STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056407	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
All Saints Healthcare Subacute	11810 Saticoy Street North Hollywood, CA 91605

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 ensure one of three sampled residents (Resident 1) received care in accordance with professional standards of practice to attain or maintain the highest practicable physical well-being by failing to: 1. Ensure Registered Nurse (RN 2) documented a Change of Condition (COC - when a significant change in a resident's physical, mental, and/or psychosocial well-being occurs that requires licensed nurses to take action per professional standards of practice), according to the facility's policy, that detailed what happened to Resident 1 on 12/30/2025, which led Nurse Practitioner (NP 1) to order a STAT (immediate) chest x-ray (a test that uses radiation - a form of energy - to take pictures of the inside of a person's body). 2. Ensure RN 2 notified Resident 1's doctor regarding Resident 1's COC on 12/30/2025, per the facility's policy, which resulted in NP 1 ordering a STAT chest x-ray. 3. Ensure NP 1 timely completed a medical/progress note that clearly outlined the clinical indications (medical-related reasons) for why NP 1 ordered a STAT chest x-ray for Resident 1 on 12/30/2025, and whether NP 1 notified Resident 1's doctor of the STAT order. These deficient practices had the potential to result in Resident 1 receiving inadequate care. Findings: a. During a review of Resident 1's admission Record, dated 1/08/2026, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. The admission Record indicated Resident 1 was diagnosed with chronic respiratory failure (when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), tracheostomy (a surgical procedure that creates a breathing hole through the neck and into the windpipe, which allows air to reach the lungs through a special tube), and dependance on ventilator (the need to use a machine to breath by moving air in and out of the lungs). During a review of Resident 1's History and Physical Examination (H&P - a comprehensive assessment of a resident's medical condition), dated 10/30/2025, the H&P indicated Resident 1 had anoxic brain injury (when the brain is completely cut off from receiving oxygen which leads to brain damage) and needed total care and constant supervision. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/09/2025, the MDS indicated Resident 1 was dependent in eating, personal hygiene, shower/bathing, and dressing (a helper does all of the effort of the activity). During an interview on 1/07/2026 at 10:43 a.m. with NP 1, NP 1 stated a nurse practitioner functions under the supervision of a doctor. NP 1 stated: You have to have a collaborative agreement between a nurse practitioner and a doctor. NP 1 stated nurse practitioners may give verbal or telephone orders to charge nurses (registered nurses) regarding medical care. NP 1 stated that if a COC occurs, NP 1 will contact the attending doctor (the doctor who is in charge of a resident's overall care) to inform the doctor of what medical care NP 1 has ordered to address the COC. NP 1 stated the doctor can change what NP 1 ordered or give additional orders. NP 1 stated the charge nurses may contact NP 1 for COC and lab results. When asked to describe NP 1's process, NP 1 stated: If I identify an issue, I will let [the attending doctor] know. I'll write an order, and [the attending (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	doctor] will co-sign later. During a concurrent interview and record review on 1/08/2026 at 10:59 a.m. with RN 1, Resident 1's Order Summary, dated 1/08/2026, and electronic medical record were reviewed. The Order Summary indicated that on 12/30/2025, a STAT chest x-ray was ordered by NP 1 via phone at 6:08 p.m. When asked what the clinical indication was for and why a STAT chest x-ray was ordered, RN 1 stated there was no COC documentation completed on 12/30/2025 that explained why Resident 1 needed a STAT chest x-ray. RN 1 stated the only information noted on 12/30/2025 about the STAT chest x-ray was from the respiratory therapist, who completed a respiratory therapy note at 6:28 p.m. indicating Resident 1 had tachycardia (abnormally high heart rate) and tachypnea (abnormally high breathing rate). RN 1 stated that tachycardia is a change of condition, so it should have been charted. RN 1 further stated a STAT order is definitely a change of condition. During a concurrent interview and record review on 1/08/2026 at 3:50 p.m. with the Director of Nursing (DON), Resident 1's electronic medical record was reviewed. The DON stated there was no COC documentation that described the signs and/or symptoms Resident 1 had on 12/30/2025 that led NP 1 to order a STAT chest x-ray. The DON stated a COC is anything that happens to a resident that is a change from the resident's baseline (the normal state of a person's health) such as [abnormal] vital signs or breathing. The DON stated if a staff member observes a COC in a resident, the staff member needs to first report to the primary nurse (the licensed nurse who is assigned to the resident). The DON stated the primary nurse will then need to notify the charge nurse who, after performing an assessment, must contact the resident's doctor. The DON stated that if the doctor does not reply within a reasonable amount of time, the charge nurse may contact a nurse practitioner, who is permitted to order certain types of medical care such as antibiotics and diagnostics tests (tests that are used to help figure out what disease or condition a person has based on their signs and symptoms). The DON stated it is important to complete a COC documentation in order to communicate to the next shifts (the nursing staff who will be assigned to care for a resident) significant events that happened to a resident, and if any medical care was ordered and administered. b. During a concurrent interview and record review on 1/08/2026 at 10:59 a.m. with RN 1, Resident 1's electronic medical record was reviewed. RN 1 stated the COC electronic form in the facility's computer system has a section indicating whether the doctor has been notified or not. RN 1 stated that since there was no COC documentation completed on 12/30/2025, it is unknown whether RN 2 notified Resident 1's doctor of Resident 1's tachycardia and tachypnea on 12/30/2025, and the STAT chest x-ray that NP 1 had ordered that same day. RN 1 further stated there was no nursing note regarding the communications between the RN and NP. RN 1 stated: If we contact the doctor or nurse practitioner, there should be a note. During an interview on 1/08/2026 at 3:50 p.m. with the DON, the DON stated it is the charge nurse's responsibility to complete a COC documentation, which includes timely notifying the resident's doctor and the resident's responsible party (the individual who is designated to make medical decisions if a resident is unable to do so for him/herself). The DON stated it is important to timely notify a resident's doctor when there is a COC to make the doctor aware and alert of the resident's most current health status, and to get orders for what needs to be done. The DON stated the standard of practice regarding nursing interventions is that if it's not documented, then it wasn't done. c. During an interview on 1/07/2026 at 10:43 a.m. with NP 1, NP 1 stated typically NP 1 will call the doctor to provide an update on a resident's COC and any medical care that NP 1 had ordered. NP 1 stated the doctor will do the progress notes. When asked if NP 1 does any type of progress notes, NP 1 stated: If I change a g-tube (gastrostomy tube - a feeding tube placed directly into the stomach through a small hole in the belly to deliver food, fluids, and medicine for people who cannot eat/swallow), I always chart that. If I have a conversation with (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	family, I will chart that, too. During a concurrent interview and record review on 1/08/2026 at 10:59 a.m. with RN 1, Resident 1's electronic medical record was reviewed. RN 1 stated there was no progress note made by NP 1 on 12/30/2025 or the following day explaining why NP 1 ordered a STAT chest x-ray on 12/30/2025 at 6:08 p.m. RN 1 stated NP 1 documented a Medical Professional Note six days later, on 1/05/2026, which indicated the following: Patient had tachycardia and was put on back up settings on ventilator DT (due to) work of breathing. RN 1 stated it is unclear if the tachycardia that is referred to in the Medical Professional Note occurred on 1/05/2026 (the date the note was entered in the computer system), or if the tachycardia occurred on 12/30/2025 (the date the STAT chest x-ray was ordered) because the timeline was not clearly specified in the Medical Professional Note. RN 1 stated the Medical Professional Note also did not indicate if Resident 1's doctor was made aware of Resident 1's COC on 12/30/2025, or the STAT chest x-ray that NP 1 ordered on 12/30/2025. During an interview on 1/08/2026 at 3:50 p.m. with the DON, the DON stated that as a professional standard of practice, nurse practitioners should write something in [their] progress notes that [they] notified the doctor when there is a COC or when the nurse practitioner gives an order for medical care. The DON further stated if a nurse practitioner gives a verbal or phone order, there should be timely documentation on why the order was given. The DON stated that nurse practitioners need to have their own documentation that is clear, with enough details, and separate from the documentation of other licensed nurses. During a review of the facility's policy and procedure (P&P) titled, Reporting Changes in Condition, dated 3/2025, the P&P indicated the following: The purpose of reporting significant changes in status of a patient is to ensure timely communication of patient/resident health status to the attending Physician. The P&P indicated the criteria for reporting changes in conditions include in the case of any emergency and suspicion of infections. The P&P further indicated as healthcare professionals, it is your obligation to make professionally sound decisions as to whether the physician should be contacted. During a review of the facility's policy and procedure (P&P) titled, Documentation Principles, dated 1/2022, the P&P indicated a resident's health record shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each resident.

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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 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 ensure the medical record of one of three sampled residents (Resident 1) was complete and accurately documented, by failing to:1. Ensure Registered Nurse (RN 2) documented a Change of Condition (COC-when a significant change in a resident's physical, mental, and/or psychosocial well-being occurs that requires licensed nurses to take action per professional standards of practice)according to the facility's policy, that detailed what happened to Resident 1 on 12/30/2025 which led Nurse Practitioner (NP 1) to order a STAT (immediate) chest x-ray (a test that uses radiation - a form of energy - to take pictures of the inside of a person's body). 2. Ensure NP 1 timely documented a medical/progress note that clearly outlined the clinical indications (medical-related reasons) for why NP 1 ordered a STAT chest x-ray for Resident 1 on 12/30/2025, and whether NP 1 notified Resident 1's doctor of the STAT order. These deficient practices resulted in an incomplete medical record for Resident 1. Findings: a. During a review of Resident 1's admission Record, dated 1/08/2026, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. The admission Record indicated Resident 1 was diagnosed with chronic respiratory failure (when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), tracheostomy (a surgical procedure that creates a breathing hole through the neck and into the windpipe, which allows air to reach the lungs through a special tube), and dependance on ventilator (the need to use a machine to breath by moving air in and out of the lungs). During a review of Resident 1's History and Physical Examination (H&P - a comprehensive assessment of a resident's medical condition), dated 10/30/2025, the H&P indicated Resident 1 had anoxic brain injury (when the brain is completely cut off from receiving oxygen which leads to brain damage) and required total care and constant supervision. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/09/2025, the MDS indicated Resident 1 was dependent in eating, personal hygiene, shower/bathing, and dressing (a helper does all of the effort of the activity). During an interview on 1/07/2026 at 10:43 a.m. with NP 1, NP 1 stated a nurse practitioner functions under the supervision of a doctor. NP 1 stated: You have to have a collaborative agreement between a nurse practitioner and a doctor. NP 1 stated nurse practitioners may give verbal or telephone orders to charge nurses (registered nurses) regarding medical care. NP 1 stated that if a COC occurs, NP 1 will contact the attending doctor (the doctor who is in charge of a resident's overall care) to inform the doctor of what medical care NP 1 has ordered to address the COC. NP 1 stated the doctor can change what NP 1 ordered or give additional orders. NP 1 stated the charge nurses may contact NP 1 for COC and lab results. When asked to describe NP 1's process, NP 1 stated: If I identify an issue, I will let [the attending doctor] know. I'll write an order, and [the attending doctor] will co-sign later. During a concurrent interview and record review on 1/08/2026 at 10:59 a.m. with RN 1, Resident 1's Order Summary, dated 1/08/2026, and electronic medical record were reviewed. The Order Summary indicated that on 12/30/2025, a STAT chest x-ray was ordered by NP 1 via phone at 6:08 p.m. When asked what the clinical indication was for why a STAT chest x-ray was ordered, RN 1 stated there was no COC documentation completed on 12/30/2025 that explained why Resident 1 needed a STAT chest x-ray. RN 1 stated the only information noted on 12/30/2025 about the STAT chest x-ray was from the respiratory therapist, who completed a respiratory therapy note at 6:28 p.m. indicating Resident 1 had tachycardia (abnormally high heart rate) and tachypnea (abnormally high breathing rate). RN 1 stated that tachycardia is a change of condition, so it should have been charted. RN 1 further stated a STAT order is definitely a change of condition. During a concurrent interview (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and record review on 1/08/2026 at 3:50 p.m. with the Director of Nursing (DON), Resident 1's electronic medical record was reviewed. The DON stated there was no COC documentation that described the signs and/or symptoms Resident 1 had on 12/30/2025 that led NP 1 to order a STAT chest x-ray. The DON stated a COC is anything that happens to a resident that is a change from the resident's baseline (the normal state of a person's health) such as [abnormal] vital signs or breathing. The DON stated it is important to timely document a COC documentation in order to communicate to the next shifts (the nursing staff who will be assigned to care for a resident) significant events that happened to a resident, and if any medical care was ordered and administered. The DON stated documentation is also important for resident safety to avoid duplicate orders. b. During an interview on 1/07/2026 at 10:43 a.m. with NP 1, NP 1 stated typically NP 1 will call the doctor to provide an update on a resident's COC and any medical care that NP 1 had ordered. NP 1 stated the doctor will do the progress notes. When asked if NP 1 documents any type of progress notes, NP 1 stated: If I change a G-tube (gastrostomy tube - a feeding tube placed directly into the stomach through a small hole in the belly to deliver food, fluids, and medicine for people who cannot eat/swallow), I always chart that. If I have a conversation with family, I will chart that, too. During a concurrent interview and record review on 1/08/2026 at 10:59 a.m. with RN 1, Resident 1's electronic medical record was reviewed. RN 1 stated there was no progress note made by NP 1 on 12/30/2025 or the following day explaining why NP 1 ordered a STAT chest x-ray on 12/30/2025 at 6:08 p.m. RN 1 stated NP 1 documented a Medical Professional Note six days later, on 1/05/2026, which indicated the following: Patient had tachycardia and was put on back up settings on ventilator DT (due to) work of breathing. RN 1 stated it is unclear if the tachycardia that is referred to in the Medical Professional Note occurred on 1/05/2026 (the date the note was entered in the computer system), or if the tachycardia occurred on 12/30/2025 (the date the STAT chest x-ray was ordered) because the timeline was not clearly specified in the Medical Professional Note. RN 1 stated the Medical Professional Note also did not indicate if Resident 1's doctor was made aware of Resident 1's COC on 12/30/2025, or the STAT chest x-ray that NP 1 ordered on 12/30/2025. During an interview on 1/08/2026 at 3:50 p.m. with the DON, the DON stated that as a professional standard of practice, a nurse practitioner should document if [he/she] receives a call from the staff about a resident's COC that requires medical interventions. The DON stated that nurse practitioners need to have their own documentation that is clear, with enough details, and separate from the documentation of other licensed nurses. The DON stated the standard of practice regarding documentation is if there is no documentation, that means we didn't do it. During a review of the facility's policy and procedure (P&P) titled, Documentation Principles, dated 1/2022, the P&P indicated the following: Health records shall be kept for each resident and the content shall be in compliance with the licensing and certification governmental agency requirements and professional standards. The P&P indicated a [r]esident's health record shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each resident. The P&P further indicated the entries must be.accurate; timely - recorded within the required time period; objective.; specific - definite; concise - to the point; legible - written clearly; clear - easily understood; [and] descriptive - adequately explained.