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	05/11/2026

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who lacked the capacity to understand and make decisions, was not made to sign the Consent to Treat Authorization on 4/7/2026. This deficient practice resulted in the violation of Resident 1's rights.Findings:During a review of Resident 1's Advance Health Care Directive (AHCD - legal document that let you state your medical care preferences in case you become unable to communicate or make decisions yourself), dated 2/24/2020, the AHCD indicated Resident 1's Family Member (FM) 2 was Resident 1's Health Care Agent.During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 4/7/2026 with diagnoses that included dementia (a progressive state of decline in mental abilities), unspecified sequelae of cerebral infarction (long-term, lasting problems or disabilities that remain after a person has had a stroke [a medical emergency that occurs when blood flow to part of the brain is blocked or a blood vessel in the brain bursts]), and aphasia (a disorder that makes it difficult to speak).During a review of Resident 1's History and Physical (H&P- a comprehensive, formal medical document created by a clinician during an initial patient encounter or hospital admission) Note, dated 4/7/2026, the H&P Note indicated Resident 7 did not have the capacity to understand and make decisions. During a review of Resident 1's Consent to Treat Authorization, dated 4/7/2026, the Consent to Treat Authorization indicated Resident 1 signed the consent. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/13/2026, the MDS indicated Resident 1 was usually understood and was sometimes able to understand. The MDS indicated Resident 1 was dependent (helper does all the effort) with toileting, showering, lower body dressing, putting on and taking off footwear and personal hygiene, and required substantial (helper does more than half the effort) with upper body dressing, and requires partial assistance (helper does less than half the effort) with oral hygiene and requires supervision (helper provides verbal cues and or touching assistance as resident completes activity) when eating. During an interview on 5/11/2026 at 7:45 a.m. with Family Member (FM) 1, FM 1 stated Resident 1's power of attorney is not FM 1 but Resident 1's FM 2. FM 1 stated on 4/7/2026 FM 1 was out of town and FM 2 does not drive. FM 1 stated the facility had Resident 1 sign documents and Resident 1 was admitted with diagnosis of dementia and unable to sign for himself (Resident 1). FM 1 stated she complained to the facility about Resident 1 not having the ability to sign for himself (Resident 1) and the facility had FM 1 sign next to Resident 1's name. FM 1 stated she was upset because the facility should have some policy where they can speak to the responsible party and/or power of attorney to give consent over the phone. During an interview on 5/11/2026 at 3:55 p.m. with the Director of Nursing (DON), the DON stated for consent to treat it is done by the nurse at bedside with the resident. The DON stated for residents who do not have the capacity to give consent, the facility will call the family and/or the responsible party. The DON stated Resident 1 did not have the capacity to give consent. The DON stated if residents sign without the capacity, then we are violating the residents' rights. The DON stated to obtain consent the proper manner is to have the family at bedside and if not, we have the staff call family on the phone, and we have a two-person verification (is a resident-safety protocol where two authorized staff members [usually nurses] (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	jointly confirm both the resident's identity and the validity of their consent). The DON stated this was not done with Resident 1.During a review of the facility's policy and procedure (P&P) titled, Privacy and Dignity, last reviewed on 1/15/2026, the P&P indicated to ensure that care and services provided by the facility promote and or enhance privacy, dignity and overall quality of life.During a review of the facility provided document titled, Consent for Treatment, with an implementation date of 10/2023, the document indicated that if you are, or become, incapable of making your own medical decisions, we will follow the direction of a person with legal authority to make medical decisions on your behalf, such as a guardian, conservator, next of kin, or a person designated in an Advance Health Care Directive or Power of Attorney for Health Care.

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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. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received the proper care and services by failing to ensure staff monitored Resident 1's risk for bleeding when on 4/7/2026 Resident 1 was prescribed Lovenox (an injectable medicine, commonly known as a blood thinner [anticoagulant], used to prevent or treat harmful blood clots) injection (the act of putting a liquid-usually medication, vaccines, or vitamins-directly into the body using a needle and syringe).This deficient practice had the potential for Resident 1 to have complications that included bleeding.Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 4/7/2026 with diagnoses that included dementia (a progressive state of decline in mental abilities), unspecified sequelae of cerebral infarction (long-term, lasting problems or disabilities that remain after a person has had a stroke [a medical emergency that occurs when blood flow to part of the brain is blocked or a blood vessel in the brain bursts]), chronic embolism (a sudden, dangerous blockage of a blood vessel [artery] by a traveling foreign object, most commonly a blood clot) and thrombosis (the formation of a blood clot [called a thrombus] inside a vein or artery that obstructs normal blood flow) of unspecified deep veins of lower extremity bilateral (involving two sides) and aphasia (a disorder that makes it difficult to speak).During a review of Resident 1's History and Physical (H&P- a comprehensive, formal medical document created by a clinician during an initial patient encounter or hospital admission) Note, dated 4/7/2026, the H&P Note indicated Resident 7 did not have the capacity to understand and make decisions.During a review of Resident 1's Order Summary Report (OSR), dated 4/7/2026, the OSR indicated Lovenox injection solution prefill syringe 40 milligram (mg- a unit of measurement) injection 1 syringe subcutaneously (injecting medication into the fatty tissue layer directly under the skin, rather than into the muscle or vein) every 24 hours for deep vein thrombosis (DVT- is a blood clot that forms in a vein deep inside your body, typically in the lower leg, thigh, or pelvis) prophylaxis (PPX- preventive care or actions taken to stop a disease or health condition before it starts).During a review of Resident 1's Care plan (CP) for anticoagulant therapy Eliquis related to DVT PPX, created on 4/8/2026, the CP indicated to monitor, document, and report to doctor as needed for signs and symptoms of anticoagulant complications; blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, and significant or sudden changes in vital signs. During a review of Resident 1' CP for regarding anticoagulant therapy (Lovenox), created on 4/8/2026, the CP indicated to administer medication as ordered and to monitor, document, and report as needed for signs and symptoms of anticoagulant complications; blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, and significant or sudden changes in vital signs.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/13/2026, the MDS indicated Resident 1 was usually understood and was sometimes able to understand. The MDS indicated Resident 1 was dependent (helper does all the effort) with toileting, showering, lower body dressing, putting on and taking off footwear and personal hygiene, and required substantial (helper does more than half the effort) with upper body dressing, and requires partial assistance (helper does less than half the effort) with oral hygiene and requires supervision (helper provides verbal cues and or touching assistance as resident completes activity) when eating. During a review of Resident 1's OSR, dated 4/21/2026, the OSR indicated a physician order for an anticoagulant medication and to monitor for decolorated urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs, shortness of breath (SOB), nose bleeds. Document N for NO if monitored and none of the above observed. Y for YES if monitored and any of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the above was observed, select chart code Other/see notes and progress notes findings. During a review of Resident 1's OSR dated 5/5/2026, the OSR indicated a physician order for Eliquis oral tablet 2.5 mg to be given one tablet by mouth two times a day for DVT PPX related to chronic embolism and thrombosis of deep veins of lower extremity, bilateral for 35 days. During a review of Resident 1's OSR dated 5/5/2026, the OSR indicated a physician order for Eliquis and to monitor for decolorated urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs, shortness of breath (SOB), nose bleeds. Document N for NO if monitored and none of the above observed. Y for YES if monitored and any of the above was observed, select chart code Other/see notes and progress notes findings.During a review of Resident 1's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for April 2026, the MAR indicated a physician order for an anticoagulant medication, monitor for decolorated urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs, shortness of breath (SOB), nose bleeds. Document N for NO if monitored and none of the above observed. Y for YES if monitored and any of the above was observed, select chart code Other/see notes and progress notes findings, was not signed off as completed by nursing staff for Resident 1. During a review of Resident 1's MAR for May 2026, the MAR indicated the following orders: - Anticoagulant medication, monitor for decolorated urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs, shortness of breath (SOB), nose bleeds. Document N for NO if monitored and none of the above observed. Y for YES if monitored and any of the above was observed, select chart code Other/see notes and progress notes findings, was not signed off as completed by nursing staff for Resident 1.- Eliquis, monitor for decolorated urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs, shortness of breath (SOB), nose bleeds. Document N for NO if monitored and none of the above observed. Y for YES if monitored and any of the above was observed, select chart code Other/see notes and progress notes findings, was not signed off as completed by nursing staff for Resident 1.During a concurrent interview and record review on 5/11/2026 at 3:55 p.m. with the Director of Nursing (DON), Resident 1's MARs for April and May 2026, the DON stated for anticoagulant medication there should be monitoring for the use of the medication specifically to monitor for bleeding. The DON reviewed Resident 1's MAR for April and May 2026 were reviewed. The DON stated monitoring is not checked off indicating staff did not do the monitoring. The DON stated if staff are not monitoring, they will not know if there are bleeding or complications to the medication. During a review of the facility's Policy and Procedure (P&P) titled, Anticoagulant Therapy, last reviewed on 1/15/2026, the P&P indicated to ensure that anticoagulant therapy is safely and effectively administered. The facility will monitor residents receiving anticoagulant therapy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure portable oxygen tanks (a sturdy, pressurized metal container, that stores compressed oxygen gas) for one of three sampled residents (Resident 2) were properly stored securely to prevent the oxygen tanks from falling. This deficient practice had the potential for the portable oxygen tanks to fall leading to accidents causing injuries to residents, staff and visitor or cause severe fires. Findings:During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted the resident on 9/28/2021 and was readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute exacerbation (a sudden worsening of a disease, chronic condition, or symptom), chronic pulmonary edema (a long-term condition where fluid slowly and consistently builds up in the air sacs of the lungs, making it hard to breathe), acute respiratory failure (a life-threatening medical emergency where the lungs suddenly cannot get enough oxygen into the blood or remove enough carbon dioxide from the body) and dependence on supplemental oxygen (a medical treatment that provides extra oxygen to people who cannot get enough through normal breathing, usually due to lung or heart conditions).During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 3/12/2026, the MDS indicated Resident 2 had severely impaired cognitive function. During a review of Resident 2's Order Summary Report (ORS), dated 4/7/2026, the ORS indicated oxygen at 2 liters per minute via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) humidification (the process of adding moisture (water vapor) to medical oxygen before it is breathed in) continuously every shift related to COPD to maintain oxygen saturations greater than 91 percent (%-a way of expressing a number or part as a fraction of 100) and call the doctor, if ineffective. During a concurrent observation and interview on 5/11/2026 at 12:12 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 2's room observed two portable oxygen tanks standing in the corner of Resident 2's room without a secured rack or cart, LVN 1 stated there are two oxygen tanks that should not be stored in the resident's room. LVN 1 stated oxygen tanks should be placed in a safe container to prevent them from falling. LVN 1 stated the oxygen tanks can fall over and injure the residents. During an interview on 5/11/2026 at 3:55 p.m. with the Director of Nursing (DON), the DON stated portable oxygen tanks are stored in an oxygen container but should be in the storage room. The DON stated portable oxygen tanks should not be on the floor without a secured rack. The DON stated there is a potential for the portable oxygen tank to fall and hurt residents and/or staff. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, last reviewed on 1/15/2026, the P&P indicated that oxygen cylinders are to be secured in a cylinder cart or bracket at all times.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records in accordance with acceptable professional standards and practices for one of three sampled residents (Resident 1), when:1. Resident 1 had a fall on 5/5/2026 and the Fall Risk Assessment (a simple check-up by a healthcare provider to see how likely an older adult is to fall) was inaccurate.2. Resident 1's Facility Task titled, Nutrition-Amount Eaten, did not match the Facility provided form titled, Restorative Nursing Assistant (RNA) dining meal percentage.These deficient practices resulted in inaccurate documentation in Resident 1's records.Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 4/7/2026 with diagnoses that included dementia (a progressive state of decline in mental abilities), unspecified sequelae of cerebral infarction (long-term, lasting problems or disabilities that remain after a person has had a stroke [a medical emergency that occurs when blood flow to part of the brain is blocked or a blood vessel in the brain bursts]), chronic embolism (a sudden, dangerous blockage of a blood vessel [artery] by a traveling foreign object, most commonly a blood clot) and thrombosis (the formation of a blood clot [called a thrombus] inside a vein or artery that obstructs normal blood flow) of unspecified deep veins of lower extremity bilateral (involving two sides) and aphasia (a disorder that makes it difficult to speak).During a review of Resident 1's History and Physical (H&P- a comprehensive, formal medical document created by a clinician during an initial patient encounter or hospital admission) Note, dated 4/7/2026, the H&P Note indicated Resident 7 did not have the capacity to understand and make decisions.During a review of Resident 1's Nursing admission Assessment, dated 4/7/2026, the Nursing admission Assessment indicated Resident 1 had a history of falling and had a fall risk score of 75 (high risk score for fall is 45 and higher). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/13/2026, the MDS indicated Resident 1 was usually understood and was sometimes able to understand. The MDS indicated Resident 1 was dependent (helper does all the effort) with toileting, showering, lower body dressing, putting on and taking off footwear and personal hygiene, and required substantial (helper does more than half the effort) with upper body dressing, and requires partial assistance (helper does less than half the effort) with oral hygiene and requires supervision (helper provides verbal cues and or touching assistance as resident completes activity) when eating. During a review of Resident 1's Change in Condition (COC) Evaluation, dated 5/5/2026 at 11:43 a.m., the COC Evaluation indicated Resident 1 had an unwitnessed fall. During a review of Resident 1's Fall Risk Assessment, dated 5/5/2026, the Fall Risk Assessment indicated Resident 1 had no prior history of falling with a fall risk score of 40 (a score of 25 to 44 indicates moderate risk for falls).During a review of Resident 1's RNA dining meal percentages, the dining meal percentage indicated the following:- 4/30/26 lunch Resident 1 ate 80% of his meal - 5/1/2026 dinner Resident 1 ate 100% of his meal - 5/3/2026 lunch Resident 1 ate 90% of his meal- 5/4/2026 dinner Resident 1 ate 100% of his meal- 5/5/2026 dinner Resident 1 ate 90% of his mealDuring a review of Resident 1's Nutrition-Amount Eaten, the Nutrition-Amount Eaten indicated the following:- 4/30/26 lunch Resident 1 ate 26 to 50% of his meal - 5/1/2026 dinner Resident 1 did not have any percentage documented.- 5/3/2026 lunch Resident 1 ate 51 to 75% of his meal- 5/4/2026 dinner Resident 1 ate 51 to 75% of his meal- 5/5/2026 dinner Resident 1 ate 26 to 50% of his mealDuring a concurrent interview and record review on 5/11/2026 at 3:12 p.m. with RNA 1, Resident 1's RNA dining meal percentages and Nutrition-Amount Eaten from 4/30/2026 to 5/5/2026 were reviewed. RNA 1 reviewed document titled, RNA dining meal percentage and RNA 1 stated slashes mean Resident 1 did not attend the dining room and R indicated Resident 1 refused to eat his meal. RNA 1 stated RNAs oversee documenting on the RNA dining meal percentage while Certified Nursing Assistants (CNA) oversee documenting on the Nutrition-Amount Eaten. RNA 1 stated the RNAs then (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tell the CNAs the percentage of Resident 1's meal eaten so that they can document on their end. RNA 1 reviewed RNA dining meal percentage and Nutrition-Amount Eaten for Resident 1 and RNA 1 stated the amount eaten did not match.During a concurrent interview and record review on 5/11/2026 at 3:55 p.m. with the Director of Nursing (DON), Resident 1's RNA dining meal percentage and Nutrition-Amount Eaten from 4/30/2026 to 5/5/2026, Resident 1's Nursing admission assessment dated [DATE], and Fall Risk assessment dated [DATE] were reviewed. The DON stated he (DON) was in the building when Resident 1 had the unwitnessed fall. The DON stated that after a fall the facility does a fall risk assessment. The DON reviewed Resident 1's Fall Risk assessment dated [DATE] and the DON stated the assessment should indicate Resident 1 had history of falls. The DON stated the Fall Risk assessment dated [DATE] was inaccurate documentation. The DON stated the initial fall risk score was a 75 indicating Resident 1 was a high risk for falls. The DON stated the current fall risk score is 40 which is inaccurate and is considered a moderate risk for fall. The DON stated this inaccuracy can affect the plan of care for Resident 1 with a high risk for fall. The DON stated the facility may miss interventions like fall mat, low bed, and constant observation. The DON stated for falls the facility is not matching the interventions to the residents needs causing a risk for another fall. The DON reviewed RNA dining meal percentages and Nutrition-Amount Eaten for Resident 1, the DON stated the amounts eaten should correlate with each other. The DON stated these are inaccurate data. The DON stated there may be a possibility for delay in care if the amounts do not match and the facility staff will not know if the resident is not eating and may not report it as change in condition and will not be reported to the doctor. During a review of the facility's Policy and Procedures (P&P) titled, Documentation, Nursing, last reviewed on 1/15/2026, the P&P indicated documentation will be concise, clear, pertinent, and accurate.