

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/21/2025
NAME OF PROVIDER OR SUPPLIER Astoria Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its abuse policy for two of three sampled residents (Resident 1 and Resident 2) by not obtaining dated and signed witness statements (It is a written summary of the evidence of a witness). This deficient practice had the potential to result in inaccurate abuse investigations and had the potential to place Resident 1 and Resident 2 at risk for further abuse. Findings: a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 9/15/2025, with diagnoses that included metabolic encephalopathy (a disorder that affects brain function), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) and repeated falls. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 10/5/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 required maximum assistance from staff for toileting, showering and dressing. During a review of Resident 1's History and Physical (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 11/4/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's eInteract Change in Condition Evaluation (COC - a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated 11/9/2025, the COC indicated altercation (an angry or heated dispute) with Resident 2. The COC indicated Resident 1 reported that he (Resident 1) was passing by the hallway when Resident 2 called Resident 1 names. The COC indicated Resident 2 hit Resident 1 all over Resident 1's face. The COC indicated staff did not witness physical contact and no injuries were noted on Resident 1 upon assessment. The COC indicated the physician was notified on 11/9/2025, at 11:28 p.m. b. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 2/17/2023, with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (occurs when blood flow to the brain is blocked, leading to symptoms such as speech difficulty, headache, motor weakness, and in severe cases, death) affecting left nondominant side, and history of fall. During a review of Resident 2's H&P dated 9/2/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 2 required maximum assistance from staff for toileting, showering and walking. During a review of Resident 2's COC, dated 11/9/2025, the COC indicated altercation with Resident 1. The COC indicated on 11/9/2025, at 8:30 p.m., heard a commotion and noted Residents 1 and 2's altercation with both hands swinging at each other (Residents 1 and 2). The COC indicated no physical contact between the two residents. The COC indicated Resident 1 tried to steal Resident 2's things and he (Resident 2) just defended himself (Resident 2). The COC indicated no injuries and no pain. The COC indicated the physician was notified on 11/9/2025, at 9:43 p.m. During a concurrent interview, and record review on 11/14/2025, at 12:51 (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056084	Facility ID: 056084 If continuation sheet Page 1 of 7

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m., with the Assistant Director of Nursing (ADON), facility's Witness Statements, dated 11/10/2025, were reviewed. The ADON stated she (ADON) had called and interviewed Registered Nurse 1 (RN 1), Licensed Vocational Nurse 1 (LVN 1) and LVN 2. The ADON stated the Witness Statement was not signed and dated. The ADON stated Certified Nursing Assistant 1 (CNA 1) was the first staff to witness the altercation. The ADON stated she (ADON) did not have a copy of CNA 1's witness statement. The ADON stated the Director of Staff development (DSD) or RN 1 might have a copy of CNA 1's witness statement. During an interview on 11/14/2025, at 1:02 p.m., with CNA 1, CNA 1 stated she (CNA 1) had written a Witness Statement and gave it to RN 1. During an interview on 11/14/2025, at 1:09 p.m., with RN 1, RN 1 stated she (RN 1) had asked CNA 1 to write a witness statement, and she (RN 1) had transcribed the written statement in the electronic medical record. RN 1 stated CNA 1's written statement was on her (RN 1) locker. RN 1 stated she (RN 1) was not sure if their policy was to submit a written signed statement. During an interview on 11/14/2025, at 1:44 p.m. with the ADON, the ADON stated she (ADON) did not ask the staff (RN 1, LVN 1 and LVN 2) to write their statements. The ADON stated after interviewing the staff (RN 1, LVN 1 and LVN 2) she (ADON) documented it and gave each staff (RN 1, LVN 1 and LVN 2) a copy of the statement. The ADON stated she (ADON) did not know that staff had to sign and date the Witness Statements. The ADON stated she (ADON) was not familiar with their policy and procedure (P&P) that witnesses had to sign and date their statements. During a concurrent interview, and record review of the facility's P&P titled, Abuse Investigations, dated 4/10/10, and last reviewed on 6/19/2025, the P&P indicated, Witness reports will be obtained in writing. Witnesses will be required to sign and date such reports. The DON stated the P&P was not followed. The DON stated the facility had interviewed the witnesses and documented the interviews. The DON stated the ADON should have asked the witnesses to date and sign the Witness Statements. During an interview on 11/18/2025, at 11:58 a.m., with the DON, the DON stated because there were no signed and dated Witness Statements, it gave an inaccurate detail of the incident, could cause a delay in the investigations and potentially place Resident 1 and Resident 2 at risk for possible abuse.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of three sampled residents (Resident 4) by failing to develop a care plan to address Resident 4's refusal of feeding assistance. This failure had the potential for Resident 4 to have a weight loss and potential for delays in the delivery of necessary care and services. Findings: During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 5/27/2013, with diagnoses that included unspecified (unconfirmed) heart failure (when the heart muscle does not pump blood as well as it should), unspecified atrial fibrillation (an irregular and often very rapid heart rhythm) and essential hypertension (high blood pressure that is not due to another medical condition). During a record review of Resident 4's Nutritional Screening and Assessment, dated 1/13/2025, the Nutritional Screening and Assessment indicated Resident 4 needed limited assistance and had chewing and swallowing difficulty. During a review of Resident 4's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 1/16/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's Order Summary Report, dated 6/28/2025, the Order Summary Report indicated regular diet puree texture (are smooth with no lumps and have a texture like pudding for those who cannot handle solid food due to things like chewing or swallowing difficulties, or gut issues) with thin liquid consistency (thickness of a liquid). During a record review of Resident 4's Weight Variance/Hydration Evaluation, dated 9/10/2025, the Weight Variance/Hydration Evaluation indicated Resident 4 was able to feed self with minimal assistance and has been known to refuse feedings assistance. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 9/25/2025, the MDS indicated Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 4 needed supervision with eating. During a review of Resident 4's Nutritional Quarterly Progress Evaluation, dated 9/26/2025, the Nutritional Quarterly Progress Evaluation indicated Resident 4 had chewing and swallowing problems. During a review of Resident 4's Care Plan, dated 10/1/2025, on self-care deficit (a condition where an individual has difficulty performing self-care activities), the Care Plan indicated Resident 4 required supervision with eating. During an observation on 11/14/2025, at 12:41 p.m., at Resident 4's doorway, observed Resident 4 eating pureed foods on her (Resident 4) own. During a concurrent observation, and interview on 11/14/2025, at 12:42 p.m., with Certified Nursing Assistant 2 (CNA 2), at Resident 4's bedside. CNA 2 stated she (CNA 2) was supposed to assist Resident 4 with eating, but Resident 4 refused and wanted to eat on her (Resident 4) own. CNA 2 stated nurses were aware that Resident 4 refused feeding assistance. During an interview on 11/14/2025, at 1:51 p.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 4 needed feeding assistance at all times. LVN 4 stated he (LVN 4) was not aware that Resident 4 refused assistance. LVN 4 stated CNA 2 should be with Resident 4 while eating to make sure she (Resident 4) eats and for safety that she (Resident 4) does not choke. LVN 4 stated providing assistance with eating encourages Resident 4 to eat adequately to prevent malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat) and dehydration (occurs when the body uses or loses more fluid than it takes in). LVN 4 stated CNA 2 should have reported so care plan could be created for Resident 4 to resolve resident refusal and monitor to prevent weight loss. During an interview on 11/14/2025, at 2:23 p.m., with the Registered Dietitian (RD), the RD stated Resident 4 can feed herself (Resident 4) but also needs assistance. The RD stated she (RD) had recommended staff to provide assistance with setting up the tray and assistance with feeding. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RD stated if feeding assistance was not provided to Resident 4, Resident 4 could generally decline and experience weight loss and dehydration. The RD stated she (RD) was aware that Resident 4 had refused feeding assistance. During an interview on 11/18/2025, at 10:04 a.m., with the Director of Staff Development (DSD), the DSD stated CNA 2 should have reported Resident 4's refusal of feeding assistance so nurses can develop a care plan to address residents' refusal. The DSD stated without the care plan, Resident 4 could have weight loss. During an interview on 11/18/2025, at 11:58 a.m., with the Director of Nursing (DON), the DON stated CNA 2 should report resident refusal with feeding assistance so nurses can develop a care plan. The DON stated care plan list the interventions to prevent Resident 4's weight loss from refusal of assistance. During a review of facility's policy and prevention (P&P), titled, Care Planning, dated 10/1/2023 and last reviewed on 6/19/2025, the P&P indicated, To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. IX. Each resident's Comprehensive Care Plan will describe the following: A. Services that are to be furnished to attain or maintain the residents' highest practicable physical, mental and psychosocial well-being; B. Any services that would be required but are not provided due to the resident's exercise of rights, which includes the right to refuse treatment.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on interview and record review, the facility failed to provide nutritional care and services for one of three sampled residents (Resident 4) by failing to ensure Resident 4 was provided with breakfast and lunch on 11/6/2025, 11/7/2025 and 11/11/2025. This failure had the potential for Resident 4 to have a weight loss and potential for delays in the delivery of necessary care and services. Findings: During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 5/27/2013, with diagnoses that included unspecified (unconfirmed) heart failure (when the heart muscle doesn't pump blood as well as it should), unspecified atrial fibrillation (an irregular and often very rapid heart rhythm) and essential hypertension (high blood pressure that is not due to another medical condition). During a record review of Resident 4's Nutritional Screening and Assessment, dated 1/13/2025, the Nutritional Screening and Assessment indicated Resident 4 needed limited assistance and had chewing and swallowing difficulty. During a review of Resident 4's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 1/16/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's Order Summary Report, dated 6/28/2025, the Order Summary Report indicated regular diet puree texture (are smooth with no lumps and have a texture like pudding for those who cannot handle solid food due to things like chewing or swallowing difficulties, or gut issues) with thin liquid consistency (thickness of a liquid). During a review of Resident 4's Minimum Data Set (MDS-a resident assessment tool), dated 9/25/2025, the MDS indicated Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 4 needed supervision with eating. The MDS indicated Resident 4 had a physician prescribed weight loss regimen. During a review of Resident 4's Care Plan, dated 9/30/2025 on at risk for nutritional problems related to inadequate meal intake, the Care Plan indicated an intervention to provide, serve diet as ordered and monitor intake and record every meal. During a review of Resident 4's Task-Nutrition, Amount Eaten, dated 11/2025, the Task-Nutrition, Amount Eaten indicated Resident 4 had 26 percent (% - one part in every hundred) to 50% food intake on the following dates and time. 1. - On 11/6/2025, at 8:06 p.m. 2. - On 11/7/2025, at 9:15 p.m. 3. - On 11/11/2025, at 6:19 p.m. During a concurrent interview and record review on 11/18/2025 at 10:25 a.m., with the Medical Records Director (MRD), Resident 4's Task-Nutrition, Amount Eaten, dated 11/2025, was reviewed. The MRD stated Resident 4 had only one meal documented on 11/6/2025, 11/7/2025 and 11/11/2025. During an interview on 11/18/2025, at 11:58 a.m., with the Director of Nursing (DON), the CNAs should accurately document Resident 4's meal intake percentage and if Resident 4 refused, CNAs should document as refused to make sure Resident 4 was eating adequately to prevent weight loss. The DON stated the facility had no documentation if breakfast and lunch was provided to Resident 4 on 11/6/2025, 11/7/2025, and 11/11/2025 and if Resident 4 had eaten or refused. During a review of facility's policy and procedure (P&P), titled, Nutrition Care undated and last reviewed on 6/19/2025, the P&P indicated, Nutrition Services staff are trained in the proper preparation of textures and diet content and nursing personnel monitor patient acceptance and proper diet service at each meal. Changes in the diet prescription are made in writing and documentation of patient knowledge, acceptance and counseling as necessary is made in the medical record and care plan. During a review of facility's P&P titled, Documentation-Nursing dated 10/1/2023 and last reviewed on 6/19/2025, the P&P indicated, To provide documentation of resident status and care given by nursing staff. Checklists, flow charts, and other documentation tools will be used as appropriate. III. Activities of Daily Living (ADL- activities such as bathing, dressing and toileting a person performs daily) Documentation A. The CNA will document the care provided on the facility's method of documentation, manually or electronic. B. The CNA will sign each entry on the ADL Flow Sheet in the appropriate area of the record according to the (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	date and shift that services were performed.C. Documentation will be completed by the end of the assigned shift.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of three sampled residents (Residents 4) by failing to follow Resident 4's physician order. This failure had the potential to result in Resident 4 experiencing hypotension (low blood pressure). Findings: During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 5/27/2013, with diagnoses that included unspecified (unconfirmed) heart failure (when the heart muscle does not pump blood as well as it should), unspecified atrial fibrillation (an irregular and often very rapid heart rhythm) and essential hypertension (high blood pressure that is not due to another medical condition). During a review of Resident 4's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 1/16/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's Order Summary Report, dated 6/28/2025, the Order Summary Report indicated hydralazine hydrochloride (medication used to lower blood pressure) oral tablet 10 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth every 12 hours for hypertension (HTN-high blood pressure). Hold for systolic blood pressure (sbp-the top/upper number. It measures the pressure of the blood pushing against the artery walls when the heart beats) less than 110 millimeters of mercury (mmHg- it indicates the level of pressure or compression) or if heart rate is less than 60 beats per minute (bpm). During a review of Resident 4's Minimum Data Set (MDS-a resident assessment tool), dated 9/25/2025, the MDS indicated Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. During a review of Resident 4's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 11/2025, the MAR indicated on 11/8/2025, at 9 p.m., Licensed Vocational Nurse 3 (LVN 3) gave hydralazine to Resident 4 who had a blood pressure of 100/67 mmHg. During a concurrent interview, and record review on 11/18/2025, at 10:04 a.m., with the Director of Staff Development (DSD), Resident 4's Order Summary Report, dated 6/28/2025, and MAR, dated 11/8/2025, was reviewed. The DSD stated LVN 3 should have held the hydralazine because Resident 4's blood pressure was below 110 mmHg. The DSD stated LVN 3 should have followed the physician's order. The DSD stated Resident 4 could experience hypotension after LVN 3 gave the hydralazine. During an interview on 11/18/2025, at 11:58 a.m. with the Director of Nursing (DON), the DON stated LVN 3 should have followed the physician's order to hold the hydralazine for blood pressure below 110 mmHg. The DON stated Resident 4's could experience dizziness, hypotension and could possibly lead to Resident 4's death. During a review of facility's policy and procedure (P&P), titled, Medication Administration dated 10/1/2023, and last reviewed on 6/19/2025, the P&P indicated, Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner.		