STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056084	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Healthcare Center	14040 Astoria Street Sylmar, CA 91342

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of three sampled residents (Resident 1, Resident 5, and Resident 6) received care consistent with professional standards of practice to prevent pressure ulcers (PU, a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) by failing to ensure Residents 1, 5, and 6 were turned and repositioned. This deficient practice placed Resident 1, Resident 5, and Resident 6 at risk for the development of pressure ulcers.Findings: During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 7/1/2025 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), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and stage 4 (severe, deep wound involving the skin, fat, muscles, tendon, and bones) pressure ulcer (PU, a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) of the sacral region (a triangular bone at the very bottom of the spine). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 10/3/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was moderately impaired. The MDS indicated Resident 1 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) on rolling to the left and right side. During an interview on 1/8/2026 at 11:02 a.m. and a concurrent review of Resident 1's medical records, reviewed with Treatment Nurse (TxN) 1, Resident 1's Braden Scale for Predicting Pressure Sore Risk, dated 10/2/2025, was 13. TxN 1 stated a Braden score of 13 indicated Resident 1 had moderate risk for developing or worsening PU. TxN 1 stated Resident 1's Care Plan on PU, initiated on 7/3/2025, indicated the resident had a stage 4 PU on the sacrococcyx. Resident 1's Care Plan Interventions indicated the resident needs assistance to turn/reposition at least every two hours, more often as needed or requested. TxN 1 stated residents at risk for developing or worsening PU should be turned and repositioned every two hours. TxN 1 stated there was no documented evidence that Resident 1 was turned and repositioned every two hours. TxN 1 stated not turning and repositioning Resident 1 had the potential for the resident's PU to get worse. During an interview on 1/8/2026 at 3:30 p.m. with the Director of Nursing (DON), the DON stated the importance of turning and repositioning a resident was to improve skin circulation and prevent development and worsening of skin breakdown and PU. The DON stated Resident 1's turning and repositioning every two hours should be documented in the resident's medical records. The DON stated the nursing staff document the residents' level of assistance required on turning and repositioning. The DON stated there was no documented evidence Resident 1 was turned and repositioned every two hours. The DON stated the facility failed to implement the nursing (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intervention of turning and repositioning of residents every two hours to prevent skin breakdown. During a review of the facility's policy and procedure (PnP) titled, Pressure Ulcer Prevention, last reviewed on 6/19/2025, the PnP indicated nursing staff will monitor interventions for effectiveness and resident tolerance. The PnP indicated the licensed nurse will document effectiveness of pressure ulcer prevention techniques in the resident's medical record on a weekly basis. During a review of Resident 5's admission Record (undated), the admission Record indicated the facility admitted the resident on 9/24/2025 with diagnoses including stage 4 PU of the sacral region, muscle weakness, and adult failure to thrive (a gradual, unexplained decline in an older adult's physical and mental health). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 5 was dependent on facility staff on rolling to the left and right side. During a review of Resident 5's Braden Scale for Predicting Pressure Sore Risk, dated 10/22/2025, the Braden Scale for Predicting Pressure Sore Risk score was 13. A Braden score of 13 indicated Resident 5 had moderate risk for developing or worsening PU. During an interview on 1/8/2026 at 11:02 a.m. and a concurrent review of Resident 5's Interdisciplinary Wound Management Care Plan, dated 12/29/2025, reviewed with TxN 1, TxN 1 stated Resident 5 had a PU on the sacrococcyx. Resident 5's Care Plan Interventions indicated reposition every 2 or as often as necessary / indicated. TxN 1 stated residents at risk for developing or worsening PU should be turned and repositioned every two hours. TxN 1 stated there was no documented evidence that Resident 5 was turned and repositioned every two hours. TxN 1 stated not turning and repositioning Resident 5 had the potential for the resident's PU to get worse. During an interview on 1/8/2026 at 3:30 p.m. with the Director of Nursing (DON), the DON stated the importance of turning and repositioning a resident was to improve skin circulation and prevent development and worsening of skin breakdown and PU. The DON stated Resident 5's turning and repositioning every two hours should be documented in the resident's medical records. The DON stated the nursing staff document the residents' level of assistance required on turning and repositioning. The DON stated there was no documented evidence Resident 5 was turned and repositioned every two hours. The DON stated the facility failed to implement the nursing intervention of turning and repositioning of residents every two hours to prevent skin breakdown. During a review of the facility's policy and procedure (PnP) titled, Pressure Ulcer Prevention, last reviewed on 6/19/2025, the PnP indicated nursing staff will monitor interventions for effectiveness and resident tolerance. The PnP indicated the licensed nurse will document effectiveness of pressure ulcer prevention techniques in the resident's medical record on a weekly basis. During a review of Resident 6's admission Record (undated), the admission Record indicated the facility admitted the resident on 10/10/2023 with diagnoses including type 2 diabetes mellitus, muscle weakness, and essential hypertension (high blood pressure that is not due to another medical condition).During a review of Resident 6's Braden Scale for Predicting Pressure Sore Risk, dated 10/2/2025, the Braden Scale for Predicting Pressure Sore Risk score was 14. A Braden score of 14 indicated Resident 6 had moderate risk for developing or worsening PU. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decision making was intact. The MDS indicated Resident 6 required moderate assistance (helper lifts, holds or supports trunk or limbs but provides less than half the effort) on rolling to the left and right side. During an interview on 1/8/2026 at 11:02 a.m. and a concurrent review of Resident 6's Interdisciplinary Wound Management Care Plan, dated 12/29/2025, reviewed with TxN 1, TxN 1 stated Resident 6 had a PU on the sacrococcyx. Resident 6's Care Plan Interventions indicated reposition every 2 or as often as necessary / indicated. TxN 1 stated residents at risk for developing or worsening PU should be turned and (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	repositioned every two hours. TxN 1 stated there was no documented evidence that Resident 6 was turned and repositioned every two hours. TxN 1 stated not turning and repositioning Resident 6 had the potential for the resident's PU to get worse. During an interview on 1/8/2026 at 3:30 p.m. with the Director of Nursing (DON), the DON stated the importance of turning and repositioning a resident was to improve skin circulation and prevent development and worsening of skin breakdown and PU. The DON stated Resident 6's turning and repositioning every two hours should be documented in the resident's medical records. The DON stated the nursing staff document the residents' level of assistance required on turning and repositioning. The DON stated there was no documented evidence Resident 6 was turned and repositioned every two hours. The DON stated the facility failed to implement the nursing intervention of turning and repositioning of residents every two hours to prevent skin breakdown. During a review of the facility's policy and procedure (PnP) titled, Pressure Ulcer Prevention, last reviewed on 6/19/2025, the PnP indicated nursing staff will monitor interventions for effectiveness and resident tolerance. The PnP indicated the licensed nurse will document effectiveness of pressure ulcer prevention techniques in the resident's medical record on a weekly basis.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure the medical records of one of three sampled residents (Resident 1) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to ensure Licensed Vocational Nurse (LVN) 1 documented the level of care provided to Resident 1 while the resident was in the facility. LVN 1 documented the level of care she provided to Resident 1 on 12/13/2025. Resident 1 was discharged to the General Acute Care Hospital (GACH) 1 on 12/10/2025. This deficient practice resulted in incomplete and inaccurate information on Resident 1's medical records and had the potential for delayed medical interventions.Findings: During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 7/1/2025 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), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and stage 4 (severe, deep wound involving the skin, fat, muscles, tendon, and bones) pressure ulcer (PU, a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) of the sacral region (a triangular bone at the very bottom of the spine). Resident 1's admission Record indicated the resident was discharged on 12/17/2025. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 10/3/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making was moderately impaired. During a review of Resident 1's Change in Condition (CIC) Evaluation, dated 12/10/2025, the CIC Evaluation indicated Resident 1 had fever, shortness of breath (SOB), and sudden change in level of consciousness or responsiveness. During a review of Resident 1's Progress Notes, dated 12/10/2025, the Progress Notes indicated on 12/10/2025 at 10:10 a.m., Resident 1 was transferred to GACH 1. Resident 1 did not return to the facility and was discharged from GACH 1. During a review of Resident 1's Progress Notes, dated 12/13/2025, the Progress Notes indicated LVN 1 documented that she received resident resting in bed, able to make needs known, on monitoring for fever/congestion/lethargy. No episodes noted during my shift, no SOB, no acute distress noted. Denied any pain or discomfort, all due meds given and tolerated well. Kept resident clean and dry, call light within reach. The Progress Notes indicated Resident 1's vital signs (measurements of the body's most basic functions that show how essential organs are working) were taken and recorded as follows: blood pressure of 125/65, heart rate of 70 beats per minute, respiratory rate on 18 breaths per minute, temperature of 97.6 Fahrenheit (F - unit of measurement), and oxygen saturation of 97 percent (% - unit of measurement) on room air. During an interview on 1/8/2026 at 3:30 p.m. and concurrent record review of Resident 1's medical records, reviewed with the Director of Nursing (DON), the DON stated Resident 1 was transferred to GACH 1 on 12/10/2025 and did not return to the facility. The DON stated Resident 1's Progress Notes dated 12/13/2025 indicated LVN 1 documented the level of care she provided to Resident 1. The DON stated LVN 1 documented inaccurate information regarding Resident 1's health condition. The DON stated the facility failed to follow the policy and procedure on accurate and complete documentation. During a review of the facility's policy and procedure (PnP) titled, Documentation - Nursing, last reviewed on 6/19/2025, the PnP indicated the purpose to provide documentation of resident status and care given by nursing staff. The PnP indicated nursing documentation will be concise, clear, pertinent, and accurate. The PnP indicated nurse's notes are dated, timed, and signed when written.documentation will be completed by the end of the assigned (continued on next page)

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