

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 03/18/2026
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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on interview and record review, the facility failed to ensure the medical record of one of five sampled residents (Resident 1) was maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to ensure: 1. Resident 1's Change of Condition (COC) Evaluation indicated the correct date and time the COC happened. Resident 1 had a change of condition (COC) on 3/9/2026, afternoon shift. The COC Evaluation indicated Resident 1's COC occurred on 3/10/2026 during the night shift. 2. Accurate documentation regarding COC notification to Resident 1's Attending Physician (MD) 1 and family member. The COC evaluation indicated on 3/10/2026, Resident 1's Attending Physician (MD) 1 was notified at 9:20 p.m. and the resident's family member was notified at 9:15 p.m. 3. The licensed nurses completed and signed Resident 1's COC Evaluation timely. Resident 1's COC Evaluation was completed and signed on 3/11/2026. These deficient practices resulted in 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, the admission Record indicated the facility admitted the resident on 12/11/2022 with diagnoses including type 2 diabetes mellitus (a disease that occurs when the blood sugar level is too high), Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to perform simple tasks), and essential hypertension (high blood pressure that is not due to another medical condition). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/31/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were severely impaired. During an interview on 3/18/2026 at 9:57 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 3/9/2026 at 9:30 p.m., Resident 2 attempted to hit Resident 1. CNA 1 stated the licensed nurses, including Licensed Vocational Nurse (LVN) 1, went to help her and was informed of the incident. During an interview on 3/18/2026 at 10:29 a.m. with LVN 1, LVN 1 stated he created a COC Evaluation for Resident 1 after the resident was involved in the physical aggression of Resident 2 on 3/9/2026 during 3 p.m. to 11 p.m. shift. LVN 1 stated he did not change the date on Resident 1's COC Evaluation from 3/10/2026 to 3/9/2026. LVN 1 stated he did not change the time Resident 1's physician and family member were notified about the resident's COC. LVN 1 stated MD 1 and Resident 1's family member were notified on 3/10/2026 after midnight. LVN 1 stated he did not remember the exact time MD 1 and Resident 1's family member were notified. LVN 1 stated Resident 1's COC Evaluation was inaccurate and could cause confusion amongst the healthcare team. During a concurrent interview on 3/18/2026 at 1:30 p.m. and concurrent record review of Resident 1's COC Evaluation, dated 3/10/2026, reviewed with the Assistant Director of Nursing (ADON), the ADON stated Resident 1 had a change in condition on 3/9/2026. The ADON stated Resident 1's COC Evaluation should be documented at the time of the resident's change of condition. The ADON stated the COC Evaluation should indicate the correct date and time that Resident 1's physician and family member were notified. The ADON confirmed Resident 1's COC Evaluation was completed and signed on 3/11/2026, two days after the resident's change of condition. The ADON stated Resident 1's COC (continued on next page)</p>

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Evaluation should be signed at the end of the licensed nurse's shift. The ADON stated failure to document the correct date and time of the resident's change of condition and the notifications required could result in delays in resident care. The ADON acknowledged and stated the facility failed to accurately and timely document the date and time of Resident 1's change of condition, the notification of MD 1, and the notification of the resident's family member. During an interview on 3/18/2026 at 1:30 p.m. and concurrent review of the facility's policy and procedure (PnP) titled, Change of Condition Notification, last reviewed on 1/15/2026, with the ADON, the ADON stated the PnP indicated the purpose to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. The PnP indicated a licensed nurse will document the following. date, time, and pertinent details of the incident. the time the attending physician was contacted. the time the family/responsible person was contacted. During a review of the facility's PnP titled Documentation - Nursing, last reviewed on 1/15/2026, the PnP indicated nursing documentation will be concise, clear, pertinent, and accurate. The PnP indicated documentation will be completed by the end of the assigned shift.</p>		