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	04/02/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards of nursing practice for one of three sampled residents (Resident 1) by failing to:1.Ensure licensed nurses monitored Resident 1's oxygen saturation (the amount of oxygen circulating in the blood) every shift from 3/14/2026 to 3/19/2026 (five days). 2.Ensure licensed nurse accurately assessed Resident 1's risk for falls following the resident's readmission on [DATE]. These deficient practices had the potential to result in the failure to identify continued or worsening clinical deterioration, thereby placing Resident 1 at risk for adverse health outcomes and compromised safety.Findings: During a review of Resident 1's undated admission Record, the admission Record indicated the facility admitted the resident on 4/2/2022 and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a brain malfunction caused by chemical imbalances or toxins in the body, rather than a direct brain injury), pneumonia (an infection that inflames the air sacs in one or both lungs, caused by a virus or bacteria), and age-related osteoporosis (a disease where bones become weak, brittle, and porous making them fragile and prone to breaking [fractures]). During a review of Resident 1's Face Sheet (admission Record), dated 4/2/2025, the Face Sheet indicated the facility admitted the resident on 4/2/2022 with an admitting diagnosis that included history of falling. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/12/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were moderately impaired. During a review of Resident 1's Physician Orders, dated 3/14/2026, the Physician Orders indicated to administer continuous oxygen at a rate of 2 liters per minute (L/min - unit of measurement) using a nasal cannula. The Physician Orders indicated to notify the attending physician if Resident 1's oxygen saturation every nursing shift was less than 90 percent (% - one part in every hundred). The Order Type section of the Physician Orders indicated no documentation required. During a review of Resident 1's Physician Orders, dated 3/15/2026, the Physician Orders indicated to administer continuous oxygen at a rate of 2 L/min using a nasal cannula. The Physician Orders indicated to notify the attending physician if Resident 1's oxygen saturation every nursing shift was less than 93 %. The Order Type section of the Physician Orders indicated no documentation required. During a review of Resident 1's Attending Physician (MD) 1 Progress Notes, dated 3/15/2026, the Progress Notes indicated the resident was admitted to the General Acute Care Hospital (GACH) from 3/2/2026 to 3/14/2026. The Progress Notes indicated on 3/15/2026, MD 1 saw Resident 1 was not on oxygen per nasal cannula (a flexible medical device with two small prongs placed into the nostrils to deliver supplemental oxygen or increased airflow). The Assessment and Plan section indicated Resident 1 had some confusion noted. During an interview on 4/2/2026 at 2:40 p.m. and a concurrent record review of Resident 1's medical records, reviewed with Licensed Vocational Nurse (LVN) 1, LVN 1 stated there was no documented evidence that Resident 1's oxygen saturation was monitored every shift from 3/14/2026 to 3/19/2026 (five days). LVN 1 stated Resident 1's Oxygen Saturation Summary, dated 3/15/2026 to 3/17/2026, indicated the resident was on room air (no supplemental oxygen used). LVN 1 stated the failure to measure Resident 1's oxygen saturation while the resident received continuous oxygen (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

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	04/02/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	therapy could cause Resident 1's hypoxia (low levels of oxygen in the body tissues) and confusion that could further lead to accidents such as falls. Resident1's Nursing admission Assessment, dated 3/14/2026, indicated the resident had no history of falls, had only one recorded diagnosis in the medical records, and had a weak gait (the manner, style, or pattern in which person walks or runs). The Fall Risk Assessment section of the Nursing admission Assessment indicated a total score of 10. A score of zero to 24 indicated Resident 1 had a low risk for falls. LVN 1 stated Resident 1 had more than one documented diagnosis in the medical record and the resident's gait was impaired. LVN 1 stated the Fall Risk Assessment defined impaired gait as difficulty rising from chair, uses chair arms to get up . cannot walk unassisted. LVN 1 stated Resident 1's fall risk score should be 45 or higher which indicated the resident was a high risk for falls. LVN 1 stated Resident 1's individualized fall risk interventions should be based on accurate fall risk score. During an interview on 4/2/2026 at 4:02 p.m. and a concurrent record review of Resident 1's medical records, reviewed with the Director of Nursing (DON), the DON stated oxygen was considered as a medication and required a physician order. The DON stated Resident 1's oxygen saturation should be monitored and documented every shift according to physician orders. There was no confirmed documented evidence of Resident 1's oxygen saturation monitoring every shift from 3/14/2026 to 3/19/2026. The DON stated that monitoring not documented was considered not done. The DON stated failure to monitor Resident 1's oxygen saturation could result in hypoxia, confusion, and accidents. The DON stated Resident 1's Nursing admission Assessment, dated 3/14/2026, indicated Resident 1's Fall Risk Assessment score should be higher based on the assessment criteria. The DON stated inaccurate assessment could result in interventions that did not match the needs of the residents. The DON acknowledged and stated the facility failed to ensure Resident 1's oxygen saturation and risk for falls was accurately assessed and monitored according to the physician orders and documented in the resident's medical records. During a review of the facility's policy and procedure (PnP) titled, Nursing Assessment, last reviewed on 1/15/2026, the PnP indicated the purpose to ensure that resident's needs, strength, goals, and life history and preferences are identified and a plan of care and a discharge plan is developed accordingly. The PnP indicated the assessment process must include direct and indirect observation and communication with the resident. licensed and nonlicensed direct care staff members on all shifts. During a review of the facility's PnP titled, Oxygen Administration, last reviewed on 1/15/2026, the PnP indicated the purpose to prevent or reverse hypoxemia and provide oxygen to the tissues. The PnP indicated to document in patient's record. oxygen saturation levels as indicated and patient's response to oxygen therapy. During a review of the facility's PnP titled, Fall Management Program, last reviewed on 1/15/2026, the PnP indicated the purpose to prevent resident falls and minimize complications associated with falls through the development of a Fall Management Program. The PnP indicated the licensed nurse will assess each resident for their risk of falling upon admission, quarterly, and with a significant change in condition. The PnP indicated based on the information gathered from the history and assessment of the resident, the nursing staff. will identify and implement interventions to reduce the risk of falls.