents would be able to call for assistance when needed. CNA 5 stated the staff should ensure the call lights are plugged to the wall and functioning properly prior to leaving the residents' rooms. CNA 5 stated Resident 107's call light should have been plugged to the wall to make sure it was functioning properly so Resident 107 would be able to call for assistance when needed. CNA 5 stated not having a functioning call light placed Resident 107 at risk for a delay in meeting the resident's needs. (continued on next page)

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	05/09/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/9/2025, at 11:31 a.m., with the Director of Nursing (DON), the DON stated the staff should ensure the residents' call lights are plugged in the wall and functioning properly prior to leaving the room so the residents would be able to call for assistance when needed. The DON stated CNA 5 should have ensured Resident 107's call light was connected to the wall and functioning properly. The DON stated if the call light was not functioning properly placed Resident 107 at risk of a delay in receiving the care the resident needed. During a review of the facility's recent policy and procedure (P&P) titled, Answering the Call Light, last reviewed on 1/16/2025, the P&P indicated to be sure that the call light is plugged in at all times, answer the residents' call as soon as possible, and to respond to the resident's needs and requests.

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	05/09/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility failed to ensure resident's medical records were updated to show documented evidence that advance directives (a legal document indicating resident preference on end-of-life treatment decisions) were discussed with three of three sampled residents (Residents 94, 17, and 72). These deficient practices violated the resident's rights and/or representative's right to be fully informed of the option to formulate their advanced directives. Findings: 1. During a review of Resident 94's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted the resident on 12/6/2024, with diagnoses including acute respiratory failure (the lungs are having a hard time getting enough oxygen into the blood and/or removing carbon dioxide from the blood) with hypoxia (a shortage of oxygen reaching the body's tissues), pneumonia (an infection/inflammation in the lungs), and cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die). During a review of Resident 94's History and Physical (H&P), dated 12/7/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 94's Minimum Data Set (MDS - a resident assessment tool), dated 3/31/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). During a concurrent interview and record review, on 5/8/2025, at 9:16 a.m., with Registered Nurse (RN) 4, Resident 94's Medical Chart and Advance Directive Acknowledgement Form were reviewed. RN 4 stated there was no Advance Directive Acknowledgement Form on Resident 94's Medical Chart. RN 4 stated it was the responsibility of the Social Services Department to offer the resident or representative the information regarding the formulation of Advance Directive and they place a copy of the Advance Directive Acknowledgement Form in the Medical Chart once it is provided. RN 4 stated it was important to offer the formulation of Advance Directive information to the residents to honor their right to formulate an advanced directive and their right to informed consent. During a concurrent interview and record review, on 5/8/2025, at 9:48 a.m., with Social Services (SS) Designee 2, Resident 94's Medical Chart and Advance Directive Acknowledgement Form were reviewed. SS Designee 2 stated she cannot find the Advance Directive Acknowledgement Form on Resident 94's Medical Chart. SS Designee 2 stated the Social Services Department is responsible for providing the formulation of advance directive to residents and representatives and they file them on the Medical Charts. SS Designee 2 stated she knew she spoke to the family member about the formulation of the advance directive but without the Advance Directive Acknowledgement Form she will not be able to prove that it was provided. (continued on next page)

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	05/09/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 5/9/2025, at 11:10 a.m., with the Director of Nursing (DON), the DON stated it was the responsibility of the Social Services Department to offer the information on the formulation of advance directives to residents or representatives. The DON stated the licensed staff should also check for the presence of the Advance Directive Acknowledgement Form in the Medical Chart to ensure it was provided. The DON stated it was important that they provided the information on formulating an advanced directive to Resident 94 to ensure the resident's right to formulate an advanced directive and informed consent was honored. During a review of the facility's recent policy and procedure (P&P) titled, Advance Directives, last reviewed on 1/16/2025, the P&P indicated the resident has the right to formulate an Advance Directive. Advance Directives are honored in accordance with state law and facility policy. Upon admission of a resident to our facility, the Social Services Director or Designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate an Advance Directive. Upon the admission of a resident, the Social Services Department will inquire about the existence of any written Advance Directive. Information about whether or not the resident has executed an Advance Directive shall be displayed in the medical record. 44244 2. During a review of Resident 17's Face Sheet, the Face Sheet indicated the facility admitted the resident on 1/9/2024 with diagnoses that included acquired absence of the right toe, idiopathic neuropathy (damage to the nerves that control automatic body functions), major depressive disorder (persistent feelings of sadness and loss of interest that can interfere with daily living), and diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 17's MDS, dated [DATE], the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated that the resident was dependent on staff for bathing, required substantial / maximal assistance for dressing, and required partial/moderate assistance for personal hygiene and mobility. During a review of Resident 17's H&P, dated 12/15/2024, the H&P indicated the resident had decision making capacity. During a review of Resident 17's Advanced Directive Acknowledgement Form, signed by the resident on 1/10/2024, the form indicated the resident had executed a Living Will and the terms of the AD would be followed by the health care facility and care givers. During a review of Resident 17's Care Plan (CP) titled, Cognitive Loss / Communication, initiated 1/9/2024, the CP indicated a goal that the resident would be able to maximize their cognitive skills and decision-making capabilities with an intervention to encourage choices of care. During a review of Resident 17's CP titled, Potential for Unavoidable Decline, initiated 1/28/2025, the CP indicated the resident was at risk for further decline in functioning with interventions including appropriate and necessary follow-up by the social services department. (continued on next page)

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	05/09/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 5/9/2025, at 9:07 a.m., with RN 8, Resident 17's Advanced Directive Acknowledgement Form, dated 1/10/2024, was reviewed. RN 8 stated the form indicated the resident had a living will. RN 8 stated Resident 8's living will was not in the resident's chart and there was no documentation regarding the resident's living will. RN 8 stated when a resident has a living will, the social services department is responsible for obtaining a copy of the living will. During an interview, on 5/9/2025, at 9:22 a.m., with SS Designee 1, SS Designee 1 stated when a resident indicates that they have a living will, it is SS Designee 1's responsibility to follow up and obtain a copy for the resident's chart. SS Designee 1 stated it was important to obtain a copy of the living will, because the living will has information regarding the resident's wishes and would be used by staff when the resident is no longer able to make decisions for himself. SS Designee 1 stated SS Designee 1 was made aware Resident 17's living will was not in the resident's chart. SS Designee 1 stated SS Designee 1 forgot to follow up to obtain a copy of Resident 17's living will. During an interview, on 5/9/2025, at 9:22 a.m., with the DON, the DON stated at the time of admission, SS Designee 1 is responsible for following up to ensure a copy of the resident's living will is obtained and placed in the resident's chart. The DON stated the importance of having the living will in the resident's chart is so the nurses know what care to provide based on the resident's wishes. The DON stated the facility P&P does not specifically indicate the living will should be in the resident's chart, but it is the facility process to have any documents related to a resident's health care wishes in the chart. The DON stated when Resident 17's living will was not followed up on and placed in the resident's chart there was a potential that staff would not follow the resident's wishes when the resident was no longer able to express themself. During a review of the facility's P&P titled, Advance Directives, last reviewed 1/16/2025, the P&P indicated the resident has the right to formulate an Advance Directive. Advance Directives are honored in accordance with state law and facility policy. Upon admission of a resident to the facility, the Social Services Director or Designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate an Advance Directive. Upon the admission of a resident, the Social Services Department will inquire about the existence of any written Advance Directive. Information about whether or not the resident has executed an Advance Directive shall be displayed in the medical record. The Interdisciplinary Team will review annually or as needed with the resident or responsible party his/her Advance Directive to ensure that such directives are still the wishes of the resident. The Nursing Supervisor will be required to inform emergency medical personnel of a resident's Advance Directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made. 43988 3. During a review of Resident 72's Face Sheet, the Face Sheet indicated the facility admitted the resident on 1/21/2025 with diagnoses including congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), retention of urine, and generalized weakness. During a review of Resident 72's H&P, dated 1/22/2025, the H&P indicated Resident 72 had the capacity to make understand and make decisions. (continued on next page)

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	05/09/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 72's MDS, dated [DATE], the MDS indicated Resident 72 had an intact cognition (mental action or process of acquiring knowledge and understanding) and required setup/touching assistance with eating; substantial/maximal assistance to total assistance from staff with all other activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 72's Advance Directive Acknowledgement Form dated 1/28/2025, the AD Acknowledgment Form indicated Resident 72 did not execute an AD and wanted to proceed in formulating an AD with the Ombudsman. During a concurrent interview and record, on 5/7/2025, at 4:20 p.m., with SS Designee 1, Resident 72's AD Acknowledgment Form, fax transmission report to the Ombudsman, and social services progress notes with SS Designee 1 were reviewed. SS Designee 1 stated upon admission, residents or their representative were asked by the social services department regarding presence of an AD and will be provided information if there is no AD and will be offered assistance in formulating an AD. SS Designee 1 stated if residents verbalized that they needed assistance in formulating an AD, the Ombudsman will be notified by faxing a copy of an Advance Health Care Directive (AHCD) Form indicating the resident's name. SS Designee 1 stated the fax transmission report indicated the form was faxed to the Ombudsman's office on 1/29/2025 at 9:06 a.m. SS Designee 1 stated there were two (2) notes pasted on the fax transmission report without the resident's name dated 3/5/2025 and 3/9/2025. SS Designee 1 stated the note dated 3/5/2025 indicated Resident 72 needed sometime regarding organ donation and the note dated 3/9/2025 indicated the resident would like to proceed with the AD. SS Designee 1 stated the facility did not follow up with the Ombudsman regarding the formulation of AD and just wait for the Ombudsman's availability to assist Resident 72. SS Designee 1 was unable to provide documentation in Resident 72's medical record if the assistance in formulating an AD was followed up with the Ombudsman. SS Designee state it had already been more than three (3) months since Resident 72 had verbalized interest in formulating an AD and that she should have followed up with the Ombudsman to prevent delay in emergency treatment or force emergency, life-sustaining procedures and not honor his wishes. During an interview, on 5/8/2025, at 2:00 p.m., with the Social Services Director (SSD), the SSD stated once a resident verbalizes that they need assistance in formulating an AD, the SS designee will notify the Ombudsman by faxing a copy of the AHCD Form indicating the resident's name in the form. The SSD stated that the Ombudsman comes to the facility at least every 2 months. The SSD stated 3 months is a long time in providing assistance to Resident 72 in formulating an AD. The SSD stated SS Designee 1 should have followed up with the Ombudsman at least quarterly during the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients). The SSD stated SS Designee 1 should have documented in Resident 72's medical record any follow up with the Ombudsman and when the resident mentioned it again regarding the formulation of an AD as it placed Resident 72 at risk for a delay in providing emergency treatment or force emergency, life-sustaining procedures and not honoring Resident 72's wishes. During a review of the facility's P&P titled, Advance Directives, last reviewed on 1/16/2025, the P&P indicated: - The resident has the right to formulate an advance directive. Advance Directives are honored in accordance with state law and facility policy. (continued on next page)

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	05/09/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- If the resident (deemed to have the capacity to make decisions by the Attending Doctor) indicated that he or she has not established an AD, the SSD/Designee will offer assistance in establishing an AD. - The SSD/Designee will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. - The Nursing Department will notify the Attending Physician of AD so that appropriate orders can be documented in the resident's medical record and plan of care.

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	05/09/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review, the facility failed to provide a safe, homelike environment for four of six sampled residents (Residents 537, 17, 14, and 107) reviewed during the Environment facility task, by failing to: 1). Ensure the wall clock was set to show the current time of day for Resident 537. This deficient practice had the potential to result in increased confusion, especially to residents with cognitive impairments (deficits in mental functions like memory, thinking, or problem-solving). 2). Ensure Resident 17's broken vertical blind slats were replaced and not left at the bedside while pieces of cardboard were used to prevent light from entering the resident's room. This deficient practice had the potential to negatively affect the residents' psychosocial wellbeing and make the residents feel uncomfortable in their living space. 3). Ensure Resident 14's fall mat/floor mat (designed to help prevent injuries by providing a soft-landing surface for patients who may accidentally fall out of bed or lose their balance while standing or walking) was not worn out and had no visible tears. These deficient practices violated the resident's rights to a safe, clean, sanitary, and homelike environment. 4). Ensure the wall sockets at the head of Resident 107's bed did not have a crack and were in disrepair. This deficient practice had the potential to negatively affect the residents' psychosocial well-being and make the residents feel uncomfortable in their living space Findings: 1. During a review of Resident 537's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted the resident on 2/24/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 537's History and Physical (H&P), dated 2/25/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. (continued on next page)

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	05/09/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 537's Minimum Data Set (MDS-a resident assessment tool), dated 3/2/2025, the MDS indicated the resident had adequate hearing, unclear speech and adequate vision. The MDS indicated that the residents sometimes make self-understood and sometimes had the ability to understand others. The MDS indicated the resident was dependent on staff for ADLs. During a review of Resident 537's Activities of Daily Living (ADL-activities such as bathing, dressing and toileting a person performs daily) Self Care Deficit Care Plan, dated 3/5/2025, the ADL Self Care Deficit Care Plan indicated the resident will minimize the risk of decline with interventions including providing a safe environment. During an observation on 5/6/2025 at 2:15 p.m., at Resident 537's bedside, the wall clock displayed 04:50. During a concurrent observation and interview on 5/7/2025 at 8:09 a.m. with Licensed Vocational Nurse (LVN) 4 while at Resident 537's bedside, the wall clock displayed 04:50. LVN 4 stated the wall clock is showing the wrong time. LVN 4 stated it should be 8:09 a.m. the actual time. LVN 4 stated it should reflect the current time because it helps orient Resident 537 to the time of day. During an interview on 5/9/2025 at 12:42 p.m. with the Director of Nursing (DON), the DON stated it is everyone's responsibility to ensure the wall clock is working and to inform the maintenance right away. The DON stated the purpose of ensuring the wall clock is working is for the resident's reality orientation and the need to be oriented daily. The DON stated the resident could potentially experience disorientation or confusion. During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Homelike Environment, with a review and approve date of 1/16/2025, the P&P indicated that residents are to be provided a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 44244 2. During a review of Resident 17's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted the resident on 1/9/2024 with diagnoses that included acquired absence of the right toe, idiopathic neuropathy (damage to the nerves that control automatic body functions), major depressive disorder (persistent feelings of sadness and loss of interest that can interfere with daily living), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 17's Care Plan (CP) titled, Discharge Care Plan - Remain at the Facility, initiated 1/7/2024, (Please confirm the date. This date is before the Resident's admitted) the CP indicated the resident and care planning team have determined that discharge to the community is not feasible. The CP further indicated an intervention to ask the residents what can be done to make the facility feel like their home. During a review of Resident 17's History and Physical (H&P), dated 12/15/2024, the H&P indicated the resident had decision making capacity. (continued on next page)

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	05/09/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 17's Minimum Data Set (MDS - resident assessment tool) dated 4/14/2025, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated that the resident was dependent on staff for bathing, required substantial/maximal assistance for dressing, and required partial/moderate assistance for personal hygiene and mobility. During a concurrent interview and record review on 5/6/2025 at 10:07 a.m., Resident 17 was observed lying awake in bed. There were missing vertical blinds at the sliding glass door and two slats on the ground on the right side of the resident's bed. Resident 17 stated there is a security light on the patio that turns on at night and the light shines in his eyes through the broken blinds. There were also pieces of cardboard taped to the sliding glass door where there were gaps from the missing blinds. During an observation on 5/7/2025 at 7:49 a.m., Resident 17 was observed asleep in bed and there were two vertical blinds slats which remained on the ground. During a concurrent observation and interview on 5/7/2025 at 3:55 p.m., Certified Nursing Assistant (CNA) 8 stood in Resident 17's doorway. Two vertical blinds were observed on the right side of the resident's bed and were visible from the door. CNA 8 stated she was caring for the resident, and he was asleep. CNA 8 walked down the hall, and the blind slats remained in the resident's room. During a concurrent observation and interview on 5/8/2025 at 7:52 a.m., Resident 17 lay awake in bed. Three vertical blind slats were observed on the ground and cardboard was on the window. Resident 17 stated the night shift nurse put cardboard up on the glass because the security lights come on at night and shine in his eyes through the broken blinds. Resident 17 stated they put up the cardboard because they got tired of waiting for maintenance to fix the blinds. Resident 17 stated he wasn't happy at all about the situation because it has been like this for months. During a concurrent observation and interview on 5/8/2025 at 7:53 a.m., with CNA 11, CNA 11 was observed in Resident 17's room. CNA 11 exited the room and stood in the doorway. CNA 11 stated there were three slats on the right side of the resident's bed because they are always falling. CNA 11 stated CNA 11 had requested for maintenance to fix the blinds in the past, but they keep falling. CNA 11 stated he recently had not requested maintenance to remove and fix the residents' blinds because CNA 11 was busy. CNA 11 stated the blind slats should not be on the ground next to the resident's bed because it was not a homelike environment. During an interview on 5/8/2025 at 8 a.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated it was important to create a homelike environment, so the residents feel good about themselves because then they are more likely to participate in activities and their care. LVN 6 stated the process when a blind slat falls, is the CNA should notify the charge nurse to call maintenance to come repair the slat. LVN 6 stated LVN 6 was not aware there were blind slats on the ground next to Resident 17's bed, but they should not be. LVN 6 stated LVN 6 would not want blind slats on the floor at LVN 6's home. LVN 6 stated blind slats should not be on the ground at bedside because it may become an infection control issue, is a safety issue if someone slips, and is not a homelike environment. LVN 6 stated when Resident 17's environment was not homelike there was the potential to disrupt how resident 17 feels about themselves resulting in the resident declining. (continued on next page)

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	05/09/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/9/2025 at 9:22 a.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedure regarding homelike environment. The DON stated the facility blind slats do fall off and maintenance should be notified. The DON stated when the slats fall off it is not a homelike environment, and it creates a privacy issue because there is a gap where one is able to see into the resident. The DON stated Resident 17's blind slats should have been immediately repaired, but they were not. The DON stated that when Resident 17's blind slats were not repaired the facility policy was not followed and it could have potentially resulted in a dignity issue with the residents feeling bad. During a review of the facility P&P titled, Maintenance Service, last reviewed 1/16/2025, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment. During a review of the facility P&P titled, Quality of Life - Homelike Environment, last reviewed 1/16/2025, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. The following functions are performed by maintenance but are not limited to: maintaining the building in good repair and free from hazards. Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order; b. Comfortable (minimum glare) yet adequate (suitable to the task) lighting; c. Inviting colors and decor; d. Personalized furniture and room arrangements. The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting. These characteristics include generic, mass-produced bedding, drapes and furniture. Comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and homelike environment 44376 3. During a review of Resident 14's Face Sheet, the Face Sheet indicated the facility admitted the resident on 5/25/2022, with diagnoses including dementia (a progressive state of decline in mental abilities), acquired absence of right leg above knee, and age-related osteoporosis (a condition where bone density and mass decrease significantly due to the natural aging process, increasing the risk of fractures [a break or crack in a bone]). During a review of Resident 14's Physician Order Sheet, dated 5/25/2022, the Physician Order Sheet indicated an order for floor mattress/low bed three times daily. Note: offer/improved safety for patients at risk of falling out of bed. (continued on next page)

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	05/09/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 14's Care Plan (CP) titled Fall Risk, dated 5/27/2024, the CP indicated an intervention keep environment hazard free and low bed w/floor mattress. During a review of Resident 14's History and Physical (H&P), dated 1/2/2025, the H&P indicated the resident had the capacity to make medical decisions. During a review of Resident 14's Minimum Data Set (MDS, a resident assessment tool), dated 2/10/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had severe cognitive impairment (having significant difficulty with basic thinking skills like memory, decision-making, and problem-solving, to the point where it impacts daily life and independence). The MDS indicated the residents were dependent, requiring supervision in mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 14's Fall Risk Assessment, dated 2/12/2025, the Fall Risk Assessment indicated the resident was high risk for falls. During a concurrent observation and interview on 5/6/2025, at 10:19 a.m., with Certified Nurse Assistant (CNA) 6, while inside Resident 14's room, Resident 14's fall mat was observed with the side table on top of the mat with a linear tear of 16 inches (used a tape measure) on the fall mat cover. CNA 6 stated there should be no tears and equipment on top of the fall mat. CNA 6 stated having a torn fall mat does not appear home-like and having a side table on top of them poses a risk to the resident. CNA 6 stated that when the resident rolls over the bed, the resident will hit the hard part of the side table causing injuries to the resident. During an interview on 5/9/2025, at 11:10 a.m., with the Director of Nursing (DON), the DON stated there should be no fall mats that are torn in the resident's bedside as it compromises the function of the fall mat to reduce the fall impact of the resident. The DON stated having a worn out, torn fall mat at the bedside does not constitute a home-like environment. The DON stated Resident 14's fall mat should have been replaced by the staff to promote a home-like environment and to prevent the resident from sustaining injury when they fall. During a review of the facility's recent policy and procedure (P&P) titled Quality of Life- Homelike Environment, last reviewed on 1/16/2025, the P&P indicated the residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. During a review of the facility-provided undated Manufacturer's Specification titled Floor Mat 1 (FM 1), the Manufacturer's Specifications indicated it is the caregiver's responsibility to ensure the FM 1 is properly positioned beside the bed. When moving equipment such as lifts and wheelchairs across the mat, always make sure wheel locks are not engaged, as locked wheels may damage the mat. Never leave heavy objects on the mat surface for extended periods, as indentations and damage may occur. Keep sharp objects away from the mat or damage may occur. 43988 (continued on next page)

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	05/09/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 107s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted the resident on 3/23/2020 and readmitted in the facility on 7/26/2024, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarct (stroke, loss of blood flow to a part of the brain) affecting right dominant side, aphasia (a disorder that makes it difficult to speak), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 107's History and Physical (H&P) dated 7/29/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 107's fall risk assessment dated [DATE] and 2/7/2025, the fall risk assessments indicated the resident was at a high risk for falls. During a review of Resident 107's Minimum Data Set (MDS, a resident assessment tool), dated 3/26/2025, the MDS indicated Resident 107 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 107 required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During an observation on 5/6/2025 at 11:44 a.m. while inside Resident 107's room, 4 wall sockets were observed at the head of Resident 107's bed with 1 socket that was missing and another socket that had a crack. During a concurrent observation and interview on 5/6/2025 at 11:50 a.m. while inside Resident 107's room with Certified Nursing Assistant (CNA) 5, CNA 5 stated there was one wall socket that was missing and another 1 that had a crack located at the head of Resident 107's bed. CNA 5 stated the maintenance department is responsible for making sure the wall sockets were not in disrepair. CNA 5 stated when staff observed any equipment in disrepair, the maintenance department is notified as soon as possible. CNA 5 stated the wall sockets at the head of Resident 107's bed should have been repaired and covered immediately as the facility was not providing a homelike environment for Resident 107 as the facility is already his home. During a concurrent observation and interview on 5/6/2025 at 4 p.m. while inside Resident 107's room with the Maintenance Supervisor (MS), the MS stated the wall sockets at the head of Resident 107's bed was missing and cracked. The MS stated the maintenance department staff make rounds monthly to ensure any equipment in the residents' rooms is in good working condition. The MS stated staff are supposed to notify the maintenance department when something in the room or bed is in disrepair for resident safety. The MS stated the maintenance department should have been notified immediately to fix the wall sockets in Resident 107's room to provide a safe, and homelike environment for Resident 107. (continued on next page)

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	05/09/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/9/2025 at 11:31 a.m. a photo of Resident 107's wall sockets located at head of the resident's bed with the Director of Nursing (DON) was reviewed. The DON stated Resident 107's wall sockets had 1 wall socket missing and another 1 that was cracked. The DON stated the maintenance department makes rounds to check on the rooms daily and ensure that the residents are provided with a safe, and homelike environment as the facility is already the residents' home. The DON stated CNA 5 should have notified MS immediately to replace the wall sockets. The DON stated if any equipment or furnishing is not in good working condition, the facility did not provide a safe and homelike environment for Resident 107. During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Homelike Environment, last reviewed on 1/16/2025, the P&P indicated residents are provided with a safe, clean, comfortable environment. During a review of the facility's P&P titled, Maintenance Service, last reviewed on 1/16/2025, the P&P indicated: - Maintenance service shall be provided to all areas of the building, ground, and equipment - The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. - The following functions are performed by maintenance but are not limited to maintaining the building in good repair and free from hazards.

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	05/09/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for five (5) of 5 sampled residents (Residents 117, 28, 90, 14, and 102) reviewed for physical restraints care area by: 1. Failing to complete Resident 117's Physical Restraint Assessment form accurately to reflect that the resident was placed on bed pad alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) on 3/28/2025. 2. Failing to complete a restraint assessment, physician's order, obtained informed consent, and develop and implement a care plan (CP) for the use of bolstered mattress (a mattress designed with raised edges to help prevent patient from falling out of bed, especially those at risk of falls) for Resident 28. 3. Failing to ensure Residents 90 and 14's restraint bed placed against the wall had a physician's order, informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), restraint assessment for bed entrapment (an event in which a patient is caught, trapped or entangled in the spaces in or about the bed rail, mattress or hospital bed frame), and a CP on its use. 4. Failing to ensure Resident 102's three (3) side rails (bars attached to the sides of a bed to help patients stay safe and secure) up and a side table on the right lower part of the bed without the side rail up had a physician's order, informed consent, restraint assessment for bed entrapment, and a CP on its use. These deficient practices had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), and death of residents. Findings: a. During a review of Resident 117's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted the resident on 3/28/2025, with diagnoses including history of falling and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 117's History and Physical (H&P), dated 4/13/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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	05/09/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 117's Minimum Data Set (MDS - a resident assessment tool), dated 4/1/2025, the MDS indicated Resident 117 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 117 required supervision or touching assistance with eating and oral hygiene; substantial/maximal assistance with upper toileting hygiene, bathing, and lower body dressing; partial/moderate assistance from staff with all other activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 117's Physician's Order Sheet, dated 3/28/2025, the Physician's order sheet indicated an order for bed pad alarm to alert staff to a potential fall when resident attempts to get out of bed. During a review of Resident 117's CP on risk for fall, initiated on 3/28/2925, the CP indicated low bed with bed pad alarm as one of the interventions to reduce the risk for fall and injury related to fall. During a review of Resident 117's fall risk assessment, dated 3/28/2025, the fall risk assessment indicated Resident 117 was at a risk for fall. During a concurrent observation and interview, on 5/6/2025, at 10:40 a.m., inside Resident 117's room with the Assistant Director of Nursing (ADON), the ADON stated Resident 117 had a bed pad alarm as she was at a high risk for falls. During a concurrent interview and record review, on 5/8/2025, at 10:52 a.m., with Registered Nurse (RN) 3, Resident 117's physician's order, CP, and restraint assessment were reviewed and RN 3 stated Resident 117 had a physician's order and CP for the use of bed pad alarm. RN 3 stated the restraint assessment did not indicate the current type of restraint being used and the reason for its use. RN 3 stated the admission nurse completes the initial restraint assessment if there is a need for restraint use after all the least restrictive measures have been attempted. RN 3 stated Resident 117's restraint assessment should have been completed by the admissions nurse to reflect the application of bed pad alarm on the resident to ensure the use of the bed pad alarm was appropriate and the least restrictive measures have been attempted. During a concurrent interview and record review, on 5/9/2025, at 11:59 a.m., with the Director of Nursing (DON), Resident 117's restraint assessment was reviewed and the DON stated Resident 117's restraint assessment was not completed accurately. The DON stated the licensed nurses are supposed to complete the restraint assessments accurately prior to application of a restraint to ensure appropriateness of restraint and that the least restrictive measures have been attempted and were not successful. The DON stated Resident 117's restraint assessment should have been completed accurately to indicate the least restrictive measures tried and the current type of restraint and reason for the use of restraint to ensure that the use of the restraint was appropriate. The DON stated if there was no proper indication for the use of restraint, it placed Resident 117 at risk for restrictions of moving freely. During a review of the facility's policy and procedure (P&P) titled, Use of Restraints, last reviewed 1/16/2025, the P&P indicated: (continued on next page)

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	05/09/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. - Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. - Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted. - Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. b. During a review of Resident 28's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 2/19/2020 and readmitted in the facility on 7/9/2024, with diagnoses including history of falling, dementia (a progressive state of decline in mental abilities), and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress). During a review of Resident 28's H&P, dated 10/3/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 28 required supervision or touching assistance with eating and oral hygiene; partial/moderate assistance with roll to left and right; substantial/maximal assistance with oral hygiene, and upper body dressing; total assistance from staff with all other ADLs. During a review of Resident 28's Physician's Order Sheet, dated 5/2025, the Physician's Order Sheet did not indicate a physician's order for the use of a bolstered mattress. During a review of Resident 28's CP on fall risk, initiated on 7/29/2024, the CP did not indicate the use of a bolstered mattress. During a review of Resident 28's fall risk assessments, dated 12/30/2024 and 3/25/2025, the fall risk assessments indicated Resident 28 was at a risk for falls. During an observation, on 5/6/2025, at 10:36 a.m., inside Resident 28's room, Resident 28 laid asleep in bed. Resident 28's bed mattress had raised edges and the resident appeared sunken in the bed. During a concurrent observation and interview, on 5/6/2025, at 11:30 a.m., inside Resident 28's room, with Licensed Vocational Nurse (LVN) 7, LVN 7 confirmed and stated Resident 28 had a bolstered mattress on both sides for safety as the resident moves a lot in the bed and was at a high risk for falls. (continued on next page)

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	05/09/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 5/6/2025, at 4 p.m., with the Quality Assurance Coordinator (QAC), Resident 28's physician's orders were reviewed and the QAC stated Resident 28 did not have a physician's order for the bolstered mattress. The QAC stated Resident 28 had a physician's order for the bolstered while on hospice care (specialized care that provides physical comfort and emotional, social and spiritual support for people nearing the end of life). When Resident 28 was discharged from hospice care on 6/10/2024, the physician's order for the bolstered mattress was not carried over to the current medical record but the facility continued to implement the use of the bolstered mattress. During a concurrent interview and record review, on 5/9/2025, at 9:58 a.m., with RN 3. Resident 28's fall risk assessments, physician's order, CP, informed consent, and restraint assessment were reviewed and RN 3 stated the physician's order, CP, informed consent, and restraint assessment were obtained on 5/6/2025, after it was identified that the resident had a bolstered mattress without a physician's order. RN 3 stated Resident 28 was identified as at risk for falls. RN 3 stated if there is a need to place residents on restraints, licensed nurses are supposed to complete a restraint assessment, obtain a physician's order, informed consent from the resident representative, and develop a CP to ensure the use of restraint was appropriate and least restrictive measures have been tried. RN 3 stated the licensed nurse should have completed a restraint assessment, obtained a physician's order, informed consent from the resident representative, and developed a CP prior to application of the restraint as the facility was restricting Resident 28 to move freely. During an interview, on 5/9/2025, at 11:54 a.m., with the DON, the DON stated prior to application of a restraint, the nurses are supposed to complete a restraint assessment to ensure appropriateness of the restraint use, then obtain a physician's order, obtain informed consent from the responsible party (RP) so they would be aware of the plan of care, and develop and implement a CP so all the staff would be aware of the interventions needed for the resident's safety. The DON stated when Resident 28 was discharged from hospice care on 6/10/2024, the nurses should have completed a restraint assessment for the continued use of the bilateral bolstered mattress, obtained a physician's order, obtained informed consent from the RP so they would be aware of the plan of care for Resident 28, and develop and implement a CP so all the staff would be aware of the interventions needed for the resident's safety. The DON stated if there was no physician's order and informed consent from the RP, the facility is restraining Resident 28 and preventing the resident from moving freely. During a review of the facility's P&P titled, Use of Restraints, last reviewed 1/16/2025, the P&P indicated: - Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. - Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. - Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted including tucking sheets so tightly that a bed-bound resident cannot move. (continued on next page)

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	05/09/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. - Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. the order shall include the following: a. The specific reason for the restraint. b. How the restraint will be used to benefit the resident's medical symptoms c. The type of restraint and period of time for the use of the restraint. - Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. - CPs will reflect interventions that address not only the immediate medical symptoms(s), but the underlying problems that may be causing the symptoms and shall also include the measures taken to reduce or eliminate the need for restraint use. 44376 c. During a review of Resident 90's Face Sheet, the Face Sheet indicated the facility admitted the resident on 8/19/2022, with diagnoses including dementia with behavioral disturbance, history of falling, and disorder of bone density (a measure of the amount of calcium and other minerals in bone) and structure. During a review of Resident 90's H&P, dated 9/2/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 90's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities are functioning well and that there is no significant impairment in areas like thinking, reasoning, memory, and problem-solving). The MDS indicated the resident was dependent to requiring set up or clean-up assistance on mobility and ADLs. During a review of Resident 90's Fall Risk Assessment, dated 4/18/2025, the Fall Risk Assessment indicated the resident was not at risk for falls. During a review of Resident 90's Physician Order Sheet, dated 4/29/2025, the Physician Order Sheet did not indicate an order for restraint bed placed against the wall. During a review of Resident 90's CP titled, Fall Risk, dated 5/1/2025, the CP indicated the resident had balance issues, cognitive impairment (someone has significant difficulty with thinking, remembering, and making decisions, impacting their ability to live independently), history of fractures (a broken bone caused by a disease rather than an injury or force), impaired safety awareness, and was using cardiac medications. The CP indicated an intervention to keep environment free of hazards. (continued on next page)

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	05/09/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview, on 5/6/2025, at 1:20 p.m., with LVN 3, inside Resident 90's room, Resident 90's bed was against the wall at the right side of the bed. LVN 3 stated placing the bed against the wall is considered as a restraint because it limits the resident from getting out of the bed to one side. LVN 3 stated before applying a restraint, the facility needs to have a physician's order, informed consent, restraint assessment for bed entrapment, and a CP on its use. During a concurrent interview and record review on 5/8/2025, at 9:18 a.m., with RN 4, Resident 90's Physician Order Sheet, Assessments, Consents, and CP were reviewed and RN 4 stated there was no order, no informed consent, no restraint assessment, and CP on the use of bed placed against the wall for Resident 90. RN 4 stated it was important to have a physician's order, restraint assessment, and a CP on the use of bed placed against the wall to ensure its safe use. RN 4 stated the informed consent is required to honor the resident's right to informed consent and to buy resident or representative time to agree or disagree with the proposed treatment. During an interview, on 5/9/2025, at 11:10 a.m., with the DON, the DON stated the licensed staff should have obtained an order, informed consent, assessed the resident for bed entrapment, and developed and implemented a CP on the use of bed placed against the wall on Resident 90 to ensure its safe use. During a review of the facility's recent P&P titled, Use of Restraints, last reviewed on 1/16/2025, the P&P indicated physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: a. using bedrails to keep resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed; d. placing a resident who uses a wheelchair so close to the wall that the wall prevents the resident from rising. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and a review to determine the need for restraints. Treatment restraints may be used for the protection of the resident during treatment and diagnostic procedures if the resident and/or representative has consented to the treatment or procedure and the use of treatment restraints. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. CPs for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). d. During a review of Resident 14's Face Sheet, the Face Sheet indicated the facility admitted the resident on 5/25/2022, with diagnoses including dementia, acquired absence of right leg above knee, and age-related osteoporosis without (w/o) current pathological fracture. During a review of Resident 14's H&P, dated 1/2/2025, the H&P indicated the resident was able to make medical decisions. (continued on next page)

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	05/09/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 14's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had severe cognitive impairment. The MDS indicated that the resident was dependent to needing set up or clean-up assistance on mobility and activities of daily living (ADLs). During a review of Resident 14's Physician Order Sheet, dated 4/29/2025, the Physician Order Sheet did not indicate an order for restraint bed placed against the wall. During a review of Resident 14's Fall Risk Assessment, dated 2/12/2025, the Fall Risk Assessment indicated the resident was at high risk for falls. During a review of Resident 14's CP titled Fall Risk, dated 5/27/2024, the CP indicated the resident had cognitive impairment, physical impairment, and had impaired safety awareness. The CP had an intervention to keep environment hazard free. During a concurrent observation and interview, on 5/6/2025, at 1:20 p.m., with LVN 3, inside Resident 14's room, Resident 14's bed was against the wall on the left side of the bed. LVN 3 stated placing the bed against the wall is considered as a restraint because it limits the resident from getting out of the bed to one side. LVN 3 stated before applying a restraint, the facility needs to have a physician's order, informed consent, restraint assessment for bed entrapment, and a CP on its use. During a concurrent interview and record review, on 5/8/2025, at 9:18 a.m., with RN 4, Resident 14's physician order sheet, assessments, consents, and CPs were reviewed and RN 4 stated there were no orders, no informed consent, no restraint assessment, and CPs on the use of bed placed against the wall on Resident 14. RN 4 stated it was important to have a physician's order, restraint assessment, and a CP on the use of bed placed against the wall to ensure its safe use. RN 4 stated the informed consent is required to honor the resident's right to informed consent and to buy resident or representative time to agree or disagree with the proposed treatment. During an interview, on 5/9/2025, at 11:10 a.m., with the DON, the DON stated the licensed staff should have obtained an order, informed consent, assessed the resident for bed entrapment, and developed and implemented a CP on the use of bed placed against the wall on Resident 14 to ensure its safe use. During a review of the facility's recent P&P titled, Use of Restraints, last reviewed on 1/16/2025, the P&P indicated physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: a. using bedrails to keep resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed; d. placing a resident who uses a wheelchair so close to the wall that the wall prevents the resident from rising. (continued on next page)

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	05/09/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prior to placing a resident in restraints, there shall be a pre-restraining assessment and a review to determine the need for restraints. Treatment restraints may be used for the protection of the resident during treatment and diagnostic procedures if the resident and/or representative has consented to the treatment or procedure and the use of treatment restraints. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. CPs for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). e. During a review of Resident 102's Face Sheet, the Face Sheet indicated the facility admitted the resident on 2/23/2022, with diagnoses including bilateral aphakia (missing the lenses in both eyes), hearing loss, and macular degeneration (an eye disease that can blur your central vision). During a review of Resident 102's H&P, dated 10/3/2024, the H&P indicated the resident was able to make medical decisions. During a review of Resident 102's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had impaired vision. The MDS indicated the resident had intact cognition and the resident was dependent to needing set-up assistance on mobility and ADLs. During a review of Resident 102's Physician Order Sheet, dated 4/29/2025, the Physician Order Sheet did not indicate an order for 3 side rails up and a side table on the left side of the bed without the side rail up. During a review of Resident 102's CP titled Fall Risk, dated 8/30/2024, the CP indicated the resident had balance issues, physical impairment, and ROM functional limitation with an intervention to keep environment hazard free. During a review of Resident 102's Fall Risk Assessment, dated 2/21/2025, the Fall Risk Assessment indicated the resident was not at risk for falls. During a concurrent observation and interview, on 5/6/2025, at 1:20 p.m., with LVN 3, inside Resident 102's room, Resident 102 had 3 side rails up, and a side table on the open side of the bed without the bed railing up. LVN 3 stated placing the 3 side rails up and a side table on the open side of the bed is considered as a restraint because the resident does not have an option to get out the bed safely. LVN 3 stated before applying a restraint, they need to have a physician's order, informed consent, restraint assessment for bed entrapment, and a CP on its use. During a concurrent interview and record review, on 5/8/2025, at 9:18 a.m., with RN 4, Resident 102's physician order sheet, assessments, consents, and CP were reviewed. RN 4 stated there was no order, no informed consent, no restraint assessment, and CP on the use of restraints 3 side rails up and a side table on the open side of bed for Resident 102. RN 4 stated it was important to have a physician's order, restraint assessment, and a CP on the use of restraints 3 side rails up and a side table on the open side of bed without the railing to ensure its safe use. RN 4 stated the informed consent is required to honor the resident's right to informed consent and to buy resident or representative time to agree or disagree with the proposed treatment. (continued on next page)

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	05/09/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 5/9/2025, at 11:10 a.m., with the DON, the DON stated the licensed staff should have obtained an order, informed consent, assessed the resident for bed entrapment, and developed and implemented a CP on the use of restraints 3 side rails up and a side table on the open side of bed on Resident 102 to ensure its safe use. During a review of the facility's recent P&P titled, Use of Restraints, last reviewed on 1/16/2025, the P&P indicated physical restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: a. using bedrails to keep resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed; d. placing a resident who uses a wheelchair so close to the wall that the wall prevents the resident from rising. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and a review to determine the need for restraints. Treatment restraints may be used for the protection of the resident during treatment and diagnostic procedures if the resident and/or representative has consented to the treatment or procedure and the use of treatment restraints. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. CPs for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s).

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	05/09/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on interview, and record review, the facility failed to ensure two of six sampled residents (Residents 154 and 121) were free from chemical restraint (use of medication to manage a patient's behavior or restrict their freedom of movement, primarily to control agitation [a feeling of irritability, mental distress or severe restlessness] or aggression [any behavior, word, or action that is intended to harm another person, animal, or object]) by failing to: 1. Ensure Resident 154 was free from unnecessary medication (use of medication that is not medically indicated or is being used inappropriately). Resident 154 was on Seroquel (medication used to treat various mental health conditions) with no diagnoses of schizophrenia (a mental illness that is characterized by disturbances in thought), depression (a mental disorder characterized by persistent sadness and loss of interest or pleasure in activities) or bipolar disorder (sometimes called manic-depressive disorder, mood swings that range from the lows of depression to elevated periods of emotional highs). 2. Ensure the pharmacy recommendation dated 4/3/2025 was followed up timely for Resident 154. 3. Ensure the psychiatrist (medical doctor who specializes in the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders) consultation was initiated as per the physician notes on 4/15/2025 for Resident 154. 4. Ensure Resident 121 was free from unnecessary medication by ordering Remeron (medication used to treat depression) without monitoring specific behaviors related to poor appetite and monitoring potential side effects (unintended or unwanted effects caused by a medication) of the medication. These failures resulted in unnecessary chemical restraint and placed Residents 154 and 121 at risk for decline, isolation and injury. Findings: a. During a review of Resident 154's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted Resident 154 on 11/13/2024, with diagnoses that included fibromyalgia (a long-term condition that involves widespread body pain), unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities) and anxiety (human response to feeling threatened or stressed). During a review of Resident 154's Physician Order Sheet May 2025, dated 11/13/2024, the Physician Order indicated to administer Seroquel 25 milligram (mg- metric unit of measurement, used for medication dosage and/or amount) tablet daily for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) manifested by yelling for no reason. During a review of Resident 154's History and Physical Examination (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 11/30/2024, the H&P indicated Resident 154 did not have the capacity to understand and make decisions. (continued on next page)

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	05/09/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 154's Care Plan on psychotherapeutic (medication that alters mood, perception, or behavior by influencing brain chemicals) medication use, dated 12/25/2024, the Care Plan indicated Resident 154 had periods of psychosis and anxiety. During a review of Resident 154's Minimum Data Set (MDS-a resident assessment tool), dated 3/18/2025, the MDS indicated Resident 154's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 154 had no hallucination (where you hear, see, smell, taste or feel things that appear to be real but only exist in your mind), delusion (mental state where someone can't differentiate between what's real and what's imagined) or behavioral symptoms. The MDS indicated Resident 154 was dependent on staff for toileting, showering, dressing and personal hygiene. The MDS indicated Resident 154 was always incontinent (unable to control) of bowel and bladder functions. During a review of Resident 154's Preadmission Screening and Resident Review (PASSR-a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care), dated 3/22/2025, the PASSR indicated Resident 154 had no serious mental illness. During a review of Resident 154's April 2025 Medications (Medication Administration Record [MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident]), dated 4/2025, the MAR indicated Resident 154 received Seroquel daily at bedtime. During a review of Resident 154's Note to Attending Physician/Prescriber (Pharmacy Recommendation), dated 4/3/2025, the Pharmacy Recommendation addressed to the Psychiatrist by the Pharmacists indicated, Resident 154 received Seroquel, currently the only acceptable diagnosis for Seroquel in the elderly is schizophrenia, depression or bipolar disorder. Please discontinue Seroquel and use an alternate medication if warranted. During a review of Resident 154's Care Plan on the use of Seroquel dated 5/8/2025, the Care Plan indicated Seroquel was used for the diagnosis of psychosis. During a concurrent interview and record review on 5/8/2025, at 12:37 p.m., with MDS Nurse 2 (MDSN 2), Resident 154's Face Sheet and Pharmacy Recommendation dated 4/3/2025 were reviewed. MDSN 2 stated the pharmacy recommendation was to use an alternate medication aside from Seroquel because Seroquel was only for schizophrenia, depression or bipolar. MDSN 2 stated Resident 154's Face Sheet did not indicate any diagnoses of schizophrenia, depression or bipolar. During an interview on 5/8/2025, at 12:51 p.m., with the Director of Nursing (DON), the DON stated Resident 154 had no diagnoses of schizophrenia, depression or bipolar. During an interview on 5/8/2025, at 1:45 p.m. with the Medical Records Director (MRD), the MRD stated Resident 154's Seroquel was started in the General Acute Care Hospital (GACH) and was continued in the facility when Resident 154 was readmitted on [DATE]. The MRD stated the order for Seroquel should have been verified with the physician upon readmission on 11/13/2024. (continued on next page)

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	05/09/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/8/2025, at 1:46 p.m. with the Quality Assurance Coordinator (QAC), the QAC stated Seroquel was indicated for residents with schizophrenia, depression or bipolar. The QAC stated Resident 154 had no diagnosis of schizophrenia, depression or bipolar. The QAC stated Resident 154 can develop tardive dyskinesia (a movement disorder that can develop after taking certain medications, particularly antipsychotics, for an extended period, characterized by involuntary, repetitive movements of the face, mouth, tongue, and limbs) due to prolonged use and Resident 154 can potentially fall. During a concurrent interview and record review on 5/9/2025, at 11:10 a.m., with the DON, regarding the facility's policy and procedure (P&P) titled, Antipsychotic (medication used to treat symptoms of psychosis) Medication Use, dated 4/2007, and last reviewed on 1/16/2025, the P&P indicated, Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The DON stated Resident 154 should not be on Seroquel. The DON stated Resident 154 was treated unnecessarily. The DON stated the effects of Seroquel were nausea, vomiting, dizziness and hypotension (low blood pressure). During a concurrent interview, and record review on 5/9/2025, at 11:10 a.m., with the DON, facility's P&P, titled, Medication Regimen Review (MRR-a process where a healthcare professional, often a pharmacist, systematically evaluates a patient's medications to ensure they are safe, effective, and appropriate) dated 5/2019 and last reviewed on 1/16/2025, the P&P indicated, The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities for example a. medication ordered in excessive doses or without clinical indication. During a concurrent interview, and record review on 5/9/2025, at 2:10 p.m., with the DON, facility's P&P titled, Identifying Involuntary Seclusion and Unauthorized Restraint, dated 9/2022, and last reviewed on 1/16/2025, the P&P indicated Unauthorized Chemical restraints: 1.Residents are free from the use of any chemical restraints not required to treat their medical condition. 2.Chemical restraint is defined as any drug that is used for discipline, or staff convenience and not required to treat medical symptoms 4. Psychotropic medications are not administered to residents with psychological or behavioral symptoms without documented indication for use and without assessing potential underlying causes for distressed behavior 6. The following examples demonstrate situations where medications are administered for staff convenience or discipline and are therefore unauthorized chemical restraints c. Medication is administered to quiet the residents because the residents continually call out without attempting alternative interventions. 7. The negative physical and psychological impacts of chemical restraint use may include: (continued on next page)

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	05/09/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. drowsiness, somnolence (a state of drowsiness, sleepiness, or feeling heavy with sleep), excessive sedation (state of calmness, relaxation, or sleepiness caused by certain drug) and hallucination. b. neurologic consequences such as akathisia (a movement disorder characterized by a subjective feeling of inner restlessness and an urge to move, often accompanied by objective signs of restlessness like pacing, rocking, or fidgeting), neuroleptic malignant syndrome (NMS-characterized by a high fever, muscle stiffness, altered mental status, and dysfunction of the autonomic nervous system, which can affect blood pressure, heart rate, and breathing), parkinsonism (refers to brain conditions that cause slowed movements, rigidity and tremors), tardive dyskinesia. c. confusion, agitation, anxiety and nervousness d. social isolation, withdrawal, loss of self esteem e. lack of participation in individualized activities, according to the residents' care plan. The DON stated use of medication unnecessarily is a chemical restraint. The DON stated the facility failed to follow its policy on Identifying Involuntary Seclusion and Unauthorized Restraint. B. During a review of Resident 154's Note to Attending Physician/Prescriber (Pharmacy Recommendation), dated 4/3/2025, the Note to Attending Physician/Prescriber addressed to the Psychiatrist by the Pharmacists indicated Resident 154 received Seroquel, currently the only acceptable diagnosis for Seroquel in the elderly is schizophrenia, depression or bipolar disorder. Please discontinue Seroquel and use an alternate medication if warranted. The Note to the Attending Physician/Prescriber did not indicate if the Physician agreed, disagreed or made other recommendations. The Note to Attending Physician/Prescriber was not signed and dated. During a concurrent interview, and record review on 5/8/2025, at 12:51 p.m., with the DON, Resident 154's Note to the Attending Physician/Prescriber dated 4/3/2025, was reviewed. The DON stated the Pharmacy Recommendation did not indicate any signature that it has been followed up with the physician. The DON stated it has been a month, and it should have been followed up. During an interview on 5/8/2025, at 1:25 p.m., with the Social Service Director (SSD), the SSD stated Resident 154 was not seen by the Psychiatrist on 4/21/2025. The SSD stated nurses receive pharmacy recommendations and the nurses need to notify social service so social service can add Resident 154 to the list to be seen by the Psychiatrist. The SSD stated Resident 154 was last seen by Psychiatrist on 7/20/2024. The SSD stated there should be a new consultation for the Psychiatrist since Resident 154 was discharged on [DATE] and readmitted on [DATE]. The SSD stated there was no initial visit from the Psychiatrist after readmission on 11/13/2024. During a concurrent interview and record review on 5/9/2025, at 11:10 a.m., with the DON, facility's P&P, titled, Medication Regimen Review dated 5/2019, and last reviewed on 1/16/2025, the P&P indicated, The consultant pharmacist reviews the medication regimen of each resident a least monthly. The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities . Within 24 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians for each resident identified as having a non-life-threatening medication irregularity. The report contains: (continued on next page)

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	05/09/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The resident's name. b. The name of the medication. c. The identified irregularity. d. The pharmacist's recommendation. An irregularity refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and or in the presence of adverse consequences. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it. The DON stated pharmacy recommendation dated 4/3/2025, was not followed up timely. The DON stated the Psychiatrist should have been informed once the pharmacy recommendation was received to ensure medication was followed through like discontinuing the Seroquel. c. During a review of Resident 154's Subjective, Objective, Assessment, and Plan (SOAP- a structured method for healthcare professionals to document resident interactions) Note (Physician Progress Notes), dated 4/13/2025, the SOAP Note indicated the Nurse Practitioner (NP) visited Resident 154 and documented to follow up with the Psychiatrist consult and continue with antipsychotics as per the Psychiatrist. The SOAP Note indicated to follow up with psychiatry consultation after readmission on 11/13/2024. During a concurrent interview, and record review on 5/8/2025, at 12:37 p.m., with the MDSN 2, Resident 154's SOAP Note dated 4/13/2025, and Psychiatrist Notes were reviewed. MDSN 2 stated the SOAP Note indicated to follow up with the Psychiatrist and to continue antipsychotic medications as per the Psychiatrist. MDSN 2 stated there were no psychiatrist notes in Resident 154's medical chart. During an interview on 5/8/2025, at 12:51 p.m., with the DON, the DON stated she (DON) was not sure if Resident 154 was seen by the Psychiatrist. During an interview on 5/8/2025, at 1:25 p.m., with the SSD, the SSD stated she (SSD) was not informed that Resident 154 needs to be seen by the Psychiatrist. The SSD stated she (SSD) should have been informed so she (SSD) can add Resident 154 to the list of residents to be seen by the Psychiatrist. The SSD stated the QAC creates the list of residents to be seen by the Psychiatrist. During an interview on 5/8/2025, at 1:46 p.m., with the QAC, the QAC stated the SSD notifies him (QAC) if resident needs to be seen by the psychiatrist. The QAC stated he (QAC) was in charge of creating a list of residents for the psychiatrist visit. The QAC stated Resident 154 was not on the 4/21/2025 list of residents visited by the Psychiatrist. The QAC stated Resident 154 should have been seen on 4/2025. (continued on next page)

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	05/09/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/9/2025, at 11:10 a.m., with the DON, facility's P&P, titled, Medication Regimen Reviews dated 5/2019, and last reviewed on 1/16/2025, the P&P indicated, If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or (if the medical director is the physician of record) the administrator. The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it. The DON stated the Psychiatrist should have been notified. The DON stated Resident 154 continued to receive the unnecessary medication Seroquel. The DON stated prolong use of Seroquel can result in Resident 154 experiencing adverse effects or side effects. During a review of the facility P&P, titled, Antipsychotic Medication Use, dated 4/2007, and last reviewed on 1/16/2025, the P&P indicated, The Attending Physician will identify, evaluate and document, with input from other disciplines and consultants, as needed, symptoms that may warrant the use of antipsychotic medications. The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications. Based on assessing the resident's symptoms and overall situation, the Physician will determine whether to continue, adjust, or stop existing antipsychotic medication. The Physician shall respond appropriately by changing or stopping problematic doses or medications or clearly documenting (based on assessing the situation) why the benefits of the medication outweigh the risks or suspected or confirmed adverse consequences. During a review of facility's undated P&P titled, Ancillary Referrals and last reviewed on 1/16/2025, the P&P indicated, The facility maintains arrangements with duly licensed medical professionals to provide a range of geriatric care within their specialties. Staff, residents, physicians, or family can identify the need for referral to a provider for evaluation or treatment. Social Services is notified, generally by nursing, or the need for services. Social Services staff and nursing department coordinate appointment schedule and follow-up visits. 38552 d. During a review of Resident 121's Face Sheet, the Face Sheet indicated the facility admitted the resident on 2/18/2021, with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute (sudden) exacerbation (worsening of the disease), schizophrenia and bipolar disorder. During a review of Resident 121's MDS, dated [DATE], the MDS indicated the resident had clear speech, makes self-understood, and had the ability to understand others. During a review of Resident 121's Physician Order, dated 5/2/2025, the Physician Order indicated Remeron 15 mg by mouth (PO) every hour of sleep (QHS) for depression manifested by poor appetite. During a review of Resident 121's H&P, dated 5/8/2025, the H&P indicated the residents can make needs known but cannot make medical decisions. During a concurrent interview, and record review on 5/9/2025, at 11:09 a.m. with MDS Nurse (MDSN) 1, Resident 121's physician orders were reviewed. MDSN 1 stated there were no orders for behavior monitoring related to poor appetite and no orders for side effects monitoring for the use of Remeron. (continued on next page)

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	05/09/2025

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, and record review on 5/9/2025, at 11:13 a.m. with Registered Nurse (RN) 2, Resident 121's physician orders and nursing progress notes were reviewed. RN 2 stated she (RN 2) missed completing the order for poor appetite behavior monitoring and monitoring of the Remeron side effects. RN 2 stated she (RN 2) should have it done when she (RN 2) got the order on 5/2/2025. RN 2 stated she (RN 2) is still getting used to the process and missed them. RN 2 stated the monitoring of behavior for poor appetite and side effects is the responsibility of the charge nurse to check when the resident and how the resident is doing with the medication. During an interview on 5/9/2025, at 12:35 p.m. with the DON, the DON stated the licensed nurse, RN or licensed vocational nurse, should have obtained the order for side effect monitoring and monitoring Resident 121's meal intake when Remeron medication was ordered. The DON stated this is to ensure Resident 121 is not being medicated unnecessarily. The DON stated that when Resident 121 is not monitored for his meal intake they would not know if the medications were effective or not and the licensed nurses would not be aware of the resident's change in condition of the potential side effects related to the use of Remeron if it's not being monitored. During a review of the facility's policy and procedure (P&P) titled, Identifying Involuntary Seclusion and Unauthorized Restraint, reviewed and approved date 1/16/2025, the P&P indicated that if psychotropic medication is used to treat a medical symptom, the use of the medication is supported by a documented rationale for its use, administered at the correct doses and duration, and with adequate monitoring. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, reviewed and approved date 1/16/2025, the P&P indicated that residents will not receive medications that are clinically indicated to treat a specific condition. The P&P indicated the residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. The P&P indicated a psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. The P&P indicated residents receiving psychotropic medications are monitored for adverse consequences (negative outcomes or effects that result from a particular action or event).

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	05/09/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on interview and record review, the facility failed to develop and implement a baseline care plan (the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care) for: 1. One of four sampled residents (Resident 291) reviewed for respiratory care (helping people breathe easier when they have trouble with their lungs or airways) by failing to develop and implement a baseline care plan on oxygen therapy (a treatment that provides extra oxygen to breathe in). 2. One of one sampled resident (Resident 289) reviewed for anticoagulant (a substance that is used to prevent and treat blood clots in blood vessels and the heart) use by failing to develop and implement a baseline care plan on the use of anticoagulant (Pradaxa). These deficient practices had the potential for delays in the provision of essential healthcare services affecting the resident's well-being. Findings: 1. During a review of Resident 291's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted the resident on 5/1/2025, with diagnoses including pneumonia (an infection/inflammation in the lungs), chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing). During a review of Resident 291's History and Physical (H&P), dated 5/2/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 291's Minimum Data Set (MDS - a resident assessment tool), dated 3/10/2025, the MDS indicated the resident had the ability to make self-understood and understand others, and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). During a review of Resident 291's Physician Order Sheet, dated 5/1/2025, the Physician Order Sheet indicated an order for oxygen (O2) at two (2) liters per minute (L/min, how much oxygen flows into your lungs each minute) per nasal cannula (a device that gives you additional oxygen [supplemental oxygen or oxygen therapy] through the nose) three times a day. During a concurrent interview and record review, on 5/8/2025, at 10:13 a.m., with Registered Nurse (RN) 4, Resident 291's medical diagnosis, physician order sheet, and baseline care plan were reviewed and RN 4 stated there was no baseline care plan developed and implemented on Resident 291's use of oxygen therapy. RN 4 stated it was important to have a baseline care plan on oxygen therapy on Resident 291 to address the resident's primary medical problem which is respiratory in nature needing supplemental oxygen. (continued on next page)

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	05/09/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/9/2025, at 11:10 a.m., with the Director of Nursing (DON), the DON stated the baseline care plan for Resident 291 regarding oxygen therapy should have been developed and implemented within 48 hours on admission. The DON stated it was important to have a baseline care plan on oxygen therapy since the resident came in with multiple respiratory issues. The baseline care plan will serve as a communication tool for all healthcare providers to deliver coordinated care. During a review of the facility's recent policy and procedure (P&P) titled, Care Plans - Baseline, last reviewed on 1/16/2025, the P&P indicated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the residents that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the residents including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASARR recommendation, if applicable. 2. During a review of Resident 289's Face Sheet, the Face Sheet indicated the facility admitted the resident on 4/25/2025, with diagnoses including chronic embolism (an obstruction or blockage in a blood vessel) and thrombosis (the formation of a blood clot [called a thrombus] inside a blood vessel) deep veins of left lower extremities, atrial fibrillation (an irregular and often rapid heart rhythm that originates in the heart's upper chambers [atria]), and atherosclerosis of aorta (the buildup of plaque [fatty deposits] inside the aorta, the main artery carrying blood from the heart to the body). During a review of Resident 289's H&P, dated 4/28/2025, the H&P indicated the resident can make needs known but cannot make medical decisions, poor judgment. During a review of Resident 289's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and usually understand others and had severe cognitive impairment (have a very hard time remembering things, making decisions, concentrating, or learning). The MDS indicated the resident was on a high-risk drug class anticoagulant. During a review of Resident 289's Physician Order Sheet, dated 4/25/2025, the Physician Order Sheet indicated an order of Pradaxa 150 milligrams (mg - a unit of weight) capsule (1 Cap) capsule by mouth two times daily. Notes: deep vein thrombosis (DVT). (continued on next page)

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	05/09/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 5/8/2025, at 9:25 a.m., with RN 4, Resident 289's medical diagnosis, physician orders sheet, and baseline care plan were reviewed and RN 4 stated there was no baseline care plan on the use of anticoagulant (Pradaxa) for Resident 289. RN 4 stated a baseline care plan should have been initiated on admission since the anticoagulant was ordered on admission to the facility. RN 4 stated the baseline care plan for anticoagulant is important to ensure the adverse effects (an undesired effect of a drug or other type of treatment, such as surgery) were monitored and the interventions were identified to combat the adverse effects of the medications. During a review of the facility's recent P&P titled, Care Plans- Baseline, last reviewed on 1/16/2025, the P&P indicated a baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the residents that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the residents including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services; and f. PASARR recommendation, if applicable

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	05/09/2025

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 - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan (CP, a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) for one of fourteen sampled residents (Resident 162) reviewed during the Accidents care area, one of six sampled residents (Resident 121) reviewed during the Unnecessary Meds, Chemical Restraints/Psychotropic Meds, and Med Regimen Review care area, for two of four sampled residents (Residents 61 and 153) reviewed for Mood/Behavior care area, for one of four sampled residents (Resident 175) reviewed during Respiratory care area, by failing to: 1. Develop and implement a care plan on smoking for Resident 162. 2. Develop and implement a care plan on the use of Remeron (an antidepressant medication) for Resident 121. This deficient practice had the potential to result in miscommunication among interdisciplinary staff, residents, and resident representatives. 3. Develop and implement a care plan on the use of Bilevel Positive Airway Pressure (BiPAP-a non-invasive ventilation therapy that uses a machine to deliver two different levels of air pressure to the patient during breathing) for Resident 175. This deficient practice had the potential for delays in the delivery of necessary care and services and the potential to promote growth and spread of bacteria on the respiratory tubing causing illness and the potential to experience respiratory problems and distress such as shortness of breath and chest congestion for Resident 175. 4. Failing to develop and implement a care plan on the use of antianxiety (a drug used to treat symptoms of anxiety, such as feelings of fear, dread, uneasiness, and muscle tightness, that may occur as a reaction to stress) (hydroxyzine HCl) for Resident 61 and lorazepam and haloperidol for Resident 153. These deficient practices had the potential to result in delays in the delivery of necessary care and services and adverse effects (an undesired effect of a drug or other type of treatment, such as surgery) to residents. Findings: a. During a record review of Resident 162's Face Sheet (FS, Admission Record), the FS indicated Resident 162 was originally admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), lack of coordination, end stage renal disease (ESRD -irreversible kidney failure), and schizophrenia (a mental illness that is characterized by disturbances in thought). (continued on next page)

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	05/09/2025

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 - Some	During a review of Resident 162's History and Physical (H&P), dated 1/16/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a record review of Resident 162's Minimum Data Set (MDS, resident assessment tool) dated 1/24/2025, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required partial assistance from staff for oral and personal hygiene, bathing, dressing, and mobility. During a review of Resident 162's Smoking Schedule form, dated 4/26/2024, the form indicated the resident was informed about smoking policies and procedures of the facility. During an observation on 5/7/2025 at 3:45 p.m., Resident 162 was assisted by the Activities Director (AD) with smoking a cigarette at the outdoor smoking patio. Resident 162 wore a smoking apron, and the AD lit the resident's cigarette. During a concurrent interview and record review on 5/8/2025 at 9:45 a.m. with the Social Services Director (SSD), the SSD reviewed Resident 162's care plans. The SSD stated residents are assessed at admission and readmission for smoking. The SSD stated if a resident indicated they would like to smoke, a smoking assessment is completed, and an acknowledgement of the smoking waiver is completed. The residents are provided with smoking policies and schedule, and a care plan is developed and implemented. The SSD stated the smoking CP is used by all facility staff to communicate the needs of residents while smoking and to ensure a safe smoking environment is maintained. The SSD stated Resident 162 requires supervision and the use of a smoking apron while smoking. The SSD reviewed Resident 162's CPs and stated there was no documented evidence that Resident 162 had a smoking CP developed and implemented. The SSD stated that without a CP, there was the potential that staff would not know what care to provide which could result in fires or harm from burns if the residents smoked unsupervised or without the apron. During a concurrent interview and record review on 5/9/2025 at 9 a.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedures regarding smoking and care plans. The DON stated CPs are a communication tool developed to ensure the staff are aware of how to provide care to residents with the implementation of appropriate interventions. The DON stated that all residents who smoke need to have a CP. The DON stated the P&P regarding smoking does not indicate to develop a CP, but it is the facility process. The DON stated that without a smoking CP, the staff wouldn't even know the resident was a smoker. The DON stated the DON was not aware Resident 162 was a smoker. The DON stated the facility P&P was not followed when a smoking CP was not developed for Resident 162 potentially resulting in harm to the resident. During a review of the facility P&P titled, Smoking - includes E- Cigarettes, last reviewed 1/16/2025, the P&P indicated the facility will comply with local and state smoking regulations, and will recognize residents' rights to smoke but this right will be in accordance with the interdisciplinary team assessment of a resident's ability to smoke to promote a safe environment. (continued on next page)

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	05/09/2025

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 - Some	During a review of the facility P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed 1/16/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; and reflects currently recognized standards of practice for problem areas and conditions. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. 38552 b. During a review of Resident 121's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted the resident on 2/18/2021 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute (sudden) exacerbation (worsening of the disease), schizophrenia (a mental illness that is characterized by disturbances in thought), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 121's Minimum Data Set (MDS-a resident assessment tool), dated 2/25/2025, the MDS indicated the resident had clear speech, makes self-understood, and had the ability to understand others. During a review of Resident 121's Physician Order, dated 5/2/2025, the Physician Order indicated to administer Remeron 15 milligrams (mg-a unit of measurement) by mouth (PO) every hour of sleep (QHS) for depression manifested by poor appetite. During a review of Resident 121's History and Physical (H&P), dated 5/8/2025, the H&P indicated the resident can make needs known but cannot make medical decisions. During a concurrent interview and record review on 5/9/2025 at 11:09 a.m. with MDS Nurse (MDSN) 1, Resident 121's care plans were reviewed. MDSN 1 stated there was no care plan developed for the use of Remeron. MDSN 1 stated the care plan should have been developed at the same time that the order was received. During a concurrent interview and record review on 5/9/2025 at 11:13 a.m. with Registered Nurse (RN) 2, Resident 121's informed consents and nursing progress notes were reviewed. RN 2 stated she missed completing the care plan for the use of Remeron. RN 2 stated she should have it done when she got the order on 5/2/2025. RN 2 stated she is still getting used to the process and missed them. RN 2 stated the monitoring of behavior for poor appetite and side effects is for the charge nurse to check when the resident how the resident is doing with the medication. (continued on next page)

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	05/09/2025

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 - Some	During an interview on 5/9/2025 at 12:35 p.m. with the Director of Nursing (DON), the DON stated the licensed nurse, RN or licensed vocational nurse, should have obtained the order for side effect monitoring and monitoring Resident 121's meal intake when Remeron medication was ordered. The DON stated this is to ensure Resident 121 is not being medicated unnecessarily. The DON stated when Resident 121 is not monitored for his meal intake they would not know if the medication were effective or not and the licensed nurses would not be aware of the resident's change in condition of the potential side effects related to the use of Remeron if it's not being monitored. The DON stated the licensed nurses should have developed a care plan of the care that is being provided to Resident 121. The DON stated it should include the resident's meal intake and the potential side effects. The DON stated that when the care plan is not developed, they would not know what interventions they have implemented to provide to Resident 121. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, reviewed and approved date 1/16/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated the comprehensive, personal-centered care plan is developed within seven (7) days of the completion of the required MDS assessment and no more than 21 days after admission. The P&P indicated each resident's comprehensive person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and reflects current recognized standards of practice for problem areas and conditions. c. During a review of Resident 175's Admission Record, the Admission Record indicated the facility admitted the resident on 4/14/2025 with diagnoses including acute respiratory failure (a condition where the respiratory system can't effectively exchange oxygen and carbon dioxide, leading to a buildup of carbon dioxide and a deficiency of oxygen in the blood), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 175's History and Physical (H&P), dated 4/14/2025, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 175's Physician Order, dated 4/14/2025, the Physician Order indicated BiPAP, apply at hours of sleep (HS), remove in AM (morning). During a review of Resident 175's Minimum Data Set (MDS-a resident assessment tool), dated 4/25/2025, the MDS indicated Resident 175 had clear speech, adequate vision and hearing. The MDS indicated that the resident makes self-understood and had the ability to understand others. During a review of Resident 175's Respiratory Distress Care Plan, dated 4/14/2025, the Respiratory Distress Care Plan indicated the resident's goal to have no signs and symptoms of respiratory distress with interventions that included using BiPAP at night. (continued on next page)

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	05/09/2025

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 - Some	During a concurrent observation and interview on 5/6/2025 at 9:25 a.m. with Resident 175, while at Resident 175's bedside, the BiPAP mask was observed hanging on the side of the resident's wheelchair brake handle. Resident 175 stated no one had come to turn off his BiPAP machine so he placed it on the side of his wheelchair. Resident 175 stated he does not touch his BiPAP machine. Resident 175 stated one of the nurses comes and turns it on and off and at night they place it on him. Resident 175 stated he only wears the BiPAP at night. It helps him breathe while he sleeps. Resident 175 stated Certified Nursing Assistant (CNA) 12, his assigned CNA, knows all about his BiPAP. Resident 175 stated no one had cleaned his BiPAP machine. The nurse would come in and remove his mask and turn it off and at night they put it on. During a concurrent observation and interview on 5/6/2025 at 9:31 a.m. with CNA 12, while at Resident 175's bedside, CNA 12 stated she does not touch the BiPAP machine, but she will move the BiPAP mask from the wheelchair to the table because she is going to transfer Resident 175 from the bed to the wheelchair to get him ready for activities in the activity room. During a concurrent observation and interview on 5/6/2025 at 9:40 a.m. with Registered Nurse (RN) 1, while at Resident 175's bedside, RN 1 stated the BiPAP mask is still on and blowing air. RN 1 stated the charge nurse removes the mask in the morning and turns off the machine. RN 1 stated it should have been turned off. RN 1 stated they do not clean the BiPAP mask and machine. RN 1 stated the BiPAP mask and nebulizer were placed in the same clear plastic bag with no label of the resident's name and date of when it should be changed. RN 1 stated there should be the resident's name and date on the plastic bag, so they know who it belongs to, and if it's the correct resident and know when the nebulizer tubing and bag need to be changed. RN 1 stated this is for infection control. During a concurrent observation and interview on 5/8/2025 at 3:36 p.m. with Licensed Vocational Nurse (LVN) 4 and LVN 5, while at the nursing station, LVN 4 stated she uses the alcohol sanitizer wipes to sanitize the BiPAP mask. LVN 5 stated she works during the evening shift and places the BiPAP mask on Resident 175. LVN 5 stated she washes the BiPAP mask using an antibacterial soap and water every night at 8 p.m. and puts it on the resident at 9 p.m. During a concurrent interview and record review on 5/8/2025 at 3:40 p.m. with LVN 4, Resident 175's care plans were reviewed. LVN 4 stated the respiratory care plan does not mention how often the BiPAP machine is to be cleaned and the duration of BiPAP treatment. LVN 4 stated the respiratory care plan only indicated BiPAP at night, it is not specific. LVN 4 stated it should be indicated in the care plan, including the cleaning and duration of therapy. LVN 4 stated the resident could potentially be at risk for infection because the air could be dirty. During a concurrent interview and record review on 5/8/2025 at 4:26 p.m. with LVN 5, Resident 175's nursing progress notes and treatment administration record from 4/2025 to 5/2025 were reviewed. LVN 5 stated she did not document when she cleaned the BiPAP mask for Resident 175. LVN 5 stated she documented on 4/20/2025 and 5/2/2025 she administered it, and no other notes documented when it was last cleaned. LVN 5 stated if it is not documented it was not done. LVN 5 stated she does not document when she cleaned the BiPAP mask. LVN 5 stated the standard of practice is to document the care and treatment provided to the residents. (continued on next page)

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	05/09/2025

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 - Some	During an interview on 5/9/2025 at 12:46 p.m. with the Director of Nursing (DON), the DON stated the order for BiPAP would include the setting, the time should be on and off, and the reason or diagnosis for the use of BiPAP. The DON stated on the administration record it should be documented 9am off and 9pm on. The DON stated BiPAP is a treatment provided for residents with sleep apnea (a sleep disorder characterized by repeated episodes of breathing cessation (apnea) or shallow breathing during sleep). The DON stated with the care and maintenance of the BiPAP machine in addition to their facility's policy they also follow the manufacturer's guidelines. The DON stated the licensed nurses, RN or LVN, should have included the cleaning and care of the BiPAP in the care plan and followed the physician order when providing BiPAP treatment. The DON stated the plastic bag container to store the nebulizer should have a label of the resident's name and date. The DON stated that when the BiPAP mask and machine is not cleaned, the nebulizer is stored in a bag with no label of the resident's name and date could cause bacterial accumulation and potentially cause infection to Resident 175. The DON stated on the administration record the morning shift 7 a.m. to 3 p.m. would initial when they turned off the machine and the night shift, 11 p.m. to 7 a.m. would initial when they turned on the machine and when they cleaned it. The DON stated this is done to ensure the resident is getting therapeutic oxygenation and it is being administered as ordered. The DON stated when this is not done the resident could potentially develop respiratory distress such as shortness of breath and chest congestion. During a review of the facility's policy and procedure (P&P) titled, Administering Medications through a Small Volume (Handheld) Nebulizer, reviewed and approved date 1/16/2025, the P&P indicated the purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. The P&P indicated when equipment is completely dry, to store in a plastic bag with the resident's name and date on it. The P&P indicated to change equipment and tubing every seven days, or according to facility protocol. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, reviewed and approved on 1/16/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated the comprehensive, personal-centered care plan is developed within seven (7) days of the completion of the required MDS assessment and no more than 21 days after admission. The P&P indicated each resident's comprehensive person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and reflects current recognized standards of practice for problem areas and conditions. 44376 d. During a review of Resident 61's Face Sheet, the Face Sheet indicated the facility admitted the resident on 12/13/2024, with diagnoses including depression (a mood disorder characterized by persistent feelings of sadness, loss of interest, and difficulties with daily life) and dementia (a progressive state of decline in mental abilities). During a review of Resident 61's History & Physical (H&P), dated 12/17/2024, the H&P indicated the resident can make needs known but cannot make medical decisions. (continued on next page)

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	05/09/2025

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 - Some	During a review of Resident 61's Physician Order Sheet, dated 4/7/2025, the Physician Order Sheet indicated an order of hydroxyzine HCl 50 milligrams (mg, a unit of weight) tablet (2 tabs) Tablet by mouth one time a day/night (HS) Med Pass. Notes: Anxiety monitor for behavior (m/b) verbalization of nervousness. During a review of Resident 61's Minimum Data Set (MDS, a resident assessment tool), dated 4/18/2025, the MDS indicated the resident usually had the ability to make self-understood and had the ability to understand others and had severe cognitive impairment (have a very hard time remembering things, making decisions, concentrating, or learning). During a concurrent interview and record review on 5/8/2025, at 7:37 a.m., with Registered Nurse (RN) 4, Resident 61's Medical Diagnosis, Physician Order Sheet, and Care Plans were reviewed with RN 4. RN 4 stated there was no comprehensive care plan developed and implemented for the use of antianxiety medication hydroxyzine HCl on the resident. RN 4 stated most psychotropic medications (medications that affect the mind, emotions, and behavior) such as hydroxyzine HCl had a black box warning (the most serious safety alert placed on a prescription drug label by the Food and Drug Administration [FDA]). RN 4 stated black box warning means the medication has potentially serious and life-threatening risks associated with the medication. RN 4 stated the comprehensive care plan can outline all the adverse effects of the medication that licensed nurses had to report to the physician for prompt intervention. RN 4 stated comprehensive care plans serve as communication to all healthcare providers to standardize care of treatment for residents. RN 4 stated without a care plan on the use of hydroxyzine HCl there is a potential for residents to be subjected to the medication's adverse effects. During an interview on 5/9/2025, at 11:10 a.m., with the Director of Nursing (DON), the DON stated that antianxiety medication (hydroxyzine HCl) is a significant medication. The DON stated the licensed nurse who received the order from the physician should have developed and implemented a care plan for its use. The DON stated the care plans are created on admission and must be reviewed/revised quarterly. The DON stated that most psychotropic medications such as antianxiety medications have black box warning meaning it has the potential for life-threatening adverse reactions that can affect the residents. The DON stated the absence of the care plan on the use of antianxiety medication (hydroxyzine HCl) predisposed Resident 61 to the adverse effects of the drug. During a review of the facility's recent policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, last reviewed on 1/16/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the residents' condition. b. when the desired outcome is not met. c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. (continued on next page)

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	05/09/2025

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 - Some	e. During a review of Resident 153's Face Sheet, the Face Sheet indicated the facility admitted the resident on 3/13/2024, with diagnoses including spinal stenosis (the spinal canal [the tunnel where the spinal cord and nerves pass through] is narrowing), depression, and palliative care (specialized medical care for people with serious illnesses that focuses on improving their quality of life by managing symptoms and providing support, both physically and emotionally). During a review of Resident 153's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and to understand others and had moderate cognitive impairment (noticeable deficits that interfere with daily activities, including memory loss, language difficulties, skewed judgment, and reduced problem-solving abilities). During a review of Resident 153's H&P, dated 4/11/2025, the H&P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 153's Physician Order Sheet, dated 4/19/2025, the Physician Order Sheet indicated an order for lorazepam 0.5 mg tablet (1) tablet by mouth as needed every four hours for fourteen days. Notes: anxiety unable to sleep comfort kit, and haloperidol lactate 2 mg/milliliters (ml, a unit of volume) oral concentrate (0.5 ml) concentrate, oral by mouth as needed every four hours for fourteen days. Note: nausea/agitation comfort kit. During a concurrent interview and record review on 5/8/2025, at 9:02 a.m., with RN 4, Resident 153's Medical Diagnosis, Physician Order Sheet, and Care Plans were reviewed with RN 4. RN 4 stated there was no comprehensive care plan developed and implemented for the use of antianxiety medications lorazepam and Haloperidol for Resident 153. RN 4 stated that most psychotropic medications such as lorazepam and Haloperidol had a black box warning. RN 4 stated black box warning means the medication has potentially serious and life-threatening risks associated with the medication. RN 4 stated the comprehensive care plan can outline all the adverse effects of the medication that licensed nurses had to report to the physician for prompt intervention. RN 4 stated comprehensive care plans serve as communication to all healthcare providers to standardize care of treatment for residents. RN 4 stated that without a care plan on the use of lorazepam and Haloperidol there is potential for residents to be subjected to its adverse effects. During an interview on 5/9/2025, at 11:10 a.m., with the DON, the DON stated that antianxiety medications (lorazepam and Haloperidol) are a significant medication. The DON stated the licensed nurse who received the order from the physician should have developed and implemented a care plan for its use. The DON stated the care plans are created on admission and must be reviewed/revised quarterly. The DON stated that most psychotropic medications such as antianxiety medication have black box warning meaning it has the potential for life-threatening adverse reactions that can affect the residents. The DON stated the absence of the care plan on the use of antianxiety medications (lorazepam and Haldol) predisposed Resident 153 to the adverse effects of the drug. During a review of the facility's recent P&P titled Care Plans, Comprehensive Person-Centered, last reviewed on 1/16/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. The interdisciplinary team reviews and updates the care plan: (continued on next page)

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	05/09/2025

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 - Some	a. When there has been a significant change in the residents' condition. b. When the desired outcome is not met. c. When the resident has been readmitted to the facility from a hospital stay. d. At least quarterly, in conjunction with the required quarterly MDS assessment.

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	05/09/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review the facility failed to ensure the comprehensive care plan (CP - a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs) was revised for one of five sampled residents (Resident 26) reviewed during the Infection Control task and two of two sampled residents (Resident 153 and 289) reviewed for pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) by failing to: 1. Review and revise the CP for Resident 26's precaution status (levels of infection control practices used in healthcare to minimize the spread of infections). 2. Review and update Resident 153 and 289's CPs on the use of low air loss mattress (LALM - a specialized medical mattress designed to help prevent and treat pressure ulcers) for preservation of skin integrity. These deficient practices had the potential to result in miscommunication among interdisciplinary staff, residents, and resident representatives and a potential for delay of necessary care and services to residents. Cross-reference F686 Findings: a. During a record review of Resident 26's Face Sheet (FS - Admission Record), the FS indicated Resident 26 was originally admitted to the facility on [DATE] and most recently admitted [DATE] with diagnoses including pneumonia (an infection/inflammation in the lungs), urinary tract infection (UTI - an infection in the bladder/urinary tract), and resistance to vancomycin (a medication used to treat infections). During a record review of Resident 26's Minimum Data Set (MDS - resident assessment tool), dated 4/1/2025, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated the resident was dependent on staff for toileting, bathing, dressing, and mobility. During a review of Resident 26's Physician Orders Sheet, the Physician Order Sheet indicated the following orders: - Dated 3/15/2025 and discontinued on 3/18/2025, contact isolation precaution (an infection control intervention designed to reduce the transmission of infections that includes donning [putting on] gowns and gloves prior to entering a resident's room) for vancomycin-resistant enterococcus (VRE, a type of bacteria called enterococci that have developed resistance to many antibiotics, especially vancomycin) of urine. (continued on next page)

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	05/09/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Dated 1/12/2025, observe enhanced standard precautions (also referred to as enhanced barrier precautions, EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted gown and glove use during high contact resident care activities) every shift. During a review of Resident 26's Care Plan (CP) titled, Antibiotic Therapy, initiated 3/15/2025, the CP indicated the resident had an infection related to VRE with an intervention to extend the use of contact isolation. During a concurrent interview and record review, on 5/7/2025, at 4:10 p.m., with Registered Nurse (RN) 6, Resident 26's physician orders and care plans were reviewed and RN 6 stated Resident 26 had a history of VRE in the urine and VRE is an MDRO. RN 6 stated Resident 26 had an order for EBP. RN 6 stated the Infection Preventionist (IP) is responsible for ensuring the correct isolation is implemented for residents. During a concurrent interview and record review, on 5/7/2025, at 4:20 p.m., with the IP, Resident 26's physician's orders, care plans, and the Antibiotic Log, dated 3/2025, were reviewed and the IP stated EBP is a method to prevent the transmission of MDROs for residents with a history of MDROs or other indwelling devices that makes resident's more susceptible to contracting MDROs. The IP stated Resident 26 was previously on contact isolation for VRE of urine, but the contact isolation order was discontinued after the resident completed the treatment. The IP stated Resident 26 had an order for EBP. The IP stated CPs guide the care of the residents. The IP stated when Resident 26's order for contact isolation was discontinued on 3/18/2025, the resident's CPs should have been updated to indicate EBP. The IP reviewed Resident 26's CPs and stated the resident's CPs were not updated to reflect the resident's current precaution status of EBP, but they should have been. During an interview, on 5/9/2025, at 9 a.m., with the Director of Nursing (DON), the DON stated CPs are a communication tool developed to ensure the staff are aware of how to provide care to residents with the implementation of appropriate interventions. The DON stated Resident 26 was on EBP for a history of VRE and the CPs should have been revised to indicate the implementation of EBP, but they were not. The DON stated when Resident 26's CP was not revised the CP indicating to implement contact isolation could create confusion among staff regarding the proper precautionary measures to prevent the spread of MDROs. The DON stated the facility policy was not followed. During a review of the facility P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed 1/16/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; and reflects currently recognized standards of practice for problem areas and conditions. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. (continued on next page)

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	05/09/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44376 b. During a review of Resident 153's Face Sheet, the Face Sheet indicated the facility admitted the resident on 3/13/2024, with diagnoses including type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic nephropathy (nerve damage that can occur with diabetes), adult failure to thrive (a condition where someone, especially older adults, experiences a noticeable decline in their health and overall well-being), and palliative care (focused on improving the quality of life for people with serious illnesses, including managing symptoms, providing comfort, and offering emotional and spiritual support). During a review of Resident 153's H&P, dated 4/11/2025, the H&P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 153's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a stage where someone has noticeable difficulties with thinking and memory, impacting their ability to do some daily tasks, but they are still generally independent). The MDS indicated the resident was dependent to requiring supervision on mobility and activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was at risk for developing pressure ulcers/injuries and had pressure reducing device for bed. During a review of Resident 153's Physician Order Sheet, dated 4/15/2025, the Physician Order Sheet indicated an order for low air loss mattress continuous. During a review of Resident 153's Braden Scale for Predicting Pressure Sore Risk, dated 4/28/2025, the Braden Scale for Predicting Pressure Sore Risk indicated the resident was at high risk for developing pressure sore/injuries. During a review of Resident 153's Monthly/Weekly Vital Signs (a group of measurements that provide clues about how well the body is functioning), dated 5/5/2025, the Monthly/Weekly Vital Signs indicated a current weight of 158 pounds (lbs. - a unit of measure for weight). During a concurrent observation and interview, on 5/6/2025, at 10:20 a.m., with Certified Nursing Assistant (CNA) 6, inside Resident 153's room, Resident 153's LALM settings indicated 130 lbs. CNA 6 stated the LALM should be set according to resident's weight to prevent Resident 153 from developing pressure injuries. During a concurrent observation and interview, on 5/6/2025, at 10:31 a.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 153's room, Resident 153's LALM settings indicated 130 lbs. LVN 1 stated the LALM should be set according to resident's weight to prevent Resident 153 from developing pressure injuries. During a concurrent interview and record review, on 5/8/2025, at 9:31 a.m., with RN 4, Resident 153's physician order sheet and CPs were reviewed and RN 4 stated the CP titled, Potential for skin Integrity impairment/pressure ulcer, dated 3/28/2025, was not reviewed and revised to include the LALM as an intervention for pressure ulcer/injury prevention. RN 4 stated care plans should be updated to reflect the current interventions being implemented to the residents to communicate the changes to all healthcare providers to provide standardized care and to prevent miscommunication. (continued on next page)

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	05/09/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 5/9/2025, at 11:10 a.m., with the DON, the DON stated the Resident 153's LALM should be set according to the resident's weight. The DON stated the purpose of the LALM is for skin maintenance and pressure sore/injury prevention. The DON stated the charge nurses, treatment nurses, and the CNAs are in charge of making sure the LALM is set according to the resident's weight. The CNAs cannot adjust the settings, but their responsibility is to alert the licensed nurses when the setting is off. The DON stated the failure of the staff to set the bed according to Resident 153's weight predisposed the resident's skin to break down. During a review of the facility's recent P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/16/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. The interdisciplinary [NAME] reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. During a review of the facility provided Manufacturer's Specification on Low Air Loss Mattress 1 (LALM 1), undated, the Manufacturer's Specification indicated the LALM 1 is designed for bed sore and wound care therapy treatment and prevention, which may occur during an extended hospital stay and nursing home/long term care environment. Pressure Adjust Knob (adjustable by patient's weight). Turn the Pressure Adjust Knob to set a comfortable pressure level by using the weight scale as a guide. c. During a review of Resident 289's Face Sheet, the Face Sheet indicated the facility admitted the resident on 4/25/2025, with diagnoses including abnormalities of gait (a manner of walking or moving on foot) and mobility, muscle weakness, and chronic embolism (an obstruction or blockage in a blood vessel) and thrombosis (occurs when blood clots block your blood vessels) deep veins of left lower extremity. During a review of Resident 289's H&P, dated 4/28/2025, the H&P indicated the resident can make needs known but cannot make medical decisions, poor judgment. During a review of Resident 289's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and usually understand others and had severe cognitive impairment. The MDS indicated the resident was dependent to requiring supervision on mobility and ADLs. The MDS indicated the resident was at risk for developing pressure injuries and was on a pressure-reducing device for bed. During a review of Resident 289's Braden Scale for Predicting Pressure Sore Risk, dated 4/25/2025, the Braden Scale for Predicting Pressure Sore Risk indicated the resident was at high risk for developing pressure ulcer/injuries. (continued on next page)

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	05/09/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 289's Resident Care Plan (RCP) titled Impaired Skin Integrity, dated 4/26/2025, the RCP indicated an intervention for LAL mattress for wound management but was not checked as part of the intervention being implemented on the resident. During a review of Resident 289's Physician Order Sheet, dated 4/28/2025, the Physician Order Sheet indicated an order for low air loss mattress three times daily. During a review of Resident 289's Monthly/Weekly Vital Signs, dated 5/1/2025, the Monthly/Weekly Vital Signs indicated the resident's latest weight was 152 lbs. During a concurrent observation and interview, on 5/6/2025, at 1:20 p.m., with LVN 3, inside Resident 289's room, Resident 289's LALM was set at 270 lbs. The sticker on the LALM machine indicated 120-150 lbs. LVN 3 stated the LALM's setting was incorrect, it should be between 120-150lbs. LVN 3 stated the incorrect setting of the LALM can cause pressure sore/injuries on Resident 289. During a concurrent interview and record review on 5/8/2025, at 9:31 a.m., with RN 4, Resident 289's physician order sheet and care plan were reviewed and RN 4 stated the RCP titled Impaired Skin Integrity was not reviewed and revised to include the LALM as an intervention for pressure ulcer/injury prevention. RN 4 stated care plans should be updated to reflect the current interventions being implemented to the residents to communicate the changes to all healthcare providers to provide standardized care and to prevent miscommunication. During an interview, on 5/9/2025, at 11:10 a.m., with the DON, the DON stated the LALM of Resident 289 should be set according to the resident's weight. The DON stated the purpose of the LALM is for skin maintenance and pressure sore/injury prevention. The DON stated the charge nurses, treatment nurses, and the CNAs are in charge of making sure the LALM is set according to the resident's weight. The CNAs cannot adjust the settings, but their responsibility is to alert the licensed nurses when the setting is off. The DON stated the failure of the staff to set the bed according to Resident 289's weight predisposed the resident's skin to break down. The DON stated the RCP of Resident 289 should have been reviewed and revised to include the intervention LALM. The DON stated it was important to review and revise the care plan timely to ensure the care is appropriate for the residents and to communicate to other healthcare providers the treatment being implemented to the residents. During a review of the facility's recent P&P titled Care Plans, Comprehensive Person-Centered, last reviewed on 1/16/2025, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. The interdisciplinary [NAME] reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. (continued on next page)

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	05/09/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility provided Manufacturer's Specification on Low Air Loss Mattress 1 (LALM 1), undated, the Manufacturer's Specification indicated the LALM 1 is designed for bed sore and wound care therapy treatment and prevention, which may occur during an extended hospital stay and nursing home/long term care environment. Pressure Adjust Knob (adjustable by patient's weight). Turn the Pressure Adjust Knob to set a comfortable pressure level by using the weight scale as a guide.

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	05/09/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on interview and record review, the facility failed to provide care in accordance with professional standards for two (2) of 2 sampled residents (Residents 107 and 12) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin administration sites. This deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat), and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross Reference F760 Findings: a. During a review of Resident 107s Face Sheet (Admission Record), the Face Sheet indicated the facility originally admitted the resident on 3/23/2020 and readmitted in the facility on 7/26/2024, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarct (stroke, loss of blood flow to a part of the brain) affecting right dominant side, diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), and gastrostomy status (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 107's History and Physical (H&P), dated 7/29/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 107's Minimum Data Set (MDS - a resident assessment tool), dated 3/26/2025, the MDS indicated Resident 107 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 107 required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 107's care plan (CP) on potential for hypoglycemia (abnormally low level of sugar in the blood) or hyperglycemia (abnormally high level of sugar in the blood), initiated on 8/8/2024, the CP indicated to administer medications as ordered. During a review of Resident 107's Physician's Order Sheet, dated 1/20/2025, the Physician Order Sheet indicated the following physician's order: - Humulin R regular insulin (a short acting insulin) 100 unit per milliliter (unit/ml - a unit of measurement) injection solution four (4) times daily per sliding scale (the increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): (continued on next page)

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	05/09/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- blood sugar is less than (<)70 or more than (>), 400 notify physician; 121 - 150 = two (2) units; 151 - 200 = 4 units; 201- 250 = six (6) units; 251- 300 = eight (8) units; 301- 350 = 10 units; 351- 400 = 12 units. If blood glucose is <70 give juice via GT then recheck blood glucose, rotate sites. During a concurrent interview and record review, on 5/8/2025, at 3:15 p.m., with Registered Nurse (RN) 3, Resident 107's physician's order, CP, and subcutaneous administration sites for Humulin R from 4/1/2025 to 5/8/2025 was reviewed and RN 3 stated Resident 107 received insulin, had a physician's order for Humulin R and to rotate sites, and were administered as follows: - 4/1/2025 4:30 p.m. - abdomen - right lower quadrant (RLQ) - 4/2/2025 6:30 a.m. - RLQ - 4/6/2025 11:30 a.m. - abdomen - left upper quadrant (LUQ) - 4/7/2025 6:30 a.m. -abdomen - LUQ - 4/9/2025 4:30 p.m. - abdomen - left lower quadrant (LLQ) - 4/9/2025 9 p.m. - abdomen - LLQ - 4/12/2025 4:30 p.m. - abdomen - LUQ - 4/13/2025 6:30 a.m. - abdomen - LUQ - 4/15/2025 4:30 p.m. - abdomen - RLQ - 4/15/2025 9 p.m. - abdomen - RLQ - 4/21/2025 6:30 a.m. - abdomen - LUQ - 4/21/2025 11:30 a.m. - abdomen - LUQ - 4/22/2025 6:30 a.m. - abdomen - LUQ - 4/22/2025 11:30 a.m. - abdomen - LUQ RN 3 stated administration sites for insulin should be rotated according to physician's orders, standards of practice and manufacturer's guidelines to prevent formation of lumps, and abnormal distribution of fats under the skin which can affect the absorption of insulin if given on the same sites. RN 3 stated the location of administration sites for Resident 107's insulin were not rotated. RN 3 stated the nurses did not rotate Resident 107's administration sites. RN 3 stated Resident 107's administration sites should have been rotated to prevent formation of lumps, and abnormal distribution of fats under the skin which can affect the absorption of the insulin. (continued on next page)

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	05/09/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 5/9/2025, at 11:45 a.m., with the Director of Nursing (DON), Resident 107's location of administration sites for Humulin R, dated between 4/1/2025 to 5/8/2025, was reviewed and the DON stated Resident 107's insulin administration sites were not rotated as indicated in the physician's order. The DON stated licensed nurses are supposed to rotate the insulin administration sites as indicated in the physician's order, manufacturer's guidelines, and according to professional standards of practice. The DON stated Resident 107's insulin administration sites for Humulin R should have been rotated to prevent bruising, pain, abnormal distribution fats or lipodystrophy and affect the absorption of insulin which may lead to hyperglycemia. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on 1/16/2025, the P&P indicated a purpose to provide guidelines for the safe administration of insulin to residents with diabetes. The P&P further indicated: - Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided manufacturer's guideline for Humulin R - insulin human injection solution, undated, the manufacturer's guideline indicated: - Change (rotate) your injection sites within the area you choose with each dose to reduce the risk of getting lipodystrophy (pits in the skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. - Do not use the exact same spot for each injection. - Do not inject where the skin has pits, is thickened, or has lumps. - Do not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged skin. 44376 b. During a review of Resident 12's Face Sheet, the Face Sheet indicated the facility admitted the resident on 2/12/2020, with diagnoses including diseases of gallbladder (a small organ that stores bile), glaucoma (a group of eye diseases that can damage the optic nerve, the nerve that connects your eye to the brain, leading to vision loss and potential blindness), and DM 2. During a review of Resident 12's H&P, dated 11/24/2024, the H&P indicated the resident was awake, alert, oriented, and responding appropriately; had left hemiplegia, more on the left upper extremity, and unable to test gait (a manner of walking or moving on foot). (continued on next page)

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	05/09/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident was on a high-risk drug class hypoglycemic (a group of drugs used to help reduce the amount of sugar present in the blood). During a review of Resident 12's Physician Order Sheet, dated 12/10/2023, the Physician Order Sheet indicated an order of Humalog U-100 Insulin 100 unit/mL subcutaneous solution (sliding scale) Vial (ml) Subcutaneous four times daily. During a review of Resident 12's Medication Administration Record, dated between 3/2025 to 5/2025, the Medication Administration Record indicated insulin Humalog U-100 Insulin 100 unit/mL subcutaneous solution (sliding scale) Vial (ml) Subcutaneous four times daily was administered on: 3/4/2025 at 9 p.m. on the Abdomen- Right Upper Quadrant (RUQ) 3/5/2025 at 6:30 a.m. on the Abdomen-RUQ 3/7/2025 at 4:30 p.m. on the Abdomen 3/7/2025 at 9 p.m. on the Abdomen 3/8/2025 at 4:30 p.m. on the Abdomen- LUQ 3/8/2025 at 9 p.m. on the Abdomen-LUQ 3/14/2025 at 11:30 a.m. on the Abdomen-LUQ 3/14/2025 at 4:30 p.m. on the Abdomen-LUQ 3/15/2025 at 11:30 a.m. on the Abdomen-RUQ 3/15/2025 at 4:30 p.m. on the Abdomen-RUQ 4/4/2025 at 4:30 p.m. on the Abdomen-LUQ 4/4/2025 at 9 p.m. on the Abdomen-LUQ 4/6/2025 at 11:30 a.m. on the Abdomen-LUQ 4/6/2025 at 4:30 p.m. on the Abdomen-LUQ 4/8/2025 at 4:30 p.m. on the Abdomen-RUQ 4/8/2025 at 9 p.m. on the Abdomen-RUQ 4/10/2025 at 6:30 a.m. on the Abdomen-LUQ (continued on next page)

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	05/09/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/10/2025 at 11:30 a.m. on the Abdomen-LUQ 4/10/2025 at 4:30 p.m. on the Abdomen 4/10/2025 at 9 p.m. on the Abdomen 4/11/2025 at 11:30 a.m. on the Abdomen-RLQ 4/11/2025 at 4:30 p.m. on the Abdomen-RLQ 4/12/2025 at 11:30 a.m. on the Abdomen-RLQ 4/12/2025 at 4:30 p.m. on the Abdomen-RLQ 4/23/2025 at 11:30 a.m. on the Abdomen-RLQ 4/23/2025 at 9 p.m. on the Abdomen-RLQ 4/26/2025 at 11:30 a.m. on the Abdomen-RLQ 4/26/2025 at 4:30 p.m. on the Abdomen-RLQ 5/3/2025 at 4:30 p.m. on the Abdomen-RLQ 5/3/2025 at 9 p.m. on the Abdomen-RLQ 5/6/2025 at 9 p.m. on the Arm- Right Upper Posterior Medial (RUPM) 5/7/2025 at 6:30 a.m. on the Arm-RUPM During a concurrent interview and record review, on 5/9/2025, at 8:49 a.m., with RN 3, Resident 12's Medical Diagnosis, Physician Order Sheet, and Medication Administration Record were reviewed and RN 3 stated there was an order for Humalog subcutaneous with sliding scale on the resident. RN 3 stated there were multiple instances that the site of insulin administration was not rotated in the Medication Administration Record from 3/2025 to 5/2025. RN 4 stated the insulin sites of administration should be rotated to prevent lipodystrophy on residents. RN 4 stated injecting insulin on the sites of lipodystrophy could affect the absorption of the insulin that can cause hypo (low)/hyperglycemia (high blood glucose [blood sugar]) to residents. During an interview, on 5/9/2025, at 11:10 a.m., with the DON, the DON stated Resident 12's insulin administration sites should be rotated to prevent lipodystrophy on residents. The DON stated that the absorption of the medication is affected if administered on the sites of lipodystrophy. The DON stated that the resident can experience hypo/hyperglycemic episodes due to poor absorption of the insulin on the sites of lipodystrophy. During a review of the facility's recent P&P titled, Insulin Administration, last reviewed on 1/16/2025, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. (continued on next page)

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	05/09/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided Highlights of Prescribing Information for Humalog (insulin lispro) injection, for subcutaneous or intravenous use, with initial U.S. approval in 1996, the Highlights of Prescribing Information indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis.

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	05/09/2025

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. 38552 Based on interview and record review, the facility failed to follow up and schedule the resident's orthopedic (broad based medical and surgical specialty dedicated to the prevention, diagnosis, and treatment of diseases and injuries of the musculoskeletal system) appointment for Resident 112. This deficient practice had the potential to result in a delay of care and treatment for Resident 112. Findings: During a review of Resident 112's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted the resident on 3/22/2025 with diagnoses including disorder of bone, unilateral (affecting only one side of the body) primary osteoarthritis (a joint disease that causes pain, stiffness, and loss of mobility) on the right knee, and generalized muscle weakness. During a review of Resident 112's History and Physical (H&P), dated 3/24/2025, the H&P indicated the computed tomography (CT-a medical imaging procedure that uses X-rays and computer processing to create a detailed cross-sectional images of the body) results of the femur (the long bone located in the thigh, connecting the hip to the knee) noted Resident 112 had possible lytic erosive bone (bone lesions characterized by the destruction and loss of bone tissue) changes and to follow up with an orthopedic referral. The H&P indicated that the resident has the capacity to understand and make decisions but has poor insight (a lack of awareness). During a review of Resident 112's Physician Order, the Physician Order indicated: - Please arrange hematology (a branch of medicine that studies the blood, its components, and the disorders that affect them)/oncology (a branch of medicine that specializes in the diagnosis, treatment, and prevention of cancer [a group of diseases where cells in the body grow uncontrollably and can spread to other parts of the body]) and orthopedic appointment, dated 3/31/2025. - Please arrange an orthopedic appointment for lytic lesion left femur, dated 5/9/2025. During a review of Resident 112's Minimum Data Set (MDS-a resident assessment tool), dated 4/11/2025, the MDS indicated the resident makes self-understood and had the ability to understand others. During a concurrent interview and record review on 5/9/2025 at 10:26 a.m. with Registered Nurse (RN) 2, Resident 112's physician orders were reviewed. RN 2 stated the written order dated 3/31/2025 and today 5/9/2025 noted to make an orthopedic appointment. RN 2 stated there was no order placed for the follow-up appointment placed after 3/31/2025. RN 2 stated, for Resident 112, RNs are responsible for clarifying with the physician if they wanted a specific orthopedic doctor and she would follow-up and document on the progress notes. RN 2 stated a new order would be placed with the appointment date and time. (continued on next page)

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	05/09/2025

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	During an interview on 5/9/2025 at 12:43 p.m. with the Director of Nursing (DON), the DON stated the licensed nurses, RN or LVN, who received the order should have called the orthopedic office to schedule the resident's appointment. The DON stated this is done right away so there is no delay in treatment. The DON stated Resident 112 could have worsening conditions if not followed up on time. The DON stated they expect the doctor's order to be completed on time and followed up promptly. The DON stated it should have been endorsed to the next shift, and it should be documented that it was endorsed when the appointment was not scheduled and/or the follow-up was not done. During a review of the facility's policy and procedure (P&P) titled, Ancillary Referrals, reviewed and approved date 1/16/2025, the P&P indicated the facility maintains arrangements with duly licensed medical professionals to provide a range of geriatric care within their specialties. The P&P indicated social services shall coordinate most resident referrals exceptions might include emergency or specialized services that are arranged directly by a physician or the nursing staff. The P&P indicated social services staff and nursing department coordinate appointment schedule and follow-up visits.

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	05/09/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on observation, interview, and record review, the facility failed to ensure resident received care consistent with professional standards of practice to prevent pressure ulcers/injury (the breakdown of skin integrity due to pressure) for two of two sampled residents (Residents 153 and 289) reviewed for pressure injury by failing to ensure the low air loss mattress (LALM, a special kind of mattress designed to help prevent and treat skin problems like pressure sores [bedsores]) was set according to the residents' weight. These deficient practices had the potential for development and worsening of pressure ulcers/injuries to residents. Findings: Cross Reference F657 1. During a review of Resident 153's Face Sheet, the Face Sheet indicated the facility admitted the resident on 3/13/2024, with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (nerve damage that can occur due to diabetes), adult failure to thrive (due to declining physical and mental health, there is lost weight, depleted energy, and the diminished ability of an individual to care for oneself), and palliative care (specialized medical care for people with serious illnesses that focuses on improving their quality of life by managing symptoms and providing support, both physically and emotionally). During a review of Resident 153's History and Physical (H&P), dated 4/11/2025, the H&P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 153's Minimum Data Set (MDS, a resident assessment tool), dated 3/14/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (noticeable deficits that interfere with daily activities, including memory loss, language difficulties, skewed judgment, and reduced problem-solving abilities). The MDS indicated the resident was dependent to requiring supervision on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was at risk for developing pressure ulcers/injuries and had pressure reducing device for bed. During a review of Resident 153's Physician Order Sheet, dated 4/15/2025, the Physician Order Sheet indicated an order for low air loss mattress continuous. During a review of Resident 153's Braden Scale for Predicting Pressure Sore Risk, dated 4/28/2025, the Braden Scale for Predicting Pressure Sore Risk indicated the resident was at high risk for developing pressure sore/injuries. (continued on next page)

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	05/09/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 153's Monthly/Weekly Vital Signs (measurements of the body's most basic functions), dated 5/5/2025, the Monthly/Weekly Vital Signs indicated a current weight of 158 pounds (lbs., a unit of weight) During a review of Resident 153's Care Plan (CP) titled Potential for Skin Integrity Impairment/Pressure Ulcers, dated 3/28/2025, the CP indicated to administer treatment/s per MD orders, keep MD aware of progress/response to the treatment plan. During a concurrent observation and interview on 5/6/2025, at 10:20 a.m., with Certified Nursing Assistant (CNA) 6, inside Resident 153's room, observed Resident 153's LALM set at 130 lbs. The sticker on the LALM machine indicated to keep LALM at 150-180 lbs. CNA 6 stated the LALM should be set according to resident's weight to prevent Resident 153 from developing pressure injuries. During a concurrent observation and interview on 5/6/2025, at 10:31 a.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 153's room, observed Resident 153's LALM set at 130 lbs. The sticker on the LALM machine indicated to keep LALM at 150-180 lbs. LVN 1 stated the LALM should be set according to resident's weight to prevent Resident 153 from developing pressure injuries. During an interview on 5/9/2025, at 11:10 a.m., with the Director of Nursing (DON), the DON stated the LALM of Resident 153 should be set according to the resident's weight. The DON stated the purpose of the LALM is for skin maintenance and pressure sore/injury prevention. The DON stated the charge nurses, treatment nurses, and the CNAs are in charge of making sure the LALM is set according to the resident's weight. The CNAs cannot adjust the settings, but their responsibility is to alert the licensed nurses when the setting is off. The DON stated the failure of the staff to set the bed according to Resident 153's weight predisposed the resident's skin to break down. During a review of the facility's recent policy and procedure (P&P) titled Pressure Ulcers/Skin Breakdown-Clinical Protocol, last reviewed on 1/16/2025, the P&P indicated the physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. During a review of the facility provided Manufacturer's Specification on DynaRest Airfloat 100 Air Mattress with Pump (LALM 1), undated, the Manufacturer's Specification indicated the LALM 1 Mattress is designed for bed sore and wound care therapy treatment and prevention, which may occur during an extended hospital stay and nursing home/long term care environment. Pressure Adjust Knob (adjustable by patient's weight). Turn the Pressure Adjust Knob to set a comfortable pressure level by using the weight scale as a guide. 2. During a review of Resident 289's Face Sheet, the Face Sheet indicated the facility admitted the resident on 4/25/2025, with diagnoses including abnormalities of gait (a manner of walking or moving on foot) and mobility, muscle weakness, and chronic embolism (an obstruction or blockage in a blood vessel) and thrombosis (the formation of a blood clot inside a blood vessel) deep veins of left lower extremity. During a review of Resident 289's H&P, dated 4/28/2025, the H&P indicated the resident can make needs known but cannot make medical decisions, poor judgment. (continued on next page)

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	05/09/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 289's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and usually understand others and had severe cognitive impairment (significant difficulties with thinking, learning, remembering, and making decisions, to the point where daily life is greatly impacted). The MDS indicated the resident was dependent to requiring supervision on mobility and activities of daily living (ADLs). The MDS indicated the resident was at risk for developing pressure injuries and was on a pressure-reducing device for bed. During a review of Resident 289's Physician Order Sheet, dated 4/28/2025, the Physician Order Sheet indicated an order for low air loss mattress three times daily. During a review of Resident 289's Braden Scale for Predicting Pressure Sore Risk, dated 4/25/2025, the Braden Scale for Predicting Pressure Sore Risk indicated the resident was at high risk for developing pressure ulcer/injuries. During a review of Resident 289's Monthly/Weekly Vital Signs, dated 5/1/2025, the Monthly/Weekly Vital Signs indicated the resident's latest weight was 152 lbs. During a concurrent observation and interview on 5/6/2025, at 1:20 p.m., with LVN 3, inside Resident 289's room, observed Resident 289's LALM was set at 270 lbs. The sticker on the LALM machine indicated 120-150 lbs. LVN 3 stated the LALM's setting was incorrect, it should be between 120-150 lbs. LVN 3 stated the incorrect setting of the LALM can cause pressure sore/injuries on Resident 289. During an interview on 5/9/2025, at 11:10 a.m., with the DON, the DON stated the LALM of Resident 289 should be set according to the resident's weight. The DON stated the purpose of the LALM is for skin maintenance and pressure sore/injury prevention, the charge nurses, treatment nurses, and the CNAs are in charge of making sure the LALM is set according to the resident's weight. The CNAs cannot adjust the settings, but their responsibility is to alert the licensed nurses when the setting is off. The DON stated the failure of the staff to set the bed according to Resident 289's weight predisposed the resident's skin to break down. During a review of the facility's recent P&P titled Pressure Ulcers/Skin Breakdown- Clinical Protocol, last reviewed on 1/16/2025, the P&P indicated the physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents. During a review of the facility provided Manufacturer's Specification on LALM 1, undated, the Manufacturer's Specification indicated the LALM 1 Mattress is designed for bed sore and wound care therapy treatment and prevention, which may occur during an extended hospital stay and nursing home/long term care environment. Pressure Adjust Knob (adjustable by patient's weight). Turn the Pressure Adjust Knob to set a comfortable pressure level by using the weight scale as a guide.

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	05/09/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 121) received appropriate Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) services to prevent a decline in range of motion (ROM, full movement potential of a joint) by failing to provide Resident 121 with active assisted range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) exercises to the left upper extremity (UE, shoulder, elbow, wrist, hand) during the 5/7/2025 RNA session, as ordered by a physician and according to Resident 121's care plan. This deficient practice had the potential for a decline in mobility, ROM, and overall functioning in Resident 121. Findings: During a review of Resident 121's Face Sheet (FS), the FS indicated Resident 121 admitted to the facility on [DATE] with diagnoses including but not limited to osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) with exacerbation. During a review of Resident 121's physician's History and Physical Examination (H&P), the H&P indicated resident could make needs known but could not make medical decisions. During a review of Resident 121's Minimum Data Set (MDS, resident assessment tool) dated 2/25/2025, the MDS indicated Resident 121 had moderate cognitive (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving) impairment. The MDS indicated Resident 121 had functional limitation in range of motion on one side of the upper extremity and no limitations on the lower extremity (hip, knee, ankle, foot). The MDS also indicated Resident 121 required set up assistance with eating, moderate assistance with dressing, sit to stand, bed to chair transfers and to walk 50 feet with two turns. During a review of Resident 121's RNA Resident Care Plan (CP) dated 12/7/2024, the CP indicated Resident 121 had decreased ROM of the following joints: both UE shoulder, elbow, wrist, fingers and had the potential for further loss of ROM and decreased functional use. The CP goal indicated Resident 121 will maintain or improve ROM. The CP approach plan indicated RNA will provide gentle joint exercise to upper extremities AAROM once a day seven times a week. During a review of Resident 121's Physician Order Sheet May 2025, the Physician Order Sheet indicated an order dated 2/19/2021 for RNA to do both upper extremity (BUE) AAROM exercises seven times a week as tolerated. (continued on next page)

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	05/09/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/7/2025 at 10:00 a.m., Resident 121 was sitting up in a wheelchair in the hallway. Restorative Nursing Aide (RNA 1) completed ambulation with Resident 121 and proceeded to bring Resident 121 back to Resident 121's room. RNA 1 performed ROM exercises to Resident 121's right shoulder, elbow, wrist and fingers and RNA 1 put on a wrist/hand splint to the right wrist/hand. RNA 1 did not do any exercises to Resident 121's LUE. RNA 1 stated we are done with RNA and brought Resident 121 to the activities room. During an interview on 5/7/2025 at 12:10 p.m., the Director of Rehabilitation (DOR) stated the RNA program was to help prevent further decline and maintain current mobility and ROM status for each resident. DOR stated the therapists created an order for RNA program for the needs of each resident such as ambulation, AAROM, or PROM. DOR stated it was very important for residents to receive their RNA program for the resident's overall quality of life, circulation, and endurance. During an interview and record review on 5/7/2025 at 2:10 p.m., RNA 1 reviewed the RNA binder with Resident 121's RNA orders and stated Resident 121's RNA orders were to do AAROM to BUE. RNA 1 stated she only did AAROM to the RUE during RNA session today. RNA 1 stated she was supposed to do AAROM to both RUE and LUE, but did not do AAROM to the LUE because Resident 121 could move the LUE himself. During an interview on 5/9/2025 at 10:36 a.m., the Director of Nursing (DON) stated the RNA program was to prevent resident physical decline and to maintain a resident's current functional status. DON stated the RNA staff should follow the RNA orders because it ensured the resident received the RNA exercises that were ordered to prevent the resident's decline. DON stated if Resident 121 did not receive AAROM to the LUE during RNA treatment, then Resident 121 could have a decline in ROM, mobility, and functioning. During a review of the facility's policies and procedures titled, Restorative Nursing Services, the P&P indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence.

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	05/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 44244 Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 12 of 15 sampled residents (Resident 96, 167, 117, 39, 107, 90, 53, 45, 14, 291,102, and 12) reviewed during the Accidents care area by failing to: 1. Ensure medications were not left unattended and readily available in the residents' shared room for Resident 96, 167, 12, and 102 . 2. Ensure an aerosolized can labeled Ant, Roach, and Spider Killer (Bug Spray 1) was not left unattended at the bedside for Resident 96 reviewed during the Accidents care area. These deficient practices had the potential to result in residents not using medications per the physician's orders and residents obtaining medication and hazardous products without staff knowledge resulting in accidental ingestion causing harm to residents. 3. Ensure there was a physician's order for Resident 117's heating pad. 4. Ensure there were no frayed wires on the bed remote control of Resident 45. These deficient practices placed Resident 117 at risk for injury such as accidental burning or electrocution which may lead to hospitalization . 5. Ensure there was no furniture or medical equipment on top of Resident 107, 39, 90, 14, and 53s' floor mats (a cushioned floor pad designed to help prevent injury should a person fall). 6. Ensure Resident 14's fall mat did not have a 16-inch linear tear on its surface. 7. Ensure Residents 291 and 102s' beds were placed in the lowest position. These deficient practices placed the residents at risk for increased chances of incurring injury such as falls with fracture (a break or crack in a bone) and even death. Findings: a.1. During a review of Resident 96's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted the resident on 8/1/2020 and most recently admitted the resident on 3/24/2025 with diagnoses that included polyneuropathy (a disorder of the peripheral nervous system that may result in pain, discomfort, and mobility issues), essential (primary) hypertension (high blood pressure with an unknown cause) major depressive disorder (persistent feelings of sadness and loss of interest that can interfere with daily living), anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), binge eating disorder (a mental illness that causes chronic, compulsive overeating), and unspecified intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently). (continued on next page)

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	05/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 96's Self-Administration of Medication Assessment, dated 3/24/2025, the Self-Administration of Medication Assessment indicated the resident did not want to self-administer medication and the resident was not a candidate for safe self-administration of medication. During a review of Resident 96's History and Physical (H&P), dated 3/26/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 96's Physician Order Sheet April 2025, dated 3/28/2025, the Physician Order Sheet indicated the following orders - Bupropion HCL XL (a psychotropic medication [any medication capable of affecting the mind, emotions, and behavior] used to treat depression) 300 milligram (mg, a unit of measurement) 24-hour tablet, extended release, give one tablet daily at the a.m. medication (med) pass by mouth, for major depressive disorder manifested by sad facial expressions, dated 3/25/2025. - Buspirone (a psychotropic medication used to treat anxiety) 10 mg tablet, give one tablet two times a day at the a.m. and dinner med pass by mouth for anxiety disorder manifested by repetitive health complaints, dated 3/24/2025. - Carvedilol (a medication used to treat high blood pressure) 25 mg tablet, one tablet two times daily at the a. m. and dinner med pass by mouth, for essential hypertension, hold (do not give) for systolic blood pressure (SBP, measures the pressure in your arteries [pathway that carries blood away from the heart] less than 110, dated 3/24/2025. - Lisdexamfetamine (a psychotropic medication used to treat binge eating disorder) 30 mg capsule, give one capsule daily at the a.m. med pass by mouth, for binge-eating disorder, dated 3/24/2025. - Vitamin D3 (a supplement) 25 mcg (microgram, a unit of measurement), three tablets daily at the a.m. med pass for supplement, dated 4/3/2025. During a review of Resident 96's Care Plan (CP) regarding activities of daily living, self-care deficit, initiated 3/31/2025, the CP indicated to minimize the resident's risk of decline by providing a safe environment. During a review of Resident 96's CP regarding hypertension, initiated 3/31/2025, the CP indicated a goal that the resident would be free from signs and symptoms of cardiac distress with a blood pressure within normal limits and with an intervention to administer medication as ordered. During a review of Resident 96's CP regarding buspirone and bupropion, initiated 3/31/2025, the CP indicated a goal to maximize the resident's functional potential and minimize the risk of potential adverse effects of medication with an intervention to administer medication as ordered. During a review of Resident 96's CP regarding the resident has nine or more medications, initiated 3/31/2025, the CP indicated there was a potential for adverse drug effects and drug interactions and to give medications as ordered. (continued on next page)

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	05/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 96's Minimum Data Set (MDS - resident assessment tool) dated 4/4/2025, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated that the resident was dependent on staff for toileting and bathing, required substantial / maximal assistance for dressing and moving from lying to sitting, and required partial/moderate assistance for personal hygiene and rolling left and right in the bed. During a concurrent observation and interview on 5/6/2025 at 10:50 a.m., with Resident 96, Resident 96 was observed sitting up in bed. A clear plastic medicine cup containing two capsules and three tablets were on the bedside rolling table. Resident 96 stated the medication belonged to Resident 96 and the Licensed Vocational Nurse (LVN) left the medication on the table because the resident does not like to take all the medication at the same time. Resident 96 stated the resident forgot to take the medication that was left by the LVN. During a concurrent observation and interview on 5/6/2025 at 11:04 a.m., with LVN 2, LVN 2 entered Resident 96's room and stated LVN 2 left the medication for Resident 96 to self-administer. LVN 2 stated Resident 96 was alert, and it was okay for Resident 96 to self-administer medication. Resident 96 swallowed the five medications in the cup. LVN 2 exited Resident 96's room and stated Resident 96 usually wants LVN 2 to leave the medication in the room to self-administer one at a time. LVN 2 stated because the resident is alert, LVN 2 often leaves medication in Resident 96's room to self-administer. During a follow-up interview and record review on 5/6/2025 at 2:35 p.m., LVN 2 reviewed Resident 96's physician orders, Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 5/2025, and Nursing Progress Notes for 5/2025. LVN 2 stated the facility medication administration process is to take the resident's medication to the bedside, watch the resident take the medication to make sure the resident safely administers all the medication, then document in the MAR the date and time the resident took the medication. LVN 2 stated the facility process for resident medication self-administration is that the resident should be assessed for the ability to safely self-administer medications and there should be a physician's order indicating what medications the resident may self-administer. LVN 2 stated Resident 96 did not have a physician's order or an assessment indicating the resident was capable of self-administering medication. LVN 2 stated LVN 2 left lisdexamfetamine, bupropion, buspirone, carvedilol, and one tablet of Vitamin D unattended at Resident 96's bedside for the resident to self-administer and the resident was not assessed and did not have a physician's order for medication self-administration. LVN 2 stated leaving medication at the bedside is a risk that the resident may not take the medication or take the medication at the wrong time and is a risk to other residents that may pass by and take the medication. (continued on next page)

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	05/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 5/6/2025 at 3:01 p.m., with Registered Nurse (RN) 1, RN 1 reviewed Resident 96's Self-Administration of Medication Assessment, dated 3/24/2025. RN 1 stated medications are never left at the bedside for a resident to self-administer because the LVN needs to be present to ensure the medications are actually administered at the correct time, to the correct resident, and not just left at the bedside. RN 1 stated when a resident requests to take medication at a later time, the medications are labeled and placed back in the medication cart and the LVN returns later and offers again to administer the medication. RN 1 stated Resident 96 is not safe for self-administration of medication and LVN 2 should not have left medications at bedside unattended. RN 1 stated when LVN 2 left Resident 96's medication at bedside there was a risk that the resident would not take the medication or take the medication too close or too far apart. RN 1 stated for Resident 96, when blood pressure medication was not administered on time, it may result in the resident's blood pressure may be too high or too low leading to a medical emergency. RN 1 stated when the resident's psychotropic medications were not administered at the correct time there may be adverse effects when the medication is not at a therapeutic level, like undesired behaviors. RN 1 stated medications should also never be left at bedside because there are residents that wander, and the residents could take the medication and have an allergic reaction that may be detrimental to the residents' health During a concurrent interview and record review on 5/9/2025 at 9 a.m., the Director of Nursing (DON) reviewed the facility policy and procedures regarding medication administration. The DON Stated the medication process is the LVN administers and observes the resident while taking medications. The DON stated medications cannot be left at the bedside because the resident may not take the medication as ordered and the unattended medications are a risk to other residents. The DON stated LVN 2 did not follow the facility policy when LVN 2 left high-risk medications at Resident 96's bedside for the resident to self-administer. The DON stated when the medications were left at bedside there was a risk that Resident 96 would not take the medication resulting in high blood pressure or unwanted behaviors. The DON stated if Resident 96 took the medication at the wrong time it may result in low blood pressure or over drowsiness. The DON stated if another facility resident took medication not intended for them there was a potential it could result in adverse effects like low blood pressure or allergic reactions in those residents. During a review of the facility P&P titled, Self-Administration of Medications, last reviewed 1/16/2025, the P&P indicated residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications are safe and clinically appropriate for the resident. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. Self-administered medications are stored in a safe and secure place which is not accessible by other residents. During a review of the facility P&P titled, Administering Medications, last reviewed 1/16/2025, the P&P indicated medications are administered in a safe and timely manner, and as prescribed. (continued on next page)

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	05/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy and procedure titled, Safety Supervision of Residents, last reviewed 1/16/2025, the policy and procedure indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting process. Employees should be trained and in-serviced in potential accident hazards and how to identify and try to prevent avoidable accidents. a.2. During a concurrent observation and interview on 5/6/2025 at 10:50 a.m., with Resident 96, Resident 96 was observed sitting up in bed. A large aerosol can labeled Ant, Roach, and Spider Killer (Bug Spray 1) placed on top of the dresser next to three soda bottles. Resident 96 stated Resident 96 had used Bug Spray 1 in the past but had not used it in a while. Resident 96 stated Resident 96 kept Bug Spray 1 in the room just in case the spray would be needed in the future. During a concurrent observation and interview on 5/6/2025 at 11:04 a.m., with LVN 2, LVN 2 entered Resident 96's room with Bug Spray 1 visible on the dresser. LVN 2 exited Resident 96's room and did not remove Bug Spray 1. During a concurrent observation and interview on 5/6/2025 at 3:01 p.m. with LVN 2 and Certified Nursing Assistant (CNA) 2, CNA 2 exited Resident 96's room and stood at the doorway with LVN 2. Bug Spray 1 was observed on the resident's dresser. CNA 2 stated Bug Spray 1 which was placed on the resident's dresser was Resident 96's personal property and the resident had a right to keep the spray. LVN 2 stated residents should not have bug spray in the room because it contains ingredients that are used to kill insects and may be harmful to residents. LVN 2 stated LVN 2 was not previously aware that Resident 96 had Bug Spray 1 in the room. During an observation on 5/7/2025 at 8 a.m., Bug Spray 1 was observed on Resident 96's dresser next to three cans of soda. During an interview on 5/7/2025 at 8:19 a.m. with LVN 6, LVN 6 stated residents could not have bug spray in their rooms because bug spray is an aerosolized hazard to residents. LVN 6 stated there are many confused residents that wander in the facility that may get ahold of the spray and spray it on themselves if they think it is something like hairspray. LVN 6 stated LVN 2 and CNA 2 should have removed the bug spray when it was identified, but they did not. During a follow up interview on 7/5/2025 at 10 a.m. with LVN 6, LVN 6 stated LVN 6 removed Bug Spray 1 from Resident 96's room and educated the resident. LVN 6 stated the resident was understanding. During a concurrent interview and record review on 5/9/2025 at 9 a.m., the DON reviewed the facility P&P regarding accident hazard prevention. The DON stated the DON was made aware that Resident 96 had Bug Spray 1 stored in the resident's room near soda cans. The DON stated bug spray is a chemical that becomes aerosolized and must be used with caution. The DON stated chemicals should never be stored next to food items. The DON stated bug spray is a potential hazard to residents who may have an allergic reaction like asthma (a chronic respiratory disease that affects the airways in the lungs, making it difficult to breathe). The DON stated the bug spray was also a potential hazard to other confused residents that may get ahold of the spray and not use it properly. The DON stated the facility policy was not followed when Resident 96 had Bug Spray 1 and CNA 2 or LVN 2 did not remove the spray when they were responsible for ensuring the safety of the resident's environment. (continued on next page)

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	05/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy and procedure titled, Safety and Supervision of Residents, last reviewed 1/16/2025, the policy and procedure indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting process. Employees should be trained and in-serviced on potential accident hazards and how to identify and try to prevent avoidable accidents. b. During a review of Resident 167's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted the resident on 4/6/2025 with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder, and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 167's History and Physical (H&P), dated 4/7/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 167's MDS dated [DATE], the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated that the resident required partial/moderate assistance with personal hygiene, dressing, and transferring from the bed to chair. During a concurrent observation and interview on 5/6/2025 at 9:45 a.m., Resident 167 was observed lying in bed, two single-use vitamin A&D ointment (a medication to treat or prevent dry, rough, itchy skin) packets were observed on the resident's bedside table and one packet on the floor. Resident 167 stated Resident 167 did not know what the packets were, and somebody probably left them there. During a concurrent observation and interview on 5/6/2025 at 9:50 a.m., CNA 3 entered Resident 167's room and stated CNA 3 uses the A&D ointment packets on Resident 167's dry feet daily. CNA 3 removed the packet from the floor, exited the room, but did not remove the A&D packets from the bedside table. During an interview on 5/7/2025 at 12:05 p.m., with LVN 6, LVN 6 stated A&D ointment is a topical medication that requires a prescription and is only applied by licensed nurses. LVN 6 stated it was not within the scope of practice for a CNA to apply A&D ointment. LVN 6 stated A&D ointment should never be left in a resident's room because there are many residents that wander, and the medication could cause an allergic reaction if applied. During a concurrent interview and record review on 5/16/2024 at 9:11 a.m., the Director of Nursing (DON) reviewed the facility policy and procedure regarding medication self-administration and accident prevention. The DON stated A&D ointment is used for skin protection and maintenance. The DON stated A&D ointment requires a physician's order and CNAs should not apply it. The DON stated that A&D ointment should not be left in the residents' room at the bedside because some residents are confused, and it could potentially cause harm. The DON stated any resident could wander into a room and mistake the A&D ointment for something that could be ingested. The DON stated A&D ointment is not meant to be ingested and could cause choking or allergic reactions in residents. The DON stated the facility policy was not followed because medications should not be left in a resident's room. (continued on next page)

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	05/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy and procedure titled, Safety and Supervision of Residents, last reviewed 1/16/2025, the policy and procedure indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting process. Employees should be trained and in-serviced on potential accident hazards and how to identify and try to prevent avoidable accidents. During a review of the facility P&P titled, Self-Administration of Medications, last reviewed 1/16/2025, the P&P indicated residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. Self-administered medications are stored in a safe and secure place which is not accessible by other residents. 43988 c. During a review of Resident 117's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility admitted the resident on 3/28/2025, with diagnoses including history of falling and osteoporosis. During a review of Resident 117's MDS, dated [DATE], the MDS indicated Resident 117 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 117 required supervision or touching assistance with eating and oral hygiene; substantial/maximal assistance with upper toileting hygiene, bathing, and lower body dressing; partial/moderate assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 117's H&P dated 4/13/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review oof Resident 117's Physician Order Sheet dated 4/29/2025, the Physician Order Sheet did not indicate a physician's order for the use of a heating pad. During an observation on 5/6/2025 at 10:26 a.m., while inside Resident 117's room, Resident 117 was observed lying in bed with a heating pad placed behind the resident's upper back area and plugged into a wall socket. During a concurrent observation and interview on 5/6/2025 at 11 a.m. while inside Resident 117's room with the Assistant Director of Nursing (ADON), the ADON stated Resident 117 had a heating pad placed under the resident's upper back area which was plugged into the wall socket and was not in use. The ADON stated she was not sure if there was a physician's order for the use of the heating pad. (continued on next page)

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	05/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/6/2025 at 11:05 a.m., Resident 117's physician's order with Licensed Vocational Nurse (LVN) 7 was reviewed. LVN 7 stated Resident 117 did not have a physician's order for the use of a heating pad provided by the family. LVN 7 stated he was not aware Resident 117 had a heating pad provided by the family. During a follow up interview with the ADON on 5/6/2025 at 11:15 a.m., the ADON stated she spoke with the resident representative (RP), and the RP stated he notified one of the nurses about the heating pad but was unable to remember the name. The ADON stated the licensed nurses are supposed to call the physician for any treatment on the residents and communicate with the rest of the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) to ensure their safety and prevent injuries. The ADON stated the licensed nurse who spoke with the son should have obtained a physician's order prior to use of the heating pad as it placed the resident at risk for sustaining injuries such as burn which may lead to hospitalization while using the heating pad without proper supervision or monitoring by the staff. During a review of the facility's recent policy and procedure (P&P) titled Safety and Supervision of Residents, last reviewed on 1/16/2025, the P&P indicated: - The facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. - Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. - The facility's individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. - The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. - Implementing interventions to reduce accident risks and hazards include communicating specific interventions to all relevant staff. d. During a review of Resident 39s Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 9/8/2023 and readmitted in the facility on 11/8/2023, with diagnoses including history of falling, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 39's fall risk assessments dated 11/9/2024 and 2/3/2025, the fall risk assessments indicated Resident 39 was a risk for falls. During a review of Resident 39's CP on fall risk initiated on 11/16/2024, the CP indicated a low bed with floor mat and to keep the environment hazard free as a few of the interventions to reduce or minimize risk of falls or injury. (continued on next page)

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	05/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 39's MDS, dated [DATE], the MDS indicated Resident 39 was able to understand others and able to make her needs known, and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 39 required supervision/touching assistance with eating; substantial/maximal assistance with upper body dressing and rolling left and right; total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 39's H&P dated 2/5/2025, the H&P indicated the resident had the capacity to understand and make decisions. During an observation on 5/6/2025 at 11:04 a.m. while inside Resident 39's room, Resident 39 was observed lying in bed awake and answering appropriately. The right floor mat beside Resident 39's bed was observed to have a visitor chair placed on the top. During a concurrent observation and interview on 5/6/2025 at 11:20 a.m. while inside Resident 39's room with Registered Nurse (RN) 7, RN 7 stated Resident 39's visitor chair was heavy and placed on top on the right floor mat and left an indentation on the mat when the chair was moved. RN 7 stated there should be no equipment or furniture placed on top of the floor mat as the equipment affects the integrity of the floor mat and the residents can hit the equipment when they fall and get injured. RN 7 stated the floor mat protects the residents from injuries in case of a fall incident. RN 7 stated Resident 39's visitor chair should not have been placed on top of the floor mat as it placed Resident 39 at risk of getting injured in case of a fall. During a review of the facility provided undated manufacturer's guideline for Floor Mat (FM) 1, the manufacturer's guideline indicated: - It is the caregiver's responsibility to ensure FM 1 is designed to be placed beside the bed in a parallel position. - When moving equipment such as lifts and wheelchairs across the mat, always make sure wheel locks are not engaged, as locked wheels may damage the surface. Sharp object may cause damage to the mat. - Never leave heavy objects on the mat surface for extended periods as indentation and damage may occur. During a review of the facility's recent policy and procedure (P&P) titled Safety and Supervision of Residents, last reviewed on 1/16/2025, the P&P indicated: - The facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. - Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. - Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: (continued on next page)

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	05/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Bed safety. c. Falls. g. Electrical Safety. e. During a review of Resident 107s Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 3/23/2020 and readmitted in the facility on 7/26/2024, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarct (stroke, loss of blood flow to a part of the brain) affecting right dominant side, aphasia (a disorder that makes it difficult to speak), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 107's H&P dated 7/29/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 107's CP on potential for falls initiated on 8/8/2024, the CP indicated a low bed with floor mat as one of the interventions to reduce or minimize risk of falls or injury. During a review of Resident 107's fall risk assessments dated 12/24/2024 and 3/25/2025, the fall risk assessments indicated Resident 107 was a risk for falls. During a review of Resident 107's MDS, dated [DATE], the MDS indicated Resident 107 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 107 required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a concurrent observation and interview on 5/6/2025 at 11:44 a.m. while inside Resident 107's room with Certified Nursing Assistant (CNA) 5, Resident 107 was observed lying in bed asleep and the overbed table was placed on top of the floor mat. CNA 5 stated the overbed table was placed on top of the left floor mat and left dents from the wheels when the table was removed from the floor mat. CNA 5 stated the purpose of the floor mat was to protect the residents from fall which can result in injury. CNA 5 stated there should be no equipment or furniture placed on top of the floor mats as it affects the integrity of the floor mat and does not protect the residents from falls when the floor mat becomes thinner. CNA 5 stated Resident 107's overbed table should have been repositioned and not placed on top of the floor mat as it placed the resident at risk for injury during a fall incident. During an interview on 5/9/2025 at 12:15 p.m. with the DON, the DON stated there should be no equipment or furniture placed on top of the floor mats as it can affect the integrity of the floor mats. The DON stated floor mats are supposed to protect residents from injury in case of a fall. The DON stated the residents can hit the table in case of a fall and get injured. The DON stated Resident 107's overbed table should not have been placed on top of the floor as it placed the resident at risk for injury during a fall which may lead to hospitalization . During a review of the facility provided manufacturer's guideline for Floor Mat (FM) 1, undated, the manufacturer's guideline indicated: (continued on next page)

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	05/09/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- It is the caregiver's responsibility to ensure FM 1 is designed to be p [TRUNCATED]

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	05/09/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44376 Based on observation, interview, and record review, the facility failed to ensure the staff providing care and services to the resident who has a feeding tube (are soft plastic tubes through which liquid nutrition travels through the gastrointestinal tract [the series of organs that food and liquids pass through as they are digested, absorbed, and leave the body as feces]) are aware of, competent in, and utilize facility protocols regarding feeding tube nutrition and care for two of four sampled residents (Residents 53 and 107) reviewed for tube feeding by failing to ensure: 1. Resident 53's gastrostomy tube (g-tube, a feeding tube inserted through the abdomen into the stomach) Glucerna 1.2 (brand of formula feeding) was labeled with the time it was hung, and the water flush bag via pump had the time it was hung with its rate of infusion. 2. Resident 53's [NAME] valve (a three-way stopcock used with feeding tubes, specifically to protect healthcare workers from accidental exposure to gastric fluids and other bodily fluids, while also facilitating access to the enteral system without opening the lines) was not disconnected from the g-tube when not in use. 3. Resident 53's [NAME] valve was capped when disconnected and hung in the feeding pump pole. 4. Resident 107's water flush bag indicated in the label the administration rate and frequency for the water flush. These deficient practices had the potential to result in altered nutritional status that can lead to over or under hydration, and gastrointestinal (GI, relating to stomach and intestines) infection to the resident. Findings: 1. During a review of Resident 53's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility admitted the resident on 10/2/2023, with diagnoses of dysphagia (difficulty swallowing), severe protein-calorie malnutrition (a condition characterized by a severe deficiency in both protein and energy, leading to significant physical and mental impairments), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 53's History and Physical (H&P), dated 2/25/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 53's Minimum Data Set (MDS, a resident assessment tool), dated 3/19/2025, the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had severe cognitive impairments (significant difficulties with thinking, learning, remembering, and making decisions, to the point where daily life is greatly impacted). The MDS indicated the resident was on a feeding tube, mechanically altered diet (a special diet where food is modified to make it easier to chew and swallow), and therapeutic diet. (continued on next page)

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	05/09/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 53's Physician Order Sheet, the Physician Order Sheet indicated the following physician's orders: 10/2/2023 Flush tube every four hours. Notes: Flush g-tube with 100 cubic centimeters (cc, a unit of volume) water every (q) 4 hours via kangaroo pump (a simple-to-use, precision enteral [of or relating to or inside the intestines] feeding pump). 6/3/2024 Continuous g-tube feeding of three times daily. Notes: Glucerna 1.2 via kangaroo pump at 65 cc/hour (hr) times (X) 20 hours to infuse 1300 cc/1560 kilocalories (kcal, the amount of energy a food provides to the body) per 24 hours via kangaroo pump. On at 1 p.m., off at 9 a.m. or until total volume met. During a review of Resident 53's Care Plan (CP) titled Enhanced Barrier Precaution, dated 4/2/2025, the CP indicated an intervention of frequent and effective environmental cleaning. During a concurrent observation an interview on 5/6/2025, at 1:20 p.m., with Licensed Vocational Nurse (LVN) 3, inside Resident 53's room, observed Resident 53's water flush bag not labeled with the time it was hung and no rate of infusion, the feeding formula (Glucerna 1.2) was not labeled with the time it was hung, and the [NAME] valve was disconnected from the resident and was left with the feeding set hanging on the feeding pump pole without a cap. LVN 3 stated the water flush bag and the feeding formula should have been labeled with the time they were hung and the water flush bag should have been labeled with the rate of infusion, to ensure accurate administration of the formula and water for hydration. LVN 3 stated labeling the feeding formula and water flush bag with the required labels ensures the nutrition and hydration is delivered accurately to the resident and it also helps during shift changes to ensure the orders were carried over to the next shift. LVN 3 stated the [NAME] valve should not have been disconnected from the g-tube and left hanging without a cap to prevent gastrointestinal infection to Resident 53. During a concurrent interview and record review on 5/8/2025, at 9:51 a.m., with Registered Nurse (RN) 4, reviewed Resident 53's Diagnosis, Physician Order Sheet, and Care Plan. RN 4 stated there was an order for the g-tube feeding (Glucerna 1.2) and water flush on Resident 53. RN 4 stated the licensed staff should label the feeding formula bottle and the water flush bag with the name of the resident, the date and time they were hung, the name of the formula, the rate of infusion, and the initial of the licensed staff who hung the formula. RN 4 stated labeling the feeding formula and water flush bag with all the required information ensures the nutrition and hydration is administered accurately per physician's order and it helps the staff during shift change to verify the order accurately. During an interview on 5/9/2025, at 11:10 a.m., with the Director of Nursing (DON), the DON stated the licensed staff should have labeled the feeding formula bottle and the water flush bag of Resident 53 with the name, date and time of when the formula and the water flush bag was hanged, the name of the formula, the rate of infusion, and the initial of the staff who hung them. The DON stated labeling the feeding bottled and water flush bag with the required information ensures the nutrition and hydration of the resident is per physician's order and it helps staff transfer information to the next shift in an accurate manner to prevent errors of administration. The DON also stated it helps the staff determine if the formula is still good for administration or not. During a review of the facility's recent P&P titled Enteral Feedings- Safety Precautions, last reviewed on 1/16/2025, the P&P indicated to ensure the safe administration of enteral nutrition. (continued on next page)

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	05/09/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Preventing errors in administration 1. Check the enteral nutrition label against the order before administration. Check the following information: a. Resident name, ID, and room number; b. Type of formula; c. Date and time formula was prepared; d. Route of delivery; e. Access site; f. Method (pump, gravity, syringe); and g. Rate of administration (mL/hour). 2. On the formula label document initials, date and time the formula was hung/administered, and initial the label was checked against the order. During a review of the facility-provided Kangaroo Omni Feeding Set With Flush Bag and ENPlus Spike, copyright 2024, indicated due to the risk of bacterial contamination and overall system accuracy, do not use feeding sets for greater than 24 hours. 43988 2. During a review of Resident 107's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 3/23/2020 and readmitted in the facility on 7/26/2024, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarct (stroke, loss of blood flow to a part of the brain) affecting right dominant side, aphasia (a disorder that makes it difficult to speak), and gastrostomy status (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 107's H&P dated 7/29/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 107's MDS, dated [DATE], the MDS indicated Resident 107 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 107 required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 107 received GT feeding. During a review of Resident 107's Physician's Order Sheet, the Physician's Order Sheet indicated the following physician's orders: (continued on next page)

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	05/09/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 9/8/2024: Flush GT with 300 ml water every six (6) hours. - 10/17/2024: Continuous GT feeding of Glucerna 1.5 Cal at 60 milliliters per hour (ml/hr - a unit of measurement) for 20 hours to provide 1200 ml per 1800 calories (cal - a unit of measurement) per 24 hours via pump. Off at 9 a.m.; on at 1 p.m. During a review of Resident 107's care plan (CP) on GT feeding initiated on 7/26/2024, the CP indicated to flush tube per order as one of the interventions to prevent dehydration. During an observation on 5/6/2025 at 11:44 a.m., inside Resident 107's room, Resident 107's EF water flush bag hanging from the EF pole and the label did not indicate the administration rate and frequency of the water flush. During a concurrent observation and interview on 5/6/2025 at 12:15 p.m., inside Resident 107's room with Licensed Vocational Nurse (LVN) 7, LVN 7 stated the label on Resident 107's water flush bag did not indicate the administration rate and frequency of the water flush. LVN 7 stated when EF bags are changed by the night shift nurses, the water flush bag needs to be changed and indicate in the label the resident's name, room number, date and time started, administration rate, and frequency. LVN 7 stated Resident 107's water flush bag label should have indicated the administration rate and frequency of the water flush so the staff would be aware if Resident 107 was receiving the correct amount of water to prevent dehydration. During a concurrent interview and record review on 5/9/2025 at 11:48 a.m. reviewed a photograph of Resident 107's water flush bag label with the Director of Nursing (DON), the DON the water flush bag label did not indicate the administration rate and frequency for Resident 107's water flush. The DON stated EF bottles, water flush bags, and medication syringes are changed by the night shift nurses or as needed whenever the current bag finishes. The DON stated EF bottles and water flush bags should be labeled with the resident's name, room number, date and time started, administration rate, and frequency. The DON stated Resident 107's water flush bag label should have indicated the administration rate and frequency so the staff would be aware of the correct amount of water flush the resident needed. The DON stated if Resident 107 was not receiving the correct amount of water flushes, it placed the resident at risk for dehydration. During a review of the facility's recent policy and procedure (P&P) titled Enteral Feedings-Safety Precautions, last reviewed on 1/16/2025, the P&P indicated a purpose to ensure the safe administration of enteral nutrition. The P&P further indicated to prevent errors in administration: 1. Check the enteral nutrition label against the order before administration. Check the following information: a. Resident name, ID And room number b. Type of formula c. Date and time formula was prepared d. Route of delivery (continued on next page)

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	05/09/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Access site f. Method (pump, gravity, syringe); and g. Rate of administration (mL/hour).

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	05/09/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review, the facility failed to ensure each resident receives necessary respiratory care and services in accordance with professional standards of practice for four of four sampled residents (Resident 175, 61, 94, and 291) reviewed during Respiratory care area, by failing to: 1. Store the Bilevel Positive Airway Pressure (BiPAP-a non-invasive ventilation therapy that uses a machine to deliver two different levels of air pressure to the patient during breathing) mask free in a manner that is free from contamination for Resident 175. 2. Store the nebulizer (a medical device that converts liquid medication into a fine mist that can be inhaled through the lungs) in a clear plastic bag, labeled with the resident's name and the date it was last changed for Resident 175. 3. Ensure the BiPAP was administered and documented according to the physician's order for Resident 175. 4. Ensure the BiPAP was cleaned according to the manufacturer's instructions for Resident 175. These deficient practices had the potential to promote growth and spread of bacteria on the respiratory tubing causing illness and causing the residents to experience respiratory problems and distress, such as shortness of breath and chest congestion to Resident 175. 5. Ensure the oxygen tubing via nasal cannulas (a simple, two-pronged device that delivers extra oxygen to the nose) and the nebulizer (a small machine that turns liquid medicine into a mist that can be easily inhaled) masks and tubing were dated with the date it was last changed for Residents 61, 94, and 291. The deficient practice had potential for residents to develop complications such as shortness of breath and desaturation (low levels of oxygen in the blood) and respiratory infections. Findings: 1. During a review of Resident 175's Admission Record, the Admission Record indicated the facility admitted the resident on 4/14/2025 with diagnoses including acute respiratory failure (a condition where the respiratory system can't effectively exchange oxygen and carbon dioxide, leading to a buildup of carbon dioxide and a deficiency of oxygen in the blood), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 175's History and Physical (H&P), dated 4/14/2025, the H&P indicated the resident has the capacity to understand and make decisions. (continued on next page)

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	05/09/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 175's Physician Order, dated 4/14/2025, the Physician Order indicated BiPAP, apply at hours of sleep (HS), remove in AM (morning). During a review of Resident 175's Minimum Data Set (MDS-a resident assessment tool), dated 4/25/2025, the MDS indicated the resident had clear speech, adequate vision and hearing. The MDS indicated that the resident makes self-understood and had the ability to understand others. During a review of Resident 175's Respiratory Distress Care Plan, dated 4/14/2025, the Respiratory Distress Care Plan indicated the resident with goals of no signs and symptoms of respiratory distress with interventions including BiPAP at night. During a concurrent observation and interview on 5/6/2025 at 9:25 a.m. with Resident 175, while at Resident 175's bedside, the BiPAP mask was hanging on the side of the resident's wheelchair's brake handle. Resident 175 stated no one had come to turn off his BiPAP machine so he placed it on the side of his wheelchair. Resident 175 stated he does not touch his BiPAP machine. Resident 175 stated one of the nurses comes and turns it on and off and at night they place it on him. Resident 175 stated he only wears the BiPAP at night. It helps him breathe while he sleeps. Resident 175 stated Certified Nursing Assistant (CNA) 12, his assigned CNA, knows all about his BiPAP. Resident 175 stated no one had cleaned his BiPAP machine. The nurse would come in and remove his mask and turn it off and at night they put it on. During a concurrent observation and interview on 5/6/2025 at 9:31 a.m. with CNA 12, while at Resident 175's bedside, CNA 12 stated she does not touch the BiPAP machine, but she will move the BiPAP mask from the wheelchair to the table because she is going to transfer Resident 175 from bed to wheelchair to get him ready for activities in the activity room. During a concurrent observation and interview on 5/6/2025 at 9:40 a.m. with Registered Nurse (RN) 1, while at Resident 175's bedside, RN 1 stated the BiPAP mask is still on and blowing air. RN 1 stated the charge nurse removes the mask in the morning and turns off the machine. RN 1 stated it should have been turned off. RN 1 stated they do not clean the BiPAP mask and machine. RN 1 stated the BiPAP mask and nebulizer was placed on the same clear plastic bag with no label of the resident's name and date of when it will be changed. RN 1 stated there should be the resident's name and date on the plastic bag, so they know who it belongs to, and it's the correct resident and to know when the nebulizer tubing and bag need to be changed. RN 1 stated this is for infection control. During a concurrent observation and interview on 5/8/2025 3:36 p.m. with Licensed Vocational Nurse (LVN) 4 and LVN 5, while at the nursing station, LVN 4 stated she uses the alcohol sanitizer wipes to sanitize the BiPAP mask. LVN 5 stated she works during the evening shift and places the BiPAP mask on Resident 175. LVN 5 stated she washes the BiPAP mask using an antibacterial soap and water every night at 8 p.m. and puts it on the resident at 9 p.m. During a concurrent interview and record review on 5/8/2025 at 3:40 p.m. with LVN 4, Resident 175's care plans were reviewed. LVN 4 stated the respiratory care plan does not mention how often the BiPAP machine is to be cleaned and the duration of BiPAP treatment. LVN 4 stated the respiratory care plan only indicated BiPAP at night, it is not specific. LVN 4 stated it should be indicated in the care plan, including the cleaning and duration of therapy. LVN 4 stated the resident could potentially be at risk for infection because the air could be dirty. (continued on next page)

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	05/09/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/8/2025 at 4:26 p.m. with LVN 5, Resident 175's nursing progress notes and treatment administration record from 4/2025 to 5/2025 were reviewed. LVN 5 stated she did not document when she cleaned the BiPAP mask for Resident 175. LVN 5 stated she documented on 4/20/2025 and 5/2/2025 when she administered it, and no other notes were documented when it was last cleaned. LVN 5 stated if it is not documented it was not done. LVN 5 stated she does not document when she cleaned the BiPAP mask. LVN 5 stated the standard of practice is to document the care and treatment provided to the residents. During an interview on 5/9/2025 at 12:46 p.m. with the Director of Nursing (DON), the DON stated the order for BiPAP would include the setting, the time the BiPAP should be on and off, and the reason or diagnosis for the use of BiPAP. The DON stated on the administration record it should be documented 9am off and 9pm on. The DON stated BiPAP is a treatment provided for residents with sleep apnea (a sleep disorder characterized by repeated episodes of breathing cessation (apnea) or shallow breathing during sleep). The DON stated with the care and maintenance of the BiPAP machine in addition to their facility's policy they also follow the manufacturer's guidelines. The DON stated licensed nurses, RN or LVN, should have included the cleaning and care of the BiPAP in the care plan and follow the physician order when providing BiPAP treatment. The DON stated the plastic bag container to store the nebulizer should have a label of the resident's name and date. The DON stated when the BiPAP mask and machine is not cleaned, and the nebulizer stored in a bag with no label of resident's name and date could cause bacterial accumulation and potentially cause infection to Resident 175. The DON stated on the administration record the morning shift 7 a.m. to 3 p.m. would initial when they turned off the machine and the night shift, 11 p.m. to 7 a.m. would initial when they turned on the machine and when they cleaned it. The DON stated this is done to ensure the resident is getting the therapeutic oxygenation and it is being administered as ordered. The DON stated when this is not done the resident could potentially develop respiratory distress such as shortness of breath and chest congestion. During a review of the facility's policy and procedure (P&P) titled, Administering Medications through a Small Volume (Handheld) Nebulizer, reviewed and approved date 1/16/2025, the P&P indicated the purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. The P&P indicated when equipment is completely dry, to store in a plastic bag with the resident's name and date on it. The P&P indicated to change equipment and tubing every seven days, or according to facility protocol. During a review of the facility's P&P titled, Charting and Documentation, reviewed and approved date 1/16/2025, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's 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. The P&P indicated the following information is to be documented in the resident medical record including objective observations and treatments or services performed. The P&P indicated Documentation of procedures and treatments will include care-specific details including: a. The date and times the procedure/treatment was provided. b. The name and title of the individual(s) who provided the care. c. The assessment data and/or any unusual findings obtained during the procedure/treatment. (continued on next page)

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	05/09/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. How the residents tolerated the procedure/treatment. e. Whether the resident refused the procedure/treatment. f. Notification of family, physician or other staff, if indicated; and g. The signature and title of the individual documenting. During a review of the undated Manufacturer's User Guide for BiPAP Machine 1 the Manufacturer's User Guide for BiPAP Machine 1 indicated the device is to be cleaned weekly and included: 1. Wash the humidifier and air tubing in warm water using mild detergent. 2. Rinse the humidifier and air tubing thoroughly and allow to dry out of direct sunlight and/or heat. 3. Wipe the exterior of the device with a dry cloth. The Manufacturer's User Guide indicated to empty the humidifier daily and wipe it thoroughly with a clean, disposable cloth and allow to dry out of direct sunlight and/or heat. During a review of the facility's P&P titled, CPAP/BiPAP Support, reviewed and approved date 1/16/2025, the P&P indicated the purpose of this policy is to provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen, improve arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease, and to promote resident comfort and safety. The P&P indicated in preparation to review and follow manufacturer's instructions for CPAP machine setup and oxygen delivery. The P&P indicated side effects associated with CPAP may include claustrophobia, sleep disturbances, discomfort upon exhaling, headaches, dry mouth, sore throat, nosebleeds, and/or gastrointestinal distension. The P&P indicated the general guidelines for cleaning: 1. These are general guidelines for cleaning. Specific cleaning instructions are obtained from the manufacturer/supplier of the PAP device . 4. Machine cleaning: Wipe machine with warm, soapy water and rinse at least once a week and as needed. 5. Humidifier (if used): a. Use clean, distilled water only in the humidifier chamber. b. Clean humidifier weekly and air dry. c. To disinfect, place vinegar-water solution (1:3) in clean humidifier. Soak for 30 minutes and rinse thoroughly. 6. Filter cleaning: (continued on next page)

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	05/09/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Rinse washable filter under running water once a week to remove dust and debris. Replace this filter at least once a year. b. Replace disposable filters monthly. 7. Masks, nasal pillows and tubing: Clean daily by placing in warm, soapy water and soaking/agitating for five minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between uses. 8. Headgear (strap): Wash with warm water and mild detergent as needed. Allow to air dry. The P&P indicated documentation includes to document the time CPAP was started and duration of the therapy, and how the resident tolerated the procedure. 44376 2. During a review of Resident 61's Face Sheet, the Face Sheet indicated the facility admitted the resident on 12/13/2024, with diagnoses including acute respiratory failure (an inability to maintain adequate oxygenation for tissues or adequate removal of carbon dioxide from tissues) with hypoxia (low levels of oxygen in your body tissues), diseases of the bronchus (a large airway that leads from the trachea [windpipe] to a lung), and dependence on supplemental oxygen (extra oxygen given to people who cannot get enough oxygen on their own through breathing). During a review of Resident 61's History and Physical (H&P), dated 12/17/2024, the H&P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 61's Care Plan (CP) titled Respiratory System, dated 12/20/2024, the CP indicated an intervention to observe appropriate infection control precautions as indicated. During a review of Resident 61's Physician Order Sheet, the Physician Order Sheet indicated an order for: 12/14/2024 Ipratropium 0.5 milligram (mg, a unit of weight)-albuterol 3 mg (2.5 mg base)/3ml nebulization (the process of turning liquid medicine into a fine mist or spray so it can be inhaled) solution (3 milliliters [ml, a unit of volume]) for acute respiratory failure with hypoxia four times daily. Notes: Administer for 15 minutes. 12/13/2024 Oxygen (O2) at 3 liters per minute (L/min, the rate at which oxygen is delivered to a person, measured in liters of oxygen flowing per minute) per nasal cannula three times daily. Notes: Monitor oxygen saturation (O2 sat., a measurement of how much oxygen is in the blood) Notify MD if below 90%. During a review of Resident 61's Minimum Data Set (MDS, a resident assessment tool), dated 4/18/2025, the MDS indicated the resident usually had the ability to make self-understood and had the ability to understand others and had severe cognitive impairment (significant difficulties with thinking, learning, remembering, and making decisions, to the point where daily life is greatly impacted). The MDS indicated the resident was on oxygen therapy (a treatment that provides extra oxygen to breathe in). (continued on next page)

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	05/09/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/6/2025, at 9:55 a.m., with the Infection Preventionist (IP), while inside Resident 61's room, the oxygen was observed infusing via a nasal cannula without a date on the tubing of the date it was last changed. A nebulizer mask and tubing were observed inside a plastic transparent bag dated 4/7/2025. The IP stated the staff should have labeled the oxygen via nasal cannula on the tubing with the date it was last replaced and the nebulizer mask and tubing inside the plastic transparent bag dated 4/7/2025 should have been discarded to prevent Resident 61 from getting a respiratory infection. The IP stated they replaced the respiratory tubing every week and it should be dated with the date it was last changed to ensure they are not using respiratory tubing for more than the allowable time to prevent respiratory infections on residents. During an interview and record review on 5/8/2025, at 7:54 a.m., with Registered Nurse (RN) 4, Resident 61's Medical Diagnosis, Physician Order Sheet, Medication Administration Record (MAR), and Care Plan were reviewed. RN 4 stated there was an order for oxygen administration and a medication for nebulization. RN 4 stated the oxygen tubing via nasal cannula and the nebulizer mask with tubing should be labeled with the date it was last changed to prevent using the tubing for more than the allowable time to prevent the residents from getting respiratory infections. RN 4 stated oxygen tubing, and the nebulizer mask should be changed every three (3) days. During an interview on 5/9/2025, at 11:10 a.m., with the Director of Nursing (DON), the DON stated that licensed staff receiving orders for oxygen administration and treatment should label the tubing with the date it was started, and the respiratory tubing should be changed every Sunday. The DON stated respiratory tubing should be dated with the date it was last changed to ensure the respiratory tubing was not used for more than the allowable time to prevent Resident 61 from getting a respiratory infection. During a review of the facility's recent policy and procedure (P&P) titled Infection Control Guidelines for All Nursing Procedures, last reviewed on 1/16/2025, the P&P indicated to provide guidelines for general infection control while caring for residents. Prior to having direct care responsibilities for residents, staff must have appropriate in-service training on managing infections in residents, including: a. Types of Healthcare-Associated Infections. b. Methods of preventing their spread. c. How to recognize and report signs and symptoms of infection; and d. Prevention of the transmission of multi-drug-resistant organisms. During a review of the facility's recent P&P titled Policy and Procedures for Oxygen Therapy, last reviewed on 1/16/2025, the P&P indicated 5. Disposable supplies (nasal cannulas, masks, tubing, etc.) A. Rate of Change: 1. Disposable supplies must be changed every 5 to 10 days or sooner if they appear unsanitary. B. Cleanliness: (continued on next page)

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	05/09/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. When the patient is not using their cannula or mask, it should be wrapped neatly around the cylinder or placed in a plastic bag. 2. It should not make contact with the floor. 3. During a review of Resident 94's Face Sheet, the Face Sheet indicated the facility admitted the resident on 12/6/2024- yes verified with attached package, with diagnoses including acute respiratory failure with hypoxia, pneumonia (an infection/inflammation in the lungs), and pulmonary hypertension (a condition that affects the blood vessels in the lungs). During a review of Resident 94's Physician Order Sheet, dated 12/6/2024, the Physician Order Sheet indicated to infuse oxygen (O2) at 2 L/min per nasal cannula three times daily. Notes: SOB - Notify MD if oxygen is less than (<)90%. The Physician Order Sheet did not indicate any medications requiring nebulization. During a review of Resident 94's H&P, dated 12/7/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 94's CP titled Respiratory System, dated 12/17/2024, the CP indicated an intervention observe appropriate infection control precautions as indicated. During a review of Resident 94's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities are functioning well and that there is no significant impairment in areas like thinking, reasoning, memory, and problem-solving). The MDS indicated the resident was on oxygen therapy. During a concurrent observation and interview on 5/6/2025, at 1:20 p.m., with LVN 3, while inside Resident 94's room, Resident 94's oxygen was observed infusing via a nasal cannula. The nebulizer mask and tubing were without a label indicating the date it was last changed. LVN 3 stated the licensed staff should have labeled the respiratory tubing of Resident 94 with the date it was last changed to ensure the tubing is not used for a longer period of time to prevent respiratory infections. During an interview and record review on 5/8/2025, at 9:23 a.m., with RN 4, Resident 94's Medical Diagnosis, Physician Order Sheet, MAR, and Care Plan were reviewed. RN 4 stated there was an order for oxygen administration however, there was no order for any medications requiring nebulization on the resident's medical chart. RN 4 stated the oxygen tubing via nasal cannula and the nebulizer mask with tubing should be labeled with the date it was last changed to prevent using the tubing for more than the allowable time to prevent residents from sustaining respiratory infections. RN 4 stated oxygen tubing, and the nebulizer mask should be changed every three (3) days. During an interview on 5/9/2025, at 11:10 a.m., with the DON, the DON stated licensed staff receiving orders for oxygen administration and treatment should label the tubing with the date it was started, and the respiratory tubing will be changed every Sunday. The DON stated respiratory tubing should be dated with the date it was last changed to ensure the respiratory tubing was not used for more than the allowable time to prevent Resident 94 from sustaining respiratory infections. (continued on next page)

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	05/09/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled Infection Control Guidelines for All Nursing Procedures, last reviewed on 1/16/2025, the P&P indicated to provide guidelines for general infection control while caring for residents. Prior to having direct care responsibilities for residents, staff must have appropriate in-service training on managing infections in residents, including: a. Types of Healthcare-Associated Infections. b. Methods of preventing their spread. c. How to recognize and report signs and symptoms of infection; and d. Prevention of the transmission of multi-drug-resistant organisms. During a review of the facility's recent P&P titled Policy and Procedures for Oxygen Therapy, last reviewed on 1/16/2025, the P&P indicated 5. Disposable supplies (nasal cannulas, masks, tubing, etc.) A. Rate of Change: 1. Disposable supplies must be changed every 5 to 10 days or sooner if they appear unsanitary. B. Cleanliness: 1. When the patient is not using their cannula or mask, it should be wrapped neatly around the cylinder or placed in a plastic bag. 2. It should not make contact with the floor. 4. During a review of Resident 291's Face Sheet, the Face Sheet indicated the facility admitted the resident on 5/1/2025, with diagnoses including pneumonia, chronic respiratory failure, and chronic obstructive pulmonary disease (COPD, a common lung disease causing restricted airflow and breathing problems). During a review of Resident 291's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. During a review of Resident 291's Physician Order Sheet, dated 5/1/2025, the Physician Order Sheet indicated an order for oxygen (O2) at 2 L/min per nasal cannula three times daily. The Physician Order Sheet did not indicate a medication needing nebulization. During a review of Resident 291's H&P, dated 5/2/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a concurrent observation and interview on 5/6/2025, at 1:20 p.m., with LVN 3, while inside Resident 291's room, Resident 291's oxygen was observed infusing via nasal cannula. The nebulizer tubing and mask were not labeled with the date it was last changed. LVN 3 stated the licensed staff should have labeled the respiratory tubing of Resident 291 with the date it was last changed to ensure the tubing is not used for a longer period of time to prevent respiratory infections. (continued on next page)

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	05/09/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 5/8/2025, at 10:13 a.m., with RN 4, Resident 291's Medical Diagnosis, Physician Order Sheet, MAR, and Care Plan were reviewed. RN 4 stated there was an order for oxygen administration however, there was no order for any medications requiring nebulization on the residents medical chart. RN 4 stated the oxygen tubing via nasal cannula and the nebulizer mask with tubing should be labeled with the date it was last changed to prevent using the tubing for more than the allowable time to prevent the residents from sustaining respiratory infections. RN 4 stated oxygen tubing, and the nebulizer mask should be changed every three (3) days. During an interview on 5/9/2025, at 11:10 a.m., with the DON, the DON stated licensed staff receiving orders for oxygen administration and treatment should label the tubing with the date it was started, and the respiratory tubing will be changed every Sunday. The DON stated respiratory tubing should be dated with the date it was last changed to ensure the respiratory tubing was not used for more than allowable time to prevent respiratory infections on Resident 291. During a review of the facility's recent P&P titled Infection Control Guidelines for All Nursing Procedures, last reviewed on 1/16/2025, the P&P indicated to provide guidelines for general infection control while caring for residents. Prior to having direct care responsibilities for residents, staff must have appropriate in-service training on managing infections in residents, including: a. Types of Healthcare-Associated Infections. b. Methods of preventing their spread. c. How to recognize and report signs and symptoms of infection; and d. Prevention of the transmission of multi-drug-resistant organisms. During a review of the facility's recent P&P titled Policy and Procedures for Oxygen Therapy, last reviewed on 1/16/2025, the P&P indicated 5. Disposable supplies (nasal cannulas, masks, tubing, etc.) A. Rate of Change: 1. Disposable supplies must be changed every 5 to 10 days or sooner if they appear unsanitary. B. Cleanliness: 1. When the patient is not using their cannula or mask, it should be wrapped neatly around the cylinder or placed in a plastic bag. 2. It should not make contact with the floor.

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	05/09/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42311 Based on interview and record review, the facility failed to ensure staff competency (a combination of knowledge, skills, abilities, and behaviors that enable an individual to perform a task or role successfully) were performed annually (yearly) for one of six sampled staff (Certified Nursing Assistant [CNA] 1). This failure had the potential to affect the care necessary to provide nursing care and related services to meet resident needs safely. Findings: During a concurrent interview and record review, on 5/8/2025, at 7:58 a.m., with the Director of Staff Development (DSD), CNA 1's employee file was reviewed. CNA1's employee file indicated CNA 1 was employed by the facility on 11/8/2022. CNA 1's last skills competency was dated 1/2024. The DSD stated the next skills competency for CNA 1 will be on 11/2025 which is the month CNA 1 was hired. During an interview on 5/8/2025, at 8:10 a.m., with the DSD, the DSD stated she (DSD) was assigned to evaluate CNAs for skills competencies. The DSD stated CNA's skills and knowledge competencies were evaluated annually and as needed. During a concurrent interview and record review, on 5/9/2025, at 11:10 a.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Performance Evaluations, dated 9/2020 and last reviewed on 1/16/2025, the P&P indicated, The job performance of each employee shall be reviewed and evaluated at least annually. Performance evaluations may be used in determining employee promotions, shift or position transfers, demotions, terminations, wage increase, and to improve the quality of the employee's work performance. The written performance evaluations will contain the directors and or supervisors' remarks and suggestions, any action that should be taken (example given further training) and goals. The DON stated skills competency are done annually. The DON stated the importance of skills competency was to ensure nurses are updated, skilled and knowledgeable of their nursing skills, and to know nurse's competency level. The DON stated CNA 1 should have had a skills competency on 1/2025 a year after the last skills competency. The DON stated the annual skills competency was already late for CNA 1. The DON stated the DSD failed to perform a skills competency check annually. The DON stated the facility does not have a specific policy for skills competency, but the facility follows the policy for Performance Evaluation since skills competency was part of the performance evaluation. During a review of facility's P&P titled, Staffing, Sufficient and Competent Nursing, dated 8/2022 and last reviewed on 1/16/2025, the P&P indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessments. Licensed nurses and certified nursing assistants are available 24 hours a day, seven days a week to provide competent resident care service including: a. assuring resident safety. (continued on next page)

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	05/09/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. attaining or maintaining the highest practicable physician mental, and psychosocial well-being of each resident. c. assessing, evaluating, planning and implementing resident care plans and. d. responding to resident needs.

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	05/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for eight of 24 sampled residents (Residents 3, 62, 291, 95, 130, 440, 19, and 96) by: 1. Failing to ensure medication was administered as per physician order. Licensed Vocational Nurse (LVN) 1 administered 100 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount) of docusate sodium (medication used to treat constipation [bowel movements are infrequent, and the stool is hard and difficult to pass]) to Resident 3 and the physician order was 250 mg. 2. Failing to ensure expired medication was not administered. LVN 2 administered expired docusate, dated 4/2025, to Resident 62 on 5/6/2025. 3. Failing to ensure medication was given one hour before or one hour after the scheduled time. LVN 2 administered eight morning medications, scheduled for administration at 9 a.m., at 10:38 a.m. to Resident 62. 4. Failing to ensure medication was given one hour before or one hour of the scheduled time. LVN 3 administered metformin (medication used to treat diabetes [DM- a disorder characterized by difficulty in blood sugar control and poor wound healing]) at 9:18 a.m., and the order indicated to administer at 7 a.m. to Resident 291. 5. Failing to ensure the Discarded Medication Log was completed. 19 discarded medications documented in the Discarded Medication Log were not dated, signed and witnessed for Residents 95, 130 and 440. 6. Failing to ensure medication was discarded after medication was completed on 4/18/2025. Two meropenem (medication used to treat infection) vials were kept in intravenous (IV - within the vein) cart for Resident 19. 7. Failing to ensure medications were administered one hour before or one hour after the scheduled time for Resident 96. These failures had the potential to result in adverse reactions (unwanted, uncomfortable, or dangerous effects that a drug may have) from the late administration of medication including hypertension (HTN - high blood pressure), hypotension (low blood pressure), and sedation in residents, and possible drug diversion (misuse of prescription medications intended for therapeutic purposes). Findings: (continued on next page)

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	05/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. During a review of Resident 3's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted Resident 3 on 9/19/2018, with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), history of falling and fibromyalgia (chronic condition that causes widespread pain, fatigue, and other symptoms like sleep disturbances). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 3/4/2025, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a review of Resident 3'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), dated 9/12/2024, the H&P indicated Resident 3 had decision making capacity. During a review of Resident 3's Physician Order Sheet, dated 10/1/2018, the Physician Order Sheet indicated docusate sodium 250 mg one capsule two times a day for constipation. During an observation, on 5/6/2025, at 8:15 a.m., outside of Resident 3's room, LVN 1 administered one tablet of stool softener (medication used to treat constipation) 100 mg tablet to Resident 3 on 5/6/2025, at 8:27 a.m. During a concurrent interview and record review, on 5/7/2025, at 9:22 a.m., with Registered Nurse (RN) 2, Resident 3's Physician Order Sheet, dated 10/1/2018, was reviewed. RN 2 stated Resident 3's Physician Order indicated docusate sodium 250 mg twice a day. RN 2 stated LVN 1 should have administered 250 mg as per physician order and not 100 mg. RN 2 stated giving medication less than the physician order will not be as effective. RN 2 stated LVN 1 did not follow the physician order. During an interview, on 5/7/2025, at 9:51 a.m., with the Director of Staff Development (DSD), the DSD stated LVN 1 should compare the physician order with the medication label. The DSD stated LVN 1 did not follow the physician order. The DSD stated medication will be less effective to treat Resident 3's constipation. During a concurrent interview and record review, on 5/9/2025, at 11:10 am., with the Director of Nursing (DON), facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019 and last reviewed on 1/16/2025, the P&P indicated, Medications are administered in accordance with prescriber's orders, including any required time frame. The DON stated LVN 1 should have followed the physician order to administer docusate sodium 250 mg to Resident 3. The DON stated LVN 1 gave 100 mg of docusate sodium which is less than the physician order. The DON stated 100 mg will not be effective in treating Resident 3's constipation. The DON stated Resident 3's constipation could prolong and cause discomfort. b. During a review of Resident 62's Face Sheet, the Face Sheet indicated the facility admitted Resident 62 on 3/16/2025, with diagnoses that included unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities), constipation, and essential HTN. During a review of Resident 62's MDS, dated [DATE], the MDS indicated Resident 62's cognitive skills for daily decisions were severely impaired. (continued on next page)

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	05/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 62's H&P, dated 3/17/2025, the H&P indicated Resident 62 can make needs known but cannot make medical decisions. During a review of Resident 62's Physician Order Sheet, dated 3/16/2025, the Physician Order indicated docusate sodium 250 mg, one capsule by mouth daily for bowel management. During a concurrent observation and interview, on 5/6/2025, at 10:26 a.m., with LVN 2, outside of Resident 62's door, LVN 2 obtained one capsule of docusate sodium 250 mg from the docusate sodium bottle with an expiration date of 4/2025. LVN 2 notified Resident 62 that he (LVN2) would start Resident 62's medication administration with the docusate sodium. The Surveyor informed LVN 2 to start with the other scheduled medications and docusate sodium last. Observed Resident 62 started taking her (Resident 62)'s medication at 10:43 a.m. When LVN 2 was about to administer Resident 62's docusate sodium, Surveyor caught the attention of LVN 2 and showed the docusate bottle expiration date. LVN 2 stated docusate sodium 250 mg should not be given to Resident 62 because it was an expired medication. LVN 2 stated he (LVN2) did not look and did not notice the expiration date. During an interview, on 5/6/2025, at 10:51 a.m., with the Infection Preventionist (IP), the IP stated expired medication should not be given to Resident 62 for safety issues. The IP stated LVN 2 should have checked the docusate sodium expiration date before medication administration. During an interview, on 5/7/2025, at 9:51 a.m., with the DSD, the DSD stated nurses should check the expiration date all the time before medication administration. The DSD stated giving expired medication will not be as effective to treat Resident 62's constipation and could result in adverse effects. During an interview, on 5/7/2025, at 1:30 p.m., with LVN 2, LVN 2 stated he (LVN 2) did not read the expiration date of docusate sodium. LVN 2 stated he (LVN 2) should have read the medication label including the expiration date. LVN 2 stated Resident 62 could experience adverse effects from receiving expired medication. During an interview, on 5/7/2025, at 4:16 p.m., with the DON, the DON stated LVN 2 should have checked the medication expiration before medication administration to any resident. The DON stated LVN 2 failed to follow their policy for medication administration. The DON stated the facility failed to ensure proper training was provided to LVN 2 for medication administration. During a concurrent interview and record review, on 5/9/2025, at 11:10 a.m. with the DON, the facility's P&P titled, Administering Medications, dated 4/2019, and last reviewed on 1/16/2025, the P&P indicated, The expiration/beyond use date on the medication label is checked prior to administering. The DON stated Resident 62 can experience side effects or adverse reaction from taking expired medications. c. During a record review of Resident 62's Physician Order Sheet, dated 3/16/2025, the Physician Order indicated the following orders: 1. Amlodipine (medication used to treat HTN) 10 mg tablet daily by mouth on AM (morning) medication pass. (continued on next page)

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 05/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Metoprolol (medication used to treat HTN) 25 mg tablet twice a day by mouth on AM and Dinner Med pass. 3. Sertraline (medication used to treat mood disorders) 25 mg tablet daily by mouth for depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities previously enjoyed) on AM medication pass. 4. Vitamin C (supplement essential for various bodily functions) 250 mg tablet, two tablets daily by mouth on AM medication pass. 5. Multivitamin (supplement with vitamins and minerals to support daily nutritional needs) daily by mouth on AM medication pass. 6. Docusate sodium 250 mg capsule daily by mouth on AM medication pass. 7. Vitamin D (supplement that helps build bones and keep them healthy) 25 mcg tablet, two tablets daily by mouth on AM medication pass. 8. Miralax (medication used to treat constipation) powder 17 grams by mouth on AM medication pass. During an observation, on 5/6/2025, at 10:26 a.m., outside of Resident 62's room, LVN 2 administered the following eight medications on 5/6/2025, at 10:43 a.m.: 1. Amlodipine 10 mg tablet daily. 2. Metoprolol 25 mg tablet twice a day. 3. Sertraline 25 mg tablet daily for depression. 4. Vitamin C 250 mg tablet, two tablets daily. 5. Multivitamin daily. 6. Docusate sodium 250 mg capsule daily. 7. Vitamin D 25 mcg tablet, two tablets daily. 8. Miralax powder 17 grams daily. During an interview, on 5/7/2025, at 9:22 a.m., with RN 2, RN 2 stated AM medication pass is scheduled at 9 a.m. RN 2 stated 10:43 a.m. is already more than 1 hour and 30 minutes late than the scheduled time. RN 2 stated medications administration should be one hour before or one hour after the scheduled time. RN 2 stated metoprolol was scheduled twice a day and if given late, metoprolol will too close to the next scheduled time and can result to bradycardia (low heart rate) and hypotension. During an interview, on 5/7/2025, at 9:51 a.m., with the DSD, the DSD stated the AM medication pass should have been administered between 8 a.m. to 10 a.m. The DSD stated metoprolol was ordered twice a day and if given late can cause HTN. (continued on next page)

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	05/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 5/9/2025, at 11:10 a.m., with the DON, (medication used to treat constipation) the facility's P&P titled, Administering Medications, dated 4/2019 and last reviewed on 1/16/2025, was reviewed and the P&P indicated, Medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The DON stated LVN 2 failed to administer medications on time. The DON stated the facility's policy was to administer medication within one hour of schedule time. The DON stated LVN 2 should have administered Resident 62's AM medications between 8 a.m. to 10 a.m. The DON stated Resident 62 can have hypotension if metoprolol was given too close to the next scheduled time. d. During a review of Resident 291's Face Sheet, the Face Sheet indicated the facility admitted Resident 291 on 5/1/2025, with diagnoses including pneumonia (an infection/inflammation in the lungs), urinary tract infection (UTI - an infection in the bladder/urinary tract) and DM. During a review of Resident 291's MDS, dated [DATE], the MDS indicated Resident 291's cognitive skills for daily decision was intact. During a review of Resident 291's H&P, dated 5/2/2025, the H&P indicated Resident 291 had capacity to understand and make decisions. During a review of Resident 291's Physician Order Sheet, dated 5/1/2025, the Physician Order indicated metformin 500 mg tablet, one tablet by mouth give with breakfast and dinner at 7 a.m. and 5 p.m. During a concurrent observation and interview, on 5/6/2025, at 8:50 a.m., outside of Resident 291's room, LVN 3 administered crushed metformin mixed with apple sauce to Resident 291 at 9:18 a.m. During a concurrent interview and record review, on 5/7/2025, at 9:22 a.m., with RN 2, Resident 291's Physician Order Sheet, dated 5/1/2025, was reviewed. RN 2 stated metformin was scheduled at 7 a.m. and 5 p.m. RN 2 stated if metformin was given late at 9:18 a.m., LVN 3 should have documented reason of late medication administration in the Nurses Notes. RN 2 stated there were no documented Nurses Notes on 5/6/2025, for late administration of medication. During an interview on 5/7/2025, at 9:51 a.m., with the DSD, the DSD stated LVN 3 failed to administer metformin on scheduled time. The DSD stated it was late medication administration. The DSD stated Resident 291 could have hyperglycemia (high blood sugar). The DSD stated LVN 3 should have followed the physician order and document in Nurses Notes reason for late administration. During a concurrent interview and record review, on 5/9/2025, at 11:10 a.m., with the DON, the facility's P&P titled, Administering Medications, dated 4/2019 and last reviewed on 1/16/2025, the P&P indicated, Medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The DON stated Resident 291 medication absorption and distribution will be affected and could cause high blood sugar due to late medication administration. e. During a review of Resident 95's Face Sheet, the Face Sheet indicated the facility admitted Resident 95 on 3/20/2025, with diagnoses that included aftercare following joint replacement, muscle weakness and DM. (continued on next page)

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	05/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 95's H&P, dated 4/8/2025, the H&P indicated Resident 95 had the capacity to understand and make decisions. During a review of Resident 95's MDS, dated [DATE], the MDS indicated Resident 95's cognitive skills for daily decisions were moderately impaired. During a record review of Resident 95's Physician Order, dated 4/8/2025, the Physician Order indicated Resident 95 was transferred to General Acute Care Hospital (GACH) 1 on 4/8/2025. During a review of Resident 130's Face Sheet, the Face Sheet indicated the facility admitted Resident 130 on 4/16/2025, with diagnoses that included unspecified anemia (a condition where the body does not have enough healthy red blood cells), muscle weakness and DM. During a review of Resident 130's H&P, dated 4/18/2025, the H&P indicated Resident 130 can make needs known but cannot make medical decisions. During a record review of Resident 130's Physician Order, dated 5/5/2025, the Physician Order indicated Resident 130 was transferred to GACH 3 on 5/5/2025. During a review of Resident 440's Face Sheet, the Face Sheet indicated the facility admitted Resident 440 on 4/3/2025, with diagnoses that included UTI, difficulty in walking and muscle weakness. During a review of Resident 440's H&P, dated 4/11/2025, the H&P indicated Resident 440 did not have the capacity to understand and make decisions. During a review of Resident 440's MDS, dated [DATE], the MDS indicated Resident 440's cognitive skills for daily decisions were moderately impaired. During a record review of Resident 440's Physician Order, dated 4/11/2025, the Physician Order indicated Resident 440 was transferred to GACH 2 on 4/11/2025. During a concurrent interview and record review, on 5/6/2025, at 7:48 a.m., with RN 5, the facility's Discarded Medication Log was reviewed. RN 5 stated nurses should date, sign, and witness discarded medication. RN 5 stated the Discarded Medication Log was not complete. RN 5 stated there were 19 medications for three residents (Resident 95, 130 and 440) that were not dated, signed, and witnessed in the Discarded Medication Log including the following: A. Resident 95 1. Benztropine Mesylate (medication used to treat Parkinsons [a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements]) 0.5mg - five tablets remaining 2. Thiothixene (medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought]) 10 mg- five tablets remaining 3. Buspirone (medication used to treat anxiety [a feeling of fear, dread, and uneasiness]) 5mg tablet - five tablets remaining (continued on next page)

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	05/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Metoprolol succinate - six tablets remaining 5. Lisinopril (medication used to treat HTN) 5mg tablet - six tablets remaining B. Resident 130 1. Tamsulosin (medication used to treat enlarged prostate) 0.4 mg capsule - 31 capsules remaining 2. Montelukast sodium (medication used to prevent difficulty breathing) 10mg - 27 tablets remaining 3. Dabigatran Etexilate (a medication used to prevent blood clots) - 31 tablets remaining 4. Dabigatran - 19 tablets remaining 5. Unknown medication - 16 tablets remaining C. Resident 440 1. Xarelto (medication used to treat blood clots) 20 mg tablet - seven tablets remaining 2. Atorvastatin (medication used to lower cholesterol) 10 mg tablet - nine tablets remaining 3. Furosemide (medication used to treat fluid retention) 40 mg tablet - eight tablets remaining 4. Finasteride (medication used to treat enlarge prostate and male pattern hair loss 5 mg tablet - 16 tablets remaining 5. Dabigatran etexilate 150 mg capsule - 16 capsules remaining 6. Dabigatran etexilate - 18 capsules remaining 7. Diltiazem (medication used to treat HTN) 120 mg - nine tablets remaining D. Unknown resident 1.Metoprolol tartrate 50 mg - 10 tablets remaining 2. Temazepam (medication used to treat insomnia [difficulty falling asleep or staying asleep] 7.5 mg - seven tablets remaining During a concurrent interview and record review, on 5/6/2025, at 3:13 p.m., with RN 5, the facility's Discarded Medication Log was reviewed. RN 5 stated some of the listed medication was not readable due to overlapping of labels. (continued on next page)

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	05/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 5/6/2025, at 3:23 p.m., with the DON, the DON stated the Discarded Medication Log was incomplete and almost blank. The DON stated the Discarded Medication Log should have a date of when the medication was discarded, the name of the nurse who discarded, and who witnessed. The DON stated looking into the Discarded Medication Log she (DON) does not know if the medication was really discarded or disposed of and could potentially result drug diversion. During a concurrent interview and record review, on 5/9/2025, at 11:10 a.m., with the DON, the facility's P&P titled, Discarding and Destroying Medications, dated 11/2022 and last reviewed on 1/16/2025, the P&P indicated, Medications that cannot be returned to the dispensing pharmacy (non-unit-dose medications [medications that are not packaged in individual or single-use dose], medications refused by the resident, and or medications left by residents upon discharge) are disposed of in accordance with federal, state, and local regulations governing management of non-hazardous (not dangerous or harmful) pharmaceuticals, hazardous (harmful) waste and controlled substances (drugs whose production, possession, and use are regulated by law). The medication disposition record contains, as a minimum, the following information a. The resident's name. b. The name and strength of the medication. c. The prescription number (if any). d. The name of the dispensing pharmacy. e. Date medication destroyed. f. The quantity destroyed. g. Method of destruction. h. Reason for destruction. i. Signature of witnesses. The DON stated if residents were transferred to GACH and stayed at GACH for more than three days, the remaining medication should be discarded, dated, signed and witnessed in the Medication Discarded Log. f. During a review of Resident 19's Face Sheet, the Face Sheet indicated the facility admitted Resident 19 on 4/16/2025, at 3:50 p.m. with diagnoses that included UTI, muscle weakness and HTN. During a review of Resident 19's Physician Order Sheet, dated 4/16/2025, the Physician Order indicated meropenem one gram IV every eight hours from 4/16/2025, to 4/18/2025. During a review of Resident 19's MAR, dated 4/2025, the MAR indicated meropenem was started on 4/16/2025, at 10 p.m., and completed on 4/18/2025, at 10 p.m., (continued on next page)

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	05/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19's Proof of Prescription Delivery, dated 4/16/2025, the Proof of Prescription Delivery, timed at 11:24 p.m., indicated the pharmacy delivered nine vials of meropenem. During an observation and interview, on 5/6/2025, at 7:48 a.m., inside the medication room of Station A, with RN 5, the IV cart was checked. Two unlabeled vials of one-gram meropenem were on the fourth drawer of the IV cart. RN 5 stated the two meropenem vials should have been discarded after the dose was completed. During an interview, on 5/6/2025, at 3:13 p.m., with RN 5, RN 5 stated the pharmacy delivered two extra vials and should have been discarded on 4/18/2025 after the dose was completed. During a concurrent interview and record review, on 5/9/2025, at 11:10 a.m., with the DON, facility's P&P, titled Discarding and Destroying Medications, dated 11/2022 and last reviewed on 1/16/2025, the P&P indicated, Medications that cannot be returned to the dispensing pharmacy (example, non-unit-dose medications, medications refused by the resident, and or medications left by residents upon discharge) are disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances. The DON stated expired and unlabeled medication should be discarded. The DON stated it should not be in the medication cart and should not be in the medication room. The DON stated the facility failed to discard expired medication as per facility policy. During a record review of facility's P&P titled, Storage of Medications, dated 4/2007 and last reviewed on 1/16/2025, the P&P indicated, Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. 44244 g. During a review of Resident 96's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 8/1/2020 and most recently admitted the resident on 3/24/2025 with diagnoses including polyneuropathy (a disorder of the peripheral nervous system that may result in pain, discomfort, and mobility issues), essential HTN, major depressive disorder (persistent feelings of sadness and loss of interest that can interfere with daily living), anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), binge eating disorder (a mental illness that causes chronic, compulsive overeating), and unspecified intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently). During a review of Resident 96's MDS, dated [DATE], the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated that the resident was dependent on staff for toileting and bathing, required substantial / maximal assistance for dressing and moving from lying to sitting, and required partial/moderate assistance for personal hygiene and rolling left and right in the bed. During a review of Resident 96's H&P, dated 3/26/2025, the H&P indicated the resident had the capacity to understand and make decisions. (continued on next page)

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	05/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 96's Physician Order Sheet, dated 3/28/2025, the Physician Order Sheet indicated the following orders: - On 3/25/2025, Bupropion HCL XL (a psychotropic medication [any medication capable of affecting the mind, emotions, and behavior] used to treat depression) 300 mg 24-hour tablet, extended release, give one tablet daily at the a.m. medication (med) pass by mouth, for major depressive disorder manifested by sad facial expressions. - On 3/24/2025, Buspirone (a psychotropic medication used to treat anxiety) 10 mg tablet, give one tablet two times a day in the a.m. and dinner med pass by mouth for anxiety disorder manifested by repetitive health complaints. - On 3/24/2025, Carvedilol (a medication used to treat high blood pressure) 25 mg tablet, one tablet two times daily at the a.m. and dinner med pass by mouth, for essential HTN, hold (do not give) for systolic blood pressure (SBP, measures the pressure in your arteries [pathway that carries blood away from the heart] less than 110. - On 3/24/2025, Lisdexamfetamine (a psychotropic medication used to treat binge eating disorder) 30 mg capsule, give one capsule daily at the a.m. med pass by mouth, for binge-eating disorder. - On 4/3/2025, Vitamin D3 25 micrograms (mcg - a unit of measurement), three tablets daily at the a.m. med pass for supplement. During a review of Resident 96's care plan (CP) regarding HTN, initiated 3/31/2025, the CP indicated a goal that the resident would be free from signs and symptoms of cardiac distress with blood pressure within normal limits and an intervention to administer medication as ordered. During a review of Resident 96's CP regarding buspirone and bupropion, initiated 3/31/2025, the CP indicated a goal to maximize the resident's functional potential and minimize the risk of potential adverse effects of medication with an intervention to administer medication as ordered. During a review of Resident 96's CP regarding the resident has nine or more medications, initiated 3/31/2025, the CP indicated there was a potential for adverse drug effects and drug interactions with an intervention to give medications as ordered. During a review of Resident 96's Self-Administration of Medication Assessment, dated 3/24/2025, the Self-Administration of Medication Assessment indicated the resident did not want to self-administer medication and the resident was not a candidate for safe self-administration of medication. During a concurrent observation and interview, on 5/6/2025, at 10:50 a.m., with Resident 96, Resident 96 sat up in bed. A clear plastic medicine cup contained two capsules and three tablets on the bedside rolling table. Resident 96 stated the medication belonged to Resident 96 and the LVN left the medication on the table because the resident does not like to take all the medication at the same time. Resident 96 stated the resident forgot to take the medication that was left by the LVN. During a concurrent observation and interview, on 5/6/2025, at 11:04 a.m., with LVN 2, LVN 2 entered Resident 96's room and stated LVN 2 left the medication for Resident 96 to self-administer. Resident 96 swallowed the five medications in the cup. (continued on next page)

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	05/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 5/6/2025, at 2:35 p.m., Resident 96's physician orders, MAR for 5/2025, and Nursing Progress Notes for 5/2025 were reviewed. LVN 2 stated the facility medication administration process is to take the resident's medication to bedside, watch the resident take the medication to make sure the resident safely administers all the medication, then document in the MAR the date and time the resident took the medication. LVN 2 stated LVN 2 left lisdexamfetamine, bupropion, buspirone, carvedilol, and one tablet of Vitamin D unattended at Resident 96's bedside for the resident to self-administer. LVN 2 stated Resident 96 did not have a physician's order or an assessment indicating the resident was capable of self-administering medication. LVN 2 stated Resident 96's medications were due during the scheduled a.m. medication (med) pass time. LVN 2 stated the a.m. med pass time is one hour before or one hour after 9 a.m. LVN 2 stated Resident 96's lisdexamfetamine, bupropion, buspirone, carvedilol, and Vitamin D were administered at 11 a.m. and not administered during the scheduled a.m. medication pass time. LVN 2 stated Resident 96 a.m. medications were administered one hour late because LVN 2 left the medication in the resident's room and the resident did not take the medication. LVN 2 stated Resident 96's medications were not administered per the physician's order to be given during the scheduled a.m. med pass time. LVN 2 stated it was important to administer Resident 96's medications per the physician's order because the timing between medication doses is important. LVN 2 stated that when medications are not administered at the correct time then two doses may be given too close or too far apart resulting in too much or too little of the medication in the body. LVN 2 stated LVN 2 did not document or notify the physician that the resident's medications were administered late. During an interview and record review, on 5/6/2025, at 3:01 p.m., with RN 1, Resident 96's MAR for 5/2025, physician's orders, and Nursing Progress Notes for 5/2025 were reviewed. RN 1 stated medications are ordered to be administered at a certain time because medications are time sensitive to ensure the therapeutic level of medication remains in the resident's body. RN 1 stated when the physician's order indicates administer at the scheduled a.m. med pass time, it means medication is due one hour before or one hour after 9 a.m. RN 1 stated medications are never left at bedside for a resident to self-administer because the LVN needs to be present to ensure the medications are actually administered at the correct time and to the correct resident. RN 1 stated when LVN 2 left medications at Resident 96's bedside and the resident took the medication at 11 a.m., it was a medication error because the medications were late and not administered per the physician's order during the scheduled a.m. med pass. RN 1 stated medications should not be administered too close or too far apart from the previous or next ordered dose because the resident may not receive the intended benefits of the medication. RN 1 stated for Resident 96, when blood pressure medication was not administered on time it could potentially result in the resident's blood pressure being too high or too low leading to a medical emergency. RN 1 stated when the resident's psychotropic medications were not administered at the correct time it could potentially result in adverse effects when the medication is not at a therapeutic level, like undesired behaviors. RN 1 stated the physician should have been notified that the medications were administered late, but there was no documented evidence the physician was notified. (continued on next page)

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	05/09/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 5/9/2025, at 9 a.m., with the DON, Resident 96's MAR for 5/2025, A.M. Med Pass record of administration times, dated 5/6/2025, and physician orders were reviewed. The DON stated the timing of medication administration is important to ensure medication is administered per the physician's orders and that the medication is effective. The DON stated that the facility uses scheduled a.m. med pass times that are due one hour before or one hour after 9 a.m. The DON stated any a.m. scheduled medications administered after 10 a.m. are considered late and the physician should be notified. The DON stated the facility P&P was not followed when LVN 2 left medications at Resident 96's bedside and the resident took the a.m. scheduled medications after 11 a.m. The DON stated when Resident 96's medications were administered late, there was a potential tha [TRUNCATED]

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	05/09/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (% - one per one hundred), two medication errors out of 31 total opportunities contributed to an overall medication error rate of 6.45% affecting two of five sampled residents (Resident's 3 and 62), observed for medication administration by: 1. Failing to ensure Licensed Vocational Nurse (LVN) 1 administered docusate sodium (medication used to treat constipation [bowel movements are infrequent, and the stool is hard and difficult to pass]) 250 milligram (mg - metric unit of measurement, used for medication dosage and/or amount) to Resident 3 as per physician order. LVN 1 administered 100 mg on 5/6/2025. 2. Failing to ensure LVN 2 checked the docusate sodium 250 mg expiration date before medication administration to Resident 62. The docusate sodium bottle had an expiration date of 4/2025. These failures had the potential to result in Resident 3 and 62 experiencing adverse medication effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and medication error. Findings: a. During a review of Resident 3's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted Resident 3 on 9/19/2018 with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), history of falling, and fibromyalgia (chronic condition that causes widespread pain, fatigue, and other symptoms like sleep disturbances). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 3/4/2025, the MDS indicated Resident 3's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a review of Resident 3's History and Physical (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 9/12/2024, the H&P indicated Resident 3 had decision making capacity. During a review of Resident 3's Physician Order Sheet, dated 10/1/2018, the Physician Order Sheet indicated docusate sodium 250 mg one capsule two times a day for constipation. During a review of Resident 3's Care Plan, dated 12/17/2024, about potential constipation, the Care Plan indicated an intervention to administer medications as ordered. During an observation, on 5/6/2025, at 8:15 a.m., outside of Resident 3's room, LVN 1 prepared one tablet of stool softener (medication used to treat constipation) 100 mg tablet and administered to Resident 3 on 5/6/2025 at 8:27 a.m. (continued on next page)

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	05/09/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 5/7/2025, at 9:22 a.m., with Registered Nurse (RN) 2, Resident 3's Physician Order, dated 10/1/2018, was reviewed. RN 2 stated Resident 3's Physician Order indicated docusate sodium 250 mg twice a day. RN 2 stated LVN 1 should have given 250 mg as per physician order and not 100 mg. RN 2 stated giving medication less than the order will not be as effective. RN 2 stated LVN 1 did not follow the physician order. During an interview, on 5/7/2025, at 9:51 a.m., with the Director of Staff Development (DSD), the DSD stated LVN 1 should compare the physician order with the medication label. The DSD stated LVN 1 did not follow the physician order. The DSD stated medication will be less effective to treat Resident 3's constipation. During a concurrent interview and record review, on 5/9/2025, at 11:10 am., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019 and last reviewed on 1/16/2025, was reviewed and the P&P indicated, Medications are administered in accordance with prescriber's orders, including any required time frame. The DON stated LVN 1 should have followed the physician order to give Resident 3 with docusate sodium 250 mg. The DON stated LVN 1 gave 100 mg of docusate sodium which is less than the physician order. The DON stated 100 mg will not be effective in treating Resident 3's constipation. The DON stated Resident 3's constipation could prolong and cause discomfort. b. During a review of Resident 62's Face Sheet, the Face Sheet indicated the facility admitted Resident 62 on 3/16/2025 with diagnoses including unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities), constipation and essential hypertension (a type of high blood pressure where the underlying cause is unknown). During a review of Resident 62's MDS, dated [DATE], the MDS indicated Resident 62's cognitive skills for daily decisions were severely impaired. During a review of Resident 62's H&P, dated 3/17/2025, the H&P indicated Resident 62 can make needs known but cannot make medical decisions. During a review of Resident 62's Physician Order Sheet, dated 3/16/2025, the Physician Order indicated docusate sodium 250 mg, one capsule by mouth daily for bowel management. During a review of Resident 62's Care Plan, dated 4/30/2025, about potential for constipation, the Care Plan indicated an intervention to administer medications as ordered. During a concurrent observation and interview, on 5/6/2025, at 10:26 a.m., with LVN 2, outside of Resident 62's door, LVN 2 obtained one capsule of docusate sodium 250 mg from the docusate sodium bottle with an expiration date of 4/2025. LVN 2 notified Resident 62 that he (LVN 2) would start Resident 62's medication with the docusate sodium. The Surveyor informed LVN 2 to start with the other scheduled medications and docusate sodium last. Resident 62 started taking her (Resident 62)'s medication at 10:43 a.m. When LVN 2 was about to administer Resident 62's docusate sodium, Surveyor caught the attention of LVN 2 and showed the docusate bottle expiration date. LVN 2 stated docusate sodium 250 mg should not be given to Resident 62 because it was an expired medication. LVN 2 stated he did not look and did not notice the expiration date. (continued on next page)

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	05/09/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 5/6/2025, at 10:51 a.m., with the Infection Preventionist (IP), the IP stated expired medication should not be given to Resident 62 for safety issues. The IP stated LVN 2 should have checked the docusate sodium expiration date before medication administration. During an interview, on 5/7/2025, at 9:51 a.m., with the DSD, the DSD stated nurses should check the expiration date all the time before medication administration. The DSD stated giving expired medication will not be as effective to treat Resident 62's constipation and could result in adverse effects. During an interview, on 5/7/2025, at 1:30 p.m., with LVN 2, LVN 2 stated he (LVN 2) did not read the expiration date of docusate sodium. LVN 2 stated he (LVN 2) should have read the medication label including the expiration date. LVN 2 stated Resident 3 could experience adverse effects from receiving expired medication. During an interview, on 5/7/2025, at 4:16 p.m., with the DON, the DON stated LVN 2 should have checked the medication expiration before medication administration to any resident. The DON stated LVN 2 failed to follow their policy for medication administration. The DON stated the facility failed to ensure proper training was provided to LVN 2 for medication administration. During a concurrent interview and record review, on 5/9/2025, at 11:10 a.m., with the DON, the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019 and last reviewed on 1/16/2025, was reviewed and the P&P indicated, The expiration/beyond use date on the medication label is checked prior to administering. The DON stated Resident 62 can experience side effects (also known as adverse reactions, are unwanted undesirable effects that are possibly related to a drug) or adverse reaction from taking expired medications.

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	05/09/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 43988 2. During a review of Resident 107's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted the resident on 3/23/2020 and readmitted in the facility on 7/26/2024, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarct (stroke, loss of blood flow to a part of the brain) affecting right dominant side, diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control and poor wound healing), and gastrostomy status (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 107's History and Physical (H&P) dated 7/29/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 107's Minimum Data Set (MDS, a resident assessment tool), dated 3/26/2025, the MDS indicated Resident 107 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 107 required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 107's care plan (CP) on potential for hypoglycemia (abnormally low level of sugar in the blood) or hyperglycemia (abnormally high level of sugar in the blood) initiated on 8/8/2024, the CP indicated to administer medications as ordered. During a review of Resident 107's Physician's Order Sheet, the Physician Order Sheet indicated the following physician's order dated 1/20/2025: - Humulin R regular insulin (a short acting insulin) 100 unit per milliliter (unit/ml - a unit of measurement) injection solution four (4) times daily per sliding scale: blood sugar is less than (<)70 or more than (>), 400 notify physician; 121 - 150 = 2 units; 151 - 200 = 4 units; 201- 250 = 6 units; 251- 300 = 8 units; 301- 350 = 10 units; 351- 400 = 12 units. If blood glucose is <70 give juice via GT then recheck blood glucose, rotate sites. During a concurrent interview and record review on 5/8/2025 at 3:15 p.m., reviewed Resident 107's physician's order, CP, and subcutaneous administration sites for Humulin R from 4/1/2025 to 5/8/2025 with Registered Nurse (RN) 3. RN 3 stated Resident 107 received insulin, had a physician's order for Humulin R and to rotate sites, and were administered as follows: - 4/1/2025 4:30 p.m. - abdomen - right lower quadrant (RLQ) - 4/2/2025 6:30 a.m. - RLQ - 4/6/2025 11:30 a.m. - abdomen - left upper quadrant (LUQ) - 4/7/2025 6:30 a.m. -abdomen - LUQ (continued on next page)

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	05/09/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 4/9/2025 4:30 p.m. - abdomen - left lower quadrant (LLQ) - 4/9/2025 9 p.m. - abdomen - LLQ - 4/12/2025 4:30 p.m. - abdomen - left upper quadrant (LUQ) - 4/13/2025 6:30 a.m. - abdomen - LUQ - 4/15/2025 4:30 p.m. - abdomen - RLQ - 4/15/2025 9 p.m. - abdomen - RLQ - 4/21/2025 6:30 a.m. - abdomen - LUQ - 4/21/2025 11:30 a.m. - abdomen - LUQ - 4/22/2025 6:30 a.m. - abdomen - LUQ - 4/22/2025 11:30 a.m. - abdomen - LUQ RN 3 stated administration sites for insulin should be rotated according to physician's orders, standards of practice and manufacturer's guidelines to prevent formation of lumps, and abnormal distribution of fats under the skin which can affect the absorption of insulin if given on the same sites. RN 3 stated the location of administration sites for Resident 107's insulin were not rotated. RN 3 stated the nurses did not rotate Resident 107's administration sites. RN 3 stated Resident 107's administration sites should have been rotated to prevent formation of lumps, and abnormal distribution of fats under the skin which can affect the absorption of the insulin. RN 3 stated if the nurses are not following the physician's order to rotate the insulin administration sites, manufacturer's guidelines, and professional standards of practice, it can be considered a medication error. During a concurrent interview and review on 5/9/2025 at 11:45 a.m., reviewed Resident 107's location of administration sites for Humulin R from 4/1/2025 to 5/8/2025 with the Director of Nursing (DON). The DON stated Resident 107's insulin administration sites were not rotated as indicated in the physician's order. The DON stated licensed nurses are supposed to rotate the insulin administration sites as indicated in the physician's order, manufacturer's guidelines, and according to professional standards of practice. The DON stated Resident 107's insulin administration sites for Humulin R should have been rotated to prevent bruising, pain, abnormal distribution fats or lipodystrophy and affect the absorption of insulin which may lead to hyperglycemia. The DON stated not following the physician's order to rotate the insulin administration sites, manufacturer's guidelines, and professional standards of practice can be considered a medication error. During a review of the facility provided manufacturer's guideline for Humulin R - insulin human injection solution, undated, the manufacturer's guideline indicated: - Change (rotate) your injection sites within the area you choose with each dose to reduce the risk of getting lipodystrophy (pits in the skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. (continued on next page)

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	05/09/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Do not use the exact same spot for each injection. - Do not inject where the skin has pits, is thickened, or has lumps. - Do not inject where the skin is tender, bruised, scaly or hard, or into scars or damaged skin. During a review of the facility's recent policy and procedure (P&P) titled Insulin Administration, last reviewed on 1/16/2025, the P&P indicated a purpose to provide guidelines for the safe administration of insulin to residents with diabetes. The P&P further indicated: - Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility's P&P titled, Adverse Consequences and Medication Errors, last reviewed on 1/16/2025, the P&P indicated: - A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. - Example of medication errors include failure to follow manufacturer's instructions and/or accepted professional standards. 44376 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) to two of two sampled residents (Residents 12 and 107) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites. The deficient practices had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Findings: Cross reference F658 (continued on next page)

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	05/09/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 12's Face Sheet, the Face Sheet indicated the facility admitted the resident on 2/12/2020, with diagnoses including diseases of gallbladder (a small organ that stores bile), glaucoma (a group of eye diseases that can damage the optic nerve, the nerve that connects your eye to your brain, leading to vision loss and potentially blindness), and type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 12's History and Physical (H&P), dated 11/24/2024, the H&P indicated the resident was awake, alert, oriented, and responding appropriately; had left hemiplegia (paralysis that affects only one side of the body), more on the left upper extremity, and unable to test gait (a manner of walking or moving on foot). During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool), dated 1/31/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident was on a high-risk drug class hypoglycemic (a group of drugs used to help reduce the amount of sugar present in the blood). During a review of Resident 12's Physician Order Sheet, dated 12/10/2023, the Physician Order Sheet indicated an order of Humalog U-100 Insulin 100 units per milliliter (unit/mL, one unit of insulin is equal to 0. 01 mL) subcutaneous solution (sliding scale, the increasing administration of the pre meal insulin dose based on the blood sugar level before the meal), Vial (ml, a unit of volume) Subcutaneous four times daily. During a review of Resident 12's Medications from 3/2025 to 5/2025, the Medications indicated insulin Humalog U-100 Insulin 100 unit/mL subcutaneous solution (sliding scale), Vial (ml) Subcutaneous four times daily was administered on: 3/4/2025 at 9 p.m. on the Abdomen- Right Upper Quadrant (RUQ) 3/5/2025 at 6:30 a.m. on the Abdomen-RUQ 3/7/2025 at 4:30 p.m. on the Abdomen 3/7/2025 at 9 p.m. on the Abdomen 3/8/2025 at 4:30 p.m. on the Abdomen- Left Upper Quadrant (LUQ) 3/8/2025 at 9 p.m. on the Abdomen-LUQ 3/14/2025 at 11:30 a.m. on the Abdomen-LUQ 3/14/2025 at 4:30 p.m. on the Abdomen-LUQ 3/15/2025 at 11:30 a.m. on the Abdomen-RUQ 3/15/2025 at 4:30 p.m. on the Abdomen-RUQ (continued on next page)

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	05/09/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/4/2025 at 4:30 p.m. on the Abdomen-LUQ 4/4/2025 at 9 p.m. on the Abdomen-LUQ 4/6/2025 at 11:30 a.m. on the Abdomen-LUQ 4/6/2025 at 4:30 p.m. on the Abdomen-LUQ 4/8/2025 at 4:30 p.m. on the Abdomen-RUQ 4/8/2025 at 9 p.m. on the Abdomen-RUQ 4/10/2025 at 6:30 a.m. on the Abdomen-LUQ 4/10/2025 at 11:30 a.m. on the Abdomen-LUQ 4/10/2025 at 4:30 p.m. on the Abdomen 4/10/2025 at 9 p.m. on the Abdomen 4/11/2025 at 11:30 a.m. on the Abdomen-Right Lower Quadrant (RLQ) 4/11/2025 at 4:30 p.m. on the Abdomen-RLQ 4/12/2025 at 11:30 a.m. on the Abdomen-RLQ 4/12/2025 at 4:30 p.m. on the Abdomen-RLQ 4/23/2025 at 11:30 a.m. on the Abdomen-RLQ 4/23/2025 at 9 p.m. on the Abdomen-RLQ 4/26/2025 at 11:30 a.m. on the Abdomen-RLQ 4/26/2025 at 4:30 p.m. on the Abdomen-RLQ 5/3/2025 at 4:30 p.m. on the Abdomen-RLQ 5/3/2025 at 9 p.m. on the Abdomen-RLQ 5/6/2025 at 9 p.m. on the Arm- Right Upper Posterior Medial (RUPM) 5/7/2025 at 6:30 a.m. on the Arm-RUPM (continued on next page)

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	05/09/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/9/2025, at 8:49 a.m., with Registered Nurse (RN) 3, reviewed Resident 12's Medical Diagnosis, Physician Order Sheet, and Medications. RN 3 stated there was an order for Humalog sq with sliding scale on the resident. RN 3 stated there were multiple instances that the site of insulin administration was not rotated in the Medications Record from 3/2025 to 5/2025. RN 4 stated the insulin sites of administration should be rotated to prevent lipodystrophy on residents. RN 4 stated injecting insulin on the sites of lipodystrophy could affect the absorption of the insulin that can cause hypo (low)/hyperglycemia (high blood glucose [blood sugar]) to residents. RN 3 stated not rotating insulin administration sites of administration as a medication error. During an interview on 5/9/2025, at 11:10 a.m., with the Director of Nursing (DON), the DON stated Resident 12's insulin administration sites should be rotated to prevent lipodystrophy on residents. The DON stated that the absorption of the medication is affected if administered on the sites of lipodystrophy. The DON stated that the resident can experience hypo/hyperglycemic episodes due to poor absorption of the insulin on the sites of lipodystrophy. The DON stated not rotating insulin administration sites is a medication error. During a review of the facility's recent policy and procedure (P&P) titled Adverse Consequences and Medication Errors, last reviewed on 1/16/2025, the P&P indicated the interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. A medication error is defined as the preparation or administration of drugs and biological which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent P&P titled Insulin Administration, last reviewed on 1/16/2025, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided Highlights of Prescribing Information for Humalog (insulin lispro) injection, for subcutaneous or intravenous use, with initial U.S. approval in 1996, the Highlights of Prescribing Information indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis.

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	05/09/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on observation, interview and record review, the facility failed to ensure safe provision of pharmaceutical services for three of four sampled medication storage (two medication carts in Station B and the medication room in Station A) by: 1. Failing to ensure medications were labeled inside the medication room. Medication room in Station A had two unlabeled meropenem (medication used to treat infection) vials (a small, usually cylindrical container, typically made of glass or plastic, designed to hold medicine), in the Intravenous (IV - within the vein) Cart. 2. Failing to ensure the medication cart does not contain expired medication. Station B medication cart had psyllium (medication used to treat constipation [infrequent or difficult bowel movements]) with an expiration date of ,d+[DATE]. 3. Failing to ensure the medication cart does not contain expired medication. Station B medication cart had docusate sodium (medication used to treat constipation) 250 milligram (mg - metric unit of measurement, used for medication dosage and/or amount) with expiration date of ,d+[DATE]. These deficient practices had the potential to cause medication errors and adverse effects (undesired effect of a drug or other type of treatment). Findings: a. During a concurrent observation and interview, on [DATE], at 7:48 a.m., inside the medication room of Station A, with Registered Nurse (RN) 5, RN 5 checked the IV cart. Two vials of meropenem one gram (g - unit of measurement for mass) were unlabeled on the fourth drawer of the IV cart. RN 5 stated the two meropenem vials should have been discarded after the dose was completed. RN 5 stated the two meropenem vials were not labeled. During a concurrent interview and record review, on [DATE], at 3:13 p.m., with RN 5, Resident 19's Face Sheet (Admission Record), Physician Orders, dated [DATE], Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated ,d+[DATE], and Proof of Prescription Delivery, dated [DATE], were reviewed. The Face Sheet indicated the facility admitted Resident 19 on [DATE], at 3:50 p.m. The Physician Orders, dated [DATE], indicated an order for meropenem one gram IV every eight hours from [DATE] to [DATE]. The Proof of Prescription Delivery, dated [DATE], timed at 11:24 p.m., indicated the pharmacy delivered nine vials of meropenem. The MAR, dated ,d+[DATE], indicated meropenem was started on [DATE], at 10 p.m., and completed on [DATE], 10 p.m., RN 5 stated the pharmacy delivered two extra vials and should have been discarded on [DATE] after the dose was completed. (continued on next page)

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	05/09/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During an observation and interview, on [DATE], at 10:53 a.m., in Station B, with the Infection Preventionist (IP), the IP checked the Station B medication cart. One container of Psyllium had an expiration date of ,d+[DATE] on the right third drawer of the medication cart. The IP stated expired medication should be discarded in the incinerator. During an interview, on [DATE], at 9:51 a.m., with the Director of Staff Development (DSD), the DSD stated expired medication should be discarded. The DSD stated Psyllium was a house supply (medication available in the facility) and available at all times. The DSD stated nurses should have checked the medication cart and discarded the expired medication. c. During a concurrent observation and interview, on [DATE], at 10:26 a.m., in front of Resident 62's room, with LVN 2, LVN 2 took one capsule of docusate sodium 250 mg from an expired bottle dated ,d+[DATE]. LVN 2 stated he (LVN 2) did not notice that the docusate sodium was expired. LVN 2 stated the medication cart should not contain expired medication to prevent medication error. During an interview, on [DATE], at 8:06 a.m., with LVN 6, LVN 6 stated expired medication should not be in the medication cart. LVN 6 stated nurses need to check the expiration of each medication before medication administration. LVN 6 stated if medication is close to expiration date, it should have been discarded and replaced with a new supply. During an interview, on [DATE], at 9:51 a.m., with the DSD, the DSD stated docusate sodium should have been discarded on the date of expiration, which was on [DATE], to prevent medication error. The DSD stated expired medication could be less effective and could cause possible adverse reaction. During a concurrent interview and record review, on [DATE], at 11:10 a.m., with the DON, the facility's policy and procedure (P&P), titled, Discarding and Destroying Medications, dated ,d+[DATE] and last reviewed on [DATE], was reviewed and the P&P indicated, Medications that cannot be returned to the dispensing pharmacy (example, non-unit-dose medications, medications refused by the resident, and or medications left by residents upon discharge) are disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances. The DON stated expired and unlabeled medication should be discarded. The DON stated it should not be in the medication cart and should not be in the medication room. The DON stated the facility failed to discard expired medication as per facility policy. The DON stated giving expired medication like Psyllium and docusate sodium would not be as effective and could result in constipation as adverse reaction to Resident 62. During a concurrent interview and record review, on [DATE], at 11:10 a.m., with the DON, the facility's P&P titled, Storage of Medications, dated ,d+[DATE] and last reviewed on [DATE], the P&P indicated, Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

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	05/09/2025

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on interview and record review, the facility failed to provide a computed tomography scan (CT scan, medical imaging technique to create detailed cross-sectional images of the body) to one of 38 sampled residents (Resident 128) in a timely manner when a CT scan ordered on 9/9/2024 was not completed until 10/21/2024. This deficient practice had the potential to cause a delay in identification of diseases and delayed follow up orthopedic (medical specialty involving muscles and bones) care for Resident 128. Findings: During a review of Resident 128's Face Sheet (FS), the FS indicated Resident 128 admitted to the facility on [DATE] with diagnoses including, but not limited to, muscle wasting and atrophy (weakening, shrinking, and loss of muscle) and right humeral neck fracture (broken bone of upper arm). During a review of Resident 128's Physician's History and Physical Examination (H&P) dated 8/10/2024, the H&P indicated Resident 128 had the capacity to understand and make decisions. During a review of Resident 128's Minimum Data Set (MDS, resident assessment tool) dated 2/10/2025, the MDS indicated Resident 128 had moderate cognitive impairments (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 128 had functional limitation impairments in range of motion (ROM, full movement potential of a joint) on one side of the upper extremity (UE, shoulder, elbow, wrist, hand) and no impairments on the lower extremity (LE, hip, knee, ankle, foot). The MDS also indicated Resident 128 required supervision for eating, dependent assistance with dressing, bathing, and maximal assistance with sit to stand and bed to chair transfers. During a review of the Orthopedic Physician's Progress Notes dated 9/9/2024, the progress note indicated for a CT scan of the right shoulder with 3-D reformation (three dimensional views to help see and detect organs/bones in body) and return to orthopedic physician (ortho) in one week with the above ordered CT scan. During a review of Clinical Nursing Notes (CNN) dated 9/9/2024, the (CNN) indicated resident came back from appointment alert, verbally responsive, with new order to return in one week with CT scan of right shoulder with 3-D reformation, copy given to business office for authorization. During a review of CNN dated 9/12/2024, the CNN indicated ortho appointment cancelled due to resident not having a CT scan authorized for medical appointment with orthopedic physician. Once CT scan done and results are on a compact disc (CD) and hard copy, call ortho and schedule appointment. During a review of Resident 128's Authorization Fax Request Form (AFRF), the AFRF indicated the facility requested an authorization for a CT scan of right shoulder with 3D reformation on 10/9/2024. (continued on next page)

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	05/09/2025

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 128's Insurance Fax dated 10/10/2024, the fax indicated Resident 128 did not require an authorization for a CT scan. During a review of Resident 128's orders, an order dated 10/11/2024 indicated CT scan of right shoulder on 10/17/2024, need CD and copy of the report. During a review of Resident 128's orders, an order dated 10/11/2024 indicated ortho follow up on 10/24/2024 at 12 PM, bring the CD and copy of the CT scan report. During a review of CNN dated 10/21/2024, the CNN indicated resident went to CT scan appointment via transport. During a review of Resident 128's CT scan report dated 10/21/2024, the CT scan report indicated the CT scan procedure date was 10/21/2024. During a review of the Orthopedic Physician's Progress Notes dated 10/24/2024, the Ortho MD indicated resident returned to office 45 days later with poor quality CT scan. During an interview and record review of Resident 128's medical records on 5/8/2025 at 10:28 a.m., Licensed Vocational Nurse (LVN 6) stated the facility made a follow up appointment with ortho after one week, but stated the appointment was cancelled because the facility was waiting for an authorization from the business office in order to schedule the CT scan appointment first. LVN 6 stated Resident 128 had to wait longer to return to the orthopedic physician because the facility was waiting for an authorization. During an interview on 5/8/2025 at 2:52 p.m., the Business Office Manager (BOM) stated the business office was in charge of submitting authorizations for radiology services such as CT scans. During an interview on 5/8/2025 at 3:01 p.m., BOM stated the facility requested an authorization for the CT scan on 10/9/2024 for Resident 128. BOM could not indicate the reason why the authorization was requested on 10/9/2024 when the order for the CT scan was received on 9/9/2024. During an interview on 5/9/2025 at 10:36 a.m., the Director of Nursing (DON) stated radiology orders, including CT scans, should be ordered the same day the order was received. DON stated physicians ordered CT scans to rule out fractures and to see internally so that physicians could diagnose cancers, etc. DON stated Resident 128 should not have received the CT scan more than a month later from the order on 9/9/2024 and that the CT scan was completed very late. DON stated the business office should have submitted the authorization right away, because Resident 128 needed the CT scan to follow up with the fracture. DON stated the delay in receiving the CT scan could cause potential harm to the resident and Resident 128 could have deteriorated. During a review of the facility's policy and procedure, revised 11/2018, titled, Lab and Diagnostic Test Results - Clinical Protocol, indicated, the physician will identify and order diagnostic .testing based on the resident's diagnosis and monitoring needs. The staff will process test requisitions and arrange for tests.

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	05/09/2025

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 38552 Based on observation, interview, and record review, the facility failed to ensure kitchen staff were routinely trained and evaluated for competency skills when one of one staff (Cook 1) was unable to verbalize and prepare puree mixed vegetables in a consistency that passed all established testing guidelines including spoon-tilt test (a test used to determine the stickiness of the food and the ability of the food to hold together) for residents on puree diet (foods that are smooth with pudding like consistency)/International Dysphagia Diet Initiative (IDDSI-a framework for categorizing food textures and drink thickness level four (4). These deficient practices resulted in an improper puree consistency which was too thick and did not pass the spoon-tilt test, which had the potential to place the residents at risk for aspiration (when something other than air gets into your airways). Cross-reference F805 Findings: During a review of the facility's menu spreadsheet (a sheet containing kind and amount of food each diet would receive), dated 5/8/2025, Thursday, the spreadsheet indicated residents on dysphagia puree diet would include the following foods in the tray: - Pureed chicken alfredo #6 scoop (holds 2/3 of a cup) - Pureed fettucini noodles #8 scoop (holds four (4) ounces [oz- a unit of measurement] of food) - Pureed mixed vegetables #8 scoop - Pureed garlic bread 1 each During an observation on 5/8/2025 at 11:47 a.m. of the trayline (an area where foods were assembled from the steamtable to resident's plate), observed puree mixed vegetables was too thick when plated on the plate. During an observation on 5/8/2025 at 11:51 a.m., the first meal cart was delivered out in the cafe dining room. During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) on 5/8/2025 at 11:52 a.m. of puree diet with [NAME] 1, [NAME] 1 stated the mixed vegetables puree did not fall off the spoon and there are still some left on the spoon. [NAME] 1 stated she checks the puree consistency by mixing clockwise and if she feels it's too thick then she would add more liquid when it's too watery she would add more thickener. [NAME] 1 stated she does not tilt the spoon and check if it falls off. [NAME] 1 stated she only mixes it that was all. [NAME] 1 stated that the puree mixed vegetables consistency was good even though not all the puree mixed vegetables fell off the spoon. (continued on next page)

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	05/09/2025

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/9/2025 at 2:49 p.m. with the Dietary Director (DD), the DD stated she provides oversight by doing spot checks, monitor evaluation, and looking to see, and does taste testing several times a week. The DD stated she does random days, rotate during breakfast, lunch or dinner. The DD stated she did notice during the trayline the spoon-tilt test was done with [NAME] 1 and that the puree mixed vegetables did not completely fall off the spoon. The DD stated it should have been adjusted by adding more liquid, so it was not too thick. The DD stated she would do a monitoring on the puree consistency test and would make sure their process is set up. The DD stated that when puree foods are too thick the residents are at risk for aspiration and intolerance. During a concurrent interview and record review on 5/9/2025 at 2:55 p.m. with the DD, reviewed the facility's recipe, Mixed Vegetables, last reviewed and approved on 1/16/2025, indicated that all IDDSI texture modifications need to pass their established testing methods at the start and every 15 minutes for the duration of service. The DD stated according to the recipe that it should pass the test and [NAME] 1 should have adjusted the puree mixed vegetables before it was served and every 15 minutes for the duration of the service. During a review of the facility's P&P titled Standardized Recipes, dated 1/16/2025, the P&P indicated a standardized recipe adjusted to appropriate yield is available for each menu item and is used in the preparation of each. During a review of the facility's P&P titled Diet Manual, dated 1/16/2025, the P&P indicated the community designates a current diet manual, which is available for all medical, nursing, and food and nutrition services department staff to use as a reference for normal therapeutic nutrition. The P&P indicated the diet manual contains a description, rationale, and description of dietary deficiencies and the appropriate title for all diets served in the community. During a review of the facility's diet and nutrition care manual titled Dysphagia Puree (Level 4) Diet, dated 1/16/2025, the manual indicated a diet used in the dietary management of dysphasia with the food texture prepared lump dash free, not firm or sticky and holds its shape on a plate. The diet requires no biting or chewing. All puree foods must pass the fork drip test and supplemental tests. Any liquids must not separate from the food and the food can fall off of a spoon intact. The food is more easily swallowed and prevents aspiration. During a review of the IDDSI guideline website titled IDDSI dated 7/2019, the IDSSI website indicated, Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test. (IDDSI, July 2019, The IDDSI Framework section). During a review of the facility's job description (JD) titled [NAME] dated and signed by [NAME] 1 on 1/30/2025, the document indicated the [NAME] prepares and serves food including texture modified and therapeutic diets according to the facility menu. During a review of the facility's checklist titled Competency Checklist - [NAME] dated signed by the DD, undated, the checklist indicated knowledge of food practices and there were no topics about puree level 4 testing including spoon-tilt test and fork-lift test. (continued on next page)

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	05/09/2025

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's JD titled Director of Food and Nutrition Services, undated, the JD indicated the director of food and nutrition services effectively manages the operation of the department of food and nutrition services. This includes planning, organizing, controlling, coordinating, directing and evaluating all aspects of food service, along with data collection for clinical charting, MDS participation, and care planning.

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	05/09/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 38552 Based on observation, interview, and record review, the facility failed to prepare foods in a form designed to meet individual needs when puree mixed vegetables was too sticky and did not pass the spoon tilt test (a test used to determine the stickiness of the food and the ability of the food to hold together) for residents on puree diet (foods that are smooth with pudding like consistency)/International Dysphagia Diet Initiative (IDDSI-a framework for categorizing food textures and drink thickness level four (4). This deficient practice had the potential to result in difficulty in swallowing, chewing, decreased food intake and nutrient intake to 21 of 21 residents on a puree diet, resulting in unintended weight loss and aspiration (when something other than air gets into your airways). Findings: During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive), dated Thursday, 5/8/2025, the spreadsheet indicated residents on a dysphagia puree diet would include the following foods on the tray: - Pureed chicken alfredo #6 scoop (holds 2/3 of a cup) - Pureed fettucine noodles #8 scoop (holds four (4) ounces [oz- a unit of measurement] of food) - Pureed mixed vegetables #8 scoop - Pureed 1 garlic bread each During an observation on 5/8/2025 at 11:47 a.m. of the trayline (an area where foods were assembled from the steamtable to resident's plate), pureed mixed vegetables were too thick when placed on the plate. During an observation on 5/8/2025 at 11:51 a.m., the first meal cart was delivered to the cafe dining room. During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) on 5/8/2025 at 11:52 a.m. of the puree diet with [NAME] 1, [NAME] 1 stated the mixed vegetables puree did not fall off the spoon and there is still some left on the spoon. [NAME] 1 stated she checks the puree consistency by mixing clockwise and if she feels it's too thick then she would add more liquid. When it's too watery she adds more thickener. [NAME] 1 stated she does not tilt the spoon and check if it falls off. [NAME] 1 stated she only mixes it, that is all. [NAME] 1 stated that the puree mixed vegetables consistency was good even though not all the puree mixed vegetables fell off the spoon. (continued on next page)

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	05/09/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/9/2025 at 2:49 p.m. with the Dietary Director (DD), the DD stated she provides oversight by doing spot checks, monitors, evaluation, and looking to see, and does taste testing several times a week. The DD stated she does random days, rotate during breakfast, lunch or dinner. The DD stated she did notice during the trayline the spoon-tilt test was done with [NAME] 1 and that the puree mixed vegetables did not completely fall off the spoon. The DD stated it should have been adjusted by adding more liquid, so it was not too thick. The DD stated she would do a monitoring on the puree consistency test and would make sure their process is set up. The DD stated that when puree foods are too thick the residents are at risk for aspiration and intolerance. During a concurrent interview and record review on 5/9/2025 at 2:55 p.m. with the DD, reviewed the facility's recipe, Mixed Vegetables, last reviewed and approved on 1/16/2025, indicated that all IDDSI texture modifications need to pass their established testing methods at the start and every 15 minutes for the duration of service. The DD stated according to the recipe that it should pass the test and [NAME] 1 should have adjusted the puree mixed vegetables before it was served and every 15 minutes for the duration of the service. During a review of the facility's P&P titled Standardized Recipes, dated 1/16/2025, the P&P indicated a standardized recipe adjusted to appropriate yield is available for each menu item and is used in the preparation of each. During a review of the facility's P&P titled Diet Manual, dated 1/16/2025, the P&P indicated the community designates a current diet manual, which is available for all medical, nursing, and food and nutrition services department staff to use as a reference for normal therapeutic nutrition. The P&P indicated the diet manual contains a description, rationale, and description of dietary deficiencies and the appropriate title for all diets served in the community. During a review of the facility's diet and nutrition care manual titled Dysphagia Puree (Level 4) Diet, dated 1/16/2025, the manual indicated a diet used in the dietary management of dysphasia with the food texture prepared lump dash free, not firm or sticky and holds its shape on a plate. The diet requires no biting or chewing. All puree foods must pass the fork drip test and supplemental tests. Any liquids must not separate from the food and the food can fall off of a spoon intact. The food is more easily swallowed and prevents aspiration. During a review of the IDDSI guideline website titled IDDSI dated 7/2019, the IDSSI website indicated, Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test. (IDDSI, July 2019, The IDDSI Framework section).

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	05/09/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen by failing to: 1. Dispose of tomato soup dated [DATE]. 2. Dispose of stewed prunes dated [DATE]. 3. Label one box mixed grapes, oranges, apple, and one carrot with an expired date and opened date 4. Label one Tutta [NAME] - Grated Parmesan Style Cheese, five (5) pounds (lbs.- a unit of measurement), received on [DATE] with an opened date. 5. Ensure sliced cheeses were not mixed with avocadoes and grapes in one clear plastic bin. 6. Label one bin of purple cabbage with received date and expired date. 7. Label leafy lettuce with a received date and expired date. 8. Label the expiration date accurately on the unopened frozen pepperoni. 9. Label the opened sliced deli meat, roast beef with an expired date and opened date. 10. Ensure one of three plate warmer machines was clean and did not have dried food debris. 11. Label the thickener placed inside a plastic bag in the dry storage room with the product name, expired date, and opened date. These deficient practices had the potential to result in harmful bacteria growth and cross-contamination (the physical movement of transfer of harmful bacteria from one person, object, or place to another) that could lead to foodborne illness (any illness of a toxic or infectious nature contracted through consumption of contaminated water or food) in 181 out of 187 medically compromised residents who receive food from the kitchen. Findings: (continued on next page)

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	05/09/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on [DATE] at 7:51 a.m. with Dietary Aide (DA) 1, during the kitchen tour, DA 1 stated while inside the walk-in freezer, there was one container of tomato soup, dated [DATE]. DA 1 stated it is good for three (3) days and should have been disposed of yesterday, [DATE]. DA 1 stated there was one container of stewed prunes, dated [DATE]. DA 1 stated this should have been disposed of as well. DA 1 stated inside one box there was mixed grapes, oranges, apple, and one carrot. DA 1 stated there was no label indicating the expired date and opened date. DA 1 stated there was one Tutta [NAME] - Grated Parmesan Style Cheese, 5 lbs., with an open date of [DATE], with no expired date. DA 1 stated whoever opened it should have labeled it with the expired date. DA 1 stated there was one clear plastic bin with sliced cheeses mixed with avocados and grapes. DA 1stated it should not be mixed due to the risk for contamination. DA 1 stated there was one bin of purple cabbage and one bin of leafy lettuce. Neither have an expired date, nor received date noted. During an observation and interview on [DATE] at 7:55 a.m. with DA 1, the kitchen tour was continued. DA 1 stated while inside the meat freezer, DA 1 stated there was a frozen unopened pepperoni bag labeled with an expired date of [DATE]. DA 1 stated she labeled this wrong, and it should have been in four to six months. DA 1 stated there was one container of open sliced deli meat, roast beef, with no label of expired date and no label of opened date. During an observation and interview on [DATE] at 8:09 a.m. with DA 1, the kitchen tour was continued. A hot plate warmer was observed with food debris. DA 1 stated they use three plate warmer machines; this is one of them. DA 1 stated this one has dried up and it should not be dirty and should have been cleaned because it could cause cross-contamination. During an interview on [DATE] at 1:48 p.m. with the Dietary Director (DD), the DD stated the kitchen staff are expected to inspect the food and produce delivered to check for damage, infections, and prevent from using it and to return it. The DD stated once it is taken out of the case, it should be labeled and dated when it was received and labeled with the expired date and opened date once it is opened. The DD stated the produce are placed in their own container to prevent from mixing. The DD stated once a food item is opened it is good for three (3) days and then discarded. The DD stated the thickener powder should not have been stored like that in the dry storage room. The DD stated it should have been left in the box with a label and expired date. The DD stated when the food plate warmers are noted to be dirty it should be cleaned and wiped down. The DD stated these procedures are done for infection control and prevention of cross-contamination of food and to assure the residents are receiving safe food for their health. The DD stated she has not been made aware of the light bulb broken and not working. The DD stated this requires a specialty order and would take time for it to be delivered to them. The DD stated this should be in working order to ensure that the kitchen staff is able to see what is inside and keep the inside of the freezer clean. During a review of the facility's policy and procedure titled, Maintenance of Equipment, reviewed and approved [DATE], the P&P indicated it is the policy of the facility to have equipment that is in optimal working condition; all equipment should be clean inside and outside. (continued on next page)

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	05/09/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Food Storage, reviewed and approved on [DATE], the P&P indicated after products have been received, they should be immediately taken to proper, secure storage areas. The P&P indicated to store all perishable items immediately in either the refrigerator or freezer; it is recommended that food items are to be dated upon receipt with the month, day and year; Rotate all dry, refrigerated, and frozen items on shelves using the first-in, first-out method; all opened and partially used foods shall be dated, labeled and sealed before being returned to the storage area. During a review of the facility's policy and procedure (P&P) titled, Labeling and Dating Foods, reviewed and approved on [DATE], the P&P indicated food delivered to the facility needs to be marked with a received date. Note that the delivery sticker is dated and it can serve as the delivery date for the product; Newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines; all prepared foods need to be covered, labeled, and dated; Produce is to be dated with received date.

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	05/09/2025

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 Based on interview and record review, the facility failed to provide Occupational Therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) treatments five times a week according to resident's OT plan of treatment and care plan for one of six sampled residents (Resident 128). This deficient practice had the potential for Resident 128 to not meet OT treatment goals and have a decline in function. Findings: During a review of Resident 128's Face Sheet (FS), the FS indicated Resident 128 admitted to the facility on [DATE] with diagnoses including, but not limited to, muscle wasting and atrophy (weakening, shrinking, and loss of muscle) and right humeral neck fracture (broken bone of upper arm). During a review of Resident 128's Physician's History and Physical Examination (H&P) dated 8/10/2024, the H&P indicated Resident 128 had the capacity to understand and make decisions. During a review of Resident 128's Minimum Data Set (MDS, resident assessment tool) dated 2/10/2025, the MDS indicated Resident 128 had moderate cognitive impairments (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 128 had functional limitation impairments in range of motion (ROM, full movement potential of a joint) on one side of the upper extremity (UE, shoulder, elbow, wrist, hand) and no impairments on the lower extremity (LE, hip, knee, ankle, foot). The MDS also indicated Resident 128 required supervision for eating, dependent assistance with dressing, bathing, and maximal assistance with sit to stand and bed to chair transfers. During a review of Resident 128's Mobility CP dated 8/19/2024, the CP indicated Resident 128 had mobility impairment related to pain/discomfort and fracture of right humerus. The CP approach/intervention indicated for OT screen, evaluation, and treatment as indicated. During a review of Resident 128's OT Care Plan (CP) dated 1/22/2025 and revised 3/17/2024, the CP indicated the approach plan included OT five times a week once a day for four weeks. During a review of Resident 128's OT Evaluation and Plan of Treatment dated 1/22/2025, the OT Evaluation and Plan of Treatment indicated OT treatment five times a week daily for four weeks. During a review of Resident 128's OT Treatment Encounter Notes (TEN), the TEN indicated Resident 128 completed the following OT treatments per week: -week of 1/22/2025 - 1/28/2025: 1/22/2025, 1/23/2025, 1/24/2025, 1/25/2025, 1/26/2025 (five times a week) - week of 1/29/2025 - 2/4/2025: 1/29/2025, 1/30/2025, 1/31/2025, 2/3/2025, 2/4/2025 (five times a week) (continued on next page)

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	05/09/2025

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 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- week of 2/5/2025 - 2/11/2025: 2/5/2025, 2/6/2025, 2/7/2025, 2/8/2025, 2/10/2025 (five times a week) - week of 2/12/2025 - 2/18/2025: 2/13/2025, 2/15/2025, 2/16/2025, 2/17/2025 (four times a week) - week of 2/19/2025 - 2/25/2025: 2/21/2025 (one time a week) - week of 2/26/2025 - 3/4/2025: 3/4/2025 (one time a week) During an interview and record review of Resident 128's OT records on 5/7/2025 at 2:44 p.m., the Director of Rehabilitation (DOR) reviewed Resident 128's OT Evaluation and Plan of Treatment and OT TENs and stated Resident 128 should be seen five times a week for OT because it was the plan of treatment for Resident 128. DOR stated Resident 128 did not receive OT treatment five times a week and the OT TEN did not indicate why Resident 128 did not receive OT treatment. DOR stated it could have been scheduling but could not be sure. DOR stated Resident 128 was at risk of not meeting his OT goals such as strength and ADLs because he was not receiving his OT treatments per the OT plan of treatment. During a review of the facility's policy and procedures (P&P) titled, Staff Occupational Therapist, the P&P indicated, follow relevant physician orders for evaluation and treatment .in consultation with the resident's physician develop and implements treatment plans for residents.

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	05/09/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41379 2. During a review of Resident 128's Face Sheet (FS), the FS indicated Resident 128 admitted to the facility on [DATE] with diagnoses including, but not limited to, muscle wasting and atrophy (weakening, shrinking, and loss of muscle) and right humeral neck fracture (broken bone of upper arm). During a review of Resident 128's Physician's History and Physical Examination (H&P) dated 8/10/2024, the H&P indicated Resident 128 had the capacity to understand and make decisions. During a review of Resident 128's Minimum Data Set (MDS, resident assessment tool) dated 2/10/2025, the MDS indicated Resident 128 had moderate cognitive impairments (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving). The MDS indicated Resident 128 had functional limitation impairments in range of motion (ROM, full movement potential of a joint) on one side of the upper extremity (UE, shoulder, elbow, wrist, hand) and no impairments on the lower extremity (LE, hip, knee, ankle, foot). The MDS also indicated Resident 128 required supervision for eating, dependent assistance with dressing, bathing, and maximal assistance with sit to stand and bed to chair transfers. During a review of Resident 128's OT Care Plan (CP) dated 1/22/2025, the CP indicated the approach plan included OT five times a week once a day for four weeks. During a review of Resident 128's OT Progress Report dated 2/24/2025, the OT Progress Report indicated it was signed and completed on 3/4/2025. During a review of Resident 128's OT Progress Report dated 3/3/2025, the OT Progress Report indicated it was signed and completed on 3/17/2025. During a review of Resident 128's OT Discharge Summary (DC) dated 3/4/2025, the OT DC indicated it was signed and completed on 3/17/2025. During an interview and record review of Resident 128's OT records on 5/7/2025 at 2:44 p.m., the Director of Rehabilitation (DOR) reviewed Resident 128's OT Progress Notes dated 2/24/2025, 3/3/2025, and OT DC dated 3/4/2025 and stated the OT Progress Notes and OT DC were documented very late. DOR stated the OT documentation should be completed timely and within one to two days after. DOR stated it was important to complete the documentation timely, because the DC summary assisted in transitioning a resident to RNA services after DC from therapy and other disciplines and medical professionals may need to see the documentation to see how the resident did in therapy and get as accurate of a picture as possible. During an interview on 5/9/2025 at 10:36 a.m., the Director of Nursing (DON) stated it was important to document timely to ensure accuracy of the documentation and for all the healthcare providers to see everything the resident received in terms of treatments. DON stated it was important for others to see what was provided to the resident so that healthcare providers could use the information for care. (continued on next page)

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	05/09/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedures (P&P) titled, Clinical Documentation Overview, the P&P indicated, a progress report must be completed .within seven days of the initial evaluation and every seven days as long as the resident is on caseload. Discharge summaries are completed .within seven days from the last day of treatment. During a review of the facility's policy and procedures (P&P) titled, Staff Occupational Therapist, the P&P indicated, complete all documentation in resident's chart including care plans .progress reports and discharge summaries. 44244 Based on observation, interview, and record review, the facility failed to maintain accurate clinical records in accordance with accepted professional standards and practices by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 2 accurately documented in the medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) the time of medication administration on 5/6/2025 for one of fourteen sampled residents (Resident 96) reviewed during the Accidents care area. This resulted in inaccurate documentation in Resident 96's medical chart. 2. Ensure Occupational Therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Progress notes and Discharge Summary were documented timely for one of six sampled residents (Resident 128). This deficient practice had the potential to cause inaccurate documentation and delay continuity of services for Resident 128. Findings: 1. During a review of Resident 96's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted the resident on 8/1/2020 and most recently admitted the resident on 3/24/2025 with diagnoses that included polyneuropathy (a disorder of the peripheral nervous system that may result in pain, discomfort, and mobility issues), essential (primary) hypertension (high blood pressure with an unknown cause) major depressive disorder (persistent feelings of sadness and loss of interest that can interfere with daily living), anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), binge eating disorder (a mental illness that causes chronic, compulsive overeating), and unspecified intellectual disabilities (a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently). During a review of Resident 96's Minimum Data Set (MDS - resident assessment tool) dated 4/4/2025, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated that the resident was dependent on staff for toileting and bathing, required substantial / maximal assistance for dressing and moving from lying to sitting, and required partial/moderate assistance for personal hygiene and rolling left and right in the bed. (continued on next page)

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	05/09/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 96's History and Physical (H&P), dated 3/26/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 96's Physician Order Sheet, the Physician Order Sheet indicated the following orders: - Bupropion HCL XL (a medication used to treat depression) 300 milligram (mg, a unit of measurement) 24-hour tablet, extended release, give one tablet daily at the a.m. medication (med) pass by mouth, for major depressive disorder manifested by sad facial expressions, dated 3/25/2025. - Buspirone (a medication used to treat anxiety) 10 mg tablet, give one tablet two times a day at the a.m. and dinner med pass by mouth for anxiety disorder manifested by repetitive health complaints, dated 3/24/2025. - Carvedilol (a medication used to treat high blood pressure) 25 mg tablet, one tablet two times daily at the a.m. and dinner med pass by mouth, for essential hypertension, hold (do not give) for systolic blood pressure (SBP, measures the pressure in your arteries [pathway that carries blood away from the heart] less than 110, dated 3/24/2025. - Lisdexamfetamine (a medication used to treat binge eating disorder) 30 mg capsule, give one capsule daily at the a.m. med pass by mouth, for binge-eating disorder, dated 3/24/2025. - Vitamin D3 (a supplement) 25 mcg (microgram, a unit of measurement), three tablets daily at the a.m. med pass for supplement, dated 4/3/2025. During a review of Resident 96's CP regarding the resident has nine or more medications, dated 3/31/2025, the CP indicated there was a potential for adverse drug effects and drug interactions and to give medications as ordered. During a concurrent observation and interview on 5/6/2025 at 10:50 a.m., with Resident 96, observed Resident 96 sitting up in bed. Observed a clear plastic medicine cup containing two capsules and three tablets on the bedside rolling table. Resident 96 stated the medication belonged to Resident 96 and the Licensed Vocational Nurse (LVN) left the medication on the table because the resident does not like to take all the medication at the same time. Resident 96 stated the resident forgot to take all the medication that was left by the LVN. During a concurrent observation and interview on 5/6/2025 at 11:04 a.m., with LVN 2, observed LVN 2 entered Resident 96's room and stated LVN 2 left the medication for Resident 96 to self-administer, but the resident did not administer the medication. Observed Resident 96 swallowed the five medications in the cup. (continued on next page)

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	05/09/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview and record review on 5/6/2025 at 2:35 p.m., LVN 2 reviewed Resident 96's physician orders, MAR, and Nursing Progress Notes. LVN 2 stated the facility medication administration process is to take the resident's medication to bedside, watch the resident take the medication to make sure the resident safely administers all the medication, then document in the MAR the date and time the resident took the medication. LVN 2 stated the a.m. med pass time is one hour before or one hour after 9 a.m. LVN 2 stated Resident 96's lisdexamfetamine, bupropion, buspirone, carvedilol, and one tablet of Vitamin D were administered at 11 a.m. and not administered during the scheduled a.m. med pass time. LVN 2 stated LVN 2 documented in the MAR before Resident 96 administered the medications. LVN 2 reviewed Resident 96's MAR and noted LVN 2 documented the administration of Resident 96's medications as administered during the a.m. scheduled medication pass time, but the medications were administered late at 11 a.m. LVN 2 stated there was no documented evidence that Resident 96's medications were administered late. LVN 2 stated Resident 96's MAR did not accurately reflect the time the medications were administered. During an interview and record review on 5/6/2025 at 3:01 p.m., with Registered Nurse (RN) 1, RN 1 stated the process for documenting in the MAR is the LVN documents after the administration of the medication to ensure that the resident took the medication, and that the documentation is accurate. During a concurrent interview and record review on 5/9/2025 at 9 a.m., the Director of Nursing (DON) reviewed Resident 96's MAR, A.M. Med Pass 5/6/2025 record of administration times, physician orders, and the facility policy and procedures regarding medication administration. The DON stated the MAR is used by nursing staff and physicians to know what medications are administered, who administered the medications, and when the medications were administered. The DON stated it is important that the MAR is correct because the resident's medical record should be accurate and reflect the actual care provided. The DON stated LVN 2 did not follow the facility P&P when LVN 2 documented in the MAR that Resident 96's medications were administered at 8:31 a.m. on 5/6/2025, but the resident actually took the medications at 11 a.m. The DON stated when Resident 96's MAR was not accurate it could have potentially resulted in miscommunication with other staff regarding when the resident took the medication and an inaccurate medical record. During a review of the facility P&P titled, Documentation of Medication Administration, last reviewed 1/16/2025, the P&P indicated a medication administration record is used to document all medications administered. A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's medication administration record (MAR). The administration of medication is documented immediately after it is given. Documentation of medication administration includes, as a minimum: a) the resident's name; b) name and strength of the drug; c) dosage; d) route of administration; e) date and time of administration; (continued on next page)

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	05/09/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility P&P titled, Charting and Documentation, last reviewed 1/16/2025, the P&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. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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	05/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44244 Based on observation, interview, and record review, the facility failed to implement appropriate infection control practices for four of eight sampled residents (Residents 26, 82, 290, 1) reviewed for Infection Control and one of four sampled residents (Resident 175) reviewed during Respiratory care area, by failing to: 1. Implement Enhanced Barrier Precautions (EBP, sometimes referred to as enhanced standard precautions, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted gown and glove use during high contact resident care activities) for Resident 26 with a history of vancomycin-resistant enterococcus (VRE, a type of bacteria called enterococci that have developed resistance to many antibiotics, especially vancomycin [an antibiotic]). 2. Ensure Restorative Nursing Aide (RNA 1) properly disinfected a cloth gait belt (safety device worn around the waist that can be used help safely transfer a person from one surface to another) during a treatment session with Resident 82. 3. Ensure a bottle of Prostat (supplement for dietary management of wounds and other conditions requiring increased protein) was kept clean and in sanitary condition before and after use for three of three sampled medication carts. 4. Ensure Certified Nursing Assistant 1 (CNA 1) wore a protective gown when providing a bed bath to Resident 290 who was on EBP. 5. Ensure Licensed Vocational Nurse 1 (LVN 1) wore a protective gown secured at the back of the neck and waist during medication administration to Resident 1 who was on EBP. 6. Ensure four linen carts were fully protected from dust. The Four linen carts were observed with loosely woven mesh cover. These deficient practices had the potential to spread infections and illnesses to residents, visitors, and staff. 7. Store the Bilevel Positive Airway Pressure (BiPAP-a non-invasive ventilation therapy that uses a machine to deliver two different levels of air pressure to the patient during breathing) mask in a manner that is free from contamination for Resident 175. 8. Store the nebulizer (a medical device that converts liquid medication into a fine mist that can be inhaled through the lungs) in a clear plastic bag, labeled with the resident's name and date it was last changed for Resident 175. 9. Ensure the BiPAP was administered and documented according to the physician's order for Resident 175. 10. Ensure BiPAP was cleaned per manufacturer's instructions for Resident 175. (continued on next page)

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	05/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These deficient practices had the potential to promote growth and spread of bacteria on the respiratory tubing causing illness and cause the residents to experience respiratory problems and distress such as shortness of breath and chest congestion to Resident 175. Findings: a. During a record review of Resident 26's Face Sheet (FS, Admission Record), the FS indicated Resident 26 was admitted to the facility on [DATE] and most recently admitted [DATE] with diagnoses including pneumonia (an infection/inflammation in the lungs), urinary tract infection (UTI- an infection in the bladder/urinary tract), and resistance to vancomycin. During a record review of Resident 26's Physician Orders Sheet, the Physician Order Sheet indicated the following orders: - Dated 3/15/205 and discontinued on 3/18/2025, contact isolation precaution for VRE of urine. - Observe Enhanced Standard Precautions every shift, dated 1/12/2025. During a record review of Resident 26's Minimum Data Set (MDS, resident assessment tool) dated 4/1/2025, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated that the resident was dependent on staff for toileting, bathing, dressing, and mobility. During a concurrent observation and interview on 6/7/2025 at 9 a.m., Resident 26 was observed lying in bed. There was no TBP sign posted on the door. LVN 9 was observed entering Resident 26's room wearing gloves and mask, but no gown. LVN 9 stood at the resident's bedside and administered Resident 26's oral medication, touching the resident's medication cup before and after the cup touched the resident. LVN 9 exited the resident's room and stated the resident was on regular standard precautions (the basic level of infection control including proper hand washing). During a concurrent observation and interview on 5/7/2025 at 4:07 p.m., with Certified Nursing Assistant (CNA) 8, Resident 26 was observed lying in bed and there was no EBP sign posted at the door. CNA 8 stated she is not assigned to care for Resident 26 but often helps the assigned CNA because the resident requires two people to provide care. CNA 8 stated Resident 26 is not on EBP because there is no isolation cart with personal protective equipment (PPE - specialized clothing used to protect from exposure to potentially infectious materials to avoid injury or disease) at the room entrance or an EBP sign posted at the door. CNA 8 stated there is no EBP sign posted at the door and CNA 8 does not wear a gown while providing linen changes to the resident. During a concurrent interview and record review on 5/7/2025 at 4:10 p.m., with Registered Nurse (RN) 6, RN 6 reviewed Resident 26's physician orders and care plans, RN 6 stated Resident 26 had a history of VRE in the urine. RN 6 stated VRE is an MDRO. RN 6 stated Resident 26 had an order for EBP. RN 6 stated the Infection Preventionist (IP) is responsible for ensuring the correct isolation is implemented for residents. (continued on next page)

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	05/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/7/2025 at 4:20 p.m., with the IP, the IP reviewed Resident 26's physician's orders, care plans, and the Antibiotic Log dated 3/2025. The IP stated EBP is a method to prevent the transmission of MDROs for residents with a history of MDROs or other indwelling devices that make a resident more susceptible to contracting MDROs. The IP stated the facility process for EBP is to place an isolation cart with PPE and an EBP sign at the entrance to the room and the staff should wear gowns, gloves, and a mask when providing care to the residents. The IP stated EBP should be implemented when medications are administered to residents on EBP. The IP stated Resident 26 was previously on contact isolation (measure aimed to prevent spread of infection by direct or indirect contact) for VRE of urine, but the contact isolation order was discontinued after the resident completed the treatment. The IP stated Resident 26 was not on EBP. The IP stated VRE is an MDRO. The IP stated residents with a history of MDRO should be on EBP, and Resident 26 had a history of an MDRO. The IP stated the IP did not implement EBP for Resident 26 but should have. The IP stated Resident 26 had an order for EBP, but the IP missed implementing EBP for the resident. The IP stated that when EBP was not implemented for Resident 26 there was a potential risk to spread MDROs to other residents in the facility because MDROs can be spread by contact from one resident to another on the staff members clothing. During a concurrent interview and record review on 5/9/2025 at 9 a.m., the Director of Nursing (DON) reviewed the facility policy and procedures (P&P) regarding EBP. The DON stated EBP uses targeted gown and glove use while providing care to residents at risk of transmitting or becoming infected with MDROs. The DON stated for residents on EBP there should be a sign posted at the door, and a gown, and gloves should be worn when providing care to the residents. The DON stated Resident 26 has a history of VRE and is considered colonized with VRE. The DON stated when EBP was not implemented for Resident 26 there was a potential to spread MDRO infections among residents. The DON stated the facility P&P were not followed. During a review of the facility P&P titled, Administering Medications, last reviewed 1/16/2025, the P&P indicated medications are administered in a safe and timely manner, and as prescribed. Staff follow established facility infection control procedures (e.g., handwashing, antiseptic techniques, gloves, isolation precautions, etc.) for the administration of medications, as applicable. During a review of the facility P&P titled, Enhanced Barrier Precautions, last reviewed 1/16/2025, the P&P indicated enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). EBPs are indicated (when contact precautions do not otherwise apply) for residents infected or colonized with the following: Vancomycin-resistant Enterococci (VRE). Standard precautions apply to the care of all residents regardless of suspected or confirmed infection or colonization status. Staff are trained prior to caring for residents on EBPs. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is available outside of the resident rooms. 41379 (continued on next page)

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	05/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a record review of Resident 82's Face Sheet (FS), the FS indicated Resident 82 was admitted to the facility on [DATE] with diagnoses including, but not limited to dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a record review of Resident 82's Physician Order Sheet May 2025, the Physician Order Sheet indicated an order dated 7/14/2024 to observe enhanced standard precaution (EBP, intervention designed to reduce transmission of infectious organisms) every shift. During a record review of Resident 82's Enhanced Standard Precaution Care Plan dated 7/24/2024, the CP indicated staff will provide frequent and effective environmental cleaning. During a record review of Resident 82's Minimum Data Set (MDS, resident assessment tool) dated 1/17/2025, the MDS indicated Resident 82 had intact cognition (sufficient judgement, planning, organization to manage average demands in one's environment). The MDS indicated Resident 82 had functional limitations in range of motion on one side of the upper extremity and one side of the lower extremity. The MDS indicated Resident 82 required supervision for eating, moderate assistance with bathing, upper body dressing, personal hygiene, sitting to stand, and bed to chair transfers. During an observation on 5/7/2025 at 9:40 a.m. while in the hallway, RNA 1 put a cloth gait belt around Resident 82's waist. RNA 1 proceeded to ambulate with Resident 82 standing to the right of Resident 82 and Restorative Nursing Aide (RNA 2) was following behind with the wheelchair. During an observation and interview on 5/7/2025 at 9:48 a.m., RNA 1 completed her RNA session with Resident 82 and exited Resident 82's room. RNA 1 had a rolled-up cloth gait belt inside the shirt pocket. RNA 1 stated she used the cloth gait belt with Resident 82 during ambulation and showed the cloth gait belt in the right pocket. RNA 1 stated she disinfected the cloth gait belt with the bleach wipes and then used the same gait belt for another resident later. During an interview on 5/7/2025 at 11:11 a.m., the Infection Preventionist (IP) staff should not use cloth gait belts with residents and should be using the vinyl gait belts. IP stated the cloth gait belts were considered porous surfaces and the disinfecting wipes could only be used for non-porous surfaces. IP stated if staff were using cloth gait belts and the gait belts were not properly disinfected between residents, the bacteria could stay on the gait belt and the bacteria could be transmitted to another resident. IP stated staff should properly disinfect all shared equipment before and after each resident use as a part of infection control to avoid spreading viruses and bacteria to another resident. IP stated if a resident was on EBP, then it was especially important to properly disinfect gait belts to prevent multi-drug-resistant organisms (MDRO, organisms that are resistant to multiple antibiotics and are difficult to treat). During an interview on 5/9/2025 at 10:36 a.m., the Director of Nursing (DON) stated staff needed to disinfect shared equipment between resident use to prevent the spread of infection. The DON stated staff have to use the right techniques to clean equipment and disinfecting wipes could not be used to clean a cloth gait belt. The DON stated that because RNA 1 did not properly disinfect the cloth gait belt between resident use, there was a potential to spread infection that Resident 82 might have to other residents. (continued on next page)

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	05/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedures titled, Cleaning and Disinfection of Resident-Care Items and Equipment, indicated resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current [Center for Disease Control] recommendations for disinfection. Reusable items are cleaned and disinfected or sterilized between residents (e.g. durable medical equipment). Durable medical equipment must be cleaned and disinfected before being reused by another resident. During a review of the facility's policy and procedures titled, Cleaning and Disinfection of Environmental Surfaces, indicated manufacturers' instructions will be followed for proper use of disinfecting products. 42311 c. During a concurrent observation, and interview on 5/6/2025, at 8:15 a.m., while outside of Resident 3's room, with LVN 1, LVN 1 poured 30 cubic centimeters (cc-unit of volume) of Prostat to a medication cup. Observed LVN 1 closed the bottle and returned the bottle to the bottom drawer of Medication Cart 1. Observed Prostat bottle with yellow drippings on the side of the bottle. During a concurrent observation, and interview on 5/6/2025, at 11:03 a.m., while in Nurses Station B, with LVN 8, Medication Cart 4 was reviewed. LVN 8 pulled Prostat from the bottom right drawer of Medication Cart 4. The Prostat bottle was sticky to touch with light yellow drippings on the side of the bottle. LVN 8 stated the Prostat bottle should be wiped clean after pouring the medication. During a concurrent observation, and interview on 5/6/2025, at 11:15 a.m., in Nurses Station A, with LVN 7, Medication Cart 3 was reviewed. LVN 7 pulled Prostat from the bottom left drawer of the Medication Cart 3. Prostat bottle sticky to touch with light yellow stains on the side of the bottle. LVN 7 stated Prostat bottle should be cleaned every after use to prevent spread of infection. During an interview on 5/7/2025, at 8:06 a.m., with LVN 6, LVN 6 stated the Prostat bottle should be cleaned before and after use. LVN 6 stated nurses should wipe it clean to prevent germs from sticking on the bottle for infection control. During an interview on 5/7/2025, at 9:51 a.m., with the Director of Staff Development (DSD), the DSD stated nurses should clean the medication bottle every time the nurses use it to prevent spillage and to prevent the medication cart from getting dirty to prevent infection. During a concurrent interview and record review on 5/9/2025, at 11:10 a.m., with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, and last reviewed on 1/16/2025, the P&P indicated, Staff follows established facility infection control procedures (handwashing, antiseptic technique [a set of procedures designed to prevent infection by minimizing or eliminating contamination from microorganisms], gloves, isolation precautions [measures designed to prevent the transmission of infectious agents in healthcare and residential settings, creating barriers between people and germs]) for the administration of medications, as applicable. The DON stated all liquid bottles should be wiped clean to prevent contamination, spread of infection and to keep the medication bottle clean for sanitary purposes. (continued on next page)

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	05/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. During a review of Resident 290's Face Sheet, the Face Sheet indicated the facility admitted Resident 290 on 4/28/2025, with diagnoses that included encounter for other orthopedic (branch of medicine dealing with the correction of deformities of bones or muscles) aftercare (the nursing and care of people who have been treated in a hospital, and who are now recovering), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and essential hypertension (a type of high blood pressure where the underlying cause is unknown). During a review of Resident 290'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), dated 4/29/2025, the H&P indicated Resident 290 had the capacity to understand and make decisions. During a review of Resident 290's Care Plan on Enhanced Standard Precaution (EBP), dated 4/29/2025, the Care Plan indicated Resident 290 was on ESP/EBP due to unhealed wounds. The Care Plan indicated the following interventions: 1. Wear personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) as indicated. 2. Post ESP/EBP communication signs. During an observation on 5/6/2025, at 8:15 a.m., while outside of Resident 290's room an EBP signage was posted. During an observation on 5/6/2025, at 8:27 a.m., while in Resident 290's room, CNA 1 was observed at Resident 290's bedside without wearing a gown. During a concurrent observation, and interview on 5/6/2025, at 8:32 a.m., while outside of Resident 290's room, with LVN 1, LVN 1 stated Resident 290 was on EBP. LVN 1 stated CNA 1 did not wear a gown while providing a bed bath to Resident 290. LVN 1 stated CNA 1 should wear a gown. During an interview on 5/7/2025, at 8:06 a.m., with LVN 6, LVN 6 stated residents with wounds, on dialysis (treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed), had a catheter (a thin, flexible tube used to drain urine from the bladder) and gastrostomy tube (g-tube a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) are on EBP. LVN 6 stated nurses who will provide care need to wear gloves, gowns and mask. LVN 6 stated CNA 1 who provided a bed bath to Resident 290 should wear a gown to prevent any transmission of infection from residents to staff or staff to residents. During an interview on 5/7/2025, at 9:51 a.m., with the DSD, the DSD stated CNA 1 should use gloves and wear a gown when providing a bed bath to Resident 290, who was on EBP, to prevent infection transmission. During an interview on 5/7/2025, at 4:16 p.m., with the DON, the DON stated, the facility failed to ensure that the staff followed infection control protocol by not wearing a gown while proving care to Resident 290. The DON stated PPE like gowns are used to prevent spread of infection. (continued on next page)

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	05/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, and record review on 5/9/2025, at 11:10 a.m., with the DON, the facility P&P titled, Enhanced Barrier Precaution, dated 8/2022, and last reviewed on 1/16/2025, the P&P indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities (tasks that involve close, direct interaction with a resident), when contact precautions (measures taken in healthcare settings to prevent the spread of infectious agents through direct or indirect contact with a patient or their environment) do not otherwise apply. a. Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room). 3. Examples of high-contact resident care activities requiring the use of gowns and gloves for EBPs include: a. Dressing. b. Bathing/showering. c. Transferring. d. Providing hygiene. e. Changing linens. f. Changing briefs or assisting with toileting. g. Device care or use and h. Wound care (any skin opening requiring a dressing). The DON stated staff need to wear a gown to protect residents and staff from cross contamination. During a review of facility's P&P titled, Infection Control Guidelines for All Nursing Procedures, dated 4/2013, and last reviewed on 1/16/2025, the P&P indicated, Wear personal protective equipment as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious materials. e. During a review of Resident 1's Face Sheet, the Face Sheet indicated the facility admitted Resident 1 on 9/21/2023, with diagnoses that included other idiopathic peripheral neuropathy (nerve damage without a known cause), multiple sclerosis (MS-a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord) and non-pressure chronic ulcer of left foot (a long-lasting open sore on the foot that is not caused by pressure from external sources). During a review of Resident 1's Care Plan on ESP/EBP dated 10/9/2023, the Care Plan indicated Resident 1 was on ESP due to the presence of an indwelling catheter and unhealed wounds. The Care Plan indicated the following intervention: (continued on next page)

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	05/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. ESP and PPE as indicated-gloves, gown, face shields (covers the face and sometimes the forehead and chin to protect it from dust, debris, and liquid splash) 2. Post ESP communication signs. During a review of Resident 1's Physician Order Sheet, dated 10/9/2023, the Physician order Sheet indicated an order to observe enhanced standard precaution every shift. During a review of Resident 1's H&P, dated 10/24/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills were moderately impaired. The MDS indicated Resident 1 was dependent on staff for toileting and showering. The MDS indicated Resident 1 had a catheter. During an observation on 5/6/2025, at 10:06 a.m., while outside of Resident 1's room, EBP signage was posted outside of Resident 1's room. LVN 1 was observed during the medication administration standing on the right side of Resident 1's bed. LVN 1 wore a gown, but it was not secured at the back. During a concurrent observation, and interview on 5/6/2025, at 10:07 a.m., while in Resident 1's door, with Registered Nurse 5 (RN 5), LVN 1 was observed standing beside Resident 1 with the gown wide open at LVN 1's back. RN 5 stated LVN 1 should have tied or closed the gown at the back. RN 5 stated the gown is closed at the back to prevent contamination (something has become dirty) and spread of infection. During an interview on 5/7/2025, at 8:06 a.m., with LVN 6, LVN 6 stated the proper way of wearing a gown was to tie it at the back of the neck and waist to protect residents and staff from infection. During an interview on 5/7/2025, at 9:51 a.m., with the DSD, the DSD stated LVN 1 should have made sure the gown was closed on the back. The DSD stated if the gown reopens at the back, the nurses had to change the gown to prevent staff and resident exposure to infection. During an interview on 5/7/2025, at 4:16 p.m., with the DON, the DON stated, the facility failed to ensure LVN 1 wore the gown correctly. The DON stated LVN 1 should have removed her (LVN 1) gloves and resecured or closed her (LVN 1)'s gown at the back. The DON stated this is done to prevent spread of infection. During a concurrent interview, and record review on 5/9/2025, at 11:10 a.m., with the DON, the facility's P&P titled, Personal Protective Equipment-Using Gowns, dated 9/2010, and last reviewed on 1/16/2025, the P&P indicated, Putting on the gown. 7. Secure at the neck (tie or Velcro [two strips of thin plastic sheet, one covered with tiny loops and the other with tiny flexible hooks, which adhere when pressed together]) 8. Overlap the gown at the back. Be sure clothing is completely covered. (continued on next page)

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	05/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Secure at the waste (tie or Velcro). The DON stated the policy for proper PPE use was for the gown to be secured at the back of the neck and waist. f. During an observation on 5/7/2025, at 7:41 a.m., while inside the Laundry Room, two linen carts with blue mesh cover were observed. The Linen cart had a loosely woven mesh cover. During a concurrent observation, and interview on 5/7/2025, at 7:44 a.m., with the Director of Laundry Services (DLS), two linen carts inside the laundry room were observed with a blue mesh loosely woven cover. The DLS stated the facility already changed all the linen cart cover with smaller mesh holes and there were only four linen cart cover left that needed to be changed. The DLS stated the linen cart cover protects the linens from dust and if mesh holes are big, the linen can get dirty and can be contaminated. During an interview on 5/7/2025, at 8:22 a.m., with CNA 9, CNA 9 stated the linen cart with blue mesh cover can easily get dirty as dust can easily go through. During an interview on 5/9/2025, at 11:10 a.m., with the DON, the DON stated the linen cart cover was used for dignity issues. The DON stated the fully covered linen cart can prevent the linen from accumulating dust and dirt. During a review of facility's P&P titled, Departmental (Environmental Services)-Laundry and Linen, dated 4/2013 and last reviewed on 1/16/2025, the P&P indicated, The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen. 38552 g. During a review of Resident 175's Admission Record, the Admission Record indicated the facility admitted the resident on 4/14/2025 with diagnoses including acute respiratory failure (a condition where the respiratory system can't effectively exchange oxygen and carbon dioxide, leading to a buildup of carbon dioxide and a deficiency of oxygen in the blood), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 175's History and Physical (H&P), dated 4/14/2025, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 175's Physician Order, dated 4/14/2025, the Physician Order indicated BiPAP, apply at hours of sleep (HS), remove in AM (morning). During a review of Resident 175's Minimum Data Set (MDS-a resident assessment tool), dated 4/25/2025, the MDS indicated had clear speech, adequate vision and hearing. The MDS indicated that the resident makes self-understood and had the ability to understand others. (continued on next page)

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 05/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 175's Respiratory Distress Care Plan, dated 4/14/2025, the Respiratory Distress Care Plan indicated the resident with goals of no signs and symptoms of respiratory distress with interventions including BiPAP at night. During a concurrent observation and interview on 5/6/2025 at 9:25 a.m. with Resident 175, while at Resident 175's bedside, the BiPAP mask was hanging on the side of the resident's wheelchair's brake handle. Resident 175 stated no one had come to turn off his BiPAP machine so he placed it on the side of his wheelchair. Resident 175 stated he does not touch his BiPAP machine. Resident 175 stated one of the nurses come and turns it on and off and at night they placed it on him. Resident 175 stated he only wears the BiPAP at night and it helps him breathe while he sleeps. Resident 175 stated Certified Nursing Assistant (CNA) 12, his assigned CNA, knows all about his BiPAP. Resident 175 stated no one had cleaned his BiPAP machine, the nurse would come in and remove his mask and turned it off and at night they put it on. During a concurrent observation and interview on 5/6/2025 at 9:31 a.m. with CNA 12, while at Resident 175's bedside, CNA 12 stated she does not touch the BiPAP machine, but she will move the BiPAP mask from the wheelchair to the table because she is going to transfer Resident 175 from bed to wheelchair to get him ready for activities in the activity room. During a concurrent observation and interview on 5/6/2025 at 9:40 a.m. with Registered Nurse (RN) 1, while at Resident 175's bedside, RN 1 stated the BiPAP mask is still on and blowing air. RN 1 stated the charge nurse removes the mask in the morning and turns off the machine. RN 1 stated it should have been turned off. RN 1 stated they do not clean the BiPAP mask and machine. RN 1 stated the BiPAP mask and nebulizer was placed on the same clear plastic bag with no label of the resident's name and date of when it will be changed. RN 1 stated there should be the resident's name and date on the plastic bag, so they know who it belongs to, and it's the correct resident and know when the nebulizer tubing and bag need to be changed. RN 1 stated this is for infection control. During a concurrent observation and interview on 5/8/2025 3:36 p.m. with Licensed Vocational Nurse (LVN) 4 and LVN 5, at the nursing station, LVN 4 stated she uses the alcohol sanitizer wipes to sanitize the BiPAP mask. LVN 5 stated she works during the evening shift and places the BiPAP mask on Resident 175. LVN 5 stated she washes the BiPAP mask using an antibacterial soap and water every night at 8 p.m. and puts it on the resident at 9 p.m. During a concurrent interview and record review on 5/8/2025 at 3:40 p.m. with LVN 4, Resident 175's care plans, LVN 4 stated the respiratory care plan does not mention how often the BiPAP machine is to be cleaned and the duration of BiPAP treatment. LVN 4 stated the respiratory care plan only indicated BiPAP at night it is not specific. LVN 4 stated it should be indicated in the care plan, including the cleaning and duration of therapy. LVN 4 stated the resident could potentially be at risk for infection because the air could be dirty. During a concurrent interview and record review on 5/8/2025 at 4:26 p.m. with LVN 5, Resident 175's nursing progress notes and treatment administration record, from 4/2025 to 5/2025 were reviewed. LVN 5 stated she did not document when she cleaned the BiPAP mask for Resident 175. LVN 5 stated she documented on 4/20/2025 and 5/2/2025 that she administered it, and no other notes documented when it was last cleaned. LVN 5 stated if it is not documented it was not done. LVN 5 stated she does not document when she cleaned the BiPAP mask. LVN 5 stated the standard of practice is to document the care and treatment provided to the residents. (continued on next page)

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	05/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/9/2025 at 12:46 p.m. with the Director of Nursing (DON), the DON stated the order for BiPAP would include the setting, the time should be on and off, and the reason or diagnosis for the use of BiPAP. The DON stated on the administration record it should be documented 9am off and 9pm on. The DON stated BiPAP is a treatment provided for residents with sleep apnea (a sleep disorder characterized by repeated episodes of breathing cessation (apnea) or shallow breathing during sleep). The DON stated with the care and maintenance of the BiPAP machine in addition to their facility's policy they also follow the manufacturer's guidelines. The DON stated licensed nurses, RN or LVN, should have included the cleaning and care o [TRUNCATED]

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	05/09/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 42311 Based on interview and record review, the facility failed to implement the policy for antibiotic (medication used to treat infection) stewardship (efforts in doctors' offices, hospitals, long-term care facilities, and other health care settings to ensure that antibiotics are used only when necessary and appropriate, means prescribing the right drug at the right dose at the right time for the right duration) for one of three sampled residents (Resident 42) by failing to ensure Resident 42's Antibiotic Log (record that involves the systematic collection, analysis, and interpretation of data related to infections within a healthcare setting) antibiotics use was accurately filled up on 4/2025. This failure had the potential to increase antibiotic resistance (the ability of bacteria and other microorganisms to survive exposure to an antibiotic that would normally kill them) from unnecessary or inappropriate antibiotic use. Findings: During a review of Resident 42's Face Sheet (Admission Record), the Face Sheet indicated the facility admitted Resident 42 on 2/12/2025, with diagnoses including other low back pain, history of falling, and essential hypertension (a type of high blood pressure where the underlying cause is unknown). During a review of Resident 42'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), dated 2/18/2025, the H&P indicated Resident 42 had the capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS - a resident assessment tool), dated 2/18/2025, the MDS indicated Resident 42's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. During a review of Resident 42'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 Form, dated 4/10/2025, the SBAR indicated Resident 42 had urinary tract infection (UTI - an infection in the bladder/urinary tract) and the physician was notified on 4/10/2025, at 11:54 a.m. During a review of Resident 42's Physician Order Sheet, dated 4/2025, the Physician Order Sheet, dated 4/10/2025, indicated ciprofloxacin (medication used to treat infection) 500 milligram (mg - metric unit of measurement, used for medication dosage and/or amount) one tablet by mouth two times a day for seven days for UTI. The Physician Order Sheet dated 4/11/2025, indicated ciprofloxacin was discontinued. During a review of Resident 42's Physician Order Sheet, dated 4/11/2025, the Physician Order Sheet indicated Keflex (medication used to treat infection) 500 mg one capsule by mouth four times a day for seven days for UTI. (continued on next page)

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	05/09/2025

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Antibiotic Log, dated 4/2025, the Antibiotic Log indicated Resident 42's ciprofloxacin was started on 4/10/2025 and completed on 4/18/2025. During an interview, on 5/7/2025, at 1:04 p.m., with Registered Nurse (RN) 3, RN 3 stated Resident 42's order for ciprofloxacin was changed to Keflex on 4/11/2025, due to a urine culture and sensitivity (a laboratory procedure used to diagnose UTI by identifying the bacteria present in a urine sample and determining which antibiotics are effective against them) result that Resident 42 was sensitive (the ability of specific antibiotics to inhibit or kill the bacteria identified in the urine sample) to ciprofloxacin. During an interview, on 5/7/2025, at 1:43 p.m., with the Infection Preventionist (IP), the IP stated Resident 42's urine was tested for urine culture and sensitivity collected on 4/11/2025, that resulted in Resident 42's resistance (when the bacteria changes and resists the effects of the antibiotic and the antibiotic no longer works well against the bacteria causing the infection) to ciprofloxacin. During a concurrent interview and record review, on 5/7/2025, at 2 p.m., with the IP, the facility's Antibiotic Log, dated 4/2025, was reviewed. The IP stated Resident 42's Keflex start date and completion date was not in the Antibiotic Log. The IP stated Resident 42's Keflex should be in the Antibiotic Log. The IP stated facility's Antibiotic log was incomplete. During an interview, on 5/7/2025, at 4:16 p.m., with the Director of Nursing (DON), the DON stated the IP should have updated the facility's Antibiotic Log. The DON stated the importance of Antibiotic Log was to make sure that the right antibiotic was given to Resident 42 following the physician order. During a concurrent interview and record review, on 5/9/2025, at 11:10 a.m., with the DON, the facility's policy and procedures (P&P) titled, Antibiotic Stewardship, dated 12/2016 and last reviewed on 1/16/2025, the P&P indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. The purpose of the Antibiotic Stewardship Program is to monitor the use of the antibiotics in our residents. The DON stated the IP's Antibiotic Log was incomplete. The DON stated it is the facility's policy to monitor and document use of all antibiotics. During a review of facility's P&P titled, The Role of the Facility Infection Prevention/Control Nurse in General and During the Coronavirus 19 (COVID-19 - a highly contagious respiratory disease is thought to spread from person to person through droplets released when an infected person coughs, sneezes or talks) Pandemic (the worldwide spread of a new disease), dated 11/11/2020 and last reviewed on 1/16/2025, the P&P indicated, The facility's IP nurse collects, records and analyzes data related to both community and facility acquired infection.

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	05/09/2025

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 0907 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough space and equipment to meet each resident's needs 41379 Based on observation, interview, and record review, the facility failed to provide sufficient space for storage of equipment to provide adequate space for rehabilitative services provided in the Physical Therapy (PT, a rehabilitation profession that restores, maintains, and promotes optimal physical function) gym. This deficient practice had the potential to minimize the usable treatment space of the PT gym and create a cluttered, unhomelike environment. Findings: During an observation and interview on 5/7/2025 at 10:43 a.m. in the Physical Therapy gym, there was a therapy mat (wide treatment table) along one wall. On top of the therapy mat were two therapy balls, a broken chair seat, two restorators (a type of arm or leg bicycle for exercising), two sliding boards (board used for transferring from one surface to another without standing), an Occupational Therapy (OT, rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) finger pinch exerciser set, seat cushion, and a variety of ambulation assistive devices (devices to help with balance while walking such as canes, crutches) stacked on top of each other on the therapy mat. Around the therapy mat were four rollators (ambulation aid with four wheels and a seat), an oxygen tank carrier, a broken office chair, and a standing stepper (exercise device used in standing position). The Director of Rehabilitation (DOR) stated facility staff used the therapy mat to store items that were to be thrown away. DOR stated the items needed to be thrown away and stored away. DOR stated the therapy mat and area around the therapy mat could not be used for residents on therapy, because of all the items stored on top and around the therapy mat. DOR stated there should not be any items stored on top of the therapy mat because the therapy mat was to be used for residents on therapy services. During an interview on 5/9/2025 at 10:36 a.m., the Director of Nursing (DON) stated it was important to keep the therapy room tidy and should not be used for storage of items and broken equipment, because the therapy room should be used for residents on therapy and the therapy room should be homelike and free of hazards. DON stated if the therapy mat and area was used for storage then it could not be used for therapy and would not feel homelike. During a record review of the facility's policy and procedures (P&P) revised 10/2009, titled, Quality of Life - Homelike Environment, the P&P indicated, the facility staff and management shall maximize to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: cleanliness and order. During an interview on 5/9/2025 at 10:00 a.m., the Medical Records Director stated the facility did not have a policy regarding maintaining uncluttered therapy areas and to not use the therapy treatment areas for storage of items.

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	05/09/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38552 Based on observation, interview, and record review, the facility failed to maintain one of three freezers (Freezer that stores milk) reviewed during Kitchen Task and maintain mechanical, electrical, and patient care equipment in safe operating condition for two (2) of 2 sample residents (Residents 65 and 107) reviewed under the Environmental Task, by failing to: 1. Ensure the light bulb was in working order in the freezer that stores milk. This deficient practice had the potential to result in poor visibility and sanitation concerns. 2. Ensure the base of Resident 65's bed controller (device used to change the height and angle of the bed) cord did not have exposed wires. 3. Ensure the wall sockets at the head of Resident 107's bed did not have a crack and were in disrepair. (Cross Reference F584). These deficient practices had the potential to place the residents at risk of incurring injury. Findings: 1. During an observation and interview on 5/6/2025 at 7:55 a.m. with DA 1, during the kitchen tour, DA 1 stated inside the meat freezer that stores milk the light bulb was not working. DA 1 stated the light bulb should be working and she does not know when the light bulb went out. DA 1 stated no one had told her the light bulb was not working. During an interview on 5/9/2025 at 1:48 p.m. with the Dietary Director (DD), the DD stated she has not been made aware that the light bulb was broken and not working. The DD stated this requires a specialty order and would take time for it to be delivered to them. The DD stated this should be in working order to ensure that the kitchen staff is able to see what is inside and keep the inside of the freezer clean. During a review of the facility's policy and procedure titled, Maintenance of Equipment, reviewed and approved 1/16/2025, the P&P indicated it is the policy of the facility to have equipment that is in optimal working condition; all equipment should be clean inside and outside; food and nutrition supervisor shall be notified if equipment needs repairs; or needs to be replaced; maintenance should be notified if equipment is broken or not functioning as it should. 43988 2. During a review of Resident 65's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted the resident on 10/3/2015 and readmitted in the facility on 10/24/2022, with diagnoses including dementia (a progressive state of decline in mental abilities), cerebral palsy (a group of permanent movement and posture disorders of the developing fetal or infant brain which limit activity), and major depressive disorder, and dysphagia (difficulty swallowing). (continued on next page)

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	05/09/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 65's History and Physical (H&P) dated 12/1/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 65's fall risk assessments dated 12/30/2024 and 3/31/2025, the fall risk assessments indicated the resident was at a high risk for falls. During a review of Resident 65's Minimum Data Set (MDS, a resident assessment tool), dated 4/2/2025, the MDS indicated Resident 107 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) but was able to sometimes understand others and make his needs known. The MDS further indicated Resident 65 required substantial/maximal assistance with oral hygiene, upper and lower body dressing, and personal hygiene; total assistance from staff toileting, bathing, and transfers; partial/moderate assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During an observation on 5/6/2025 at 9:38 a.m., while inside Resident 65's room, Resident 65 was lying in bed asleep with the bed controller attached to the right upper siderail with the green, white, red, and black wires exposed at the base. During a concurrent observation and interview on 5/6/2025 at 11:57 a.m. while inside Resident 107's room with Certified Nursing Assistant (CNA) 5, CNA 5 stated Resident 65's bed controller had the green, white, red, and black wires exposed at the base. CNA 5 stated the maintenance department is responsible for changing the bed controller if they were in disrepair. CNA 5 stated when staff observed any equipment in disrepair, the maintenance department is notified as soon as possible. CNA 5 stated the maintenance should have been notified that the base of Resident 65's bed controller had the wires exposed so they can change the bed controller. CNA 5 stated it placed Resident 65 at risk for incurring injury due to the exposed wires. CNA 5 stated Resident 65 can get electrocuted which may lead to hospitalization . During a concurrent observation and interview on 5/6/2025 at 4:15 p.m. while inside Resident 65's room with the Maintenance Supervisor (MS), the MS stated the base of Resident 65's bed controller had the green, red, white, and black wires exposed. The MS stated the maintenance department staff makes rounds monthly to ensure any equipment in the residents' rooms are in good working condition. The MS stated staff are supposed to notify the maintenance department when something in the room or bed is in disrepair for resident safety. The MS stated the maintenance department should have been notified immediately to change Resident 65's bed controller to provide a safe, and homelike environment for Resident 65. During a concurrent interview and record review on 5/9/2025 at 11:31 a.m. a photo of Resident 65's bed controller was reviewed with the Director of Nursing (DON). The DON stated Resident 65's had the green, red, white, and black wire exposed. The DON stated the maintenance department makes rounds to check on the rooms daily and ensure that the residents are provided with a safe environment. The DON stated CNA 5 should have notified MS immediately to replace Resident 65's bed controller. The DON stated if any equipment or furnishing is not in good working condition, the facility did not provide a safe and hazard free environment for Resident 65 as it placed the resident at risk for incurring injuries due to fire or electrocution which may lead to hospitalization . During a review of the facility's policy and procedure titled, Maintenance Service, last reviewed on 1/16/2025, the P&P indicated: (continued on next page)

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	05/09/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Maintenance service shall be provided to all areas of the building, ground, and equipment - The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. - The following functions are performed by maintenance but are not limited to maintaining the building in good repair and free from hazards. During a review of the facility's recent policy and procedure (P&P) titled Safety and Supervision of Residents, last reviewed on 1/16/2025, the P&P indicated: - The facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. - Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. - Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed safety. g. Electrical Safety. 3. During a review of Resident 107's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted the resident on 3/23/2020 and readmitted in the facility on 7/26/2024, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarct (stroke, loss of blood flow to a part of the brain) affecting right dominant side, aphasia (a disorder that makes it difficult to speak), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 107's History and Physical (H&P) dated 7/29/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 107's Minimum Data Set (MDS, a resident assessment tool), dated 3/26/2025, the MDS indicated Resident 107 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 107 required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 107's fall risk assessment dated [DATE] and 2/7/2025, the fall risk assessments indicated the resident was at a high risk for falls. During an observation on 5/6/2025 at 11:44 a.m. while inside Resident 107's room, there were four wall sockets at the head of Resident 107's bed with one socket that was missing and another socket that had a crack. (continued on next page)

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	05/09/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/6/2025 at 11:50 a.m. while inside Resident 107's room with Certified Nursing Assistant (CNA) 5, CNA 5 stated there was one wall socket that was missing and another one that had a crack located at the head of Resident 107's bed. CNA 5 stated the maintenance department is responsible for making sure the wall sockets were not in disrepair. CNA 5 stated when staff observed any equipment in disrepair, the maintenance department is notified as soon as possible. CNA 5 stated the wall sockets at the head of Resident 107's bed should have been repaired and covered immediately as the facility was not providing a homelike environment for Resident 107 as the facility is already his home. During a concurrent observation and interview on 5/6/2025 at 4 p.m. while inside Resident 107's room with the Maintenance Supervisor (MS), the MS stated the wall sockets at the head of Resident 107's bed was missing and cracked. The MS stated the maintenance department staff make rounds monthly to ensure any equipment in the residents' room is in good working condition. The MS stated staff are supposed to notify the maintenance department when something in the room or bed is in disrepair for resident safety. The MS stated CNA 5 stated the maintenance department should have been notified immediately to fix the wall sockets in Resident 107's room to provide a safe, and homelike environment for Resident 107. During a concurrent interview and record review on 5/9/2025 at 11:31 a.m. a photo of Resident 107's wall sockets located at head of the resident's bed was reviewed with the Director of Nursing (DON). The DON stated Resident 107's wall sockets had one wall socket missing and another one that was cracked. The DON stated the maintenance department makes rounds to check on the rooms daily and ensure that the residents are provided with a safe, and homelike environment as the facility is already the residents' home. The DON stated CNA 5 should have notified MS immediately to replace the wall sockets. The DON stated if any equipment or furnishing is not in good working condition, the facility did not provide a safe and homelike environment for Resident 107. During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Homelike Environment, last reviewed on 1/16/2025, the P&P indicated residents are provided with a safe, clean, comfortable environment. During a review of the facility's P&P titled, Maintenance Service, last reviewed on 1/16/2025, the P&P indicated: - Maintenance service shall be provided to all areas of the building, ground, and equipment - The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. - The following functions are performed by maintenance but are not limited to maintaining the building in good repair and free from hazards. During a review of the facility's recent policy and procedure (P&P) titled Safety and Supervision of Residents, last reviewed on 1/16/2025, the P&P indicated: - The facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. (continued on next page)

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	05/09/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. - Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed safety. g. Electrical safety.