STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555723	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASTOR HEALTHCARE CENTER	**247 E. BOBIER DRIVE VISTA, CA 92084**

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 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure full privacy was maintained during individual care for one of two Residents (1) reviewed for privacy. This failure violated Resident 1's right to privacy during personal care. Findings: Resident 1 was admitted on [DATE] with a [DIAGNOSES REDACTED]. During an interview on 2/18/20 at 8:52 A.M., the DON stated Witness 1 and Witness 2 were driving by the facility on 2/13/20 at 5:43 P.M. and observed Resident 1 receiving personal care. The DON stated Witness 1 informed the DON of what she observed. The DON stated CNA 1 provided personal care for Resident 1 with the curtains open. During an interview on 2/18/20 at 9:36 A.M., Witness 2 stated she saw Resident 1 on his backside, naked from the hip down while receiving care from CNA 1. During an interview on 2/18/20 at 11:57 A.M., the DSD stated CNA 1 should not have left the window curtains open while providing care for Resident 1. The DSD stated it was an invasion of Resident 1's privacy. The DSD stated when residents receive personal care, the window curtains should be closed to promote resident privacy and dignity while receiving personal care. During an interview with the DON on 2/18/20 at 2:26 P.M., the DON stated it was Resident 1's basic right to have complete privacy during his personal care. During an interview on 2/19/20 at 9:59 A.M., CNA 1 stated she gave care to Resident 1 with the curtains to his window open. CNA 1 stated she should have closed Resident 1's curtains before providing personal care for the resident. CNA 1 stated it was not respectful of Resident 1 to leave the curtains to his window open. According to a review of the facility's policy, revised 10/2013, titled Confidentiality of Information and Personal Privacy, .our facility will protect and safeguard resident .privacy the facility will strive to protect the resident's privacy regarding his .personal care
F 0625 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of bed-hold for one of two residents (1) sent to an acute care hospital. As a result, Resident 1 may not have been aware of the facility's bed-hold policy upon transfer to the acute care hospital. Findings: Per the facility's Admission Record, Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].). Resident 1 was transferred on 12/10/19 to an acute care hospital. Per the facility's Nursing Progress Note, dated 12/10/19 at 11:58 A.M., by the DON, Resident 1 assaulted another resident, was placed on a psychiatric hold for being a danger to others, and the sheriff took the resident to an acute care hospital. On 12/28/20 at 12:30 P.M., an interview was conducted with the DON. The DON stated, when a bed-hold was offered to a resident, it was usually documented in the nursing notes or on the transfer form. The DON further stated, the facility did not offer a bed-hold to Resident 1 during her latest discharge. The facility's Notice of Proposed Transfer/Discharge for Resident 1, dated 12/10/19, did not indicate the facility provided written notice of bed-hold information to Resident 1, or Resident 1's responsible party. The facility's Progress Notes for Resident 1, dated 12/10/19 through 12/11/19 did not indicate the facility provided written notice of bed-hold information to Resident 1, or Resident 1's responsible party. Per the facility's undated policy, titled Bed-Holds and Returns, Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy . 3. Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: a. The rights and limitations of the resident regarding bed-holds .

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.