California Department of Public Health

POC ACCEPTED 06/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The following reflects the findings of the California Department of Public Health during a relicensing survey conducted from 5/28/2024 to 5/30/2024. Representing the Department: Surveyor ID No. 41379, Occupational Therapy Consultant Surveyor ID No. 43418, Health Facilities Evaluator Nurse Surveyor ID No. 43988, Health Facilities Evaluator Nurse Surveyor ID No. 44244, Health Facilities Evaluator Nurse Surveyor ID No. 44376, Health Facilities Evaluator Nurse Surveyor ID No. 47441, Dietary Consultant Surveyor ID No. 49947, Health Facilities Evaluator Nurse Surveyor ID No. 50033, Health Facilities Evaluator Nurse The resident census at the time of survey was 173.	C 000		
C 885	T22 DIV5 CH3 ART3-72313(a) Nursing Service--Administration of Medication (a) Medications and treatments shall be administered as follows: This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure the patient's entire medication regimen was managed and monitored to promote the patient's highest practicable mental, physical, and psychosocial well-being to one out of six sampled patients (Patient 127) selected for unnecessary medications review by failing to:	C 885	See attached.	6/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 885	Continued From page 1 1. Ensure the order for as needed (PRN) psychotropic medication (medications that affect the mind, emotions, and behavior) (Trazadone, used to treat depression) was limited to a 14-day duration unless longer timeframe was deemed appropriate by the attending physician. 2. Monitor adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to psychotropic medication (Escitalopram and Sertraline, antidepressants [medication used to treat depression]) use. These deficient practices placed patients at risk for adverse effects leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: A review of Patient 127's Face Sheet indicated the facility admitted the patient on 8/27/2023, with diagnoses including major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy) and dementia (loss of memory, language, problem-solving, and other thinking abilities that are severe enough to interfere with daily life). A review of Patient 127's History and Physical (H&P), dated 4/18/2024, indicated the patient had decision making capacity. A review of Patient 127's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/26/2024, indicated the patient had the ability to make self-understood and understand others. The MDS indicated the	C 885		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 885	Continued From page 2	C 885		

patient was receiving 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) and antidepressant medications (a type of medicine used to treat clinical depression).

A review of Patient 127's Physician Order indicated the following orders:
-8/27/2023 Sertraline 100 milligram (mg, a unit of mass or weight) tablet (1 Tab) tablet oral. One time daily for major depressive disorder, recurrent, moderate. Monitor for behavior (M/B) verbalization of sadness.
-4/18/2024 Trazadone 50 mg tablet (1/2 tab [25 mg]) tablet oral. As needed hour of sleep for major depressive disorder, recurrent, moderate. For depression m/b inability to sleep.

The physician orders did not indicate orders to monitor and report specific adverse effects of Sertraline and Trazadone to the physician.

A review of Patient 127's Care Plan titled, "Psychotherapeutic Medication Use," last reviewed on 2/2024, indicated to monitor for potential adverse drug effects and complications. Report to MD when noted.

During a concurrent interview and record review on 5/15/2024, at 5 p.m., with Registered Nurse 1 (RN 1), reviewed Patient 127's Physician Order, Medication Administration Record, and Treatment Administration Record (TAR). RN 1 stated there was no specific order on what adverse effects of Sertraline and Trazadone to watch for and report to the attending physician. RN 1 stated it was important to monitor the specific adverse effect of psychotropic drugs to ensure appropriate and safe use of the medication. RN 1 stated the PRN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 885	Continued From page 3	C 885		

order for Trazadone oral (PO) was not limited to 14 days. RN 1 stated according to the facility policy, PRN orders for psychotropic medications should be limited to 14 days unless the medication was deemed by the physician after evaluation of the patient, that it is appropriate for the medication to be extended beyond 14 days and the physician documented the reason for the need for continued use. RN 1 further stated that it was important to ensure PRN psychotropic medications are not used for more than 14 days to prevent adverse effects and unnecessary use of the medications.

During an interview on 5/17/2024, at 4:56 p.m., with the Director of Nursing (DON), the DON stated the licensed nurses should have contacted the attending physician to clarify what specific adverse effects should be monitored for Patient 127's use of Sertraline and Trazadone. The DON further stated orders for PRN psychotropic medications should be limited to 14 days unless the physician has evaluated the patient and believed that extending the order beyond 14 days is appropriate, and the rationale for extending the use of the medication should be documented in the patients' medical record. The DON stated monitoring for specific adverse effects and making sure PRN orders for psychotropic medications are limited to 14 days prevent the patient from experiencing adverse effects and unnecessary use of the medications.

A review of the facility's recent policy and procedure titled, "Psychotropic Medication Use," last reviewed on 1/18/2024, indicated psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. Residents (patients), families and/or the representative are involved in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 885	Continued From page 4 the medication management process. Psychotropic medication management includes: d. adequate monitoring for efficacy and adverse consequences; and e. preventing, identifying and responding to adverse consequences. Psychotropic medications are not prescribed or given on a PRN basis unless the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. Resident receiving psychotropic mediations are monitored for adverse consequences, including: a. anticholinergics effects- flushing, blurred vision, dry mouth, altered mental status, difficulty urinating, falls, excessive sedation and constipation; b. cardiovascular effects- irregular heart rate or pulse, palpitations, lightheadedness, shortness of breath, diaphoresis, chest/arm pain, increased blood pressure, orthostatic hypotension; c. metabolic effects- increased cholesterol and triglycerides, poorly controlled or unstable blood sugar, weight gain; d. neurologic effects- agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinsonism, tardive dyskinesia, cerebrovascular events; and e. psychosocial effects- inability to perform ADLs or interact with others, withdrawal or decline from usual social patterns, decreased engagement in activities, diminished ability to think or concentrate.	C 885		
C1535	T22 DIV5 CH3 ART3-72335(a) Dietetic Service--Food Service (a) The dietetic service shall provide food of the	C1535	See attached.	6/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1535	Continued From page 5 quality and quantity to meet each patient's needs in accordance with the physicians' orders and to meet "The Recommended Daily Dietary Allowance," the most current edition, adopted by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences, and the following: This Statute is not met as evidenced by: Based on observation, interview, and record review the facility failed meet patient's (Patient 17) food preferences when there were missing items on the patient's tray. This deficient practice had the potential to cause frustrations and decrease food intake resulting to unintended (not done on purpose) weight loss. Findings: During a concurrent dining observation on 5/14/2024 at 12:44 p.m. and interview with Patient 17, Patient's 17 meal ticket for lunch indicated avocado slices as food preference. Patient 17 stated her tray did not have any avocado slices. A review of Patient 17's Admission Record, indicated Patient 17 was admitted to the facility on 2/24/2019 with diagnoses including chronic obstructive pulmonary disease (a lung disease causing restricted airflow and breathing problems), hypertensive heart disease with heart failure (a heart disease caused by high blood pressure that is present over a long time), and chronic kidney disease stage 3 (a disease when kidneys do not work well as they should to filter waste and extra fluid out of your blood).	C1535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1535	Continued From page 6 A review of Patient 17's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 4/2/2024, indicated Patient 17 was cognitively severely impaired (having a hard time remembering things and making decisions), able to eat with partial or moderate assist when eating. A review of Patient 17's diet order by Physician, dated 3/27/2024, indicated finely chopped (foods that were chopped less than quarter (1/4) of an inch ([in] a unit of measurement), mechanical soft (a diet consisting of soft foods for patients who have difficulty chewing and swallowing, small portions. A review of Patient 17's meal ticket placed on Patient 17's lunch tray indicated mechanical soft finely chopped, small portions, avocado slices. During an interview with Certified Nursing Assistant 3 (CNA 3) on 5/14/2024 at 12:45 p.m., CNA 3 stated Patient's 17 did not have avocado slices. CNA 3 stated if there was a missing item from the tray ticket, they usually ask the kitchen for the item. CNA 3 stated she should have requested the avocado from the kitchen. During an interview with Food Service Director (FSD) on 5/14/2024 at 4:02 p.m., FSD stated they hand write food preferences on the tray cards and the food preferences would get communicated to the staff. FSD stated they tried to cater almost every food preference and would communicate to the patients when they run out of the product. FSD sated the Certified Nursing Assistant (CNA) calls her directly to communicate food preferences. FSD state possible outcome for not catering food preferences would be frustrations or psychosocial harm. FSD stated they have	C1535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1535	Continued From page 7 avocados, but they run out of it yesterday however they would have a delivery today. FSD was not sure and would check if avocados were available today. During an interview with FSD on 5/14/2024 at 5:36 a.m., FSD stated they run out of avocado yesterday, but they would have a delivery tomorrow. FSD stated the realized the product was expensive, but a lot of patients would like it in their trays. FSD stated avocados were a source of good fat. A review of facility's policy and procedures (P&P) titled "Resident/Patient Food Preferences," dated 1/18/2024, indicated, "PROCEDURES: (1) The director of food and nutrition services or designee should visit resident/patient within 24-48 hours of admission to determine food preferences. (2) The resident/patient food preferences should be placed on the profile card and identified on the tray card."	C1535		
C1660	T22 DIV5 CH3 ART3-72345(a) Dietetic--Sanitation (a) All kitchens and kitchen areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Equipment, utensils, and kitchen cleanliness a. Reach-in freezer with ice build-up.	C1660	See attached.	6/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1660	Continued From page 8	C1660		

b. Walk-in refrigerator shelves and drying racks were not smooth, cracked, chipped with amber discoloration.

c. Seventy-seven (77) of 100 patient trays used for lunch service had cracks and chips.

d. Kitchen hood had dirt and dust buildup.

e. Staff were not following air drying process for dishes, domes, cups, pots, and pans by stacking them wet and cups had food residues.

f. Staff did not follow manufacturer's guidelines for using chlorine test strip when testing for dish machine chlorine (a solution used in sanitizing dishes) concentration.

g. Patient's refrigerator had food and dirt buildup.

These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, and other toxins) in 167 of 173 medically compromised patients who received food and ice from the kitchen.

Findings:

1. a. During an observation of the reach-in freezer near the preparation area on 5/14/2024 at 8:26 a.m., the freezer roof had ice buildup.

During an observation of the reach-in freezer near the dry storage area on 5/14/2024 at 8:28 a.m., the bottom shelves had ice buildup.

During a concurrent observation of the reach-in freezer on 5/14/2024 at 3:34 p.m. and interview with FSD, FSD stated the reach-in freezer was deep cleaned last Thursday. FSD stated they did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1660	Continued From page 9	C1660		

not follow a cleaning schedule, but they deep cleaned, and staff wiped the reach in freezer when it was dirty. FSD stated they needed to clean and remove the ice build up to ensure appropriate temperatures, air circulation so that the freezer could maintain the same internal temperature to prevent it from being on the temperature danger zones (a range of temperature in which food-borne bacteria could grow).

A review of the facility's policies and procedures (P&P) titled "Refrigerator and Freezer," dated 1/18/2024 indicated, "Maintaining a clean refrigerator and freezer can improve the safety and quality of your foods. For the best cleaning results, always refer to your owner's manual. (1) Refrigerator and freezer should be on a weekly cleaning schedule. (2) Wipe up spills immediately."

A review of the facility's P&P titled "Cleaning and Defrosting," dated 1/18/2024 indicated, "Policy: Reach-in freezers will be cleaned and sanitized once a week and walk-in freezers once a month or more often as necessary. Freezers will be defrosted as per manufacturer's instructions or as ice-build up occurs."

b. During a concurrent observation of the walk-in freezer on 5/14/2024 at 8:37 a.m., shelves in the walk-in freezer was cracked, not smooth and had an amber discoloration.

During an interview with LDA on 5/14/2024 at 8:50 a.m. LDA stated she does not know what the discoloration of the shelves were but learned that the shelves must be maintained. LDA stated the shelves maintenance was up to the supervisor and ask the supervisor for questions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1660	Continued From page 10 During an observation of the racks in the storage area used for drying on 5/14/2024 at 8:56 a.m., the racks had tarnish and amber discoloration. During a concurrent observation of the freezer and storage racks and interview with FSD on 5/14/2024 at 9:40 a.m., FSD stated the shelves and racks in the walk-in freezer had not been replaced for over 15 years. FSD stated the racks should be replaced if you could not clean it, it had rust marks, corroded or unable to get debris off. FSD stated the racks in the walk-in freezer were stained and rusted. FSD stated it was important to maintain the racks in good condition as rust and cracks could fall on the food and might cause injury to the patients. c. During an observation of the patient's tray for lunch's use on 5/14/2024 at 9:23 a.m., 77 of 100 trays had crack and chip. During a concurrent observation of the patient's tray inside the carts for lunch use and interview with FSD on 5/14/2024 at 11:54 a.m., FSD stated she just bought the trays last week and the trays got chipped from the dishwasher pressure. FSD stated the trays had scratch and some had chip and it was not okay due to physical safety as the patients could injure themselves however it would be an okay practice when it comes to food safety as the cracks were on the side of the trays and it was not touching the food. FSD stated there was not food safety concern using cracked or chipped trays for lunch service. A review of the facility's P&P titled "Sanitation" dated 1/18/2024, indicated, "(11) All utensils, counters, shelves, and equipment shall be kept clean, maintained in	C1660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1660	Continued From page 11	C1660		

good repair and shall be free from breaks, corrosion, open seam, cracks, and chipped areas."

A review of "Food Code 2017" indicated "4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections."

d. During an observation of the kitchen hood where the cooks prepare and cook foods for the patients on 5/14/2024 at 11:46 a.m., kitchen hood had dust buildup and dirt debris.

During a concurrent observation of the kitchen hood on 5/14/2024 at 3:35 p.m. and interview with FSD on 3:55 p.m., FSD stated the kitchen hood was deep cleaned last Thursday, 4/29/2024 by an outside company and kitchen staff cleaned it on 5/9/2024. FSD stated the left side of the hood had more dirt build up compared to the right side. FSD stated it was important to clean the kitchen hood for safety as it could catch fire and dust could fall in the food. FSD stated the kitchen hood needed to be cleaned.

A review of facility's P&P titled "Cleaning Stove and Hood," dated 1/18/2024, indicated, POLICY: Hoods (vents) will be cleaned weekly or monthly as needed."

A review of "Food Code 2017" indicated "4-602.13 Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues."

e. A review of Patient 142's Admission Record, indicated Patient 142 was admitted to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1660	Continued From page 12	C1660		

facility on 6/12/2023 with diagnoses including essential hypertension (high blood pressure), chronic kidney disease stage 3 (a disease when kidneys do not work well as they should to filter waste and extra fluid out of your blood) and pleural effusion (buildup of excessive fluid in the space between the lung and the chest wall).

A review of Patient 142's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/14/2024, indicated Patient 142 was cognitively intact (able to understand and make decisions), needed setup and clean up assistance when eating.

A review of Patient 142's diet order by Physician, dated 2/14/2024, indicated no added salt ([NAS] no salt packet on the trays), regular diet (diet with no restrictions).

During an interview with Patient 142 on 5/14/2024 at 10:02 a.m., Patient 142 stated the napkins on the trays were always wet because the kitchen did not dry the trays all the way. Patient 142 stated she wished they gave more napkins or dry the trays because she did not have a way to wipe her hands.

During an observation of the glasses stored in the preparation area on 5/14/2024 at 9:15 a.m. glasses were stored and stacked wet.

During a concurrent observation of the plastic glasses on 5/14/2024 at 6:12 p.m. and interview with FSD, observed the plastic glasses had food residue and were stored and stacked wet. FSD stated the dishwashing process included air drying as the last process prior to putting dishes away. FSD touched the plastic glasses and stated the glasses were still hot, just got washed, had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1660	Continued From page 13	C1660		

food debris, was not cleaned, and needed to be washed. FSD stated the practice was not right as the dishes needed to be cleaned, free from food debris and air dried prior to reusing them. FSD stated the base of the plates were stacked wet and needed to be individually air-dried. FSD stated she would correct the practice right away as it was not right, and it was not the proper procedure.

A review of Patient 146's Face Sheet (Admission Record) indicated the facility admitted Patient 146 on 3/4/2024 with diagnoses including, but not limited to, quadriplegia (paralysis of all four limbs), neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), and benign prostatic hyperplasia (BPH - enlarged prostate [male body part that surround the tube that empties the bladder]).

A review of Patient146's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 3/26/2024, indicated Patient 146 was able to understand and make decisions, was dependent on staff for activities of daily living, such as eating, hygiene, toileting, and surface-to-surface transfers, and had an indwelling catheter (a tube inserted into the bladder used to drain urine outside of the body).

A review of Patient 146's History and Physical, dated 3/6/2024, indicated Patient 146 has the capacity to understand and make decisions.

A review of Patient 146's Physician Order Sheet, dated 3/10/2024, indicated Patient 146 was ordered a regular diet with think liquid consistency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1660	Continued From page 14 A review of Patient 146's Care Plan, dated 3/21/2024, indicated Patient146 has the potential risk for unavoidable decline in functioning with interventions including, but not limited to, encouraging adequate hydration and nutrition as per dietary restrictions. During an interview with Patient 146, on 5/15/2024, at 5:15 p.m., Patient 146 stated within the past two weeks, there were brownish to orangish colored food particles caked onto his cereal bowl during breakfast. Patient 146 further stated his spoons also had leftover food particles on them. During an interview with Certified Nursing Assistant (CNA) 9, on 5/16/2024, at 10:09 a.m., CNA 9 stated she was assigned to Patient 146 and has been assigned to him in the past. CNA 9 stated she assists Patient 146 with his meals. CNA 9 stated Patient 146 prefers to have his breakfast cereal separated from his bowl because he wants to check the cleanliness of his cereal bowl before the cereal and milk are poured into the bowl. CNA 9 stated within the past two weeks, Patient 146 was served cereal and milk in a bowl with leftover food particles and Patient 146 became upset and it decreased Patient 146 appetite. During an interview with the Director of Nursing (DON), on 5/17/2024, at 4:51 p.m., the DON stated leftover food particles on dishware can be a source of infection, can affect the dignity of the patient, and can possibly cause loss of appetite and can lead to weight loss. A review of the facility's P&P titled "Dishwashing Procedures," dated 1/18/2024, indicated "(9) Dishwasher will allow rack of dishes to air dry. If	C1660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1660	Continued From page 15	C1660		

drying space is not ample for dishes to air dry, use utility carts."

A review of "Food Code 2017" indicated "4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining. (B) May not be cloth dried."
f. During a concurrent demonstration of dishmachine chlorine concentration testing and interview with Food Service Worker 1 (FSW 1) on 5/14/2024 at 5:59 p.m., FSW 1 got a test strip from the container, dipped it in the dish rack with water for 13 seconds (timed using a phone), and compared the test strip to the color chart. FSW 1 stated the chlorine concentration was 100 ppm which was acceptable.

During a concurrent review of sanitizer and cleaner chlorine test paper and interview with FSW 1 on 5/14/2024 at 5:59 p.m., the sanitizer and cleaner chlorine test paper manufacturer's guidelines indicated Lot: 22423, expiration date 9/1/2025. Dip and remove quickly. Blot immediately with paper towel. Compare to color chart at one." FSW 1 stated the test strips was darker because he dipped it too long and he did not blot it with the paper towel. FSW 1 stated it was important to follow the manufacturer's guidelines of the test strips for chlorine concentration accuracy and if the concentration was not accurate, the chlorine would not be sanitizing dishes properly. FSW 1 stated the possible outcome would be cross-contamination.

A review of facility's P&P titled "Dishwashing Procedures" dated 1/18/2024, indicated "(3) Obtain "test" strips from dietary office for testing ppm on dishmachine. (8) Dishwashing will be done under manufacturer's recommendations in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1660	Continued From page 16	C1660		

dishwashing to ensure sanitation of dishes and utensils."

A review of "Food Code 2017" indicated "4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitation- Temperature, pH, Concentration, and Hardness. Verifying the adequacy of chlorine-based solutions can be accomplished on an on-going basis by confirming that the concentration, temperature, and pH of the sanitizing solutions comply with paragraphs 4-501.114 (A) using acceptable test methods and equipment. The manufacturer should provide methods (e.g. test strips, kits, etc.) to verify that the equipment consistently generates solution on-site at the necessary concentration to achieve sanitation."

g. During concurrent observation of the patients' refrigerator in stations 1, 2 and 3 on 5/15/2024 at 9:24 a.m. and interview with LVN 6, the patient's refrigerator door, bottom shelves and vegetables compartment had dried food sauce spills and dirt build up. LVN 6 stated the refrigerator was cleaned last week and it was dirty due to food spill and dirt build up. LVN 6 stated it was important to maintain the refrigerator cleanliness for infection control and could cause a spread of infection that could cause stomach pain and diarrhea to the patients.

A review of the facility's P&P titled "Cleaning Refrigerator," dated 1/18/2024, indicated "Policy: Reach-in refrigerator will be cleaned and sanitized once a week and walk-in refrigerator once a month or more often if necessary. Messes and spills will be cleaned as they occur."

A review of "Food Code 2017" indicated "4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be clean to sight and touch. (B)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1660	Continued From page 17 Nonfood-Contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue and other debris."	C1660		
C1725	T22 DIV5 CH3 ART3-72349(a) Dietetic Service--Equipment and Supplies (a) Equipment of the type and in the amount necessary for the proper preparation, serving and storing of food and for proper dishwashing shall be provided and maintained in good working order. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: Proper food storage: a. Unlabeled food for expiration date in the walk-in refrigerator and in the kitchen. b. Uncovered fruit plates and key lime pie inside the walk-in refrigerator. c. One (1) dented can was stored in the dry storage area along with the undented cans. d. Patient's food from home/outside had no label and date and stored with the staff food in the patients' refrigerator. e. Blank refrigerator and freezer logs from 4/10/2024 to 5/16/2024. These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, and other toxins) in 167 of 173 medically compromised	C1725	See attached.	6/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1725	Continued From page 18	C1725		

patients who received food and ice from the kitchen.

Findings:

1.a. During an observation of the walk-in refrigerator and the kitchen on 5/14/2024 at 8:19 a.m., the following foods were labeled:
- cooked ham 5/13/2024
- ham 5/13/2024
- roast beef 5/10/2024
- thawed ground meat pull date 5/12/2024.
- thawed chunks of beef no date

During an interview of DA 2 on 5/14/2024 at 8:59 a.m., they labeled and dated food with a receive date and expiration date once they opened or prepared the food item. DA 2 stated they follow the Julian calendar (calendar of 365 days in every year with an additional leap day every fourth year without exception). and the dry storage shelf-life guidelines.

During an observation of individual packets of sugar on 5/14/2024 at 9:10 a.m., the individual packets of sugar had multiple use-by-dates (date indicates when a product will be of best flavor or quality).

During an observation of the oatmeal container in the dry storage area on 5/14/2024 at 9:11 a.m., the oatmeal container had no label and date.

During an observation of the sugar container in bulk on 5/14/2024 at 9:21 a.m., sugar container had no label and date.

During an interview with FSD on 5/14/2024 at 3:42 p.m. FSD stated their process of labeling and dating for all their food in the kitchen included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1725	Continued From page 19	C1725		

labeling food with delivery date, use-by-date, and date food was opened. FSD stated prepared foods had 72 hours self-life. FSD stated it was important to label and date food to prevent serving food to patients that would cause food borne illness, to keep patients safe and prevent from keeping/storing potentially spoil food.

During a concurrent observation of the drying storage area and interview with FSD on 5/14/2024 at 3:44 p.m., potato flakes container had two dates, two (2) bulk oatmeal were both opened and stored in its original container inside a container. FSD stated the potato flakes container had two dates and they would not know which date was it for and it should have an expiration date. FSD stated labeling and dating also applied to thawing of food and staff labeled food with the thaw date and the date when the product would be cooked or utilized. FSD stated it was important to ensure the food was used on the date it needed to be cooked as bacteria could grow if it was stored if food product remained unused.

A review of facility's P&P titled "Canned and Dry Goods Storage," dated 1/18/2024, indicated, "All open food items will have an open date and use-by-date per manufacturer's guidelines. (9) Metal, plastic containers (with tight fitting lids and NSF approved), or resealable plastic bag will be used for staples and opened packages of items such as pasta, rice, dry cereals, etc. Food items will be labeled and dated when placed into containers."

A review of the facility's P&P titled "Refrigerated Storage," dated 1/18/2024, indicated, "Procedures: (10) All frozen uncooked meat, poultry and fish should be placed on the bottom

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1725	Continued From page 20 shelf for proper thawing, with pull date and use by date. A review of the facility's P&P titled "Thawing of Meats," dated 1/18/2024, indicated, "Procedure: (1) Allow 2 to 3 days to defrost." A review of "Food Code 2017" indicated "3-501.17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture's use-by- date if the manufacturer determined the use-by date based on food safety." b. During an initial kitchen tour observation of the walk-in refrigerator on 5/14/2024 at 8:37 a.m. there were uncovered fruit plates in the walk-in refrigerator shelves. During an interview with LDA on 5/14/2024 at 8:39 a.m., LDA stated stored food needed to be in a covered container to prevent dust, for food safety and maintain the quality of food however, the food inspector told them not to cover fruit plate because it could get moisture. LDA stated she learned from ServSafe course (a training program that provides current materials for food	C1725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1725	Continued From page 21	C1725		

safety) that uncovered fruit plate was an okay practice because rules changed and was okay for as long as the food was not exposed outside the refrigerator.

During an interview with FSD on 5/14/2024 at 9:32 a.m. FSD stated they used to cover food when storing in the walk-in refrigerator, however, the health inspector told them not to cover food as the watermelon could be at risk of contamination because of bacterial growth. FSD stated she followed the health inspector instruction and there was a report of it.

During an observation of the walk-in refrigerator on 5/14/2024 at 12:31 p.m. there were uncovered key lime pies stored in the walk-in refrigerator.

A review of the facility's P&P titled "Labeling and Dating Foods" dated 1/18/2024, indicated "(3) All prepared foods need to be covered labeled and dated."

A review of "Food Code 2017" indicated "3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301-3-306."

c. During a concurrent observation of the dry storage area on 5/14/2024 at 8:59 a.m. and interview with Dietary Assistant 1 (DA 1), there was one dented can stored with the undented cans. DA 1 stated they separate dented cans from non-dented cans as they were not allowed to use dented cans due to bacterial growth.

A review of the facility's P&P titled "Food Storage-Dented Cans" dated 1/18/2024, indicated "Policy: Food in unlabeled, rusty, leaking, broken

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1725	Continued From page 22	C1725		

containers or cans with side seam dents, rim dents, or swell shall not be retained or used by the facility. Procedure: All dented cans (defined as side seam or rim dents) and rusty cans are to be separated from remaining stock and placed in a specified labeled area for return to purveyor for refund."

A review of "Food Code 2017" indicated "3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of §3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard."

d. During a concurrent observation of the patient's refrigerator and freezer in station one (1), two (2) and three (3) on 5/15/2024 at 9:24 a.m. and interview with Licensed Vocational Nurse 6 (LVN 6), the following food had no name and date:
- container of food for a resident
- a blue plastic of tamales

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1725	Continued From page 23 - container of soup and crackers - grocery store plastic bag of food - a container of flan - a bag of toast and scrambled eggs - uncovered scrambled eggs in a disposable bowl - a brown bag of ice cream - iced tea with boba - food in a foil - a container of salsa - a plastic bag of tortilla LVN 6 stated the refrigerator in the nurses' lounge was for storing patients' food. LVN 6 stated once they received patients outside food, they labeled it with name, room number and date it was received. LVN 6 stated they kept the food for only one week and it would be thrown away after a week if not consumed. LVN 6 stated it was important to label the food with the name to identify whose food it was to prevent giving it to other patient that could cause allergic reactions such as upset stomach. LVN 6 stated it was important to date the food to prevent storage of food for a long time resulting to spoiled food that could cause stomach issues to the patients. LVN 6 stated they counted five (5) days from the date the food was received then toss it out and those food without a label would be discarded. e. During a concurrent observation of the patients' refrigerator and freezer in Station one (1), two (2) and (3) and interview with LVN 6 on 5/15/2024 at 9:24 a.m., the temperature logs from 4/10/2024 to 5/15/2024 were blank. LVN 6 stated the supervisor who worked 11-7 PM was the one who monitored the refrigerator and freezer temperatures. LVN 6 stated it was important to monitor and maintain the refrigerator and freezer temperatures because foods needed to be in proper temperatures and food could spoil if not on proper temperatures. LVN 6 stated the	C1725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1725	Continued From page 24	C1725		

potential outcome of patients eating spoiled food would be stomach pain and diarrhea.

A review of temperature log titled "Refrigerator Temp Log" with date ranges of 1/1/2024 to 5/16/2024 given by the facility staff, indicated 4/10/2024 to 5/10/2024 had temperature records for refrigerator and freezer. The staff recorded freezer temperature ranges from two (2) degrees Fahrenheit (°F, a scale of temperature) to seven (7) °F.

During an interview with the Housekeeping Supervisor (HKS) and ADM on 5/16/2024 at 3:36 p.m., HKS stated her staff were responsible in monitoring temperature and cleaning the patients' refrigerator and freezer in the nursing unit. HKS stated she learned how to log and read the dial of refrigerator and freezer however, she was not aware of the acceptable ranges of temperature of refrigerator and freezer. HKS stated it was important to maintain the temperatures of refrigerator and freezer because food needed to be at a certain temperature to prevent bacterial growth, to maintain food quality and prevent food from spoiling. HKS stated patients could have stomachache and issues upon eating the spoil food as a potential outcome.

A review of the facility's Policy and Procedure (P&P) titled "Refrigerators and Freezers" dated 1/18/2024, indicated (1) Acceptable temperatures should be 35 degrees Fahrenheit (°F, a degree of temperature) and less than 0°F for freezers. (2) Monthly tracking sheets for all refrigerator and freezers will be posted to record temperatures."

A review of the facility's P&P titled "Freezer Storage" dated 1/18/2024, indicated "(2) Freezer temperatures should be recorded two times a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1725	Continued From page 25 day, (3) The freezer should be maintained at a temperature equal or less than 0°F."	C1725		
C4550	T22 DIV5 CH3 ART5-72528(b)(1) Informed Consent Requirements (b) The information material to a decision concerning the administration of a psychotherapeutic drug or physical restraint, or the prolonged use of a device that may lead to the inability of the patient to regain use of a normal bodily function shall include at least the following: (1) The reason for the treatment and the nature and seriousness of the patient's illness. This Statute is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure patients 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 patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) by: 1. Failing to obtain an informed consent from the patient or their represenatative rior to placing their bed against the wall for Patient 40 and 127. 2. Failing to indicate in the informed consent the resson for the use of bilateral upper half side rails (SR, rails placed along the side of the bed to prevent a person from falling or getting out of bed) for Patient 7. This deficient practice had the potential to violate	C4550	See attached.	6/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C4550	Continued From page 26	C4550		

the patient's or their represenatative's right to be fully informed of the patients' treatment and plan of care.

Findings:

1. a. A review of Patient 40's Face Sheet indicated the facility admitted the patient on 10/4/2021, with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), dementia with behavioral disturbance (a type of dementia where a person loses most of their skills and abilities accompanied by behavioral and psychological disturbances such as agitation, depression, and psychosis), and history of falling.

A review of Patient 40's History and Physical (H&P), dated 10/5/2023, indicated the patient had the capacity to understand and make decisions.

A review of Patient 40's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/3/2024, indicated the patient usually had the ability to make self-understood and understand others. The MDS indicated the patient had severe cognitive impairment (a person has a trouble remembering, learning new things, concentrating, or making decisions that affect everyday life). The MDS indicated the patient required substantial to partial assistance on mobility and transfers.

During a concurrent observation and interview on 5/14/2024, at 11:03 a.m., with Licensed Vocational Nurse 8 (LVN 8), inside Patientt 40's room, observed the patient's bed placed against the wall. LVN 8 stated placing the bed against the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C4550	Continued From page 27	C4550		

wall was a form of a restraint and there should have been a physician's order, a consent obtained from the patient or the patient representative, and an assessment for the need of use prior to placing the bed against the wall.

During an interview and record review on 5/14/2024, at 12:07 p.m., with the Medical Records Staff (MRS), reviewed Patient 40's consents in the Clinical Chart. The MRS stated there was no informed consent obtained from the patient or their representative on placement of bed against the wall.

During an interview on 5/15/2024, at 3:46 p.m., with Registered Nurse 1 (RN 1), RN 1 stated it is important to obtain the informed consent prior to placing the bed against the wall so the patient's representative is aware of the risk and benefits of placing the bed against the wall. RN 1 also stated not obtaining an informed consent from the pateint or their representative prior to placing the patient's bed against the wall violated the patients right for self-determination and the right to be informed.

During an interview on 5/17/2024, at 4:36 p.m., with the Director of Nursing (DON), the DON stated placing the bed against the wall is a restraint and prior to use of a restraint, there should be a physician's order, an informed consent from the patient or the patient's representative, an assessment for the need, and a care plan. The DON stated an informed consent should be obtained from the patient or their representative after explaining the risk and benefits of applying restraints so they can make an informed decision. The DON stated it is important to conduct an assessment for the use of restraints to prevent injury.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C4550	Continued From page 28 A review of the facility's recent policy and procedure titled, "Use of Restraints," last reviewed on 1/18/2024, indicated restraints shall only be used for safety and well-being of the resident(s) [patients] and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. "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: d. Placing a resident who uses a wheelchair so close to the wall that wall prevents the resident from rising. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need of restraints. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint. Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the	C4550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C4550	Continued From page 29	C4550		

alternatives to restraint use. Care Plans 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 symptoms(s). Care Plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use.

1.b. A review of Patient 127's Face Sheet indicated the facility admitted the patient on 8/27/2023, with diagnoses including nondisplaced intertrochanteric fracture (a type of hip fracture or broken hip), difficulty walking, history of falling.

A review of Patient 127's H&P, dated 4/18/2024, indicated the patient had the decision-making capacity.

A review of Patient 127's MDS, dated 2/26/2024, indicated the patient had the ability to make self-understood and understand others. The MDS indicated the patient required dependent to substantial assistance with mobility and transfers.

During a concurrent observation and interview on 5/14/2024, at 11:03 a.m., with LVN 8, inside Patient 127's room, observed the bed of the patient placed against the wall. LVN 8 stated placing the bed against the wall is a form of a restraint. LVN 8 stated there should be a physician's order, a consent from the patient or the patient's representative, and an assessment for the need of placing the bed against the wall.

During an interview and record review on 5/14/2024, at 12:12 p.m., with the MRS, reviewed Patient 127's medical record. The MRS stated there was no physician's order, no informed consent from the patient or patient representative,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C4550	Continued From page 30	C4550		

and no assessment on the use of restraint bed placed against the wall.

During an interview on 5/15/2024, at 3:50 p.m., with RN 1, RN 1 stated it was important to have a physician's order, an informed consent, and an assessment prior use of restraint to make the pateint or the patient's representative aware of the risks and benefits of the treatment so they will be able to make informed decisions.

During an interview on 5/17/2024, at 4:36 p.m., with the Director of Nursing (DON), the DON stated placing the bed against the wall is a restraint and prior to use of a restraint, there should be a physician's order, an informed consent from the patient or their representative, an assessment for its need, and a care plan. The DON stated an informed consent should be obtained from the patient or their representative after explaining the risk and benefits of applying restraints so they can make an informed decision. The DON stated it is important to conduct an assessment for the use of restraints to prevent patient injury.

A review of the facility's recent policy and procedure titled, "Use of Restraints," last reviewed on 1/18/2024, indicated restraints shall only be used for safety and well-being of the resident(s) [patients] and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. "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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C4550	Continued From page 31	C4550		

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:
d. Placing a resident who uses a wheelchair so close to the wall that wall prevents the resident from rising.
Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need of restraints. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following:
a. The specific reason for the restraint (as it relates to the resident's medical symptom);
b. How the restraint will be used to benefit the resident's medical symptom; and
c. The type of restraint, and period of time for the use of the restraint.
Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use. Care Plans 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 symptoms(s). Care Plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use.

2. A review of Patient 7's Admission Record indicated the facility admitted the patient on 2/1/2016 and readmitted the patient on 4/30/2020 with diagnoses hemiplegia (paralysis affecting one side of the body) following cerebral infarction (also known as stroke - refers to damage to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C4550	Continued From page 32 tissues in the brain due to a loss of oxygen to the area) A review of Patient 7's Annual Custodial History and Physical (H&P) dated 1/1/2024, indicated the patient did not have decision making capacity. A review of Patient 7's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 2/21/2024, indicated the patient had severely impaired cognition (mental action or process of acquiring knowledge and understanding), required substantial/maximal assistance to dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). A review of Patient 7's Physician's Order Sheet indicated an order dated 4/30/2020 for bilateral upper half SR to aid with bed mobility, repositioning, and independence to assist with transfers. A review of Patient 7's Facility Verification of Informed Consent to Physical Restraints, Psychotherapeutic Drugs or Prolonged Use of a Device dated 2/7/2024 for the use bilateral upper half SR up did not indicate the reason for the use of restraint.	C4550		
C4790	T22 DIV5 CH3 ART5-72533(a)(1)(I) Employee Personnel Records (a) Each facility shall maintain current complete and accurate personnel records for all employees. (1) The record shall include:	C4790	See attached.	5/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C4790	Continued From page 33 (I) Performance evaluations. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to maintain current, complete personnel records for Certified Nursing Assistant 6 (CNA 6), Certified Nursing Assistant 9 (CNA 9), Certified Nursing Assistant 15 (CNA 15), and Certified Nursing Assistant 16 (CNA 16) by failing to document evidence of emergency procedures training, per the facility policy and procedure, during newly hired employee orientation. This deficient practice had the potential to result in staff not responding during an emergency resulting in harm to patients, other staff, and visitors. Findings: During a concurrent interview and record review on 5/16/2024 at 2:17 p.m., the Director of Staff Development (DSD) reviewed CNA 9's Orientation Checklist dated 2/28/2024. The DSD stated she provides orientation to newly hired CNAs. The DSD stated there is a checklist that includes all the subject areas provided during orientation and she does not provide any orientation not listed on the checklist. The DSD stated CNA 9's orientation checklist did not include emergency preparedness for CNAs, but it did include fire safety and earthquake disaster review. During a concurrent interview and record review on 5/16/2024 at 5:25 p.m. the Director of Nursing (DON) reviewed CNA 9's Orientation Checklist dated 2/28/2024 and the facility policy and procedure regarding the orientation program for	C4790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C4790	Continued From page 34	C4790		

newly hired employees. The DON stated the facility policy indicated all employees would be oriented on emergency preparedness including unusual occurrences, fire safety, disaster preparedness, accident prevention, and emergency first aid. The DON stated CNA 9's orientation checklist did not include documentation for emergency preparedness orientation for unusual occurrences or accident prevention and emergency first aid. The DON stated all the CNAs are oriented using the same orientation check list and all the CNAs were not oriented on emergency preparedness for unusual occurrences or accident prevention and emergency first aid. The DON stated it was every employee's responsibility to respond in an emergency and all staff should know how to respond based on the protocol and procedure presented during orientation. The DON stated if the CNAs were not oriented for procedures for all emergencies, then it could affect the safety and wellbeing of patients, staff, and visitors with a potential to cause harm.

During a concurrent interview and record review on 5/17/2024 at 2 p.m., the DSD reviewed CNA 6's Orientation Checklist dated 11/8/2022, CNA 9's Orientation Checklist dated 2/28/2024, CNA 15's Orientation Checklist dated 3/22/2022, and CNA 16's Orientation Checklist dated 3/20/2024. The DSD stated she wanted to be truthful, and the CNAs orientation training did not include elopement procedures, wandering procedures, accident prevention, or first aid training. The DSD reviewed and noted the following:
-CNA 6's Orientation Checklist dated 11/8/2022, emergency procedure for unusual occurrences and accident prevention and first aid were not included.
-CNA 9's Orientation Checklist dated 2/28/2024,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C4790	Continued From page 35 emergency procedure for unusual occurrences and accident prevention and first aid were not included. -CNA 15's Orientation Checklist dated 3/22/2022, emergency procedure for unusual occurrences and accident prevention and first aid were not included. -CNA 16's Orientation Checklist dated 3/20/2024, emergency procedure for unusual occurrences and accident prevention and first aid were not included. The DSD stated everyone is responsible for emergency procedures when there is an emergency and CNAs should be provided the training at orientation and there was no documentation that it was provided. A review of the facility provided Policy and Procedure titled, "Orientation Program for Newly Hired Employees, Transfers, Volunteers," last reviewed 1/18/2024, indicated an orientation program shall be conducted for all newly hired employees, transfers from other departments, and volunteers. All newly hired personnel must attend a 10-hour orientation program within their first five days of employment. The orientation program includes, but is not limited to instructions in procedures to be followed in an emergency which includes, but is not limited to unusual occurrences with patients (i.e. accidents, wandering, missing, etc.) and accident prevention and emergency first aid procedures. A check list is used to record materials reviewed with each employee.	C4790		
C5015	T22 DIV5 CH3 ART5-72547(a) Content of Health Records (a) A facility shall maintain for each patient a	C5015	See attached.	6/7/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5015	Continued From page 36 health record which shall include: This Statute is not met as evidenced by: Based on interview and record review the facility failed to ensure patients are free of any significant medication errors to two out of three sampled patients (Patients 40 and 18) investigated during review of insulin use by failing to rotate (a method to ensure repeated injections are not administered in the same area) insulin (a medication that regulates sugar in the blood) injections sites. The deficient practices had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (a rare disease that occurs when a protein called amyloid builds up in organs). Findings: a. A review of Patient 40's Face Sheet indicated the facility admitted the patient on 10/4/2021, with diagnoses including type 2 diabetes mellitus (a disease that occurs when the glucose, also called blood sugar, is too high) with neuropathy (damage, disease, or dysfunction of one or more nerves) and diabetic retinopathy (a diabetes complication that affects eyes) of the right eye. A review of Patient 40's History and Physical (H&P), dated 10/5/2023, indicated the patient did not have the capacity to understand and make decisions. A review of Patient 40's Minimum Data Set (MDS,	C5015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5015	Continued From page 37	C5015		

a standardized assessment and care screening tool), dated 4/3/2024, indicated the patient had impaired cognition and was on a high-risk drug class medication hypoglycemic (a group of drugs used to help reduce the amount of sugar present in the blood).

A review of Patient 40's Physician Order Sheet indicated the following orders:
-10/4/2021 Humulin R Regular U-100 Insulin 100 units per milliliters (unit/ml, a unit of fluid volume) Injection Solution (sliding scale, increasing administration of the pre-meal insulin dose based on the blood sugar level before the meal) vial milliliters (ml, unit used to measure capacity) subcutaneous (beneath, or under, all the layers of the skin). Four times daily for type 2 diabetes mellitus.
Accucheck (a reliable and easy-to-use blood glucose monitoring system) before meals (AC) meals & at bed time (HS) with Regular Insulin per sliding scale: Insulin units less than (<)70 or greater than (>)400 notify MD; 80-199, 0 units; 200-249, 4 units; 250-300, 6 units; 301-349, 10 units; 350-400, 12 units; If blood sugar (BS) greater than 400, call MD. If BS less than 80 & alert give a snack. Check BS within 30 minutes, hold insulin. Call MD if unresponsive.
-2/8/2024 Lantus U-100 Insulin 100 unit/ml subcutaneous solution (25 units) vial (ml) subcutaneous. One time daily for type 2 diabetes mellitus. Rotate site.

A review of Patient 40's Non-if needed (PRN) Medication Notes for 1/2024 to 5/2024, indicated:
a. Humulin R regular U-100 insulin 100 unit/ml injection solution (sliding scale) vial (ml) subcutaneous four times daily was administered on:
2/6/2024 at 11:30 a.m. on the Abdomen - Left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5015	Continued From page 38 Upper Quadrant 2/6/2024 at 9:00 p.m. on the Left Upper Quadrant 2/7/2024 at 4:30 p.m. on the Arm - Right Upper Posterior Medial 2/7/2024 at 9:00 p.m. on the Arm - Right Upper Posterior Medial 2/10/2024 at 9:00 p.m. on the Abdomen - Left Lower Quadrant 2/11/2024 at 11:30 a.m. on the Abdomen - Left Lower Quadrant 2/12/2024 at 9:00 p.m. on the Arm - Right Upper Posterior Lateral 2/13/2024 at 4:30 p.m. on the Arm - Right Upper Posterior Lateral 2/13/2024 at 9:00 p.m. on the Arm - Left Upper Posterior Lateral 2/14/2024 at 4:30 p.m. on the Arm - Left Upper Posterior Lateral 2/19/2024 at 4:30 p.m. on the Abdomen - Left Upper Quadrant 2/19/2024 at 9:00 p.m. on the Abdomen - Left Upper Quadrant 2/20/2024 at 11:30 a.m. on the Arm - Left Upper Posterior Lateral 2/20/2024 at 4:30 p.m. on the Arm - Left Upper Posterior Lateral 2/20/2024 at 9:00 p.m. on the Arm - Left Upper Posterior Lateral 3/6/2024 at 4:30 p.m. on the Arm - Left Upper Posterior Lateral 3/6/2024 at 9:00 p.m. on the Arm - Left Upper Posterior Lateral 3/12/2024 at 11:30 a.m. on the Abdomen - Left Upper Quadrant 3/12/2024 at 4:30 p.m. on the Abdomen - Left Upper Quadrant 3/24/2024 at 4:30 p.m. on the Abdomen - Right Lower Quadrant 3/24/2024 at 9:00 p.m. on the Abdomen - Right Lower Quadrant	C5015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5015	Continued From page 39 3/28/2024 at 4:30 p.m. on the Abdomen - Right Lower Quadrant b. Lantus U-100 insulin 100 unit/ml subcutaneous solution (25 units) vial (ml) one time daily was administered on: 2/13/2024 on the Arm - Left Upper Posterior Lateral 2/14/2024 on the Arm - Left Upper Posterior Lateral 3/1/2024 on the Arm - Right Upper Posterior Lateral 3/2/2024 on the Arm - Right Upper Posterior Lateral 3/12/2024 on the Abdomen - Right Lower Quadrant 3/13/2024 on the Abdomen - Right Lower Quadrant 3/25/2024 on the Arm - Right Upper Posterior Lateral 3/26/2024 on the Arm - Right Upper Posterior Lateral 4/13/2024 on the Abdomen - Left Lower Quadrant 4/14/2024 on the Abdomen - Left Lower Quadrant 4/15/2024 on the Abdomen - Left Lower Quadrant 4/18/2024 on the Abdomen - Right Lower Quadrant 4/19/2024 on the Abdomen - Right Lower Quadrant 4/20/2024 on the Arm - Left Upper Posterior Medial 4/21/2024 on the Arm - Left Upper Posterior Lateral 4/24/2024 on the Abdomen - Left Lower Quadrant 4/25/2024 on the Abdomen - Left Lower Quadrant	C5015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5015	Continued From page 40 4/26/2024 on the Abdomen - Left Lower Quadrant 4/27/2024 on the Abdomen - Left Lower Quadrant During a concurrent interview and record review on 5/15/2024, at 3:40 p.m. with Registered Nurse 1 (RN 1), reviewed Patient 40's Physician Order and the Non-PRN Medication Notes. RN 1 stated there were documented entries of repeated use of the same insulin injection sites from 1/2024 to 5/2024. RN 1 stated insulin injection sites should be rotated to prevent damage to the skin tissues of the patient. RN 1 further stated not following the physician's order to rotate insulin injection sites is considered a medication error. During an interview on 5/17/2024, at 4:36 p.m., with the Director of Nursing (DON), the DON stated insulin administrations sites should be rotated to prevent bruising, hardening of the skin injection sites, and lipodystrophy. The DON stated not following the physician's order and manufacturer's guidelines and not adhering to nursing professional practice of rotating insulin administration sites constitute a medication error. A review of the facility's recent policy and procedure titled, "Adverse Consequences and Medication Errors," last reviewed on 1/18/2024, 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's specifications, or accepted professional standards and principles of the professional(s) providing services. A review of the facility's recent policy and procedure titled, "Insulin Administration," last reviewed on 1/18/2024, indicated to select an injection site.	C5015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5015	Continued From page 41 a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior and lateral areas of the thighs and abdomen. Avoid the are approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). A review of the facility-provided FDA Label for Humulin R, undated, indicated to rotate injection sites within the same region form one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. Do not inject into areas of lipodystrophy or localized cutaneous amyloidosis. b. A review of Patient 18's Face Sheet indicated the facility admitted the patient on 1/9/2024, with diagnoses including type 2 diabetes mellitus with diabetic polyneuropathy (complication of diabetes mellitus characterized by progressive death of nerve fibers, which leads to loss of nerves, increased sensitivity, and the development of foot ulcers) and type 2 diabetes mellitus with diabetic peripheral angiopathy (involves damage to cells in the blood vessels caused by high levels of glucose, also called blood sugar). A review of Patient 18's H&P, dated 1/11/2024, indicated the patient had the capacity to understand and make decisions. A review of Patient 18's MDS, dated 4/15/2024, indicated the patient had the ability to make self-understood and understand others. The MDS indicated the patient was on a high-risk drug class hypoglycemic. A review of Patient 18's Physician Order Sheet, dated 1/10/2024, indicated an order for Humulin	C5015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5015	Continued From page 42 R Regular U-100 Insulin 100 units/ml Injection solution (per sliding scale) vial (ml) subcutaneous. Four times daily. Sliding scale insulin: Insulin units < 70 or >400 Notify MD; 70-200, 0 units; 201-250, 1 unit; 251-300, 2 units; 301-350, 3 units; 351-400, 4 units. A review of Patient 18's Non-PRN Medication Notes for 1/2024 to 5/2024, indicated: a. Humulin R Regular U-100 Insulin 100 unit/ml injection solution (per sliding scale) vial (ml) subcutaneous four times daily was administered on: 4/6/2024 at 4:30 p.m. on the Arm - Right Forearm Anterior Lateral 4/6/2024 at 9:00 p.m. on the Arm - Right Forearm Anterior Lateral During a concurrent interview and record review on 5/15/2024, at 3:40 p.m. with RN 1, reviewed Patient 18's Physician Order and the Non-PRN Medication Notes. RN 1 stated on 4/16/2024 the injection sites of insulin were not rotated. RN 1 stated the sites of insulin administration should be rotated to prevent damage to the skin tissues of the patient. During an interview on 5/17/2024, at 4:36 p.m., with the DON, the DON stated insulin administrations sites should be rotated to prevent bruising, hardening of the skin injection sites, and lipodystrophy. The DON stated not following the physician's order and manufacturer's guidelines and not adhering to nursing professional practice of rotating insulin administration sites constitute a medication error. A review of the facility's recent policy and procedure titled, "Adverse Consequences and Medication Errors," last reviewed on 1/18/2024,	C5015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5015	Continued From page 43 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's specifications, or accepted professional standards and principles of the professional(s) providing services. A review of the facility's recent policy and procedure titled, "Insulin Administration," last reviewed on 1/18/2024, indicated to select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior and lateral areas of the thighs and abdomen. Avoid the are approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). A review of the facility-provided FDA Label for Humulin R, undated, indicated to rotate injection sites within the same region form one injection to the next to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. Do not inject into areas of lipodystrophy or localized cutaneous amyloidosis.	C5015		
C5090	T22 DIV5 CH3 ART5-72547(a)(5)(G) Content of Health Records (a) A facility shall maintain for each patient a health record which shall include: (5) Nurses' notes which shall be signed and dated. Nurses' notes shall include: (G) Documentation of oxygen administration.	C5090	See attached.	6/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5090	Continued From page 44	C5090		

This Statute is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure patients who need respiratory care are provided care consistent with professional standards of practice for one of six sampled patients investigated under the respiratory care area (Patient 38) by failing to ensure Patient 38 was administered oxygen (O2) as needed (PRN, when necessary) per physician orders, oxygen was documented when administered, and oxygen was monitored while in use.

These deficient practices had the potential to place patients at risk for respiratory distress.

Findings:

A review of Patient 38's Face Sheet (Admission Record) indicated the facility admitted the patient on 11/27/2023 with diagnoses that included acute (present) respiratory failure (a serious condition that occurs suddenly when the lungs cannot get enough oxygen) with hypoxia (low oxygen in the blood), heart failure (a condition in which the heart cannot pump enough blood to meet the body's needs), and Alzheimer disease (a type of dementia [general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life]) with early onset.

A review of Patient 38's Minimum Data Set (MDS - an assessment and screening tool) dated 4/26/2024, indicated the patient was able to understand others and was able to make herself understood. The MDS further indicated the patient required supervision from staff for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5090	Continued From page 45 dressing, mobility, and personal hygiene. A review of Patient 38's History and Physical (H&P), dated 12/1/2023, indicated the patient had the capacity to understand and make decisions. A review Patient 38's Care Plan (CP) titled, "Respiratory System," initiated 12/3/2023, indicated the patient was at risk for breathing pattern alteration related to diagnosis of congestive heart failure and a history of pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid). The CP indicated a goal that the patient would be free from signs and symptoms (s/s) of respiratory distress as evidenced by shortness of breath. The CP indicated the staff would provide supplemental oxygen as ordered and report to the physician as noted any significant abnormalities / changes in condition. A review of Patient 38's Physician's Orders indicated an order for oxygen at two liters per minute (LPM, a unit of measurement) with humidification (water is combined with the normal flow of oxygen, reducing sensations of dryness in the upper airways) PRN for shortness breath and to maintain oxygen above 92 percent (%, a measurement of oxygen in the blood), dated 12/1/2023. During an observation on 5/14/2024 at 10:42 a.m., Patient 38 lay in bed wearing a nasal cannula (a medical device to provide supplemental oxygen therapy to people who have lower oxygen levels) with the oxygen concentrator (a medical device that provides extra oxygen) set to two LPM. During a concurrent observation and interview on	C5090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5090	Continued From page 46 5/14/2024 at 10:45 a.m., Certified Nursing Assistant 7 (CNA 7) stated she was caring for Patient 38 and the patient is using oxygen via NC. During a concurrent observation, interview, and record review on 5/15/2024 at 5:21 p.m., Licensed Vocational Nurse 7 (LVN 7) reviewed Patient 38's physician orders. LVN 7 stated she is regularly assigned to care for Patient 38, the patient is administered oxygen continuously, and the oxygen is always administered when she cares for the patient. LVN 7 reviewed Patient 38's physician orders and stated the oxygen order indicated oxygen to be administered PRN for shortness of breath or oxygen saturation less than 92%. LVN 7 stated when oxygen is administered to Patient 38 it should be documented, but she was not sure how to check if it was documented. Observed LVN 7 enter Patient 38's room and LVN 7 stated the patient was currently being administered oxygen at two LPM via NC. Patient 38 stated she always wears the NC because she has difficulty breathing. During a concurrent observation, interview, and record review on 5/15/2024 at 5:32 p.m., with Registered Nurse 3 (RN 3) reviewed Patient 38's physician orders, Treatment Administration Record (TAR, a record of all treatments administered to a patient on a day-to-day basis) dated April and May 2024, and progress notes. RN 3 stated Patient 38's physician order for oxygen was PRN and it was not an order for continuous oxygen administration. RN 3 stated if Patient 38 was administered oxygen PRN, it should be documented in the TAR including documentation of the patient's oxygen saturation that required the need for oxygen administration. RN 3 stated there was no documented evidence that Patient 38 was administered oxygen, the	C5090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5090	Continued From page 47	C5090		

reason oxygen was administered, or monitoring for oxygen usage. RN 3 stated she was not aware Patient 38 was being administered oxygen. Observed RN 3 walk down the facility hallway to LVN 7. LVN 7 stated she was not aware Patient 38's oxygen order was PRN and she thought it was a continuous order. RN 3 returned to the nursing station and stated if Patient 38 complained of shortness of breath or had an oxygen saturation less than 92% and oxygen was administered, it should also be documented as a change of condition. RN 3 stated there was no documentation that Patient 38 complained of shortness of breath or had an oxygen saturation less than 92%. RN 3 stated if oxygen was needed and administered then there should have been a change of condition completed and the physician notified with continued monitoring for the need for supplemental oxygen, but no change of condition was documented. RN 3 stated Patient 38's oxygen usage was not monitored, and staff may have missed that Patient 38 had a change of condition that required medical intervention. RN 3 stated interventions should be put in place as soon as possible when there is a change of condition so there is no damage to the patient's organs.

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 oxygen administration. The DON stated she was made aware that staff did not follow Patient 38's physician's order for oxygen PRN. The DON stated staff administered oxygen without monitoring the patient's oxygen usage to ensure the patient was getting the correct amount and staff did not document when the patient needed oxygen. The DON stated if the patient required oxygen more than five times in a week

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5090	Continued From page 48 then the documentation would have justified the need for a continuous order, but there was no documentation. The DON stated there should have been notification to the physician for a change of condition because the patient required oxygen continuously. The DON stated the facility policy was not followed because oxygen was not administered per the physician's order with documentation for the necessity for oxygen PRN usage. A review of the facility procedure titled, "Oxygen Administration," last reviewed 1/18/2024, indicated the purpose of the procedure was to provide guidelines for safe oxygen administration. Verify that there is a physician's order for the procedure. Review the physician's orders or facility protocol for oxygen administration. Before oxygen administration and while the patient is receiving oxygen therapy, assess for the following: -signs of symptoms (s/s) of cyanosis (i.e. blue tone to the skin and mucous membranes) -s/s of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion) -s/s of oxygen toxicity (i.e., difficulty breathing, or slow, shallow rate of breathing) -vital signs -lung sounds -oxygen saturation The following should be recorded in the patient's medical record: -the date and time oxygen was administered. -the name of the individual who administered the oxygen. -the rate of oxygen flow and rationale. -the reason for PRN administration. -all assessment data obtained before, during, and after oxygen administration. -how the patient tolerated the oxygen	C5090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5090	Continued From page 49 administration. A review of the facility policy and procedure titled, "Change of Condition," last reviewed 1/18/2024, indicated the facility shall promptly notify the patient, his or her attending physician, and representative of changes in the patient's medical condition. The Nurse Supervisor will notify when there is a need to alter the patient's medical treatment significantly. A significant change of condition is a decline that will not normally resolve itself without intervention by staff. A review of the facility policy and procedure titled, "Charting and Documentation," last reviewed 1/18/2024, indicated all services provided to the patient, progress toward the care plan goals, or any changes in the patient's medical physical, functional or psychosocial condition shall be documented in the patient's medical record. The medical record shall facilitate communication between the interdisciplinary team regarding the patient's condition and response to care. Medications administered, treatments performed, changes in the patient condition are to be documented in the medical record. Documentation in the medical record will be objective, complete, and accurate.	C5090		
C5235	T22 DIV5 CH3 ART5-72551(c) External Disaster and Mass Casualty Program (c) The plan shall be reviewed at least annually and revised as necessary to ensure that the plan is current. All personnel shall be instructed in the requirements of the plan. There shall be evidence in the personnel files, or the orientation checklist, indicating that all new employees have been oriented to the plan and procedures at the	C5235	See attached.	5/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5235	Continued From page 50 beginning of their employment. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to educate and train five of eight sampled employees (Restorative Nursing Aide 1 (RNA 1), Certified Nursing Assistant 6 (CNA 6), Certified Nursing Assistant 9 (CNA 9), Certified Nursing Assistant 15 (CNA 15), and Certified Nursing Assistant 16 (CNA 16)) to the facility's emergency plans and procedures, per facility policy and procedure, during newly hired employee orientation. This deficient practice had the potential to result in staff not responding appropriately during an emergency resulting in potential harm to patients, staff, and visitors. Findings: During a concurrent interview and record review of RNA 1's employee files, on 5/15/2024 at 5:52 p.m., the Director of Staff Development (DSD) stated RNA 1's employee files did not have evidence that the facility instructed RNA 1 on the facility's emergency plans upon hire in 2017. DSD stated it was important for all employees, including newly hired employees to be oriented to the emergency plans so that the employees would know what to do in the case of an emergency, including where to evacuate and their roles and responsibilities. DSD stated that the facility did not include education or orientation to the facility emergency plan upon hire. DSD stated the training for employees to the emergency plan was completed every two years for staff. During a concurrent interview and record review on 5/16/2024 at 2:17 p.m., the DSD reviewed	C5235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5235	Continued From page 51 CNA 9's Orientation Checklist dated 2/28/2024. The DSD stated she provided orientation to newly hired CNAs. The DSD stated there was a checklist that included all the subject areas provided during orientation and she did not provide any orientation not listed on the checklist. The DSD stated CNA 9's orientation checklist did not include emergency preparedness for CNAs, but it did include fire safety and earthquake disaster review. During a concurrent interview and record review on 5/16/2024 at 5:25 p.m. the Director of Nursing (DON) reviewed CNA 9's Orientation Checklist dated 2/28/2024 and the facility policy and procedure regarding the orientation program for newly hired employees. The DON stated the facility policy indicated all employees would be oriented on emergency preparedness including unusual occurrences, fire safety, disaster preparedness, accident prevention, and emergency first aid. The DON stated CNA 9's orientation checklist did not include documentation for emergency preparedness orientation for unusual occurrences or accident prevention and emergency first aid. The DON stated all the CNAs were oriented using the same orientation check list and all of the CNAs were not oriented on emergency preparedness for unusual occurrences or accident prevention and emergency first aid. The DON stated it was every employee's responsibility to respond in an emergency and all staff should know how to respond based on the protocol and procedure presented during orientation. The DON stated if the CNAs were not oriented for procedures for all emergencies then it could affect the safety and wellbeing of patients, staff, and visitors with a potential to cause harm.	C5235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5235	Continued From page 52 During a concurrent interview and record review on 5/17/2024 at 2 p.m., the DSD reviewed CNA 6's Orientation Checklist dated 11/8/2022, CNA 9's Orientation Checklist dated 2/28/2024, CNA 15's Orientation Checklist dated 3/22/2022, and CNA 16's Orientation Checklist dated 3/20/2024. The DSD stated she wanted to be truthful, and the CNAs orientation training did not include elopement procedures, wandering procedures, accident prevention, or first aid training. The DSD reviewed and noted the following: -CNA 6's Orientation Checklist dated 11/8/2022, emergency procedure for unusual occurrences and accident prevention and first aid were not included. -CNA 9's Orientation Checklist dated 2/28/2024, emergency procedure for unusual occurrences and accident prevention and first aid were not included. -CNA 15's Orientation Checklist dated 3/22/2022, emergency procedure for unusual occurrences and accident prevention and first aid were not included. -CNA 16's Orientation Checklist dated 3/20/2024, emergency procedure for unusual occurrences and accident prevention and first aid were not included. In the same interview, DSD stated everyone was responsible for emergency procedures when there is an emergency and CNAs should be provided the training at orientation and there was no documentation that it was provided. A review of the facility's policy and procedure reviewed 1/18/2024, titled, "Orientation Program for Newly Hired Employees, Transfers, Volunteers," indicated An orientation program shall be conducted for all newly hired employees, transfers from other departments, and volunteers. All newly hired personnel must attend a 10 hour	C5235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA920000002	A. BUILDING: _____ B. WING _____	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTORIA NURSING AND REHAB CENTER	14040 ASTORIA STREET SYLMAR, CA 91342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C5235	Continued From page 53 orientation program within their first five days of employment. the orientation program includes instructions in procedures to be followed in an emergency which includes, but Is not limited to: unusual occurrences with residents (patients), fire safety, disaster preparedness, and accident prevention and emergency first aid procedures. A check list is used to record materials reviewed with each employee.	C5235		

ASTORIA
Nursing & Rehabilitation Center

State Relicensing Survey

This Plan of Correction constitutes Astoria Nursing and Rehabilitation Center's written credible allegation of compliance for the deficiencies noted.

Responses to the cited deficiencies do not constitute an admission or agreement by this facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies.

The Plan of Correction is prepared solely for the purpose of compliance with Federal and/or State law.

C885

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 5/20/2024, the Director of Nursing gave an in-service to the Licensed Nurses regarding obtaining a Physician's Order for specific adverse reactions of the psychotropic medication ordered and putting a 14 day stop and re-evaluation for continuation for the PRN medication ordered.

On 6/7/2024, the Licensed Pharmacy Consultant gave an in service to the Licensed Nurses regarding obtaining a Physician's Order for specific adverse reactions of the psychotropic medication ordered and putting a 14 day stop and re-evaluation for continuation for the PRN medication ordered

On 6/9/2024, the Licensed Nurse called Resident # 127's PMD, received an order for a 14 day stop date and re-evaluation for continuation for the PRN medication ordered

On 6/9/2024, the Licensed Nurse called Resident # 127's PMD, received an order to monitor for specific adverse reaction related to the psychotropic medication ordered.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 05/20/2024 and 05/21/2024 the Assistant Director of Nursing and Quality Assurance Nurse reviewed the MRR done by the Pharmacy Consultant. No residents were affected by the same practice identified.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 6/10/2024, new orders for psychotropic medications will be audited by the Medical Records Director and/or Designee at least 5x a week to ensure that the new orders of psychotropic medications include monitoring for specific adverse effect and the PRN psychotropic medication should be limited to 14 days then a reevaluation to continue/discontinue the medication. Findings will be submitted to the DON for follow up.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 6/10/2024, the Director Of Nursing, Assistant Director Of Nursing, Quality Assurance Nurse and/or Designee will gather data and provide a monthly report of findings and monitoring efforts on specific monitoring of adverse reactions of the psychotropic medication and a 14 day limit for PRN medication with reevaluation to continue/discontinue the psychotropic medication every month and as needed to ensure that corrective actions and compliance are achieved, maintained and sustained.

The Administrator and Director of Nursing will monitor and evaluate compliance and report monthly and as needed to the Quality Assurance Committee to ensure that corrective actions are achieved, maintained and sustained.

Dates when corrective action will be completed: 6/10/2024

C1535 – Food Preferences

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 5/14/2024, the Food Service Director/Registered Dietitian interviewed Resident # 17 regarding other food preferences in the event that current preference is not available.

On 5/20/2024, the Administrator conducted a one on one in-service and re-education training to the Food Service Director/Registered Dietitian regarding adherence to food preferences of residents and timely procurement of preferences or substitutes.

On 5/14/2024, the Food Service Director/Registered Dietitian conducted a one on one in-service to Cook 1 and Cook 2 regarding other food preferences in the event that current preference is not available.

On 5/23/2024, the Food Service Director/Registered Dietitian gave an in-service and re-education training to the Dietary staff regarding adherence to food preferences of residents and timely procurement of preferences or substitutes.

On 6/9/2024, the Facility Registered Dietitian Consultant conducted a skills competency training with the Food Service Director/Registered Dietitian.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

On 5/14/2024, the Licensed Nurses inspected residents meal trays prior to distribution. No other residents were affected by the same practice identified.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

Beginning 5/20/2024, the Food Service Director/Registered Dietitian and/or Designee will review food preferences of 10 residents a week until preferences of in-house residents have been established to ensure availability and alternate options if preference is not available.

Beginning 5/20/2024, the Food Service Director/Registered Dietitian and/or Designee will review food preferences on residents during scheduled IDT meetings for new admits, during Quarterly IDT meetings and Annual IDT meetings to ensure that food preferences are updated, available and written on tray cards.

Beginning 5/20/2024, the Administrator or his designee will conduct random tray card inspection of 5 residents every week x 4, then every month x 4 then quarterly x 4 to ensure that food preferences are written on tray cards and preferences are available to the residents.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 5/20/2024, the Food Service Director and/or Designee will gather data and provide a monthly report of inconsistencies on completeness of food items on the residents tray meeting the residents food preferences on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained. The Facility threshold on reviewing/updating/following resident food preferences will be no less than 90%.

The Administrator, Food Service Director, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will

be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 6/9/2024

C1660 – Reach-in freezer with ice build up

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 05/15/2024, the Food Service Director/Registered Dietitian called the Facility's vendor for Heating and Cooling that maintains the reach-in freezer and walk-in refrigerator and reported the ice build-up on the roof of the freezer.

On 05/15/2024, the technician that maintains the reach-in freezer and walk-in refrigerator came to remove the ice build-up and performed necessary repair to prevent the freezer from building ice.

On 5/20/2024, the Administrator conducted a one on one in-service with the Food Service Director/Registered Dietitian regarding proper monitoring and maintenance of the kitchen's refrigerator and freezer and timely reporting for repair.

On 5/28/2024, the Food Service Director/Registered Dietitian conducted an in-service with Dietary Staff regarding proper monitoring and maintenance of the kitchen's refrigerator and freezer and timely reporting for repair.

On 6/9/2024, the Facility Registered Dietitian Consultant conducted a skills competency training with the Food Service Director/Registered Dietitian.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 5/15/2024, the Food Service Director conducted a visual inspection of the kitchen's refrigerator and freezer and there were no ice build-up on both equipment. No other residents were affected by the same identified practice.

On 5/14/2024, the Food Service Director/Registered Dietitian assessed 167 residents for signs and symptoms of food borne illnesses, i.e. nausea, vomiting, diarrhea, stomach cramps,

malaise, fever, and fatigue, related to cross contamination and harmful bacteria growth. No residents were affected by the same practice identified.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 5/20/2024 the Food Service Director and/or Designee will utilize the daily kitchen monitoring form that includes the daily monitoring and maintenance of the kitchen's refrigerator and freezer. The Food Service Director and/or Designee will immediately report equipment failure to Heating and Cooling Vendor. The Food Service Director will ensure compliance and will report findings to the Administrator and/or designee.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 5/20/2024, the Food Service Director and/or Designee will gather data and provide a monthly report of inconsistencies on maintenance and efficiency of kitchen equipment in the Facility's kitchen on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained. The Facility threshold on proper monitoring and maintenance of the kitchen's refrigerator and freezer and timely reporting for repair will be no less than 100%.

The Administrator, Food Service Director, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 6/9/2024

C1660 – Walk-in fridge racks were chipped and amber looking discoloration

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 5/20/2024, the Administrator conducted a one on one in-service with the Food Service Director/Registered Dietitian regarding proper monitoring, maintenance and keeping the kitchen's equipment in good repair specifically the refrigerator, freezer and storage rack for the safety of the staff and residents.

On 5/28/2024, the Food Service Director conducted an in-service with Dietary Staff regarding proper monitoring, maintenance and keeping the kitchen's equipment in good repair specifically the refrigerator, freezer and storage rack for the safety of the staff and residents.

The Food Service Director/Registered Dietitian ordered the following: drying racks/shelves on 5/22/2024 and 5/29/2024, dry storage rack/shelves s on 5/30/2024, and refrigerator and freezer racks/shelves on 5/31/2024.

On 6/9/2024, the Facility Registered Dietitian Consultant conducted a skills competency training with the Food Service Director/Registered Dietitian.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 5/20/2024, the Food Service Director/Registered Dietitian and Maintenance Director conducted a visual inspection of the storage racks/shelves in the kitchen. All racks/shelves were scheduled for replacement. No other residents were affected by the same identified practice.

On 5/14/2024, the Food Service Director/Registered Dietitian assessed 167 residents for signs and symptoms of food borne illnesses, i.e. nausea, vomiting, diarrhea, stomach cramps, malaise, fever, and fatigue, related to cross contamination and harmful bacteria growth. No residents were affected by the same practice identified.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 5/20/2024, the Food Service Director and/or Designee will utilize the daily kitchen monitoring form that includes the daily monitoring and maintenance of the kitchen's refrigerator and freezer storage rack/shelves, dry goods storage racks/shelves, and drying racks/shelves. The Food Service Director and/or Designee will immediately report equipment loss of integrity to Maintenance Director and/or Designee for repair or replacement. Food Service Director/Registered Dietitian will ensure compliance and will report findings to the Administrator and/or designee.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 5/20/2024, the Food Service Director and/or Designee will gather data and provide a monthly report of inconsistencies on the integrity of the kitchen's refrigerator and

freezer storage rack/shelves, dry goods storage racks/shelves, and drying racks/shelves on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained. The Facility threshold on proper monitoring, maintenance and keeping the kitchen's equipment in good repair specifically the refrigerator, freezer and storage rack for the safety of the staff and residents will be no less than 100%.

The Administrator, Food Service Director, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 6/9/2024

C1660 – Food trays 77/100 were chipped and scratched

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 5/29/2024, the Food Service Director/Registered Dietitian ordered 120 pieces of new food trays. On 6/7/2024, the new food trays were delivered and the chipped and scratched food trays were discarded.

On 6/11/2024, the Food Service Director/Registered Dietitian ordered additional 120 pieces of new food trays as inventory to replace chipped/scratched food trays.

On 5/20/2024, the Administrator conducted a one on one in-service with the Food Service Director/Registered Dietitian regarding proper maintenance and keeping the kitchen's equipment in good condition specifically the resident food trays.

On 5/28/2024, the Food Service Director/Registered Dietitian conducted an in-service with Dietary Staff regarding proper maintenance and keeping the kitchen's equipment in good condition specifically the resident food trays.

On 6/9/2024, the Facility Registered Dietitian Consultant conducted a skills competency training with the Food Service Director/Registered Dietitian.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 5/16/2024, the Food Service Director and Lead Dietary Aide conducted a visual inspection of the other 23 food trays and no other food trays were chipped and scratched. No other residents were affected with the same identified practice.

On 5/14/2024, the Food Service Director/Registered Dietitian assessed 167 residents for signs and symptoms of food borne illnesses, i.e. nausea, vomiting, diarrhea, stomach cramps, malaise, fever, and fatigue, related to cross contamination and harmful bacteria growth. No residents were affected by the same practice identified.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 5/20/2024, the Food Service Director and/or Designee will utilize the daily kitchen monitoring form that includes the daily monitoring and maintenance of the resident food trays. The Facility will keep an inventory of spare replacement food trays to replace food trays when they get chipped and scratched. The Food Service Director will ensure compliance and will report findings daily to the Administrator and/or designee.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 5/20/2024, the Food Service Director and/or Designee will gather data and provide a monthly report of inconsistencies on the integrity of the resident food trays on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained. The Facility threshold on proper maintenance and keeping the kitchen's equipment in good condition specifically the resident food trays will be no less than 100%.

The Administrator, Food Service Director, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 6/11/2024

C1660 - Kitchen hood had dirt buildup

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 5/15/2024, the Dietary Aide cleaned and removed the dirt/debris build up on the kitchen hood.

On 5/20/2024, the Administrator conducted a one on one in-service with the Food Service Director/Registered Dietitian regarding proper maintenance and cleaning of the kitchen's equipment specifically the kitchen hood.

On 5/28/2024 the Food Service Director/Registered Dietitian conducted an in-service with Dietary Staff regarding proper maintenance and cleaning of the kitchen's equipment specifically the kitchen hood.

On 6/9/2024, the Facility Registered Dietitian Consultant conducted a skills competency training with the Food Service Director/Registered Dietitian.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 5/15/2024, the Food Service Director/Registered Dietitian conducted a visual inspection of the other kitchen hood and the kitchen hood was clean and free of dust debris. No other residents were affected by the same identified practice.

On 5/14/2024, the Food Service Director/Registered Dietitian assessed 167 residents for signs and symptoms of food borne illnesses, i.e. nausea, vomiting, diarrhea, stomach cramps, malaise, fever, and fatigue, related to cross contamination and harmful bacteria growth. No residents were affected by the same practice identified.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 5/20/2024, the Food Service Director/Registered Dietitian and/or Designee will utilize the daily kitchen monitoring form that includes the daily monitoring and maintenance of the kitchen hood. The Facility will utilize the kitchen cleaning schedule and clean the kitchen hood weekly and as needed. The Food Service Director will ensure compliance and will report findings daily to the Administrator and/or designee.

Beginning on 6/3/2024, the food service staff will post and utilize the cleaning schedule.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 5/20/2024, the Food Service Director/Registered Dietitian and/or Designee will gather data and provide a monthly report of inconsistencies on the maintenance and cleanliness of the kitchen hood on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained. The Facility threshold on proper maintenance and cleaning of the kitchen's equipment specifically the kitchen hood will be no less than 100%.

The Administrator, Food Service Director/Registered Dietitian, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 6/9/2024

C1660 – Dishwashing and air drying

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 05/19/2024, the Food Service Director/Registered Dietitian visited and reassured Resident #142 and Resident #146 regarding sanitization and complete air drying for pots, trays, pans, cups, and domes.

On 5/20/2024, the Administrator conducted a one on one in-service with the Food Service Director/Registered Dietitian regarding proper cleaning, disinfecting, dishwashing and dishes air drying process.

On 5/20/2024, the Food Service Director/Registered Dietitian conducted an in-service with Dietary Staff regarding proper cleaning, disinfecting, dishwashing and dishes air drying process.

On 6/9/2024, the Facility Registered Dietitian Consultant conducted a skills competency training with the Food Service Director/Registered Dietitian.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 5/15/2024, the Food Service Director/Registered Dietitian conducted a visual inspection of the cleaned, disinfected, and air dried dishes, utensil, and food trays and no other dishes, utensils, and food trays were with food residue and wet. No other residents were affected by the same identified practice.

On 5/14/2024, the Food Service Director/Registered Dietitian assessed 167 residents for signs and symptoms of food borne illnesses, i.e. nausea, vomiting, diarrhea, stomach cramps, malaise, fever, and fatigue, related to cross contamination and harmful bacteria growth. No residents were affected by the same practice identified.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 5/20/2024, the Food Service Director/Registered Dietitian and/or Designee will utilize the daily kitchen monitoring form that includes the daily monitoring of proper cleaning, disinfecting, dishwashing and proper air drying procedure. The monitoring will include random inspection of the cleaned, disinfected, air dried dishes, utensil, and food trays. The Food Service Director/Registered Dietitian will ensure compliance and will report findings daily to the Administrator and/or designee.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 5/20/2024, the Food Service Director/Registered Dietitian and/or Designee will gather data and provide a monthly report of inconsistencies on the proper cleaning, disinfecting, dishwashing, and air drying procedure in the kitchen on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained. The Facility threshold on sanitizing and complete air drying for pots, trays, pans, cups, and domes will be no less than 100%.

The Administrator, Food Service Director/Registered Dietitian, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 6/9/2024

C1660 – Failure to follow chlorine test paper manufacturer's guidelines

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 5/15/2024, the Food Service Director/Registered Dietitian conducted a one on one in-service with FSW1 regarding proper use of dish machine, efficiency of dish machine, dish machine chlorine concentration testing and following the manufacturer's guideline on using the chlorine test strip.

On 5/20/2024, the Administrator conducted a one on one in-service with the Food Service Director/Registered Dietitian regarding proper use of dish machine, efficiency of dish machine, dish machine chlorine concentration testing and following the manufacturer's guideline on using the chlorine test strip.

On 5/21/2024, the Food Service Director/Registered Dietitian conducted an in-service with the Dietary Staff regarding proper use of dish machine, efficiency of dish machine, dish machine chlorine concentration testing and following the manufacturer's guideline on using the chlorine test strip.

On 6/9/2024, the Facility Registered Dietitian Consultant conducted a skills competency training with the Food Service Director/Registered Dietitian.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 5/15/2024, the Food Service Director/Registered Dietitian observed the Facility Dishwasher on proper use of the dish machine per manufacturer's guidelines and proper use of chlorine test strips per manufacturer's guidelines and proper procedure were followed. No other residents were affected.

On 5/14/2024, the Food Service Director/Registered Dietitian assessed 167 residents for signs and symptoms of food borne illnesses, i.e. nausea, vomiting, diarrhea, stomach cramps, malaise, fever, and fatigue, related to cross contamination and harmful bacteria growth. No residents were affected by the same practice identified.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 5/20/2024, the Food Service Director and/or Designee will utilize the daily kitchen monitoring form that includes the daily monitoring of proper use of dish machine per

manufacturer's guideline and proper use of chlorine test strips per manufacturer's guidelines. The monitoring will The Food Service Director will ensure compliance and will report findings daily to the Administrator and/or designee.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 5/20/2024, the Food Service Director and/or Designee will gather data and provide a monthly report of inconsistencies on the proper use of dish machine per manufacturer's guideline and proper use of chlorine test strips per manufacturer's guidelines in the kitchen on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained. The Facility threshold on proper use of dish machine, efficiency of dish machine, dish machine chlorine concentration testing and following the manufacturer's guideline on using the chlorine test strip will be no less than 100%.

The Administrator, Food Service Director, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 6/9/2024

C1660 – Resident's food refrigerator had food and dirt build up

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 05/16/2024, the Housekeeper cleaned and sanitized Resident's Refrigerator and Freezer in Station 1, 2 and 3.

On 5/16/2024, the Administrator conducted a one on one in-service with the Housekeeping Supervisor regarding importance of proper maintenance, cleaning and disinfection of the Resident's Refrigerator and Freezer.

On 5/17/2024 and 6/7/2024, the Housekeeping Supervisor conducted an in-service with the Housekeeping Staff regarding importance of proper maintenance, cleaning and disinfection of the Resident's Refrigerator and Freezer.

On 6/9/2024, the Facility Registered Dietitian Consultant conducted a skills competency training with the Food Service Director/Registered Dietitian.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 05/16/2024, the Housekeeping Supervisor inspected the Resident's Refrigerator and Freezer in Station 1, 2 and 3 and the Housekeeper cleaned and Sanitized the Resident's Refrigerator and Freezer. No other residents were affected by the same identified practice.

On 5/14/2024, the Food Service Director/Registered Dietitian assessed 167 residents for signs and symptoms of food borne illnesses, i.e. nausea, vomiting, diarrhea, stomach cramps, malaise, fever, and fatigue, related to cross contamination and harmful bacteria growth. No residents were affected by the same practice identified.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 5/20/2024, the Food Service Director and/or Designee will utilize the daily kitchen monitoring form that includes the daily monitoring the Resident's Refrigerator and Freezer. The Food Service Director/Registered Dietitian will utilize the kitchen cleaning schedule and clean the Resident's Refrigerator and Freezer weekly and as needed.

Beginning on 5/16/2024, the Housekeeping Supervisor and/or Designee will utilize the Daily Resident's Refrigerator and Freezer Cleaning Form to ensure that Resident's Refrigerator and Freezer is cleaned and sanitized daily.

The Food Service Director and Housekeeping Supervisor will ensure compliance and will report findings daily to the Administrator and/or designee.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 5/20/2024, the Food Service Director/Registered Dietitian, Housekeeping Supervisor, and/or Designee will gather data and provide a monthly report of inconsistencies on the maintenance and cleanliness of the kitchen hood on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained. The Facility threshold of proper maintenance, cleaning and sanitizing of the Residents' Refrigerator and Freezer will be no less than 100%.

The Administrator, Food Service Director, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 6/9/2024

C1725 – Unlabeled food for expiration date in the walk-in refrigerator and in the kitchen

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 5/14/2024, the Food Service Director/Registered Dietitian discarded the undated sugar packets, oatmeal, and potato flakes and replaced with a new one labeled with “open date” and “use by date”.

On 5/14/2024, the Food Service Director/Registered Dietitian discarded the thawed chunks of beef with no date.

On 5/20/2024 the Administrator conducted a one on one in-service with the Food Service Director/Registered Dietitian regarding labeling of open food items with an open date and use-by-date, labeling of food items when placed in the container, and frozen uncooked meat, poultry, and fish placed at the bottom of the rack/shelf for thawing with thaw date use by date. Lesson plan did not reflect – it goes under the professional standards.

On 5/20/2024, the Food Service Director/Registered Dietitian conducted an in-service with the Dietary Staff regarding labeling of open food items with an open date and use-by-date, labeling of food items when placed in the container, and frozen uncooked meat, poultry, and fish placed at the bottom of the rack/shelf for thawing with thaw date use by date.

On 6/9/2024, the Facility Registered Dietitian Consultant conducted a skills competency training with the Food Service Director/Registered Dietitian.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 5/14/2024, the Food Service Director/Registered Dietitian conducted a visual inspection of the kitchen for unlabeled open food items and unlabeled frozen uncooked meat, poultry, and fish for thawing and no other food items were unlabeled. No other residents were affected by the same identified practice.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 5/20/2024, the Food Service Director/Registered Dietitian and/or Designee will utilize the daily kitchen monitoring form that includes the daily monitoring of proper labeling of open food items and proper labeling of frozen uncooked meat, poultry, and fish for thawing. The Food Service Director/Registered Dietitian will ensure compliance and report findings to the Administrator for follow-up.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 05/20/2024, the Food Service Director and/or Designee will gather data and provide a monthly report of inconsistencies on proper labeling of open food items and proper labeling of frozen uncooked meat, poultry, and fish for thawing in the Facility's kitchen on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained. The Facility threshold on kitchen staff for proper labeling and dating of open food items, frozen uncooked meat, poultry, and fish for thawing will be no less than 90%.

The Administrator, Food Service Director, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 6/9/2024

C1725 – Uncovered fruit plate

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 05/14/2024, the Food Service Director/Registered Dietitian discarded the uncovered fruit plate.

On 05/14/2024, the Food Service Director/Registered Dietitian conducted a one on one in-service with LDA regarding covering and protection of prepared food from contamination and bacteria dispersed in the environment.

On 5/20/2024, the Administrator conducted a one on one in-service with the Food Service Director/Registered Dietitian regarding covering and protection of prepared food from contamination and bacteria dispersed in the environment.

On 5/21/2024, the Food Service Director/Registered Dietitian conducted an in-service with Dietary Staff regarding covering and protection of prepared food from contamination and bacteria dispersed in the environment.

On 6/9/2024, the Facility Registered Dietitian Consultant conducted a skills competency training with the Food Service Director/Registered Dietitian.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 5/14/2024, the Food Service Director/Registered Dietitian conducted a visual inspection of the kitchen for covering and protection of prepared food and no other prepared food items were uncovered. No other residents were affected by the same identified practice.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 5/20/2024, the Food Service Director and/or Designee will utilize the daily kitchen monitoring form that includes the daily monitoring covering and protection of prepared food from contamination and bacteria dispersed in the environment. The Food Service Director/Registered Dietitian will ensure compliance and report findings to the Administrator for follow-up.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 05/20/2024, the Food Service Director/Registered Dietitian and/or Designee will gather data and provide a monthly report of inconsistencies on covering and protection of prepared food in the Facility's kitchen on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained. The Facility threshold on kitchen staff for covering and protection of prepared food from contamination and bacteria dispersed in the environment will be no less than 90%.

The Administrator, Food Service Director/Registered Dietitian, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 6/9/2024

C1725 – Dented can

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 05/14/2024, the Food Service Director/Registered Dietitian placed the one dented canned food on the dented can designated area.

On 5/20/2024, the Administrator conducted a one on one in-service with the Food Service Director/Registered Dietitian regarding storage of food and no usage of dented, rusty, leaking, and unlabeled cans in the Facility.

On 5/17/2024, the Food Service Director/Registered Dietitian conducted an in-service with Dietary Staff regarding storage of food and no usage of dented, rusty, leaking, and unlabeled cans in the Facility.

On 6/9/2024, the Facility Registered Dietitian Consultant conducted a skills competency training with the Food Service Director/Registered Dietitian.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 5/14/2024, the Food Service Director/Registered Dietitian conducted a visual inspection of the kitchen for dented, rusty, leaking, and unlabeled cans and no other canned food items were dented, rusty, leaking, and unlabeled. No other residents were affected by the same identified practice.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 5/20/2024 the Food Service Director and/or Designee will utilize the daily kitchen monitoring form that includes the daily monitoring integrity of canned food items in the Facility's kitchen. The Food Service Director and/or Designee will ensure compliance and report findings to the Administrator for follow-up.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 05/20/2024, the Food Service Director and/or Designee will gather data and provide a monthly report of inconsistencies on integrity of canned food items in the Facility's kitchen on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained. The Facility threshold on kitchen storage of food and no usage of dented, rusty, leaking, and unlabeled cans will be no less than 90%.

The Administrator, Food Service Director, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 6/9/2024

C1725 – Resident food from home has no label and mixed with staff food

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 05/15/2024, the Resident's Refrigerator in Station 1, 2 and 3 was cleaned and the unlabeled food items were discarded by the Certified Nurse Assistant and Housekeeping Supervisor.

On 5/17/2024, the Administrator conducted an in-service to Facility Department Managers regarding labeling of food in the Facility Staff's Refrigerator/Freezer, labeling of food in the Resident's Refrigerator/Freezer, and not mixing the food of the staff and residents together.

On 5/20/2024, the Administrator conducted an in-service to Facility Food Service Director/Registered Dietitian regarding labeling of food in the Facility Staff's Refrigerator/Freezer, labeling of food in the Resident's Refrigerator/Freezer, and not mixing the food of the staff and residents together.

On 5/21/2024 and 6/7/2024, the Director of Staff Development, Maintenance Director, and Infection Preventionist Nurse conducted an in-service to Facility Staff regarding labeling of food in the Facility Staff's Refrigerator/Freezer, labeling of food in the Resident's Refrigerator/Freezer, and not mixing the food of the staff and residents together.

On 05/29/2024, the Administrator ordered a new refrigerator with freezer for the residents which was delivered on 05/31/2024 and was labeled "Resident's Use Only and Not For Use By Staff".

On 6/9/2024, the Facility Registered Dietitian Consultant conducted a skills competency training with the Food Service Director/Registered Dietitian.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 5/17/2024, the Food Service Director and Housekeeping Supervisor conducted a visual inspection of the Resident's Refrigerator/Freezer. No unlabeled food and no staff food were found in the Resident's Refrigerator/Freezer. No other residents were affected by the same identified practice.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 05/20/2024, the Housekeeping Supervisor and/or Designee will utilize the updated Daily Refrigerator and Freezer Cleaning Log form.

Beginning on 5/20/2024, the facility staff will utilize a resident/staff food label that includes the name, date received and expiration date. This will ensure that all food items stored in the residents' and staffs' refrigerator/freezer are labeled, not mixed together and discarded beyond the expiration date.

Beginning on 5/20/2024, the Food Service Director/Registered Dietitian and/or Designee will utilize the kitchen monitoring tool to inspect proper food covering, labeling, and dating in the resident and staff refrigerator.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 05/20/2024, the Housekeeping Supervisor, Food Service Director and/or Designee will gather data and provide a monthly report of inconsistencies on cleanliness, labeling of food and mixing of resident and staff food in the Resident's Refrigerator/Freezer on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained. The Facility

threshold on food items stored in the residents' and staffs' refrigerator/freezer are labeled, not mixed together and discarded beyond the expiration date will be no less than 100%.

The Administrator, Housekeeping Supervisor, Food Service Director, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 6/9/2024

C1725 – Blank Refrigerator and Freezer Logs

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 05/16/2024, the Administrator conducted a one on one in-service with the Maintenance Director regarding keeping and maintaining the temperature log of the Resident's Refrigerator/Freezer and temperature log of the Staff's Refrigerator/Freezer.

On 5/17/2024, the Maintenance Director conducted an in-service to the Maintenance Staff regarding keeping and maintaining the temperature log of the Resident's Refrigerator/Freezer and temperature log of the Staff's Refrigerator/Freezer.

On 6/9/2024, the Facility Registered Dietitian Consultant conducted a skills competency training with the Food Service Director/Registered Dietitian.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 05/17/2024, the Maintenance Director and Maintenance Assistant conducted visual rounds on Resident and Staff's Refrigerator and Freezer and logged the correct temperature on the Refrigerator and Freezer Temperature Log. No other residents were affected by the same identified practice.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 05/17/2024, the Maintenance Director, Maintenance Assistant and/or designee will include on their daily Facility rounds visual inspection of the Resident and Facility Staff Refrigerator and Freezer and maintain the temperature log of the equipment. The Maintenance Director will ensure compliance and will report findings to the Administrator and/or designee.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 05/17/2024, the Maintenance Director, Maintenance Assistant, and/or Designee will gather data and provide a monthly report of inconsistencies on temperature and proper operation Resident and Staff's Refrigerator and Freezer in the Facility on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained. The Facility threshold on keeping and maintaining the temperature log of the Resident's and Staff's Refrigerator/Freezer will be no less than 100%.

The Administrator, Maintenance Director, and/or Designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated periodically for effectiveness.

Dates when corrective action will be completed: 6/9/2024

C4550

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 5/14/2024, the Licensed Nurse obtained an informed consent for bed against the wall from the Responsible Party of Resident # 40.

On 5/20/2024, Resident # 127 was reassessed by the RN Supervisor and determined that there is no need for the bed to be against the wall. The resident's PMD was informed of reassessment with no new orders given.

On 5/20/2024, the Director of Nursing conducted an in-service and reeducation to the Licensed nurses regarding the facility's policy on the use of physical or chemical restraints to ensure that residents are free from physical or chemical restraints used for the purposes of convenience or discipline and that are not required for treating a resident's medical symptoms.

On 5/21/2024, the Director of Staff Development conducted an in-service and reeducation to the Certified Nursing Assistants regarding the facility's policy on the use of physical or chemical restraints to ensure that residents are free from physical or chemical restraints used for the purposes of convenience or discipline and that are not required for treating a resident's medical symptoms.

On 5/20/2024, the Director of Staff Development conducted a one on one in-service and reeducation to the C.N.A. assigned to Resident # 127 regarding the facility's policy on the use of physical or chemical restraints to ensure that residents are free from physical or chemical restraints used for the purposes of convenience or discipline and that are not required for treating a resident's medical symptoms.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 5/20/2024, the Medical Records staff initiated an audit beginning with 15 residents a day who have orders for bilateral half upper side rails as enabler to aid in bed mobility to ensure that assessments, physician's orders, consent forms and care plans are in place. Upon completion, no other residents were affected by the practice identified.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning 5/20/2024, the Medical Records Director and /or designee will conduct an audit of new orders for restraints within 72 hours to ensure that physician's orders, assessments, care plans and facility verification of informed consent indicating the use of restraints are completed and available in the resident's clinical records.

Beginning 5/20/2024, results of audits will be provided to the Director of Nursing and/or designee for further follow-up if necessary.

Beginning 5/21/2024, the Director of Nursing will discuss findings of audits during the facility's stand-up meetings for further recommendations as necessary.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning 5/20/2024, the Director of Nursing will gather data and provide a monthly report of findings of monitoring efforts through medical records audit regarding use of restraints which includes physician's orders, assessments, care plans and informed consents to the Quality Assurance Committee every month and as needed to ensure that corrective actions and compliance are achieved, maintained and sustained x 12 months.

The Administrator, and Director of Nursing will monitor and evaluate compliance and report monthly and as needed to the Quality Assurance Committee to ensure that corrective actions are achieved, maintained and sustained x 12 months.

Dates when corrective action will be completed: 6/5/2024

C4790

What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice:

On 5/21/2024, the Director of Staff Development conducted an Emergency Preparedness Training with proof of Training to CNA 6, CNA 9, CNA 15. CNA 16 is no longer an employee of the facility.

On 5/17/2024, the Administrator conducted a one on one in-service to the Director of Staff Development regarding provision of training during orientation of newly hired employees on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of Emergency.

On 5/16/2024, the Administrator conducted a one on one in-service to the Maintenance Director regarding provision of training during orientation of newly hired employees on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of Emergency.

On 5/17/2024, the Maintenance Director conducted an in-service to the Maintenance Staff regarding provision of training during orientation of newly hired employees on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of Emergency.

On 5/17/2024, the Administrator conducted an in-service to the Facility Department Heads regarding the requirement and provision of training during orientation of newly hired employees on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of an Emergency.

How other patients having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:

Beginning on 5/21/2024, the Director of Staff Development started to review the personnel record of current employees and conducted training on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of Emergency. No other residents were affected by the same practice identified.

What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not occur:

Beginning on 5/21/2024, the Director of Staff Development, Maintenance Director, and/or Designee will conduct training during orientation of newly hired employees on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of Emergency and utilize the New Employee emergency Operation Attestation Form.
Beginning on 5/21/2024, the Director of Staff Development, and/or Designee will review at least 10 employee personnel files per week to ensure Facility employees receive training on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of Emergency and utilize the New Employee emergency Operation Attestation Form.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 5/21/2024, the Director of Staff Development and/or Designee will gather data and provide a monthly report of inconsistencies on Facility's new hire orientation on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of Emergency on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained.

The Administrator, the Director of Staff Development, Maintenance Director, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 5/21/2024

C5015

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 5/15/2024, a skin assessment was done by the Treatment Nurse on Resident # 40. No skin discoloration, no lipodystrophy nor cutaneous amyloidosis noted on both upper and lower quadrant, right and left upper posterior medial arm, right and left posterior lateral arm, right and left upper posterior lateral arm.

On 5/15/2024, a skin assessment was done by the Treatment Nurse on Resident # 18. No skin discoloration, no lipodystrophy nor cutaneous amyloidosis noted on both upper and lower quadrant, right and left upper posterior medial arm, right and left posterior lateral arm, right and left upper posterior lateral arm.

On 5/20/2024, the Director of Nursing conducted an in-service to the Licensed Nurses regarding insulin administration with the emphasis on rotating insulin injection sites.

On 6/7/2024, the Licensed Pharmacy Consultant conducted an in-service to the Licensed Nurses regarding insulin administration with the emphasis on rotating insulin injection sites.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken:

On 5/20/2024, the Assistant Director of Nursing conducted an assessment and MAR audit of 25 residents receiving insulin. No other residents were affected by the practice identified.)

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 5/20/2024, the Medical Record Director and/or Designee will conduct an MAR audit on residents receiving insulin injection at least once a week x 3 months then once a month thereafter to ensure that the administered insulin are being rotated to different injection sites. Findings of MAR audits will be submitted to the Director of Nursing for follow up.

The Director of Nursing will discuss the findings during the stand-up meeting at least 5x a week for recommendations.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 05/20/2024, the Director of Nursing, Assistant Director Of Nursing, Medical Records and/or Designee will gather data and provide a monthly report of findings of monitoring efforts on the rotation of insulin injection sites every month and as needed to ensure that corrective actions and compliance are achieved, maintained and sustained.

The Administrator, and Director of Nursing will monitor and evaluate compliance and report monthly and as needed to the Quality Assurance Committee to ensure that corrective actions are achieved, maintained and sustained.

Date when corrective action will be completed: 6/7/2024

C5090

How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

On 5/14/2024, Resident # 28's Treatment Nurse replaced the oxygen nasal cannula, labeled it with the current date and the tubing was secured so it will not be touching the floor.

On 5/16/2024, Resident # 38's Primary MD was notified by the Licensed Nurse and new order was received to discontinue PRN order of oxygen and start on Oxygen at 2L/min via NC continuously for SOB.

On 5/20/2024, the Director of Nursing conducted an in-service to the Licensed Nurses regarding oxygen administration meeting professional standards and complete and accurate documentation.

On 5/24/2024, the Director of Staff Development conducted a one on one in-service to C.N.A. 10 regarding oxygen administration meeting professional standards

On 6/5/2024, the Director of Staff Development and Infection Preventionist Nurse conducted an in-service to the Licensed Nurses and CNAs regarding oxygen administration meeting professional standards and complete and accurate documentation.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken:

On 5/14/2024, Director of Staff Development and Infection Preventionist Nurse checked the other residents with order of continuous oxygen inhalation ensuring that oxygen tubing cannulas are labeled and secured and not touching the floor. No other residents were affected by the same practice identified.

What measures or systemic changes the facility will make to ensure that the deficient practice does not recur:

Beginning on 5/20/2024, the RN Supervisor/s and Licensed Charge Nurses will monitor the residents on oxygen inhalation during their rounds every shift ensuring that nasal cannula tubing is labeled, secured and not touching the floor. The RN supervisor on each shift will report their findings to the Director Of Nursing for follow up.

Beginning on 5/20/2024, Medical Record Director and/or Designee will audit the treatment flow sheet for residents with PRN order of Oxygen inhalation to ensure that PRN oxygen is documented and monitored when administered. The Medical Records Director and/or Designee will submit the audit to the Director Of Nursing for follow up.

Beginning on 5/20/2024, Infection Preventionist Nurse nurse and Director of Staff Development will conduct a random visual observation of residents with oxygen inhalation at least 5x a week ensuring that all residents with oxygen inhalations has their oxygen nasal cannula tubing labeled, dated and not touching the floor.

The Director Of Nursing, Assistant Director Of Nursing, Director of Staff Development, Quality Assurance Nurse and Infection Preventionist Nurse will discuss the report and findings to the Department manages during the daily stand up meeting 5x a week

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 5/20/2024, the Director Of Nursing, Assistant Director Of Nursing and Quality Assurance Nurse and/or Designee will gather data and provide a monthly report of findings and monitoring efforts regarding oxygen administration and complete and accurate documentation every month and as needed to ensure that corrective actions and compliance are achieved, maintained and sustained.

The Administrator and Director Of Nursing will monitor and evaluate compliance and report monthly and as needed to the Quality Assurance Committee to ensure that corrective actions are achieved, maintained and sustained.

Date when corrective action will be completed: 6/5/2024

C5235

What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice:

On 5/21/2024, the Director of Staff Development conducted an Emergency Preparedness Training with proof of Training to RNA 1, CNA 6, CNA 9, CNA 15, and CNA 16 is no longer employed.

On 5/17/2024, the Administrator conducted a one on one in-service to the Director of Staff Development regarding provision of training during orientation of newly hired employees on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of Emergency.

On 5/16/2024, the Administrator conducted a one on one in-service to the Maintenance Director regarding provision of training during orientation of newly hired employees on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of Emergency.

On 5/17/2024, the Maintenance Director conducted an in-service to the Maintenance Staff regarding provision of training during orientation of newly hired employees on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of Emergency.

On 5/17/2024, the Administrator conducted an in-service to the Facility Department Heads regarding the requirement and provision of training during orientation of newly hired employees on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of an Emergency.

How other patients having the potential to be affected by the same deficient practice be identified and what corrective action will be taken:

Beginning on 5/21/2024, the Director of Staff Development started to review the personnel record of current employees and conducted training on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of Emergency. No other residents were affected by the same practice identified.

What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not occur:

Beginning on 5/21/2024, the Director of Staff Development, Maintenance Director, and/or Designee will conduct training during orientation of newly hired employees on the subject of

Emergency Preparedness and Facility Operation Procedures in the Event of Emergency and utilize the New Employee emergency Operation Attestation Form.
Beginning on 5/21/2024, the Director of Staff Development, and/or Designee will review at least 10 employee personnel files per week to ensure Facility employees receive training on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of Emergency and utilize the New Employee emergency Operation Attestation Form.

A description of the monitoring process and positions of persons responsible for monitoring:

Beginning on 5/21/2024, the Director of Staff Development and/or Designee will gather data and provide a monthly report of inconsistencies on Facility's new hire orientation on the subject of Emergency Preparedness and Facility Operation Procedures in the Event of Emergency on the monthly Quality Assurance Committee meeting to ensure that corrective action is sustained.

The Administrator, the Director of Staff Development, Maintenance Director, and/or designee will monitor and evaluate compliance regularly and report compliance every month to Quality Assurance Committee and governing body. Gathered feedback and concerns will be acted promptly by the facility and will be discussed monthly and as needed on the Quality Assurance Committee meeting. The Quality Assurance Committee will ensure that the corrective actions and systemic changes are achieved, sustained and re-evaluated for effectiveness.

Dates when corrective action will be completed: 5/21/2024