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	06/16/2026

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Attending Physician (AP) performs the comprehensive visit before allowing the Nurse Practitioner (NP) to visit one of three sampled residents (Resident 1).This failure had the potential to result in an undetected decline in medical, health or psychosocial condition and could lead to a delay in necessary care, treatment and services to Resident 1.Findings:During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 3/16/2026, with diagnoses that included unspecified (unconfirmed) malignant melanoma of skin (the most serious type of skin cancer, aggressive and potentially fatal [capable of causing death] if it spreads to other parts of the body, it is highly curable if caught and treated in its early stage), and other parts of nervous system (brain, spinal cord and nerves) and unspecified pneumothorax (a collapsed lung when air leaks into the space between the lung and chest wall.During a review of Resident 1's Nursing admission Assessment, dated 3/16/2026, the Nursing admission Assessment indicated Resident 1 was admitted to the facility on [DATE], at 8:30 p.m.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 3/16/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. The H&P indicated the Nurse Practitioner electronically signed the H&P on 3/23/2026, at 9:32 p.m.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 4/7/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact.During an interview on 6/16/2026, at 11:34 a.m., with the Assistant Director of Nursing (ADON), Resident 1's H&P, dated 3/16/2026, were reviewed. The ADON stated Resident 1's H&P, dated 3/16/2026, were done by the NP. The ADON stated there was no documented evidence in Resident 1's medical record that the AP came and visited Resident 1 upon admission on [DATE].During an interview on 6/16/2026, at 12:37 p.m., with the Director of Nursing (DON), the DON stated Resident 1's H&P, dated 3/16/2026, were signed by the NP. The DON stated H&P should be conducted by the AP so Resident 1 could be assessed thoroughly and initial care plan could be developed.During a review of facility's policy and procedure (P&P) titled, Physician Services and Visits, dated 10/1/2023, and last reviewed on 1/15/2026, the P&P indicated, To ensure that the Facility provides residents with care under an Attending Physician. Physician Services are services provided by physicians responsible for the care of individual patients in the Facility.Physician services include, but are not limited to: .I. Authority of Non-Physician Practitioners:Initial Comprehensive Visit may not be performed by the Physician Assistant (PA), NP, Clinical Nurse Specialist (CNS) employed by the facility.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of three sampled residents (Resident 1) by failing to accurately reconcile (the formal process of creating the most accurate list of a resident current medications including names, dosages, frequencies, and routes and comparing it against their new medications or medical orders to avoid errors like omissions, duplications, dosing errors, or harmful drug interaction) dabrafenib (medication that blocks the action of an abnormal protein that signals cancer [a disease where the body's cells grow and multiply out of control] cells to multiply and also helps stop the spread of cancer cells) upon Resident 1's readmission on [DATE]. This failure resulted in Resident 1 receiving only one capsule of dabrafenib for 20 days that could have resulted in Resident 1's untreated cancer. Findings:During a review of Resident 1's General Acute Care Hospital (GACH), dated 3/16/2026, the GACH indicated a new prescription (a doctor's written order to a pharmacist detailing exactly which medicine you need, how much to take, and how often to take) of dabrafenib 75 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) two capsules by mouth two times a day for 60 days. First dose started on 3/15/2026, at 11:39 a.m. and stop date was scheduled on 5/14/2026.During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 3/16/2026, with diagnoses that included unspecified (unconfirmed) malignant melanoma of skin (the most serious type of skin cancer, aggressive and potentially fatal [capable of causing death] if it spreads to other parts of the body, it is highly curable if caught and treated in its early stage), and other parts of nervous system (brain, spinal cord and nerves) and unspecified pneumothorax (a collapsed lung when air leaks into the space between the lung and chest wall.During a review of Resident 1's Nursing admission Assessment, dated 3/16/2026, the Nursing admission Assessment indicated Resident 1 was admitted to the facility on [DATE], at 8:30 p.m.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 3/16/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. The H&P indicated progressive metastatic disease (cancer has spread from where it first started to other parts of the body and is continuing to grow or multiply) and oncology (medical specialty that focuses on the diagnosis, treatment, and care of cancer) initiated targeted therapy with dabrafenib and trametinib (medication used to block specific proteins that help cancer cells grow and multiply) with early signs of response. The H&P indicated Resident 1 was discharged to Skilled Nursing Facility (SNF) with dabrafenib 150 mg by mouth twice a day. The H&P indicated plan to continue targeted oncology therapy with dabrafenib and trametinib.During a review of Resident 1's Physician Order, dated 3/16/2026, the Physician Order indicated dabrafenib mesylate 75 mg, give two capsules by mouth two times a day for malignant melanoma.During a review of Resident 1's Medication Administration Record, dated 3/20206, the MAR indicated the nurses administered dabrafenib 75 mg two capsules to Resident 1 from 3/16/2026, to 3/28/2026, at 10 a.m., and 10 p.m.During a review of Resident 1's Order Recapitulation Report, dated 3/28/2026, the Order Recapitulation Report indicated Resident 1 was transferred to GACH for evaluation after a fall while out on pass (a currently admitted hospital or residential care resident has been granted temporary, official permission to leave the facility for a few hours or day) with familyDuring a review of Resident 1's Progress Notes, dated 4/1/2026, the Progress Notes indicated Resident 1 was readmitted to the facility on [DATE], at 10:39 p.m., after a recent hospitalization for right rib fracture (break in the bone).During a review of Resident 1's Order Recapitulation Report, dated 4/1/2026, the Order Recapitulation Report indicated an order to admit Resident 1 back to skilled care.During a review of (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1's H&P, dated 4/1/2026, the H&P indicated GACH discharged Resident 1 to SNF with order of dabrafenib 150 mg by mouth twice a day. The H&P indicated the Attending Physician (AP), planned to continue dabrafenib and trametinib therapy per oncology recommendations.During a review of Resident 1's MAR, dated 4/2026, the MAR indicated dabrafenib 75 mg two capsules by mouth was administered to Resident 1 on 4/1/2026, at 10 p.m.During a review of Resident 1's Physician Order, dated 4/1/2026, the Physician Order indicated dabrafenib mesylate 75 mg, give one capsule by mouth every 12 hours for malignant melanoma.During a review of Resident 1's Subjective, Objective, Assessment and Plan (SOAP) Note (Physician Note), dated 4/3/2026, the SOAP Note indicated dabrafenib 150 mg by mouth twice a day.During a review of Resident 1's SOAP Note, dated 4/7/2026, the SOAP Note indicated dabrafenib 150 mg by mouth twice a day.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 4/7/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact.During a review of Resident 1's SOAP Note, dated 4/11/2026, the SOAP Note indicated dabrafenib 150 mg by mouth twice a day.During a review of Resident 1's SOAP Note, dated 4/14/2026, the SOAP Note indicated dabrafenib 150 mg by mouth twice a day.During a review of Resident 1's SOAP Note, dated 4/21/2026, the SOAP Note indicated dabrafenib 150 mg by mouth twice a day.During a review of Resident 1's MAR, dated 4/2026, the MAR indicated dabrafenib 75 mg one capsule by mouth was administered to Resident 1 from 4/2/2026 at 9 a.m. to 4/22/2026 at 9 a.m.During an interview on 6/12/2026, at 3:29 p.m., with Family Member 1 (FM 1), FM 1 stated the facility did not administer the correct dose of the anti-cancer (any agent, drug, or treatment used to prevent, arrest, or treat cancer) medication and only administered one pill instead of two pills. During a concurrent interview and record review on 6/16/2026, at 11:34 a.m., with the Assistant Director of Nursing (ADON), Resident 1's Discharge Summary, and Physician Order, dated 4/1/2026, and SOAP Notes, dated 4/3/2026, 4/7/2026, 4/11/2026, 4/14/2026 and 4/21/2026, were reviewed. The ADON stated the Discharge Summary from GACH indicated an order for dabrafenib 75 mg two capsules by mouth every 12 hours. The ADON stated the Physician Order, dated 4/1/2026, indicated an order for dabrafenib 75 mg of only one capsule by mouth every 12 hours. The ADON stated the process for readmission was to look at the Discharge Summary, inform and confirm with the Physician if to continue the medications. The ADON stated the dabrafenib should still be 75 mg two capsules every 12 hours. The ADON stated the Nurse Practitioner (NP) had documented dabrafenib 75 mg of two capsules from 4/3/2026 to 4/21/2026, and it should have been followed. The ADON stated Resident 1 received less dose of the anti-cancer medication for 20 days. The ADON stated dabrafenib is an anti-cancer medication that if not given as ordered can be less effective in treating the cancer and could result in the progression of Resident 1's cancer.During an interview on 6/16/2026, at 12:37 p.m. with the Director of Nursing (DON), the DON stated the facility was informed by Resident 1's family of the medication issue for the anti-cancer medication after Resident 1 was already discharged from the facility. The DON stated Resident 1 was sent to GACH after a fall at home on 3/28/2026, and upon readmission on [DATE], the nurse entered the dabrafenib dose incorrectly, instead of 150 mg, it was entered as 75 mg only. The DON stated the effect of administering dabrafenib less that the dose order by the physician would result in Resident 1 not receiving the full therapy to fight the cancer.During a review of facility's policy and procedure (P&P), titled, Medication-Administration, dated 10/1/2023, and last reviewed on 1/15/2026, the P&P indicated, I. Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner. The licensed nurse must know the following information about any medication they are administering: .E. The drug's usual dosage.

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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 accurate and complete medical record for one of three sampled residents (Resident 1) by failing to accurately document time of family notification on 3/16/2026.This failure had the potential to cause confusion in Resident 1's care and the medical records containing inaccurate documentation.Findings:During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 3/16/2026, with diagnoses that included unspecified (unconfirmed) malignant melanoma of skin (the most serious type of skin cancer, aggressive and potentially fatal [capable of causing death] if it spreads to other parts of the body, it is highly curable if caught and treated in its early stage), and other parts of nervous system (brain, spinal cord and nerves) and unspecified pneumothorax (a collapsed lung when air leaks into the space between the lung and chest wall.During a review of Resident 1's Nursing admission Assessment, dated 3/16/2026, the Nursing admission Assessment indicated Resident 1 was admitted to the facility on [DATE], at 8:30 p.m. The Nursing admission Assessment indicated Registered Nurse 1 (RN 1) notified Family Member 1 (FM 1) of Resident 1's admission at the facility on 3/16/2026, at 12 midnight (eight hours before Resident 1 was admitted to the facility).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 3/16/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 4/7/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact.During a concurrent interview and record review on 6/16/2026, at 11:34 a.m., with the Assistant Director of Nursing (ADON), Resident 1's Nursing admission Assessment, dated 3/16/2026, was reviewed. The ADON stated the facility's process of family notification was to inform family after the resident is admitted to the facility. The ADON stated RN 1 made incorrect documentation of the time FM 1 was notified. The ADON stated the Nursing admission Assessment did not indicate the correct time of the actual notification of FM 1. The ADON stated based on the documentation of RN 1, it looked like he (RN 1) had notified FM 1 of Resident 1's admission even before Resident 1 was admitted to the facility.During an interview on 6/16/2026, at 12:37 p.m., with the Director of Nursing (DON), the DON stated RN 1 incorrectly documented the timing of family notification. The DON stated assessment documentation should be accurate to show no laps in care.During a review of facility's policy and procedure (P&P), titled, Documentation-Nursing, dated 10/1/2023 and last reviewed on 1/15/2026, the P&P indicated, Nursing documentation will be concise, clear, pertinent, and accurate.D. Any communications with family, durable power of attorney (DPOA-a legal document that designates a trusted person to make medical and healthcare decisions on your behalf if you become incapacitated or unable to communicate your wishes), or physician is to be noted in nurse's notes.