

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 056084	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/19/2020
NAME OF PROVIDER OF SUPPLIER ASTORIA NURSING AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP 14040 ASTORIA STREET SYLMAR, CA 91342	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0550 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect as evidenced by: -Facility staff did not want to render care for a resident who was diagnosed with [REDACTED]. This deficient practice has the potential to affect Resident 1's self-esteem and self-worth. Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility, on 3/29/2020, with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and screening tool), dated 4/10/2020, indicated Resident 1's cognitive skills for daily decisions making was independent. The MDS indicated the resident required assistance with transfers and walking in the corridor. During an interview on 4/23/2020 at 10:19 a.m., Resident 1 stated that she was placed in a room by herself and nursing staff did not provide care for her until the resident was about to be transferred to the hospital at 12 p.m. Resident 1 stated nursing staff did not check on her nor was she served breakfast that morning. Resident 1 stated she felt helpless and alone. During an interview on 4/23/2020 at 2:33 p.m., with the Infection Control Preventionist Nurse (IPN), she stated Resident 1 was transferred to a private room because the staff received confirmation from the lab that the resident was positive for COVID19. The IPN stated the facility had issues with nursing staff because they were scared to enter Resident 1's room. The IPN stated that she did not expect this reaction from their staff. During an interview on 4/23/2020 at 2:42 p.m., the Director of Staff Development (DSD) stated on the morning of 4/10/2020, Resident 1 was assigned to Certified Nursing Assistant 1 (CNA1) however she was not able to care for Resident 1 because she had a medical health condition. The DSD stated that the staff did not want to take care of Resident 1 because of her diagnosis. Resident 1 was then assigned to another staff member. During an interview on 4/23/2020, at 2:50 p.m., the IPN stated the facility staff were scared of the resident. The IPN stated the facility should have been prepared. During an interview on 4/23/2020, at 3:04 p.m., with Licensed Vocation Nurse (LVN1), she stated when the CNAs found out that Resident 1 was COVID19 positive, they did not want to take care of the resident. During an interview and concurrent record review, on 4/23/2020, at 3:11 p.m., with Registered Nurse (RN1), she stated that the staff did not want to take care of the resident. The RN1 did not respond when asked why she did not take care of the resident. During an interview on 4/23/2020 at 3:23 p.m., with the Administrator (ADM), ADM stated the facility was not ready to care for COVID19 residents. A review of the facility's policies and procedures titled Quality of Life- Dignity, undated, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy continues to indicate Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.		
F 0623 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the State Long Term Care Ombudsman (public advocate) of the transferred from the facility for one of three sampled residents (Resident 1). This deficient practice has the potential for Resident 1 not to be protected from being inappropriate transfer. Findings: A review of Resident 1's Admission Record indicated an admission date of [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and screening tool) dated 4/10/2020, indicated Resident 1's cognitive skills for daily decisions making was independent. The MDS indicated the resident needed supervision with bed mobility, required limited assistance with transfer, walking in the room, and walking in the corridor. The resident required extensive assistance with locomotion in unit, locomotion off unit, dressing, and toilet use. The MDS indicated the resident had urinary incontinence (loss of bladder control, inability to control urination) frequently and bowel incontinence (loss of bowel control, causing you to pass stool unexpectedly) frequently. During an interview and concurrent record review with Director of Social Services (DSS), on 4/23/2020, at 6:28 p.m., she stated she was unable to find documented evidence the ombudsman was notified of Resident 1's transfer to the hospital. The DSS stated that Resident 1 was transferred out of the facility on a Friday. The DSS also stated that the Ombudsman should have been notified by the following Monday or Tuesday. The facility's policy, titled Discharge/Transfer of Resident, revised 10/2011, indicated notices of discharge will be in accordance with state and federal regulations.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.