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	05/01/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record review, the facility failed to report the allegation of a resident-to-resident physical abuse (any intentional act causing injury or trauma to another person through bodily contact) to the State Survey Agency (SSA) for one of four sampled residents (Resident 1). On 4/17/2026, an allegation that Resident 2 pulled Resident 1's hair was reported to Registered Nurse (RN) 1, the Director of Nursing (DON), and the Administrator (ADM). The SSA did not receive the report from the Abuse Coordinator for the allegation of abuse. This deficient practice had the potential to result in unidentified abuse and failure to protect other residents from abuse.Findings: During a review of Resident 1's undated admission Record, the admission Record indicated the facility admitted the resident on 7/27/2017 with diagnoses including type 2 diabetes mellitus (a disease that occurs when the blood sugar level is too high), diastolic congestive heart failure (a condition where the heart's main pumping chamber becomes too stiff or thick to relax between beats, preventing it from filling fully with blood), and essential hypertension (high blood pressure that is not due to another medical condition). 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 8/7/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/4/2026, 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 an interview on 4/30/2026 at 10:44 a.m. with Resident 1, Resident 1 stated Resident 2 pulled her hair. Resident 1 could not recall the date and time the allegation occurred but stated there were facility staff that witnessed the alleged abuse. Resident 1 stated the licensed nurse assessed her after the incident. Resident 1 stated she reported the incident to the licensed nurse the following morning. During an interview on 4/30/2026 at 11:29 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 4/18/2026, Resident 1 reported that Resident 2 pulled her hair the previous day. LVN 1 stated the allegation of abuse was reported to RN 1, the DON, and the ADM. During a telephone interview on 4/30/2026 at 11:58 a.m. with RN 1, RN 1 stated Resident 1's family member reported that Resident 2 pulled Resident 1's hair. RN 1 stated she (RN 1) could not remember the date and time of the reported allegation of abuse. RN 1 stated she sent a text message to the DON and the ADM on the same day she (RN 1) was informed about the alleged abuse. RN 1 stated the DON informed her that they (the DON and the ADM) will follow up with Resident 1. RN 1 stated the alleged abuse was not reported to the SSA. During a concurrent interview and record review on 4/30/2026 at 2:15 p.m. with the Assistant Director of Nursing (ADON), the facility-provided staffing assignment, dated 4/17/2026 and 4/18/2026, was reviewed. The facility-provided staffing assignment indicated RN 1 was the RN supervisor on 4/17/2026 (3 p.m. to 11 p.m. shift) and 4/18/2026 (7 a.m. to 3 p.m. shift). During an interview on 4/30/2026 at 3:41 p.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated he witnessed Resident 2 touch Resident 1's back of the head. CNA 6 stated he informed LVN 5 and LVN 5 reported the incident to RN 1. During an interview on 5/1/2026 at 11:47 a.m. with the DON, the DON stated on 4/17/2026, CNA 8 reported to (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him (the DON) that Resident 2 touched Resident 1's hair. The DON stated he did not ask Resident 1 if Resident 2 pulled her hair. The DON stated on 4/18/2026, RN 1 and LVN 2 informed him (the DON) that Resident 1's family member had concerns regarding the allegation of abuse on 4/17/2026. The DON stated Resident 1's allegation against Resident 2 was not reported to the SSA. The DON stated Resident 1 had the potential to experience psychosocial distress (an emotional discomfort caused by social situations, personal relationships, or major changes). During a concurrent interview and record review on 5/1/2026 at 11:59 a.m. with the ADM, the facility's policy and procedure (P&P) titled Abuse Prevention and Prohibition Program, dated 1/15/2026 was reviewed. The P&P indicated the facility is committed to protecting residents from abuse by anyone, including. other residents. The P&P indicated the facility will report allegations of abuse. immediately, but no later than two hours after forming the suspicion - if the alleged violation involves abuse. to the state survey agency, adult protective services, law enforcement, and the Ombudsman. The ADM stated he was the facility's Abuse Coordinator. The ADM stated Resident 1's allegation of Resident 2 pulling Resident 1's hair should be reported within two hours to the SSA, Ombudsman, and law enforcement. The ADM stated not reporting Resident 1's allegations of abuse could put the resident safety at risk and the alleged abuse to continue. The ADM acknowledged and stated the facility failed to report the allegation of abuse within two hours.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure licensed nurses appropriately assessed and monitored Resident 1's medical and psychosocial status (a person's overall mental, emotional, and social well-being) following the resident's change of condition (COC) on 4/17/2026 related to an alleged physical abuse. This deficient practice had the potential to result in the failure to identify continued or worsening clinical and psychosocial 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 7/27/2017 with diagnoses including type 2 diabetes mellitus (a disease that occurs when the blood sugar level is too high), diastolic congestive heart failure (a condition where the heart's main pumping chamber becomes too stiff or thick to relax between beats, preventing it from filling fully with blood), and essential hypertension (high blood pressure that is not due to another medical condition). 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 8/7/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/4/2026, 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 2's undated admission Record, the admission Record indicated the facility admitted the resident on 4/9/2026 with diagnoses including Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking, and eventually the ability to perform simple daily tasks), unspecified psychosis (a mental health symptom where a person loses touch with reality, making it difficult to distinguish what is real from what is not), and essential hypertension. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making were severely impaired. During an interview on 4/30/2026 at 10:44 a.m. with Resident 1, Resident 1 stated Resident 2 pulled her hair. Resident 1 could not recall the date and time the allegation occurred but stated there were facility staff that witnessed the alleged abuse. Resident 1 stated she reported the incident to the licensed nurse the following morning. During a concurrent interview and record review on 4/30/2026 at 11:29 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Progress Notes dated 4/14/2026 to 4/30/2026, COC Evaluations, and Care Plans were reviewed. LVN 1 stated on 4/18/2026, Resident 1 reported that Resident 2 pulled her hair the previous day. LVN 1 stated she did not document Resident 1's allegation and interventions in the resident's medical record. LVN 1 stated Resident 1 should be monitored every shift for 72 hours following a change of condition. LVN 1 stated a COC Evaluation should have been created that addressed Resident 1's allegation of Resident 2 pulling Resident 1's hair. LVN 1 stated there was no documented evidence that the Attending Physician (MD) was notified following the alleged abuse. LVN 1 stated there were no progress notes and care plan that addressed the monitoring and interventions provided to Resident 1 following the alleged abuse. LVN 1 stated that failure to notify Resident 1's MD, monitor Resident 1's medical status, and create a care plan following a change of condition related to the resident's allegation could put Resident 1's safety at risk. LVN 1 stated the quality of care provided for Resident 1 had the potential to be compromised. During a telephone interview on 4/30/2026 at 11:58 a.m. with RN 1, RN 1 stated Resident 1's family member reported that Resident 2 pulled Resident 1's hair. RN 1 stated she (RN 1) could not remember the date and time of the reported allegation of abuse. RN 1 could not recall if she (RN 1) documented the assessment and interventions provided to Resident 1 following the allegation of abuse. During a concurrent interview and record review on 4/30/2026 at 2:15 p.m. with the Assistant Director of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing (ADON), the facility-provided staffing assignment, dated 4/17/2026 and 4/18/2026, was reviewed. The facility-provided staffing assignment indicated RN 1 was the RN supervisor on 4/17/2026 (3 p.m. to 11 p.m. shift) and 4/18/2026 (7 a.m. to 3 p.m. shift). During an interview on 4/30/2026 at 3:41 p.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated on 4/17/2026, he witnessed Resident 2 touch Resident 1's back of the head while the residents were in the hallway. CNA 6 stated he informed LVN 5 and LVN 5 reported the incident to RN 1. During a concurrent interview and record review on 5/1/2026 at 10:03 a.m. with the Social Services Director (SSD), Resident 1's Progress Notes, dated 4/14/2026 to 4/30/2026 were reviewed. The Progress Notes did not indicate documented evidence addressing Resident 1's allegation of physical abuse. The SSD stated she was informed about Resident 1's allegation of physical abuse during the State Survey Agency (SSA) investigation. The SSD stated Resident 1 should receive a psychosocial visit from the social service staff every day for three days following the resident's COC. The SSD stated Resident 1 did not receive psychosocial visits from the social services staff from 4/17/2026 to 4/30/2026. During a concurrent interview and record review on 5/1/2026 at 11:47 a.m. with the Director of Nursing (DON), Resident 1's Progress Notes dated 4/14/2026 to 4/30/2026, COC Evaluations, and Care Plans were reviewed. The DON stated on 4/17/2026, CNA 8 reported to him (the DON) that Resident 2 touched Resident 1's hair. The DON stated he did not ask Resident 1 if Resident 2 pulled her hair. The DON stated on 4/18/2026, RN 1 and LVN 2 informed him (the DON) that Resident 1's family member had concerns regarding the allegation of abuse on 4/17/2026. The DON stated there was no documented evidence of Resident 1's COC evaluation, nursing and social services monitoring, and care plan that addressed Resident 1's allegation of physical abuse. The DON stated resident care not documented was considered not provided. The DON acknowledged and stated the facility failed to identify, document, and monitor Resident 1's change of condition.