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	01/29/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:A. Ensure one of five sampled residents (Resident 18), who was investigated for pressure ulcers/injuries (also known as pressure sores and decubitus ulcers, localized damage to the skin and/or underlying tissue caused by prolonged pressure or friction, often over bony areas), received care consistent with professional standards of practice to prevent pressure ulcers and maintain skin integrity (the condition of the skin being intact, healthy and free from damage). Resident 18 had Moisture Associated Skin Damage (MASD - inflammation [becomes reddened, swollen or hot] or skin erosion [breakdown of outer layers of skin] caused by prolonged exposure to moisture-like urine, stool, sweat) on 10/28/2025, was assessed as at risk for developing pressure ulcers, required assistance with turning while in bed and while seated in a chair, and was incontinent of bowel and bladder (having no or insufficient voluntary control over urination or defecation) function. The facility failed to ensure that Resident 18 did not develop a pressure ulcer while in the facility and failed to provide appropriate treatment and services to maintain skin integrity by failing to:A1. Ensure licensed nurses, Licensed Vocational Nurses (LVNs), and Treatment Nurses (TNs) completed at least weekly evaluations of Resident 18's MASD skin breakdown and documented the findings, including a description of the MASD.A2. Ensure that Treatment Nurse 1 (TN 1) reported Resident 18's wounds to Medical Doctor 1 (MD 1 - Resident 1's physician) and Medical Doctor 2 (MD 2 - a wound care specialist physician), upon Resident 18's readmission on [DATE].A3. Ensure TN 1 followed up and obtained treatment orders from MD 1 and MD 2 on 10/28/2025 when MASD was identified on Resident 18's left buttock. A4. Ensure Certified Nurse Assistants (CNAs) repositioned Resident 18 every two (2) hours (hrs - a unit of measurement for time) and as needed.A5. Implement the facility's policy and procedure (P&P) titled, Decubitus Ulcer Prevention, last reviewed on 1/21/2025, which indicates the implementation of preventative measures and regular assessments to identify the presence of any pressure ulcers.These deficient practices resulted in the development of one facility-acquired pressure ulcer (a new, preventable skin injury that develops after a resident is admitted or readmitted , typically caused by unrelieved pressure or friction) for Resident 18, as identified by MD 2 on 1/20/2026. On 1/23/2026, MD 2 identified a stage 2 (partial thickness loss of skin, presenting as a shallow open sore or wound) pressure ulcer on Resident 18's left buttock.B. Provide care consistent with professional standards of practice to prevent pressure ulcers for four of five sampled residents (Resident 11, Resident 39, Resident 81, and Resident 72), who were at risk for pressure ulcer/injury, required assistance with turning while in bed and chair, were incontinent of bowel and bladder, by failing to:B1. Ensure pressure ulcer wound care treatment was administered and documented on 9/10/2025 and 9/11/2025 for Resident 11.B2. Set Resident 39's and Resident 81's low air loss mattress (LALM - a special type of air mattress that uses a constant, gentle flow of air through microscopic holes to keep the skin dry and prevent pressure wounds) according to weight and the physician's order.B3. Apply Resident 72's bilateral (both sides) heel protectors (a boot-like device that floats the heel off the mattress or other surface to entirely relieve pressure and prevent painful bedsores or pressure ulcers) while off of Ankle-Foot Orthosis (AFOs - a support intended to control the position and motion of the ankle and (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
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F 0686 Level of Harm - Actual harm Residents Affected - Few	compensate for weakness or correct deformities).These deficient practices had the potential for development and worsening of pressure ulcers/injuries to Resident 11, Resident 39, Resident 81, and Resident 72.Findings: A. During a review of Resident 18's admission Record (AR), the AR indicated that the facility originally admitted Resident 18 on 12/7/2023 with diagnoses including chronic respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood), nontraumatic intracerebral hemorrhage (bleeding into the substance of the brain in the absence of trauma or surgery) in hemisphere (sides of the cerebrum [area that controls movement, sensation, language, and thinking]), dysphagia (difficulty swallowing) following cerebral infarction (also known as stroke, loss of blood flow to a part of the brain), and hydrocephalus (the buildup of fluid in cavities deep within the brain called ventricles). During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool), dated 10/2/2025, the MDS indicated Resident 18 had the ability to understand others sometimes and rarely or never makes self understood. The MDS indicated Resident 18 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 18 was dependent on staff for bed mobility including rolling to the left and right. The MDS indicated Resident 18 had no unhealed pressure ulcer but was identified as being at risk for developing pressure ulcers. During a review of Resident 18's Clinical admission Screener (CAS – a pre-admission document used to evaluate a prospective resident's medical and physical needs to ensure the facility can provide appropriate care) form, dated 10/28/2025, the CAS form indicated Resident 18 had left buttock MASD. During a review of Resident 18's admission Progress Notes (APN - a comprehensive, written, or electronic document created by a provider upon a resident's entry into an inpatient facility that includes gathering a thorough medical history from the resident and performing a physical examination to assess their overall health and identify any potential medical concern), dated 10/29/2025, the APN indicated Resident 18 did not have the capacity to understand and make decisions. The APN indicated that Resident 18's skin had no erythema (superficial reddening of the skin as a result of injury or irritation). During a review of Resident 18's Assessment of Decubitus Ulcer Potential (ADUP - a scoring tool used to predict a resident's risk of developing pressure ulcer, the higher the score, the greater the potential to develop decubitus ulcers), dated 12/24/2025, the ADUP indicated residents with a score above 12 should be considered at risk for developing pressure ulcers. The ADUP indicated Resident 18 scored 23. During a review of Resident 18's ADUP, dated 12/26/2025, the ADUP indicated Resident 18 scored 25. During a review of Resident 18's Physician Order, dated 1/19/2026, the Physician Order indicated the following treatment : Cleanse the Left Buttock open blister (bubble on the skin filled with clear, watery liquid or blood, usually caused by friction, rubbing, or burns) with normal saline (NS - sterile water used to cleanse and moisten wounds), apply moist gauze (a wound care product designed to absorb wound drainage and protect the wound), pat dry with dry gauze, apply xeroform (a moist yellow dressing that covers the wound and promotes wound healing) and cover with a foam dressing every day shift for one (1) Day, with the Wound Doctor to reassess on 1/20/2026. During a review of Resident 18's wound care Progress Note Details (PND), dated 1/20/2026, the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	wound care PND indicated that Resident 18 had the following wound: Left buttock open blister, measuring 1.6 centimeters (cm- a unit of measure) in length x (by) 1.5 cm in width x 0.1 cm in depth, with a small amount of serous (clear, thin, watery fluid that's typically pale yellow in color) drainage noted. During a review of Resident 18's Physician Order, dated 1/20/2026, the Physician Order indicated the following treatment: Cleanse the Left Buttock open blister with NS, apply moist gauze, pat dry with dry gauze, apply xeroform and cover with a foam dressing every day shift for 14 Days. During a review of Resident 18's wound care PND, dated 1/27/2026, the wound care PND indicated that Resident 18 had the following wound: Left buttock stage 2 pressure ulcer, measuring 1.2 cm in length x 0.8 cm in width x 0.2 cm in depth, with a moderate amount of serous drainage, and a wound bed (exposed tissue surface within a wound) 76 to 100 percent (%). During a review of Resident 18's Physician Order, dated 1/27/2026, the Physician Order indicated the following treatment: Cleanse the Left Buttock Stage 2 Pressure Ulcer with NS, apply moist gauze, pat dry, apply xeroform and cover with a foam dressing every day and as needed for 30 days. During a concurrent interview and record review on 1/27/2026 at 1:08 p.m., with TN 1, Resident 18's Physician Orders and Nursing Progress Notes from 10/28/2025 to 1/27/2026 were reviewed. TN 1 stated that there were no treatment orders and no monitoring for Resident 18's MASD on the left buttock during this period (10/28/2025 to 1/27/2026). TN 1 stated that Resident 18's progress notes indicated Resident 18's open blister on the left buttock was first identified on 1/19/2026 during perineal care (peri-care – gently washing the genitals [male or female reproductive organ] and anal [opening at the end of the digestive tract, where stool leaves the body] area to maintain hygiene, comfort, and prevent infection or skin irritation) provided by the CNAs. TN 1 stated a one-time wound treatment order was placed on 1/19/2026. TN 1 also stated that Resident 18 had an order to be evaluated by MD 2, a wound specialist physician, on 1/20/2026. TN 1 further stated that the open blister was classified as a stage 2 pressure ulcer. During a concurrent interview and record review on 1/27/2026 at 1:41 p.m., with TN 1, Resident 18's care plans in effect as of 1/27/2026 were reviewed. TN 1 stated there was no care plan developed for Resident 18's MASD on the left buttock identified on 10/28/2025. TN 1 further stated that the care plan titled Wound Management, last revised on 1/20/2026, did not include Resident 18's stage 2 pressure ulcer on the left buttock. TN 1 stated that she (TN 1) forgot to add the pressure ulcer to the care plan and should have been added on the day it was identified. TN 1 stated repositioning and turning the resident every 2 hours and as needed should be included in the care plan. TN 1 stated the purpose of the care plan is to manage the wound and ensure the resident does not develop an infection. TN 1 further stated that she (TN 1), along with the LVNs, and Registered Nurses (RNs) taking care of Resident 18, review the care plan interventions. During an interview on 1/27/2026 at 1:49 p.m. with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated she (CNA 2) is the assigned CNA for Resident 18 today, 1/27/2026. CNA 2 stated she (CNA 2) and another CNA (did not specify) reposition Resident 18. CNA 2 stated Resident 18 does not have any wounds on her (Resident 18) buttocks. CNA 2 stated she (CNA 2) usually repositions Resident 18 every two hours. CNA 2 stated she (CNA 2) sometimes does not reposition Resident 18 every two hours. CNA 2 stated it sometimes takes more than two hours to reposition Resident 18 because it is not possible. CNA 2 stated turning residents requires two people. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 1/27/2026 at 2:10 p.m., with Registered Nurse 8 (RN 8), Resident 18's Physician Orders and Care Plans from 10/28/2025 to 1/27/2026 were reviewed. RN 8 stated that upon Resident 18's readmission on [DATE], she (RN 8), Treatment Nurse 2 (TN 2), and Licensed Vocational Nurse 4 (LVN 4) assessed Resident 18's skin. RN 8 stated TN 2 is responsible for measuring wounds, developing care plans related to skin and wound issues, contacting the wound care physician (referring to MD 2), and initiating wound treatment orders, if indicated. RN 8 further stated TN 2 should have developed a care plan for Resident 18's MASD on the left buttock and initiated the appropriate treatment orders. During a concurrent interview and record review on 1/27/2026 at 4:56 p.m., with TN 2, Resident 18's Physician Orders, Care Plans, and Nursing Progress Notes from 10/28/2025 to 1/27/2026 were reviewed. TN 2 stated that when she (TN 2) identifies wounds, redness, skin discoloration (any change in your natural skin tone) on residents, the charge nurse (RN) and the primary nurse (LVN), document the findings in the admission Notes, and the charge nurse enters orders for any identified skin issues. TN 2 stated she (TN 2) is not responsible for documenting findings in the admission Notes and that only the primary nurse and the charge nurse complete admission documentation. TN 2 stated she (TN 2) assists with wound measurements and wound treatments, depending on the Physician's Orders. TN 2 further stated that the charge nurse or whoever enters the order, is responsible for developing the care plan. TN 2 stated that only charge nurses are allowed to enter physician orders and that the charge nurse would contact the resident's primary physician or the wound care physician, who visits weekly. TN 2 stated when Resident 18 was readmitted on [DATE], she (TN 2) worked with the primary nurse (LVN 4), and the charge nurse (RN 8). TN 2 stated she (TN 2) did not document her (TN 2) findings because RN 8 and LVN 4 documented in their (RN 8 and LVN 4) notes. TN 2 stated she (TN 2) provided RN 8 and LVN 4 with the wound measurements and related details. TN 2 stated she (TN 2) did not call the wound care physician (MD 2) on 10/28/2025 for Resident 18. During a concurrent observation and interview on 1/28/2026 at 10:08 a.m., with TN 2, at Resident 18's bedside, observed TN 2 measured Resident 18's wounds. TN 2 stated Resident 18's stage 2 pressure ulcer on the left buttock measured at 1.5 cm in length x 1.2 cm in width x 0.2 cm in depth with a small amount of yellow drainage and granulation (the formation of new connective tissue and blood vessels [a network of hollow, elastic tubes that circulate blood throughout the body] that fill in a wound bed during the proliferative [rapid growth] phase of healing) with pinkish red wound edges. During a concurrent interview and record review on 1/28/2026 at 3:51 p.m., with TN 1, Resident 18's Wound Assessments and Nursing Progress Notes from 10/28/2025 to 1/28/2026 were reviewed. TN 1 stated there were no weekly skin assessments done prior to 1/20/2026. TN 1 stated weekly skin assessments should have been performed to monitor the left buttock's wound progress, determine whether it was improving or worsening, and because assessments are part of the facility's monitoring process. During a concurrent interview and record review on 1/29/2026 at 8:27 a.m., with LVN 4, Resident 18's admission summary, dated [DATE], timed at 3:10 p.m. was reviewed. The admission Summary indicated [MD 1] went to assess [Resident 18], new order of labs in [morning] and to continue previous orders and treatment. Orders noted and carried out. [Responsible party] . at bed side. LVN 4 stated she (LVN 4) did not communicate with MD 1 regarding Resident 18's admission orders. LVN 4 stated that RN 8 was the one who communicated with MD 1 regarding Resident 18's admission orders. During an interview on 1/28/2026 at 10:35 a.m., with MD 2, MD 2 stated that during rounds on (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1/20/2026, he (MD 2) was notified of Resident 18's wounds. MD 2 stated he (MD 2) did not have any documentation or notes for Resident 18 prior to 1/20/2026. MD 2 stated Resident 18 is contracted (a condition in which a joint or body part becomes fixed in a bent or twisted position and cannot move through its full, normal range of motion). MD 2 stated that blisters located over pressure points that do not heal can progress to stage 2 pressure ulcers. MD 2 further stated treatments he (MD 2) would have recommended for Resident 18 included turning and repositioning while in bed. MD 2 stated residents should not remain on one side for prolonged periods and that regular turning is good clinical practice. During an interview on 1/29/2026 at 11:57 a.m., with RN 8, RN 8 stated she (RN 8) communicated with MD 1 regarding Resident 18's admission, on 10/28/2025, and wounds at that time (unable to recall specific date and time). RN 8 stated notifying the wound care physician (MD 2), should have been done by TN 2. RN 8 stated she did not call MD 2 to inform him (MD 2) of Resident 18's left buttock wounds. During an interview on 1/29/2026 at 12:26 p.m., with MD 1, MD 1 stated that he (MD 1) may have been in the facility and seen Resident 18 on 10/28/2025, but he (MD 1) does not have progress notes on 10/28/2025. MD 1 stated MD 3, the covering physician, saw Resident 18 the following day, on 10/29/2025. MD 1 stated the charge nurse would notify him (MD 1) when a resident is in the facility and requests orders. MD 1 stated MD 2, the wound doctor, would follow the resident and see the residents for wound evaluation. MD 1 stated the wound treatment nurses are usually on top of reporting wounds and they would tell him (MD 1) and MD 2 about the residents' wounds. During an interview on 1/29/2026 at 3:07 p.m. with the Director of Nursing (DON), the DON stated when a resident is admitted or readmitted to the facility, the licensed nurses complete a full body assessment, and if there are skin issues identified, the licensed nurses are responsible for notifying the wound (treatment) nurse. The DON stated the communication goes from the primary nurse (LVN) to the treatment nurse, and the TN communicates to the charge nurse (RN). The DON stated the charge nurses are usually the ones directly communicating to the physician, but all of them RN 8, LVN 4, and TN 2, did not do anything about Resident 18's wound, there was a communication gap, and the wound was not documented. The DON stated it was a miscommunication on the facility's part. The DON stated the facility did not document the communication between RN 8, LVN 4, TN 2, MD 1, and MD 2; therefore, the communication was not done. The DON stated TNs should be responsible for communicating and informing the wound care physician, as TNs conduct weekly wound rounds (visits). The DON stated the wound care physician rounds weekly and should have been notified of Resident 18's left buttock MASD. The DON stated that the swelling and redness on Resident 18's left buttock should have been measured and assessed weekly to monitor if the MASD is healing and to track the progress. The DON stated measuring and checking are part of the facility's decubitus ulcer prevention practices. The DON stated that upon admission, the facility also takes photographs of wounds at the discretion of the TNs. The DON stated the primary nurses also document wounds during daily skin assessments or in their nursing progress notes. During a concurrent interview and record review on 1/29/2026 at 3:25 p.m., with the DON, the facility's P&P titled, Decubitus Ulcer Prevention, last reviewed on 1/21/2025, was reviewed. The DON stated the TN is responsible for developing the care plan upon identification of a wound including pressure ulcer. The DON stated she (DON) was not aware of Resident 18's left buttock stage 2 pressure ulcer or the left buttock MASD on readmission. The DON stated TN 2 should have communicated with RN 8 that the wound care physician needs to be notified and that she (TN 2) should have documented the communication for Resident 18's left buttock MASD. The DON further (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	stated TN 2 should have developed the care plan for Resident 18's MASD immediately and followed through with interventions. The DON stated that because TN 2 did not develop the care plan, MD 2 was not notified, and there was no follow-through for Resident 18's wounds. The DON stated that the care plan should have been updated to reflect the current approaches to wound care. The DON stated wound treatment care plan interventions are usually updated every 2 weeks, and skin and wounds are assessed weekly by the TN. The DON stated if a resident has a wound, the wound care physician follows up weekly. The DON stated that without a care plan developed, a resident's wounds can worsen. The DON stated Resident 18's left buttock MASD had not been noted, and the wound care physician had not been called. The DON stated Resident 18's stage 2 pressure ulcer on the left buttock was avoidable and that this was the first time Resident 18 had a pressure ulcer of this type. The DON stated that the facility's P&P titled, Decubitus Ulcer Prevention, was not followed for Resident 18. During a concurrent interview and record review on 1/29/2026 at 3:29 p.m., with the DON, Resident 18's Activities of Daily Living (ADL - activities such as bathing, dressing and toileting a person performs daily) task for position (Follow Up Question Report for Position), for the month of 1/2026, was reviewed. The DON stated resident turning and repositioning are interventions that must be included in the care plan. The DON stated that on multiple days including 1/1/2026, 1/2/2026, 1/3/2026, 1/4/2026, 1/5/2026, 1/6/2026, 1/7/2026, 1/8/2026, 1/9/2026, 1/10/2026, 1/11/2026, 1/12/2026, 1/13/2026, 1/14/2026, 1/15/2026, 1/16/2026, 1/17/2026, 1/18/2026, 1/19/2026, 1/20/2026, and 1/21/2026, Resident 18 was positioned on her (Resident 18) left side or back for more than two hours. The DON stated repositioning residents is a key intervention to prevent skin breakdown and provide comfort for the resident. The DON stated that remaining in one position such as laying on one side for too long can cause discomfort for the resident. During a review of Resident 18's Follow Up Question Report for Position, from 1/1/2026 to 1/29/2026, the Follow Up Question Report indicated the date, time, and resident's position as follows:ˆ 1/1/2026 at 6 a.m. – Left ˆ 1/1/2026 at 8 a.m. – Left ˆ 1/1/2026 at 10 a.m. – Left ˆ 1/1/2026 at 2 p.m. – Left ˆ 1/1/2026 at 4 p.m. – Left ˆ 1/1/2026 at 6 p.m. – Left ˆ 1/1/2026 at 8 p.m. – Left ˆ 1/2/2026 at 4 a.m. – Left ˆ 1/2/2026 at 6 a.m. – Left ˆ 1/2/2026 at 8 a.m. – Left ˆ 1/2/2026 at 2 p.m. – Left ˆ 1/2/2026 at 4 p.m. – Left ˆ 1/3/2026 at 10 p.m. – Left ˆ 1/4/2026 at 12 a.m. – Left ˆ 1/4/2026 at 2 a.m. – Left ˆ 1/4/2026 at 4 a.m. – Left ˆ 1/5/2026 at 4 a.m. – Left ˆ 1/5/2026 at 6 a.m. – Left ˆ 1/5/2026 at 8 a.m. – Left ˆ 1/5/2026 at 2 p.m. – Left ˆ 1/5/2026 at 4 p.m. – Left ˆ 1/5/2026 at 6 p.m. – Rightˆ 1/5/2026 at 10 p.m. – Right ˆ 1/6/2026 at 8 a.m. – Left ˆ 1/6/2026 at 10 a.m. – Left ˆ 1/6/2026 at 2 p.m. – Left ˆ 1/6/2026 at 4 p.m. – Left ˆ 1/6/2026 at 10 p.m. – Left ˆ 1/7/2026 at 12 a.m. – Left ˆ 1/7/2026 at 4 a.m. – Backˆ 1/7/2026 at 6 a.m. – Backˆ 1/7/2026 at 2 p.m. – Left ˆ 1/7/2026 at 4 p.m. – Left ˆ 1/7/2026 at 8 p.m. – Left ˆ 1/7/2026 at 10 p.m. – Left ˆ 1/8/2026 at 8 p.m. – Left ˆ 1/8/2026 at 10 p.m. – Left ˆ 1/9/2026 at 10 a.m. – Backˆ 1/9/2026 at 12 p.m. – Backˆ 1/9/2026 at 6 p.m. – Left ˆ 1/9/2026 at 8 p.m. – Left ˆ 1/9/2026 at 10 p.m. – Left ˆ 1/10/2026 at 12 a.m. – Left ˆ 1/10/2026 at 2 p.m. – Left ˆ 1/10/2026 at 4 p.m. – Left ˆ 1/10/2026 at 6 p.m. – Leftˆ 1/11/2026 at 2 p.m. – Left ˆ 1/11/2026 at 4 p.m. – Left ˆ 1/11/2026 at 6 p.m. – Left ˆ 1/11/2026 at 8 p.m. – Rightˆ 1/11/2026 at 10 p.m. – Rightˆ 1/12/2026 at 6 a.m. – Left ˆ 1/12/2026 at 8 a.m. – Left ˆ 1/12/2026 at 2 p.m. – Left ˆ 1/12/2026 at 4 p.m. – Left ˆ 1/12/2026 at 6 p.m. – Backˆ 1/12/2026 at 8 p.m. – Backˆ 1/13/2026 at 6 a.m. – Left ˆ 1/13/2026 at 8 a.m. – Left ˆ 1/13/2026 at 2 p.m. – Left ˆ 1/13/2026 at 4 p.m. – Left ˆ 1/13/2026 at 6 p.m. – Left ˆ (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1/13/2026 at 8 p.m. – Left^ 1/14/2026 at 4 p.m. – Left ^ 1/14/2026 at 6 p.m. – Left^ 1/14/2026 at 10 p.m. – Left ^ 1/15/2026 at 12 a.m. – Left ^ 1/15/2026 at 4 a.m. – Back^ 1/15/2026 at 6 a.m. – Back^ 1/16/2026 at 12 a.m. – Left^ 1/16/2026 at 2 a.m. – Left ^ 1/16/2026 at 2 p.m. – Left ^ 1/16/2026 at 4 p.m. – Left ^ 1/16/2026 at 10 p.m. – Right^ 1/17/2026 at 12 a.m. – Right^ 1/17/2026 at 8 a.m. – Left ^ 1/17/2026 at 10 a.m. – Left ^ 1/17/2026 at 2 p.m. – Left ^ 1/17/2026 at 4 p.m. – Left ^ 1/17/2026 at 8 p.m. – Left ^ 1/17/2026 at 10 p.m. – Left ^ 1/18/2026 at 12 a.m. – Left ^ 1/18/2026 at 4 a.m. – Back^ 1/18/2026 at 6 a.m. – Back^ 1/18/2026 at 6 p.m. – Back ^ 1/18/2026 at 8 p.m. – Back^ 1/19/2026 at 4 a.m. – Back^ 1/19/2026 at 6 a.m. – Back^ 1/19/2026 at 2 p.m. – Left ^ 1/19/2026 at 4 p.m. – Left ^ 1/20/2026 at 6 a.m. – Left ^ 1/20/2026 at 8 a.m. – Left ^ 1/20/2026 at 2 p.m. – Left ^ 1/20/2026 at 4 p.m. – Left ^ 1/20/2026 at 6 p.m. – Left ^ 1/20/2026 at 8 p.m. – Left^ 1/20/2026 at 10 p.m. – Left ^ 1/21/2026 at 12 a.m. – Left^ 1/21/2026 at 2 a.m. – Right^ 1/21/2026 at 4 a.m. – Right During a review of the facility's P&P titled, Decubitus Ulcer Prevention, last reviewed on 1/21/2025, The P&P indicated: Policy: 1. The Registered Nurse will evaluate the Residents/ Patients on admission and then on a daily basis to establish the presence of any pressure sores. Preventive Measures:1. Bed Residents/Patients will be repositioned every two hours and PRN (as needed). There will be charting substantiating the repositioning and direction of the body turn.2. Charge Nurses will make rounds at least four times daily.3. Immediate measures will be taken to eliminate pressure to this particular area. As necessary treatment orders will be obtained from the attending physician (mattress, air mattress, gel mattress, etc.).4. Nurses will chart a description and evaluation of the skin breakdown or the ulceration at least weekly.5. Any Resident/Patient admitted with a pressure sore will have immediate and appropriate action to treat the problem. Proper documentation of the presence, location, size and description of the pressure sore will be recorded in the Resident/Patient health record.6. Proper documentation of the treatment performed via the Physician Orders will be in the treatment book.7. Should a Resident/Patient or responsible party refuse procedures by the Nursing Staff to prevent or treat a pressure sore, adequate documentation will be noted in the Resident/Patient health records. Risks and benefits will be explained to Resident/Patient and/or Responsible Party by MD or Registered Nurse. Special Observations: All pressure points, especially bony prominences, should be assessed for redness, irritated or lacerated (a jagged, torn or ripped wound affecting the skin and underlying tissues) skin:. Buttocks, Sacrum. Include: Back of head, shoulder blades, various skin folds, any ischemic skin (refers to tissue damage, discoloration, or death caused by severely reduced blood flow) area or any area subject to pressure or abrasion (superficial injury where skin is scraped or rubbed off). Residents/Patients Most Vulnerable:1. Residents/Patients required to lie in one position due to immobilization (the act of stopping movement or restricting motion) or restrictive appliances (devices or items attached to or adjacent to a person's body that limit freedom of movement or access to their own body and cannot be easily removed by them). 2. Residents/Patients incapable of voluntary movement. 3. Residents/Patients who are abnormally thin, elderly, debilitated (severely weakened or impaired in strength), incontinent.4. Residents/Patients with poor circulation or peripheral vascular disease (slow, progressive circulation disorder characterized by the narrowing, blockage or spasms of blood vessels). (continued on next page)

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	01/29/2026

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

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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 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's P&P titled, Pressure Ulcer, last reviewed on 1/21/2025, the P&P indicated the following: Purpose: Assessment and documentation is an ongoing process. Accurate documentation provides for timely preventative interventions. These interventions may minimize the frequency and the severity of pressure ulcers. Policy: All wounds will be assessed and documented in the Patient's permanent record. Documentation of the pressure ulcer will include location, stage, size, depth, exudate, odor, eschar, pain and peri wound (the skin immediately surrounding a wound) skin condition. Effective January 1, 2022, all wounds will be evaluated by the wound M.D. for proper treatment. Equipment: Skin Assessment/Documentation Tool Pen Procedures: At least weekly or as changes are noted (or as State requirements dictate), chart the following in the permanent record: 1. Location of wound2. Stage of wound3. Size of wound (use a measuring guide)a. Length (cm)b. Width (cm)4. Depth of wounda. Insert sterile (germ-free), flexible six inch cotton-tipped applicator gently into the deepest part of the wound.b. Grasp with thumb and forefinger at skin surface and withdraw.c. Measure distance from the tip to fingers in centimeters.5. Exudate (fluid that leaks out of blood vessels into the wound bed during the healing process), describe type6. Odor, if present, describe.7. Eschar (a thick, dry black or brown layer of dead tissue that forms over severe wounds, burns or infections)/necrotic (dead) tissuea. Color b. Consistencyc. Location in wound or edgesd. Pain (presence or absence)e. Peri wound skin condition B1. During a review of Resident 11's AR, the AR indicated the facility admitted the resident on 1/7/2022 and most recently admitted the resident on 2/25/2025 with diagnoses including chronic respiratory failure with hypoxia (low oxygen in the tissues), tracheostomy (trach - opening surgically created through the front of the neck and into the trachea [windpipe]), dependence of respirator (ventilator - a medical device to help support or replace breathing), and Huntington's disease (inherited condition that affects movement, thinking and behavior). During a review of Resident 11's H&P, dated 2/26/2025, the H&P indicated that the resident had a history of multiple pressure injuries on the lower extremities and osteomyelitis (a bone infection). During a review of Resident 11's MDS, dated [DATE], the MDS indicated the resident rarely/never was able to understand others and rarely/never was able to make herself understood. The MDS further indicated that the resident was dependent on staff for bathing, dressing, oral and personal hygiene, toileting, and mobility. During a review of Resident 11's Order Summary Report (OSR), the OSR indicated the following orders:- Dated 9/10/2025, left distal (away from the center of the body) plantar (sole of the foot) stage four (4) (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) pressure injury, cleanse with NS moist gauze, pat dry, apply calcium alginate (a specialized dressings to treat wounds), cover with foam dressing every shift for 30 days. - Dated 9/10/2025, left dorsal (the top, upper surface) foot stage 4, cleanse with NS moist gauze, pat dry, apply calcium alginate, cover with foam dressing, every day shift for 30 days.- Dated 9/1

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	01/29/2026

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All Saints Healthcare Subacute	11810 Saticoy Street North Hollywood, CA 91605

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for two (2) of two (2) sampled residents (Resident 26 and 39) reviewed for physical restraints by failing to: 1. Complete a restraint assessment prior to application of the hand mitten (a large, soft glove that covers a patient's hands and prevent them from pulling out any lines or tubes) for Resident 26. 2.Ensure Resident 39's restraint bed placed against the wall had a/an: a)Physician's order b)Informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from the resident and/or representative c)Physical restraint assessment for its safe use. d)Comprehensive Care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments). These deficient practices had the potential to result in the restriction of resident's freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (an occurrence involving a patient who is caught, trapped, or entangled in a hospital bed system), and death of residents. Findings: a. During a review of Resident 26's admission Record (AR front page of the chart that contains a summary of basic information about the resident), the AR indicated the facility originally admitted Resident 26 on 6/1/2025 and readmitted in the facility on 1/6/2026, with diagnoses including congenital malformation (also known as birth defect, physical abnormalities which can affect various parts of the body that occurs before a baby is born), tracheostomy (an opening a surgeon makes through the neck and into the trachea [also known as windpipe] to help a patient breathe), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 26's History and Physical (H&P) dated 1/6/2026, the H&P indicated Resident 26 did not have the capacity to understand and make decisions. During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool), dated 11/2/2025, the MDS indicated Resident 26 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was not able to understand and make his needs known. The MDS further indicated Resident 26 required substantial or maximal assistance to total assistance from staff with all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 26's Order Summary Report dated 1/29/2026, the Order Summary Report indicated a physician's order dated 1/8/2026 for both hand mittens as needed to prevent self-inflicted injury, release every two (2) hours for 15 minutes for circulation check while in use as needed. The Order Summary Report indicated that informed consent was verified with the physician. During a review of Resident 26's informed consent form dated 1/8/2026, the form indicated that an informed consent was obtained from the responsible party thru the phone for the use of both hand mittens as needed. During a review of Resident 26's care plan (CP) on use of restraints both hand mittens initiated on (continued on next page)

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	01/29/2026

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/20/2026, the CP indicated to apply safety device as ordered, continue to implement less restrictive measures such as talking to the resident in a calm, firm manner, explaining procedures and nursing care, and release restraint every two (2) hours or when providing care and/or when resident is closely supervised as a few of the interventions to maintain resident without any episode of falls and injury at all times. During a review of Resident 26's restraint assessment dated [DATE], the restraint assessment did not mention the application of both hand mittens as needed to prevent self-inflicted injury and any least restrictive measures attempted by the facility prior to use of both hand mittens. During a concurrent observation and interview on 1/26/2026 at 9:45 a.m. inside Resident 262's room with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 26 had mitten on the right hand, and she releases the hand mitten every two hours to check the skin for circulation, breakdown, or bruising and report to the nurse if she finds anything. During a concurrent interview and record review on 1/28/2026 at 2:14 p.m., Resident 26's physician's orders, informed consent, CP, and restraint assessment were reviewed with the MDS Coordinator (MDSC). The MDSC stated that Resident 26 had a physician's order for both hand mittens as needed to prevent self-inflicted injury. The MDSC stated that Resident 26's restraint assessment did not indicate any least restrictive measures attempted prior to application of both hand mittens. The MDSC stated that Resident 26's restraint assessment did not indicate application of both hand mitten as a recommendation by the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) to prevent self-inflicted injury. The MDSC stated least restrictive measures should have been attempted first by the IDT and documented prior to application of both hand mitten. The MDSC stated that Resident 26's restraint assessment should have been completed to reflect the IDT recommendation to apply both hand mittens as needed to prevent self-inflicted injury to ensure that the use of the restraint is appropriate and it placed Resident 26 at risk for restriction of his freedom of movement of his hand and fingers which could lead to a decline in physical functioning of the hands and fingers. During an interview on 1/28/2026 at 2:45 p.m. with the Director of Nursing (DON), the DON stated restraint assessments are completed prior to application of restraints or any device. The DON stated the IDT should try least restrictive measures prior to application of restraints and document in the restraint assessment to ensure the use of the restraint or device is appropriate to prevent unnecessary use of physical restraints. The DON stated Resident 26's restraint assessment should have been completed prior to application of both hand mittens to reflect that the least restrictive measures attempted by the IDT or staff were not effective and should also reflect the recommendation to use the hand mitten. The DON stated it was important to complete Resident 26's restraint assessment prior to application of both hand mitten as it placed Resident 26 at risk for restriction of his freedom to move his hands and fingers. The DON stated if Resident 26 cannot use his fingers freely it could lead to a decline of his physical functioning on the hands and fingers. During a review of the facility's policy and procedure (P&P) titled, Hand Mittens for Resident Safety, last reviewed on 1/21/2025, the P&P indicated that residents who have the potential for self-injury such as scratching, placing objects into their mouth, pulling monitor's lines, self-decannulation of tracheostomy tubes) may use hand mitten to prevent such injury. During a review of the facility's P&P titled, Protective Devices and Restraints, last reviewed on 1/21/2025, the P&P indicated that protective devices or restraints should be used only under explicit (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	circumstances, for the resident's benefit. Whenever possible, alternatives to these devices should be tried first. With rare exception, a physician's authorization is required initially for their use. When protective devices or restraints are used, the staff should make observations and take precautions to attempt to prevent problems and complications related to their use. The P&P further indicated that periodically the attending physician and nursing staff will consider whether an individual still needs the device(s), or if their use could be reduced or eliminated. Whenever possible the nursing staff will discontinue the device(s) for a trial period and observe and report the results. b. During a review of Resident 39's AR, the AR indicated the facility admitted the resident on 12/3/2015, and readmitted the resident on 3/15/2023, with diagnoses including convulsions (a condition in which muscles contract and relax quickly and cause uncontrolled shaking of the body), cortical blindness (is theˆtotal or partial loss of vision in a normal-appearing eyeˆcaused by damage to the brain's occipital cortex), and fracture of femur (isˆaˆbreak or crack in the thighbone). During a review of Resident 39's H&P, dated 1/27/2025, the H&P indicated the resident was delayed (a child who has not gained the developmental skills expected of him or her, compared to others of the same age), spastic (born with a disability which makes it difficult for them to control their muscles, especially in their arms and legs) with upper extremity flexion contracture (a bent (flexed) joint that cannot be straightened actively or passively), and non-verbal. During a review of Resident 39's MDS, dated [DATE], the MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 39's Resident at Risk for Falls Assessment (RFA), dated 2/11/2025, the RFA indicated the resident was at risk for falls. During a concurrent observation, interview, and record review on 1/26/2026, at 9:15 a.m., with the Manager of Pediatrics (MP), observed Resident 39's bed was placed against the wall on the right side of the bed with all 4 side rails up. The MP stated placing the bed against the wall is a restraint and requires a physician's order, informed consent, restraint assessment, and a care plan. The MP reviewed Resident 39's Diagnoses, Informed Consents, Order Summary Report (OSR), Restraint Assessments, and Care Plans. The MP stated he (MP) did not find any physician's order, informed consent, restraint assessment, and care plan on the use of bed placed against the wall on Resident 39's chart. The MP stated they did not do any of the requisites prior to application of the restraint bed against the wall on Resident 39 because it is not appropriate for the resident. The MP stated placing the bed against the wall had the potential to violate the resident's right to freedom of movement and can result to deconditioning (theˆloss of physical fitness and strengthˆthat happens when a person is inactive for a prolonged period) on the resident. The MP also stated the resident was also predisposed to accidents such as bed entrapment. During an interview on 1/29/2026, at 8:37 a.m., with the DON, the DON stated the licensed staff should have obtained a physician's order, informed consent from the resident or the representative, performed a restraint assessment, and developed and implemented a care plan on the use of restraint bed placed against the wall to ensure its safe use. The DON stated the failure of the licensed staff to obtain a physician's order, informed consent from the resident or the representative, perform a restraint assessment, and developed and implemented a care plan on the use of restraint bed placed against the wall had predisposed the resident to accidents such as bed entrapment and major injuries such as fractures. (continued on next page)

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	01/29/2026

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All Saints Healthcare Subacute	11810 Saticoy Street North Hollywood, CA 91605

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent policy and procedure (P&P) titled, Protective Devices and Restraints, last reviewed on 1/21/2025, the P&P indicated protective devices or restraints should be used only under explicit circumstances, for resident's benefit. Wherever possible, alternatives to these devices should be tried first. With rare exception, a physician's authorization is required initially for their use. When protective devices or restraints are used, the staff should make observations and take precautions to attempt to prevent problems and complications related to their use.ˆ Procedure: 2. The physician's order will contain the specific type of protective device(s) to be used (for example, wrist restraints, pelvic device, waist device, or padded mittens)/ Also, the physician's orders or progress notes should reflect the reason for ordering the device(s). Periodically, the attending physician and nursing staff will consider whether an individual still needs the device(s), or if their use could be reduced or eliminated. Wherever possible, the nursing staff will discontinue the device(s) for a trial period and observe and report the results.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received services and assistance for three of three sampled residents (Residents 42, 43, and 3) reviewed for urinary tract infection (UTI, a common infection that occurs when bacteria enters and multiplies in the urinary system, which includes the kidneys, bladder, and urethra) by failing to ensure: 1. Resident 42 and 43's suprapubic catheter (a urinary catheter that is inserted into the bladder from a small cut in the tummy, just above the pubic bone) had a leg strap (a common and simple medical device used to securely hold the catheter tubing or a urine collection bag (leg bag) against the patient's leg) or a securement device in place. 2. Resident 3's suprapubic catheter had a leg strap or a securement device in place and the suprapubic catheter tubing was free of loops or kinks. The deficient practice had the potential for residents to develop catheter associated urinary tract infection (CAUTI, a type of infection that occurs when germs (usually bacteria) enter the urinary system via a urinary catheter) and dislodgement of the suprapubic catheter. Findings: 1a. During a review of Resident 42's admission Record (AR), the AR indicated the facility admitted the resident on 9/11/2023, and readmitted the resident on 2/20/2025, with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), tracheostomy (isˆa surgically created hole in the front of the neck that goes into the windpipe (trachea)), and dependence on respirator status (if a patient is unable to wean off a ventilator and breathe independently). During a review of Resident 42's History and Physical (H&P), dated 2/20/2025, the H&P indicated the resident was on a ventilator (a medical device to help support or replace breathing), alert, with eyes open intermittently (stopping and starting repeatedly rather than continuously), looking around and smiled to provider voice, with no acute distress. During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated 12/14/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a person has extreme difficulty with fundamental mental tasks like thinking, learning, remembering, and making decisions, to the point where they are unable to live independently). The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 42's Order Summary Report (OSR), the OSR indicated an order of: 12/18/2025 Bolster suprapubic catheter at all times every 12 hours for catheter maintenance. 2/20/2025 Suprapubic Catheter: Change catheter #16 French size (FR, is a universal system used to measure theˆouter thickness, or diameter, of the catheter tube) every 2 weeks and as needed out or plugged. During a review of Resident 42's Care Plan (CP) Report titled, At Risk for UTI related to resident has suprapubic catheter in place, last revised on 6/16/2025, the CP indicated a goal of the resident will not exhibit any signs and symptoms of UTI e.g. elevated temperature, elevated white blood cells (WBC, a key part of the body's immune system), dark yellow or tea colored urine and presence of sediments with an intervention to keep suprapubic catheter tubing free from coils and dignity bag for suprapubic catheter in place at all times, monitor every (q) shift. During a concurrent observation and interview on 1/26/2026 at 11:34 a.m., with Registered Nurse (RN) 3, inside Resident 42's room, observed Resident 42's suprapubic catheter without a leg strap or securement device in place. RN 3 stated the resident's suprapubic catheter should have a securement device in place to prevent dislodgment of the tubing and to prevent tugging and pulling on the tube causing skin tears that can be a portal of infection to set in. During an interview on 1/29/2026, at 7:49 a.m., with the Manager of Pediatrics (MP), the MP stated that Resident 42's suprapubic catheter should have a leg strap or securement device to preventer tugging and dislodgement of the tubing causing trauma to the insertion site of the resident. The MP also stated (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the licensed staff should also be checking for loops or kinks, and to make sure the bag is lower than the bladder of the resident to prevent backflow of urine causing UTI. The MP also added that the drainage bag should not be touching the floor due to ascending infection (an infection that starts in a lower part of the body's system (like the lower urinary or biliary tract) and then travels or spreads upward to affect higher organs). During an interview on 1/29/2026, at 8: 37 a.m., with the Director of Nursing (DON), the DON stated the licensed staff should always be checking Resident 42's suprapubic catheter to make sure the catheter has a securement device, the tube should have no loops or kinks, and the bag is below the level of the bladder of the resident to prevent backflow of urine that can cause UTI. The DON stated the failure of the staff to place a securement device had predisposed the resident to tugging and pulling of the suprapubic catheter tubing that can cause trauma to the insertion site that can open a portal of entry to infection and potential dislodgement of the tubing. During a review of the facility's recent policy and procedure (P&P) titled, Catheterization, Suprapubic, last reviewed on 1/21/2025, the P&P indicated to drain the bladder via a tube placed in the bladder from the supra pubic area. To divert the flow of urine from the urethra. General Instructions: 1. Physician's order Procedure: 2. An obstructed flow must be maintained on indwelling catheters a. Keep the catheter and drainage system free of kinks and the drainage bag below the level of the bladder. Completion of indwelling catheterization: 4. Secure catheter to prevent movement and urethral traction. 6. Maintain tubing in a position that facilitates gravity drainage bag must be lower than bladder. During a review of the facility's recent P&P titled, Catheter-Associated Urinary Tract Infection (CAUTI), last reviewed onˆ1/21/2025, the P&P indicated the purpose of this policy is to prevent and manage Catheter Associated Urinary Tract Infections (CAUTI). Procedure: Proper Insertion - Properly secure catheters after insertion to prevent movement and urethral traction, do not attach to movable parts in bed. Proper Maintenance/Prevention of UTI - Check for kinks and dependent loops in catheter tubing. 1b. During a review of Resident 43's AR, the AR indicated the facility admitted the resident on 9/11/2023, with diagnoses including neuromuscular dysfunction of bladder (is a condition where a person lacks proper bladder control because of a problem with the nerves that connect the brain and spinal cord to the bladder), chronic kidney disease stage three (the kidney's function has been cut by half, and most patients experience ancillary problems likeˆhigh blood pressureˆor bone difficulties), and UTI. During a review of Resident 43's H&P, dated 10/29/2025, the H&P indicated the resident was well nourished, with global disability (the experience of aˆphysical or mental condition that limits a person's ability to participate fully in society, largely due to societal barriersˆlike inaccessible environments, discrimination, and lack of support), no distress, and awake. The resident was not interactive, no purposeful response, opens eye spontaneously but no tracking. During a review of Resident 43's MDS, dated [DATE], the MDS indicated the resident had rarely to never had the ability to make self-understood and understand others and had severely impaired cognition. The MDS indicated the resident was dependent on mobility and ADLs. During a review of Resident 43's OSR, the OSR indicated an order for: 12/18/2025 Bolster suprapubic catheter at all times every 12 hours for catheter maintenance. 12/1/2025 Suprapubic Catheter: Change catheter #14 FR every two weeks and prn out or plugged as needed out or plugged. During a review of Resident 43's CP Report titled, At Risk for UTI related to resident has suprapubic catheter in place, last revised on 6/14/2025, the CP indicated a goal of the resident will not exhibit any signs and symptoms of UTI e.g. elevated temperature, elevated WBC, dark yellow or tea colored urine and presence of sediments with an intervention to keep suprapubic catheter tubing free from coils and dignity bag for suprapubic catheter in place at all times, monitor q shift. During a concurrent observation and interview on 1/26/2026, at 11:37 a.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 43's room, observed Resident 43's suprapubic catheter without a leg strap or securement device in place. LVN 1 stated the resident's suprapubic catheter should have a securement device in place to prevent dislodgment of the tubing and to prevent tugging and pulling on the tube causing skin tears that can be a portal of infection to set in. During an interview on (continued on next page)

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	01/29/2026

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

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/29/2026, at 7:49 a.m., with the MP, the MP stated that Resident 43's suprapubic catheter should have a leg strap or securement device to preventer tugging and dislodgement of the tubing causing trauma to the insertion site of the resident. The MP also stated the licensed staff should also be checking for loops or kinks, and to make sure the bag is lower than the bladder of the resident to prevent backflow of urine causing UTI. The MP also added the drainage bag should not be touching the floor due to ascending infection. During an interview on 1/29/2026, at 8:37 a.m., with the DON, the DON stated the licensed staff should always be checking Resident 43's suprapubic catheter to make sure the catheter has a securement device, the tube should have no loops or kinks, and the bag is below the level of the bladder of the resident to prevent backflow of urine that can cause UTI. The DON stated the failure of the staff to place a securement device had predisposed the resident to tugging and pulling of the suprapubic catheter tubing that can cause trauma to the insertion site that can open a portal of entry to infection and potential dislodgement of the tubing. During a review of the facility's recent P&P titled, Catheterization, Suprapubic, last reviewed on 1/21/2025, the P&P indicated to drain the bladder via a tube placed in the bladder from the supra pubic area. To divert the flow of urine from the urethra. General Instructions: 1. Physician's order Procedure: 2. An obstructed flow must be maintained on indwelling catheters a. Keep the catheter and drainage system free of kinks and the drainage bag below the level of the bladder. Completion of indwelling catheterization: 4. Secure catheter to prevent movement and urethral traction. 6. Maintain tubing in a position that facilitates gravity drainage bag must be lower than bladder. During a review of the facility's recent P&P titled, Catheter-Associated Urinary Tract Infection (CAUTI), last reviewed onˆ1/21/2025, the P&P indicated the purpose of this policy is to prevent and manage Catheter Associated Urinary Tract Infections (CAUTI). Procedure: Proper Insertion - Properly secure catheters after insertion to prevent movement and urethral traction, do not attach to movable parts in bed. Proper Maintenance/Prevention of UTI - Check for kinks and dependent loops in catheter tubing. 2. During a review of Resident 3's AR, the AR indicated the facility admitted the resident on 8/3/2022, and readmitted the resident on 3/12/2024, with diagnoses including retention of urine (the inability to fully empty your bladder, or in severe cases, to urinate at all), presence of urogenital implants (medical devices that are surgically placed inside the body to restore or support the function of the urinary and reproductive organs), and UTI. During a review of Resident 3's H&P, dated 10/3/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated the resident was dependent on mobility and ADLs. The MDS indicated the resident had a catheter (indwelling). During a review of Resident 3's OSR, dated 10/31/2025, the OSR indicated an order of suprapubic catheter FR #16 X 10 cubic centimeters (cc, a metric unit for measuringˆvolume): Change q monthly and PRN when out or plugged (urinary retention) as needed. During a review of Resident 3's CP Report titled, At Risk for UTI related to suprapubic catheter, last revised on 8/20/2025, the CP indicated a goal of the resident will not exhibit any signs and symptoms of UTI e.g. elevated temperature, elevated WBC, dark yellow or tea colored urine and presence of sediments with an intervention to keep suprapubic catheter tubing free from coils and bag below the waist and provide suprapubic catheter care q shift and PRN. During a concurrent observation and interview on 1/26/2026 at 11:45 a.m., with RN 4, inside Resident 3's room, observed Resident 3's suprapubic catheter without a leg strap or securement device in place and the tubing was looped. RN 4 stated the resident's suprapubic catheter should have a securement device in place to prevent dislodgment of the tubing and to prevent tugging and pulling on the tube causing skin tears that can be a portal of infection to set in. RN 4 also stated there should be no loops on the suprapubic catheter tubing to prevent backflowing of the urine to the bladder that can cause UTI to residents. During an interview on 1/29/2026, at 7:49 a.m., with the MP, the MP stated that Resident 3's suprapubic catheter should have a leg strap or securement device to prevent tugging and dislodgement of the tubing causing trauma to the insertion site of the resident. The MP also stated the licensed staff should also be checking for loops or kinks, and to make sure the bag is lower than (continued on next page)

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	01/29/2026

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

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the bladder of the resident to prevent backflow of urine causing UTI. The MP also added the drainage bag should not be touching the floor due to ascending infection. During an interview on 1/29/2026, at 8: 37 a.m., with the DON, the DON stated the licensed staff should always be checking Resident 3's suprapubic catheter to make sure the catheter has a securement device, the tube should have no loops or kinks, and the bag is below the level of the bladder of the resident to prevent backflow of urine that can cause UTI. The DON stated the failure of the staff to place a securement device had predisposed the resident to tugging and pulling of the suprapubic catheter tubing that can cause trauma to the insertion site that can open a portal of entry to infection and potential dislodgement of the tubing. During a review of the facility's recent P&P titled, Catheterization, Suprapubic, last reviewed on 1/21/2025, the P&P indicated to drain the bladder via a tube placed in the bladder from the supra pubic area. To divert the flow of urine from the urethra. General Instructions: 1. Physician's order Procedure: 2. An obstructed flow must be maintained on indwelling catheters a. Keep the catheter and drainage system free of kinks and the drainage bag below the level of the bladder. Completion of indwelling catheterization: 4. Secure catheter to prevent movement and urethral traction. 6. Maintain tubing in a position that facilitates gravity drainage bag must be lower than bladder. During a review of the facility's recent P&P titled, Catheter-Associated Urinary Tract Infection (CAUTI), last reviewed onˆ1/21/2025, the P&P indicated the purpose of this policy is to prevent and manage Catheter Associated Urinary Tract Infections (CAUTI). Procedure: Proper Insertion - Properly secure catheters after insertion to prevent movement and urethral traction, do not attach to movable parts in bed. Proper Maintenance/Prevention of UTI - Check for kinks and dependent loops in catheter tubing.

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	056407	A. Building B. Wing	01/29/2026

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the staff providing care and services to residents who had feeding tubes (are soft plastic tubes through which liquid nutrition travels through the gastrointestinal tract [the series of organs that food and liquids pass through as they are digested, absorbed, and leave the body as feces]) were aware of, competent in, and utilized facility protocols regarding feeding tube nutrition and care for four of five sampled residents (Residents 42, 3,105 and 41) reviewed for tube feeding by failing to ensure: 1. Resident 42's tube feeding bag was labeled with the complete name of the resident, the rate of infusion, and the initials of the licensed nurse who hung the tube feeding bag. 2. Resident 3's water flush bag was labeled with the complete name of the resident, the rate of infusion, and the initials of the licensed nurse who hung the water flush bag. 3. Resident 105's EF bag indicated the resident's name, room number, start date and time, and administration rate. 4. Residents 105's and 41's medication syringes were properly rinsed after use. The deficient practices had the potential to result in altered nutritional status that can lead to over or under hydration, gastrointestinal (GI, relating to stomach and intestines) infection to the resident. Findings: 1. During a review of Resident 42's admission Record (AR), the AR indicated the facility admitted the resident on 9/11/2023, and readmitted the resident on 2/20/2025, with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), gastro-esophageal reflux disease (GERD, a chronic (long-lasting) condition where stomach contents, including harsh stomach acid, frequently flow back up into the esophagus (food pipe)), and constipation (a problem with passing stool). During a review of Resident 42's History and Physical (H&P), dated 2/20/2025, the H&P indicated the resident was on a ventilator (a medical device to help support or replace breathing), alert, with eyes open intermittently (stopping and starting repeatedly rather than continuously), looking around, smiled to provider voice, with no acute distress, responded appropriately to exam, face symmetric (both sides of the body are identical), and moved all extremities equally. During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated 12/14/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a person has extreme difficulty with fundamental mental tasks like thinking, learning, remembering, and making decisions, to the point where they can no longer live independently). The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was on a feeding tube while a resident at the facility. During a review of Resident 42's Order Summary Report (OSR), dated 5/19/2025, the OSR indicated an order of enteral feed (a way of providing nutrition to the body using the natural digestive system (the gut) when a person cannot eat or swallow enough food by mouth to meet their nutritional needs) order five times a day gastrostomy tube (GT, a soft, flexible tube inserted through the belly wall directly into the stomach) feeding: Fibersource HN (aˆnutritionally complete liquid formulaˆused for tube feeding) 1.2 at 140 cubic centimeters per hour (cc/hr, it is a unit of measurement that describes aˆrate of flow, or how much of something is moving over a specific period of time) via pump five times a day to provide 700 cubic centimeters (cc, a measurement ofˆvolume—the amount of three-dimensional space an object or a substance occupies)/840 kilocalorie (kcal, a measurement ofˆvolume—the amount of three-dimensional space an object or a substance occupies) every (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(q) 24 hours a day. During a review of Resident 42's Care Plan (CP) Report titled, Alteration in nutrition and hydration, last revised on 8/19/2025, the CP indicated a goal of patient will not have any significant weight changes q month till next review, and an intervention to provide tube feeding as ordered. During a concurrent observation and interview on 1/26/2026, at 11:13 a.m., with Registered Nurse (RN) 3, observed Resident 42's feeding bag not labeled with the complete name of the resident, the rate of infusion, and the initials of the licensed nurse who hung the feeding bag. RN 3 stated the licensed nurse should have labeled the feeding bag of Resident 42 with the resident's complete name, the rate of infusion of the feeding formula and the licensed nurse who hung the feeding bag to ensure its safe use and to ensure they are giving the right nutrition to the resident. During an interview on 1/29/2026, at 7:49 a.m., with the Manager of Pediatrics (MP), the MP stated the licensed nurse should have labeled the feeding bag of Resident 42 with the complete name of the resident, the name of the formula, the date and time it was hung, the rate of infusion, and the initial of the licensed nurse who hung the feeding bag to ensure they were providing the right nutrition to the resident and can be used as a cross reference when endorsing to incoming nurse during shift changes to catch errors in the orders. The MP stated that labeling the feeding bag accurately and completely is what a prudent nurse should be doing. During an interview on 1/29/2026, at 8:37 a.m., with the Director of Nursing (DON), the DON stated the feeding bag of Resident 42 should have been completely labeled with the name of the resident, the name of the formula, the date and time it was hung, the rate of infusion, and the bag should be initialed by the nurse who hung the bag to ensure they are providing the right nutrition to the right resident. The DON stated the failure of the staff to label the bag completely can cause errors in the infusion of the formula causing nutritional deficits to the resident. During a review of the facility's recent policy and procedure (P&P) titled, Labeling Tube Feeding/Water Flush, last reviewed on 1/21/2025, the P&P indicated to ensure patient safety by establishing standardized labeling requirements for all tube feeding formulas, and water flushes. All tube feeding formulas and water flush sets must be labeled with the name of the patient, room and bed number, time started and the rate. During a review of the facility's recent P&P titled, Enteral Feeding- General Policy, last reviewed on 1/21/2025, the P&P indicated enteral nutrition is provided for those Resident who cannot or will not take necessary nutrients by mouth due to disease process or physical disorders and who have a functioning gastrointestinal tract. Storage of Formula: 3. Label formula with time, date, Resident's name and nurse's initials when hung. 2. During a review of Resident 3's AR, the AR indicated the facility admitted the resident on 8/3/2022, and readmitted the resident on 3/12/2024, with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), gastrostomy, and anoxic brain damage (happens when the brain is completely deprived of oxygen, usually for four minutes or longer, causing brain cells to die rapidly and leading to severe damage, disability, coma, or even death). During a review of Resident 3's H&P, dated 10/3/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's MDS, dated [DATE], the MDS indicated the resident was dependent on mobility and ADLs. The MDS indicated the resident had a feeding tube while a resident in the facility. During a review of Resident 3's OSR, dated 11/21/2025, the OSR indicated an order of enteral feed order every shift: Continuous water flush feeding tube with 30 cc of water x 22 hr. During a review of Resident 3's CP Report titled, Presence of Nasogastric (NG, nose to stomach) /jejunostomy (JT, a soft, flexible tube that a doctor places directly into the small intestine through the skin of the abdomen)/ gastrostomy tube (GT, a soft tube inserted through the belly wall directly into the stomach, acting as a shortcut for delivering food, fluids, and medicine when someone cannot eat or drink enough by mouth, or to help decompress the stomach) at risk for potential or actual malnutrition (a serious condition that happens when your diet does not contain the right amount of nutrients) and dehydration (a condition where the body loses more fluid than what is taken in, and does not have enough water to function properly) related to long term use of artificial nutrition, last revised on 11/7/2025, the CP indicated an intervention to administer feeding formula and water flushes as ordered. During a concurrent observation and interview on 1/26/2026, at 11:40 a.m., with RN 4, inside Resident 3's room, observed Resident 3's water flush bag not labeled with the complete name of the resident, the rate of infusion, and the initials of the nurse who hung the water flush bag. RN 4 stated the licensed staff who hung the water flush bag of Resident 3 should have placed the complete name of the resident, the name of the solution being infused, the date and the time it was hung, the rate of infusion, and the initials of the licensed nurse who hung the bag. RN 4 stated it was important to label the water flush bag accurately and completely to ensure they are providing the right hydration to the right patient. RN 4 stated the failure of the licensed staff to label the water flush bag completely could result to improper infusion of the solution causing dehydration to the resident and had the potential for errors in administration. During an interview on 1/29/2026, at 7:49 a.m., with the MP, the MP stated the licensed nurse should have labeled the water flush bag of Resident 3 with the complete name of the resident, the name of the formula/solution, the date and time it was hung, the rate of infusion, and the initial of the licensed nurse who hung the feeding bag to ensure they were providing the right hydration to the resident and can be used as a cross reference when endorsing to incoming nurse during shift changes to catch errors in the orders. The MP stated that labeling the feeding/water flush bag accurately and completely is what a prudent nurse should be doing. During an interview on 1/29/2026, at 8:37 a.m., with the DON, the DON stated the water flush bag of Resident 3 should have been completely labeled with the name of the resident, the name of the formula/solution, the date and time it was hung, the rate of infusion, and the bag should be initialed by the nurse who hung the bag to ensure they are providing the right hydration to the right resident. The DON stated the failure of the staff to label the bag completely can cause errors in the infusion of the formula causing nutritional deficits and dehydration to the resident. During a review of the facility's recent P&P titled, Labeling Tube Feeding/Water Flush, last reviewed on 1/21/2025, the P&P indicated to ensure patient safety by establishing standardized labeling requirements for all tube feeding formulas, and water flushes. All tube feeding formulas and water flush sets must be labeled with the name of the patient, room and bed number, time started and the rate. (continued on next page)

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	01/29/2026

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All Saints Healthcare Subacute	11810 Saticoy Street North Hollywood, CA 91605

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled, Enteral Feeding- General Policy, last reviewed on 1/21/2025, the P&P indicated enteral nutrition is provided for those Resident who cannot or will not take necessary nutrients by mouth due to disease process or physical disorders and who have a functioning gastrointestinal tract. Storage of Formula: 3. Label formula with time, date, Resident's name and nurse's initials when hung. 3. During a review of Resident 105's admission Record, the admission Record indicated the facility originally admitted Resident 105 on 10/10/2017, and readmitted in the facility on 4/19/2019, with diagnoses including cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture caused by damage that occurs to the developing brain, most often before birth), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and gastrostomy (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 105's History and Physical (H&P) dated 10/3/2025, the H&P indicated Resident 105 did not have the capacity to understand and make decisions. During a review of Resident 105's Minimum Data Set (MDS, a resident assessment tool), dated 12/18/2025, the MDS indicated Resident 105 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was not able to understand and make his needs known. The MDS further indicated Resident 105 required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 105 received tube feeding while a resident in the facility. During a review of Resident 105's Order Summary Report dated 1/29/2026, the Order Summary Report indicated the following physician's orders: - 5/8/2025: every four (4) hours GT feeding: Enteral Feeding (EF) 1 at 230 milliliters (ml – a unit of measurement) bolus (refers to administration of a single relatively large amount of a substance such as GT feeding) six (6) times per day to provide 1380 mi per 1656 kilocalories (kcals – a unit of measurement for calories) every 24 hours. - 9/17/2025: every four hours enteral: Flush feeding tube with 120 ml of water six times per day, to provide 720 ml per day. During a review of Resident 105's care plan (CP) titled, The resident requires tube feeding, initiated on 4/18/2025, and last revised on 8/19/2025, the CP indicated to administer feeding formula and water flushes as ordered, monitor for signs and symptoms of malnutrition and dehydration, weigh resident every month, monitor and report for any signs and symptoms of infection as a few of the interventions to maintain nutritional and hydration status, and will remain free of side effects or complications related to tube feeding. During an observation on 1/26/2026 at 9:35 a.m. inside Resident 105's room, observed Resident 105's EF 1 bag was hanging from the EF pole and the EF 1 bag did indicate Resident 105's name, room number, start date and time, and administration rate and that the medication syringe was not rinsed properly and had some medication residuals left on the tip of the medication syringe. During a concurrent observation and interview on 1/26/2026 at 10:06 a.m., a photograph of Resident 105's EF bag and medication syringe was reviewed with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 105's EF bag did not indicate the resident's name, room number, start date and time, and administration rate and that the medication syringe was not rinsed properly and had some (continued on next page)

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	01/29/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication residuals left on the tip of syringe. LVN 1 stated that during medication administration thru the GT, the GT should be flushed with 50 ml of water before and after each medication administration to ensure all the medications were administered to the resident. LVN 1 stated the medication syringe is supposed to be rinsed properly after each use. LVN 1 stated that when an EF bag is changed, the bag should be labeled with the resident's name, room number, start date and time, and administration rate. LVN 1 stated Resident 105's EF bag label should have indicated the resident's name, room number, start date and time, and administration rate so the staff would be aware if Resident 105 was receiving the correct amount of feeding to prevent malnutrition or dehydration. LVN 1 stated he should have rinsed the medication syringe properly to ensure there were no residuals left at the tip as it is an infection control issue and that Resident 105 received the full dose of the medication. During a concurrent interview and record review on 1/27/2026 at 1:52 p.m. a photograph of Resident 105's EF bag and medication syringe were reviewed with Registered Nurse (RN) 7. RN 7 stated Resident 105's EF bag did not indicate the resident's name, room number, start date and time, and administration rate and that the medication syringe was not rinsed properly and had some medication residuals left on the tip of syringe. RN 7 stated that EF bags are changed by the night shift nurse usually at 6 a.m. and should be labeled with the resident's name, room number, start date and time, and administration rate. RN 7 stated that after each medication administration, the medication syringe should be properly rinsed to ensure there were no residuals left on the tip. RN 7 stated that Resident 105's EF bag should have been labeled with the resident's name, room number, start date and time, and administration rate at the time it was hung by the nurse so the staff would be aware that the EF bag hanging was the correct EF and amount to be received and that the EF bag was not expired. RN 7 stated that the nurse should have properly rinsed Resident 105's medication syringe after medication administration to ensure there were no medication residuals left on the tip as the tip can be contaminated and placed Resident 105 at risk for complications such as infection. During a concurrent interview and record review on 1/29/2026 at 8:37 a.m., a photograph of Resident 105's EF bag and medication syringe and the original plastic packaging of the medication syringe were reviewed with the Director of Nursing (DON). The DON stated the photograph of the EF bag did not indicate the resident's name, room number, start date and time, and administration rate and that the medication syringe was not rinsed properly and had some medication residuals left on the tip of syringe. The DON stated the original plastic packaging of the medication syringe indicated to rinse the container and syringe thoroughly with hot water after each use and must be replaced every 24 hours. The DON stated that EF bottles should be labeled with the resident's name, room number, start date and time, and administration rate when a new bag is hung and that the medication syringe should be properly rinsed after each use to ensure there were no residuals left. The DON stated Resident 105's EF bag should have indicated the resident's name, room number, start date and time, and administration rate when a new bag is hung and that the medication syringe should be properly rinsed after each use to ensure there were no residuals left as indicated in the original plastic packaging. The DON stated if Resident 105 was not receiving the correct bolus feeding, it would place the resident at risk for malnutrition or dehydration. The DON stated that if the medication syringe was not rinsed properly to ensure there were no residuals left on the tip, it placed Resident 105 at risk for health complications such as infection due to a contaminated medication syringe. During a review of the facility provided original plastic packaging for the medication syringe, undated, the original plastic packaging indicated to rinse the container and syringe thoroughly with hot water after each use and must be replaced every 24 hours. During a review of the facility's policy and procedure (P&P) titled, Enteral Feeding – General (continued on next page)

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	01/29/2026

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

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy, last reviewed on 1/21/2025, the P&P indicated enteral nutrition is provided for those residents who cannot or will not take necessary nutrients by mouth due to disease process or physical disorders and who have a functioning gastrointestinal tract. The P&P further indicated: - Label the formula with time, date, resident's name and nurse's initials when hung. - Administration bag and/or tubing shall be labeled with date and time and nurse's initials when changed. During a review of the facility's P&P titled, Labeling Tube Feeding/Water Flush, last reviewed on 1/21/2025, the P&P indicated a purpose to ensure patient safety by establishing standardized labeling requirements for all tube feeding formulas, and water flushes. The P&P further indicated all tube feeding and water flush sets must be labeled with: - Patient last name - Room number and bed number of patient - Date and time prepared or opened - Rate of the tube feeding 4. During a review of Resident 41's admission Record, the admission Record indicated Resident 41 was originally admitted in the facility on 5/25/2017, and readmitted in the facility on 6/17/2025, with diagnoses including respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture caused by damage that occurs to the developing brain, most often before birth). During a review of Resident 41's History and Physical (H&P) dated 6/18/2025, the H&P indicated Resident 41 did not have the capacity to understand and make decisions. During a review of Resident 41's MDS, the MDS assessment indicated Resident 41 had severely impaired cognition (mental action or process of acquiring knowledge and understanding), required total assistance from staff with all activities of daily living. The MDS indicated Resident 41 required suctioning (mechanical removal of a patient's secretions with artificial airway such as tracheostomy). During a review of Resident 41's Order Summary Report dated 1/29/2026, the Order Summary Report indicated the following physician's orders: - 6/17/2025: every four hours GT feeding: EF 2 at 240 ml bolus every four hours to provide 1440 ml per 2160 kcals. - 6/17/2025: every shift enteral: flush 50 ml water thru the GT before and after medication administration and 5-10 ml in between medications. - 6/17/2025: flush feeding tube with 150 ml of water manual bolus every two hours to provide 1800 ml per day. During a review of Resident 41's care plan (CP) titled, The resident requires tube feeding, initiated on 4/24/2025 and last revised on 8/21/2025, the CP indicated to monitor for signs of malnutrition and dehydration and notify the physician, weigh resident every month or as needed, and monitor and report for any signs and symptoms of infection as a few of the interventions to maintain nutritional and hydration status, and will remain free of side effects or complications related to tube feeding. During an observation on 1/26/2026 at 9:46 a.m., inside Resident 41's room, observed Resident 41's medication syringe was not rinsed properly and had some residuals left on the tip. During a concurrent observation and interview on 1/26/2026 at 10:06 a.m., a photograph of Resident 41's medication syringe was reviewed with LVN 1. LVN 1 stated Resident 41's medication syringe was not rinsed properly and had some medication residuals left on the tip of syringe. LVN 1 stated that during medication administration thru the GT, the GT should be flushed with 50 ml of water (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	before and after each medication administration to ensure all the medications were administered to the resident. LVN 1 stated the medication syringe is supposed to be rinsed properly after each use. LVN 1 stated he should have rinsed the medication syringe properly to ensure there were no residuals left at the tip as it is an infection control issue and that Resident 41 received the full dose of the medication. During a concurrent interview and record review on 1/27/2026 at 1:52 p.m. a photograph of Resident 41's medication syringe was reviewed with RN 7. RN 7 stated Resident 41's medication syringe was not rinsed properly and had some medication residuals left on the tip of syringe. RN 7 stated that after each medication administration, the medication syringe should be properly rinsed to ensure there were no residuals left on the tip. RN 7 stated that LVN 1 should have properly rinsed Resident 41's medication syringe after medication administration to ensure there were no medication residuals left on the tip as the tip can be contaminated and placed Resident 41 at risk for complications such as infection. During a concurrent interview and record review on 1/29/2026 at 8:37 a.m., a photograph of Resident 41's original plastic packaging of the medication syringe was reviewed with the DON. The DON stated the photograph indicated the medication syringe was not rinsed properly and had some medication residuals left on the tip of syringe. The DON stated the original plastic packaging of the medication syringe indicated to rinse the container and syringe thoroughly with hot water after each use and must be replaced every 24 hours. The DON stated that the medication syringe should be properly rinsed after each use to ensure there were no residuals left. The DON stated Resident 41's medication syringe should have been properly rinsed after each use to ensure there were no residuals left as indicated in the original plastic packaging. The DON stated that if the medication syringe was not rinsed properly to ensure there were no residuals left on the tip, it placed Resident 41 at risk for health complications such as infection due to a contaminated medication syringe. During a review of the facility provided original plastic packaging for the medication syringe, undated, the original plastic packaging indicated to rinse the container and syringe thoroughly with hot water after each use and must be replaced every 24 hours. During a review of the facility's P&P titled, Infection Control Program, last reviewed on 1/21/2025, the P&P indicated that the facility shall establish an infection control program designed to provide a safe, sanitary and comfortable environment for residents and staff to help prevent the development and transmission of disease and infection.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow professional standards of practice for respiratory care by failing to: 1. Ensure Respiratory Therapist (RT) 4 provided tracheostomy (trach - opening surgically created through the front of the neck and into the trachea [windpipe] that is held open by a specialized tube [cannula]) care per the physician's orders by cleaning the resident's stoma (actual physical opening in the skin at the front of the neck) with hydrogen peroxide (H2O2 -a liquid chemical used to clean wounds and reduce risk of infection from a wide variety of microorganisms) for one of five sampled residents (Resident 93) reviewed for respiratory care. 2. Ensure RT 4 performed hand hygiene (process of cleaning one's hands to prevent the spread of infectious diseases) before and after glove use during tracheostomy care for one of five sampled residents (Resident 93) reviewed for respiratory care. 3. Ensure RT 4 performed tracheostomy care per the facility policy and procedure (P&P) by cleaning the neck and stoma prior to inserting the sterile inner cannula (a smaller, removable tube that fits inside the main outer tracheostomy tube) for one of five sampled residents (Resident 93) reviewed for respiratory care. 4. Ensure the suction catheter (SC) indicated the date they were last changed for three residents (Residents 41, 94, and 13) reviewed for respiratory care. 5. Ensure a resident`s Hand Held Nebulization (HHN, deliver medicines in the form of aerosols to add moisture and help control your respiratory symptoms) setup was changed per physician`s order for one of five sampled residents (Resident 57) reviewed for respiratory care. These deficient practices placed residents at risk for respiratory infections resulting in hospitalization and death. Findings: 1. During a review of Resident 93's admission Record (AR), the AR indicated the facility admitted the resident on 9/20/2022, and most recently admitted the resident on 10/8/2024, with diagnoses that included chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood), tracheostomy, dependence of respirator (ventilator - a medical device to help support or replace breathing), unspecified intracranial brain injury (a brain injury that is caused by an outside force) with loss of consciousness of unspecified duration, and sepsis (a life-threatening blood infection). During a review of Resident 93's Minimum Data Set (MDS – resident assessment tool) dated 12/16/2025, the MDS indicated the resident rarely/never was able to understand others and rarely/never was able to make himself understood. The MDS further indicated that the resident was dependent on staff for bathing, toileting, dressing, oral and personal hygiene, and mobility. The MDS indicated while in the facility the resident was on an invasive mechanical ventilator and received tracheostomy care. During a review of Resident 93's Order Summary Report, the Order Summary Report indicated the following orders: -Tracheostomy care every shift and as needed (PRN): cleanse stoma with H202. Rinse with normal saline (NS – a sterile solution), dated 2/18/2025. - Ventilator dependent resident: change inner cannula daily and PRN, every day shift, dated 2/18/2025. - Suction tracheostomy secretions every two hours and PRN, dated 10/21/2025. During a review of Resident 93's Care Plan (CP) titled, Presence of tracheostomy: ineffective airway clearance related to inability to expel excess secretions.potential for infection., initiated 4/13/2025, the CP indicated a goal that the resident would remain free from signs and symptoms of infection at all times. The CP indicated interventions that included suction tracheal secretions every two hours and render trach care every shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 93's CP titled, Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted gown and glove use during high contact resident care activities)., initiated 7/30/2025, the CP indicated a goal that the resident would remain free from infections. The CP indicated interventions that included to observe good hand washing before and after contact with residents or resident equipment. During a tracheostomy care observation on 1/28/2026 at 11:15 a.m. with RT 4 and Licensed Vocational Nurse (LVN) 2, observed RT 4 and LVN 2 entered Resident 93's room and performed HH. RT 4 donned (put on) clean (non-sterile) blue gloves. RT 4 then suctioned Resident 93's mouth with a yankauer (disposable medical tool used to suction), doffed (took off) the blue gloves, and donned a new pair of blue gloves. Observed RT 4 did not perform HH between glove changes. RT 4 then opened a pair of sterile gloves and placed a sterile glove over the top of the left-hand blue glove. LVN 2 stated do not double glove (practice of wearing two pairs of gloves simultaneously). RT 4 then removed both sets of gloves, opened a new sterile glove package, and donned the sterile gloves. Observed RT 4 did not perform HH between changing gloves. RT 4 then suctioned Resident 93's trach and inserted the sterile inner cannula wearing sterile gloves, doffed the sterile gloves, and donned blue gloves. Observed RT 4 did not perform HH between glove changes. RT 4 then used NS to clean Resident 93's neck around the stoma, changed gloves, and then applied a new dressing at the stoma. Observed RT 4 did not use H2O2 to clean around the stoma, did not perform HH between glove changes, and performed the insertion of the sterile inner cannula before cleaning the area around the stoma. RT 4 exited the resident's room and performed HH. During an immediate follow-up interview with RT 4, RT 4 stated she (RT 4) usually double gloves to perform the sterile procedure of suctioning and placing a sterile inner cannula. RT 4 stated LVN 2 told her not to double glove, so she stopped and removed all the gloves. RT 4 then stated she (RT 4) changed gloves multiple times during Resident 93's trach care and did not perform HH between glove changes. RT 4 stated she (RT 4) only performs HH before and after resident care and not between glove changes. RT 4 further stated RT 4 did not use H2O2 to cleanse around Resident 93's stoma. RT 4 proceeded to review Resident 93's physician's orders and stated the order indicated to use H2O2 and rinse with NS. RT 4 stated the RT Manager (RTM) told her (RT 4) to use only NS to clean around the stoma, so she only used NS and not H2O2. During a concurrent interview and record review on 1/28/2026 at 12:02 p.m., with the RTM and RT 4, the RTM reviewed Resident 93's physician orders. The RTM stated it was important to clean around the stoma during tracheostomy care to prevent infection. The RTM stated that tracheostomy care should be provided per the physician's orders. The RTM stated Resident 93's order indicates to use H2O2 to cleanse around the stoma, and RT 4 should have used H2O2 during trach care for Resident 93. RT 4 stated she was nervous and did not use H2O2 for Resident 93's trach care. The RTM then stated HH should be performed between glove changes and the RT should not double glove. The RTM stated HH between glove changes prevents contamination from any bacteria from the used gloves transferring to the new gloves. The RTM stated RT 4 should have performed HH between glove changes and she did not. The RTM stated when RT 4 did not perform HH between glove changes and did not use H2O2 per the physician's orders, there was the potential to result in a respiratory infection in Resident 93. During a follow-up interview and record review on 1/28/2026 at 1:03 p.m. with the RTM, the RTM (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed the P&P regarding trach care. The RTM stated the facility P&P for trach care indicates to first provide cleaning of the area around the stoma, then change to sterile gloves and insert the sterile inner cannula. The RTM stated cleaning first and then inserting the sterile cannula prevents infection. The RTM stated RT 4 did not follow the P&P when RT 4 replaced the sterile cannula before cleaning the area around the stoma. During a concurrent interview and record review on 1/29/2026 at 9:20 a.m. with the Director of Nursing (DON), the DON reviewed the facility P&P regarding hand hygiene and trach care. The DON stated proper technique during trach care is very important because bad practices could introduce infections to residents. The DON stated sterile procedures are completed after clean procedures because everything has to be removed and cleaned per physician's orders with H2O2 before inserting the inner cannula during a sterile procedure. The DON stated this process prevents the growth of microorganisms at the stoma site from entering the airway. The DON stated double gloving during trach care is a bad practice and only protects the staff performing trach care and not the resident. The DON stated when RT 4 attempted to double glove and did not perform HH between glove changes, there was the potential for cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). The DON stated RT 4 did not demonstrate professional standards of practice for trach care and did not follow the facility P&Ps potentially leading to pneumonia and other respiratory infections resulting in hospitalization and death in the resident. During a review of the facility P&P titled, Hand Washing and Sanitizing, last reviewed 1/21/2025, the P&P indicated, Purpose: . The purpose of this policy and procedure is to minimize transmission of microorganisms in the healthcare setting. Compliance with this policy also provides a clean, healthy environment for patients and staff. Hand washing and the use of alcohol-based hand rub are the most effective techniques for preventing spread of infection. Hand washing or the use of alcohol-based hand rub should be done before and after resident contact, and between clean and dirty procedures. Hand washing or alcohol-based hand rub will be done at any time when hands are visibly soiled or contaminated. Hand washing will be done even when staff has donned gloves during a procedure. (Rationale: hands may become contaminated even with glove use and may transfer organisms to a fresh set of gloves). During a review of the facility P&P titled, Tracheostomy Care / Routine Daily Care / Inner Cannula Care, last reviewed 1/21/2025, the P&P indicated, Standard of Care: . Tracheostomies will be kept clean and the airway clear of mucus. Tracheostomy care will be done daily and PRN. Purpose. I. To maintain an adequate airway and to clear excessive secretion. 2. To prevent encrustation of the tracheostomy tube inner cannula (if used). 3. To prevent breakdown or irritation of the surrounding skin. 4. To maintain patency, placement, and security of the tracheostomy. Equipment Needed: . 1. NS . 2. Hydrogen peroxide. 3. Gauze. 6. Inner cannula if applies. 7. Plastic bag for waste. Procedure Steps: . 1. Remove old gauze and place in waste bag. 2. Remove trach tie. 3. Clean around stoma with NS and Hydrogen Peroxide moist gauze. 4. Clean around neck with NS moist gauze. 5. Pat dry neck and stoma with dry gauze. 6. Place new trach tie to secure trach tube. 7. Place new 4x4 around stoma. 8. If applies remove old inner cannula. 9. Change gloves to sterile and insert new inner cannula. 2. During a review of Resident 41's AR, the AR indicated Resident 41 was originally admitted in the facility on 5/25/2017, and readmitted in the facility on 6/17/2025, with diagnoses including respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy, and cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	caused by damage that occurs to the developing brain, most often before birth). During a review of Resident 41's History and Physical (H&P) dated 6/18/2025, the H&P indicated Resident 41 did not have the capacity to understand and make decisions. During a review of Resident 41's MDS dated [DATE], the MDS assessment indicated Resident 41 had severely impaired cognition (mental action or process of acquiring knowledge and understanding), required total assistance from staff with all activities of daily living (ADLs- routine tasks/activities. The MDS indicated Resident 41 required suctioning (mechanical removal of a patient's secretions with artificial airway such as tracheostomy). During a review of Resident 41's CP on impaired breathing due to risk respiratory failure initiated on 4/24/2025, and last revised on 11/4/2025, the CP indicated to suction secretions as necessary as one of the interventions to achieve Resident 41's airway patent at all times. During a concurrent observation and interview on 1/26/2026 at 9:46 a.m. inside Resident 41's room with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 41's SC was placed inside the plastic storage bag, not in the original packaging and did not indicate the date it was last changed. During a concurrent observation and interview on 1/26/2025 at 10:08 a.m. inside Resident 41's room with RT 2, RT 2 stated Resident 41's SC did not indicate the date it was last changed. RT 2 stated SC are supposed to be changed every week and as needed if soiled, placed inside a plastic storage bag, and should indicate the date it was last changed. RT 2 stated night shift RT assigned is supposed to change the SC. RT 2 stated Resident 41's SC should have indicated the date it was last changed so the staff would know that the SC was changed and clean as it placed Resident 41 at risk for getting infection from a contaminated or old SC. During an interview on 1/29/2026 at 7:58 a.m. with the RTM, the RTM stated the facility practice for SC changes is daily during the night shift and as needed if soiled and should indicate the date of when it was last changed. RTM stated Resident 41's SC should have indicated the date it was last changed so the staff would it was actually changed and it was clean. RTM stated the staff would not know if Resident 41's SC was contaminated which placed the resident at risk for acquiring infection. During a review of the facility's P&P titled, Respiratory Equipment Maintenance, last reviewed on 1/21/2025. The P&P indicated to maximize the prevention of infections and control communicable disease to patients and personnel associated with respiratory care equipment and procedures within patient care areas, suction canister and tubing are changed twice per week and as needed. During a review of the facility's P&P titled, Infection Control Program, last reviewed on 1/21/2025, the P&P indicated that the facility shall establish an infection control program designed to provide a safe, sanitary and comfortable environment for residents and staff to help prevent the development and transmission of disease and infection. 3. During a review of Resident 94's AR, the AR indicated Resident 94 was originally admitted in the facility on 5/2/2019 and readmitted in the facility on 6/9/2019, with diagnoses including respiratory failure, tracheostomy, and dependence on respirator status. During a review of Resident 94's H&P dated 10/3/2025, the H&P indicated Resident 94 did not have the capacity to understand and make decisions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 94's MDS dated [DATE], the MDS assessment indicated Resident 94 had severely impaired cognition (mental action or process of acquiring knowledge and understanding), required total assistance from staff with all activities of daily living (ADLs- routine tasks/activities. The MDS indicated Resident 94 required suctioning (mechanical removal of a patient's secretions with artificial airway such as tracheostomy). During a review of Resident 94's CP on excessive secretions initiated on 6/16/2025 and last revised on 11/5/2025, the CP indicated frequent visual monitoring and suction secretions as needed as one of the interventions to keep Resident 94 free from infection at all times. During an observation on 1/26/2026 at 10:15 a.m. inside Resident 94's room observed Resident 94's SC was placed inside the plastic storage bag, not in the original packaging and did not indicate the date it was last changed. During a concurrent observation and interview on 1/26/2025 at 10:09 a.m. inside Resident 94's room with RT 2, RT 2 stated Resident 94's SC did not indicate the date it was last changed. RT 2 stated SC are supposed to be changed every week and as needed if soiled, placed inside a plastic storage bag, and should indicate the date it was last changed. RT 2 stated night shift RT assigned is supposed to change the SC. RT 2 stated Resident 94's SC should have indicated the date it was last changed so the staff would know that the SC was changed and clean as it placed Resident 94 at risk for getting infection from a contaminated or old SC. During an interview on 1/29/2026 at 7:58 a.m. with the RTM, the RTM stated the facility practice for SC changes is daily during the night shift and as needed if soiled and should indicate the date of when it was last changed. RTM stated Resident 94's SC should have indicated the date it was last changed so the staff would it was actually changed and it was clean. RTM stated the staff would not know if Resident 94's SC was contaminated which placed the resident at risk for acquiring infection. During a review of the facility's P&P titled, Respiratory Equipment Maintenance, last reviewed on 1/21/2025. The P&P indicated to maximize the prevention of infections and control communicable disease to patients and personnel associated with respiratory care equipment and procedures within patient care areas, suction canister and tubing are changed twice per week and as needed. During a review of the facility's P&P titled, Infection Control Program, last reviewed on 1/21/2025, the P&P indicated that the facility shall establish an infection control program designed to provide a safe, sanitary and comfortable environment for residents and staff to help prevent the development and transmission of disease and infection. 4. During a review of Resident 13's AR, the AR indicated Resident 13 was originally admitted in the facility on 9/9/2025 and readmitted in the facility on 10/20/2025, with diagnoses including respiratory failure, tracheostomy, and dependence on respirator status. During a review of Resident 13's H&P dated 10/22/2025, the H&P indicated Resident 13 did not have the capacity to understand and make decisions. During a review of Resident 13's MDS dated [DATE], the MDS assessment indicated Resident 13 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs- routine tasks/activities. The MDS indicated Resident 13 required suctioning. (continued on next page)

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	01/29/2026

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 13's CP titled, The resident has a tracheostomy related to respiratory failure, initiated on 10/21/2025 and last revised on 1/19/2026, the CP indicated to suction secretions as needed as one of the interventions to keep Resident 13 free from signs and symptoms of infection. During an observation on 1/27/2026 at 8:50 a.m. inside Resident 13's room observed Resident 13's SC was placed inside the plastic storage bag and inside the opened original packaging but did not indicate the date it was last changed. During a concurrent observation and interview on 1/27/2025 at 8:54 a.m. inside Resident 13's room with RT 3, RT 3 stated Resident 13's SC did not indicate the date it was last changed. RT 3 stated SC are supposed to be changed every week and as needed if soiled, placed inside a plastic storage bag, and should indicate the date it was last changed. RT 3 stated night shift RT assigned change the SC and he ensures that the SC for his patients are changed during hand off report. RT 3 stated Resident 13's SC should have indicated the date it was last changed so the staff would know that the SC was changed and clean as it placed Resident 13 at risk for getting infection from a contaminated or old SC. During an interview on 1/29/2026 at 7:58 a.m. with the RTM, the RTM stated the facility practice for SC changes is daily during the night shift and as needed if soiled and should indicate the date of when it was last changed. RTM stated Resident 13's SC should have indicated the date it was last changed so the staff would it was actually changed and it was clean. RTM stated the staff would not know if Resident 13's SC was contaminated which placed the resident at risk for acquiring infection. During a review of the facility's P&P titled, Respiratory Equipment Maintenance, last reviewed on 1/21/2025. The P&P indicated to maximize the prevention of infections and control communicable disease to patients and personnel associated with respiratory care equipment and procedures within patient care areas, suction canister and tubing are changed twice per week and as needed. During a review of the facility's P&P titled, Infection Control Program, last reviewed on 1/21/2025, the P&P indicated that the facility shall establish an infection control program designed to provide a safe, sanitary and comfortable environment for residents and staff to help prevent the development and transmission of disease and infection. 5. During a review of Resident 57's admission Record (AR), the AR indicated the facility admitted the resident on 9/20/2011, and readmitted the resident on 5/27/2025, with diagnoses including hypercapnia (a condition where there is too much carbon dioxide (CO2) in the bloodstream), tracheostomy (a surgical procedure that creates a small opening in the front of the neck, leading directly into the windpipe (trachea)), and dependence on respirator status (means a person cannot breathe adequately on their own and requires a machine to push air into their lungs to sustain life). During a review of Resident 57's H&P dated 5/27/2025, the H&P indicated the resident was on a ventilator (a medical device to help support or replace breathing), nonverbal and did not follow commands at baseline. During a review of Resident 57's MDS dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a person has a serious loss of mental abilities—like thinking, remembering, and reasoning—that makes it impossible for them to live independently and manage basic daily tasks without complete dependence on others). The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person (continued on next page)

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	01/29/2026

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All Saints Healthcare Subacute	11810 Saticoy Street North Hollywood, CA 91605

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	performs daily). The MDS indicated the resident was on oxygen therapy (a medical treatment that provides extra oxygen to people who cannot get enough on their own from breathing normal air). During a review of Resident 57's Order Summary Report (OSR), dated 5/27/2025, the OSR indicated an order of: - Change HHN setup every Wednesday and if needed (PRN) every night shift every Wed. - Budesonide 0.5 microgram (mcg, a very small unit of weight used for measuring tiny amounts of substances like vitamins, minerals, and medications)/2 milliliters (ml, a unit of volume) susp 0.5 mg via trach two times a day for chronic lung disease. - Ipratropium bromide 0.02%-sol 250 mcg via trach two times a day for anti-secretory. During a review of Resident 57's Care Plan (CP) Report titled, The resident is ventilator dependent related to head injury, respiratory failure, last revised on 5/5/2025, the CP indicated a goal of the resident will be free from ventilator associated pneumonia ([NAME], a term used to describe pneumonia (lung infection) that develops in a patient who has been on mechanical ventilation for more than 48 hours) through the review date and an intervention to administer aerosol treatments using an in-line nebulizer. During a concurrent observation and interview on 1/26/2026, at 10:53 a.m., with Registered Nurse (RN) 3, inside Resident 57's room, observed Resident 57's HHN set up dated 10/6/2025 on the medication instillation barrel and on the plastic bag it indicated 1/3/2026. RN 3 stated the HHN set up should have been changed every Wednesdays and PRN. RN 3 stated the failure of the licensed staff to change the HHN set up per MD order predisposed the resident to [NAME]. During a concurrent interview and record review on 1/27/2026 at 9:35 a.m., with RN 2, reviewed Resident 57's Medical Diagnosis, OSR, and CP. RN 2 stated there was an order for Resident 57 to change HHN setup every Wednesday and PRN. RN 2 stated the staff should have changed the HHN set up per physician's order to prevent the resident from respiratory infections. During an interview on 1/29/2026, at 7:49 a.m., with the Manager of Pediatrics (MP), the MP stated the Respiratory Therapist (RT) is responsible for changing the HHN setup. The MP stated the failure of the RT to change the HHN set can lead to [NAME] on Resident 57. The MP also stated the licensed staff should also be checking for the dates of respiratory contraptions on the resident and report for overdue contraptions to be changed by RT. During an interview on 1/29/2026, at 8:37 a.m., with the Director of Nursing (DON), the DON stated the RT should have changed Resident 57's HHN setup as ordered by the physician. The DON stated that all licensed staff are also responsible to ensure that the respiratory contraptions attached to the residents are up to date. The DON stated the licensed staff should report to the RT the contraptions that needed to be changed to prevent respiratory infections to residents. During a review of the facility's recent policy and procedure (P&P) titled, Respiratory Equipment Maintenance, last reviewed on 1/21/2025, the P&P indicated to maximize the prevention of infections and control communicable diseases to patients and personnel associated with respiratory care equipment and procedures within patient care areas. Guidelines: 2. Equipment will be discarded in appropriate waste receptacles (standard vs. isolation) by RCP, Respiratory Care Aide and/or Nursing. a. For Pediatrics: i. Nebulizers, tubing, disposable masks, trach collars, nasal cannulas, adapters, and tubing is changed Q week and PRN. ii. Ventilator circuit tubing is changed Q month and PRN. iii. Suction Canister and tubing changed twice per week and PRN.

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	056407	A. Building B. Wing	01/29/2026

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assure that all nursing staff possess the competencies, and skill sets to safely provide nursing and related services to meet the resident's needs for two of five sampled staff, reviewed for sufficient and competent nurse staffing by failing to ensure: 1. Registered Nurse (RN) 1 was competent in documenting and monitoring for adverse effects (an unwanted, harmful, or unpleasant result of a medical treatment, drug, or other intervention) on the use of antibiotics (a medicine used to treat infections caused by bacteria) as prophylaxis (any action taken to prevent a disease or stop it from spreading). 2. RN 2 recognized the gastrostomy tube (g-tube, a soft tube placed through the skin and abdominal wall directly into the stomach, acting as a shortcut for delivering food, fluids, and medicine when someone cannot eat or drink enough by mouth) venting had back flowed with feeding formula during her shift. The deficient practices had the potential for unrecognized adverse effects on the use of antibiotics that can lead to antibiotic resistance (bacteria have changed and become superbugs that can fight off the medicines (antibiotics) designed to kill them, making infections harder or impossible to cure and posing a major health threat) for Residents 39 and 71 and development of gastric infection due to contaminated feeding formula administered via open system for Resident 71. Findings: 1. During a review of Resident 39's admission Record (AR), the AR indicated the facility admitted the resident on 12/3/2015, and readmitted the resident on 3/15/2023, with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), acute tracheitis (anˆinflammation and infection of the windpipe (trachea), usually caused by bacteria after a common viral cold or the flu), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 39's History and Physical (H&P), dated 1/27/2025, the H&P indicated the resident was delayed (a child who has not gained the developmental skills expected of him or her, compared to others of the same age), spastic (muscles that are stiff, tight, and hard to control, leading to jerky, involuntary movements or spasms, often due to brain or nerve damage) with upper extremity flexion contracture (a condition where a joint, like a knee or elbow, becomesˆstuck in a bent positionˆand cannot be fully straightened, either by the person themselves or with assistance), and non-verbal. During a review of Resident 39's Minimum Data Set (MDS, a resident assessment tool), dated 11/10/2025, the MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 39's Order Summary Report (OSR), dated 11/24/2025, the OSR indicated an order of Erythromycin Ethyl succinate Oral Suspension Reconstituted 200 milligrams (mg, a unit of weight)/5 milliliters (ml, a unit of volume) (Erythromycin Ethyl succinate). Give 70 mg via g-tube every six hours due to (d/t) delayed gastric emptying for six months. Give 70 mg via g-tube every six hours for gastric motility (the movement of the stomach muscles that helps to mix, grind, and move food through the digestive system). During a review of Resident 39's Care Plan (CP) Report titled, At risk for adverse effects due to long term use of antibiotic therapy, last revised on 8/12/2025, the P&P indicated an intervention to monitor for signs and symptoms (s/s) of side effects and adverse reactions to antibiotics and intervene appropriately. During a concurrent interview and record review on 1/27/2026, at 9:49 a.m., with RN 2, reviewed Resident 39's Medical Diagnosis, OSR, Progress Notes, and Nursing Assessments. RN 2 stated there was no order from the physician to monitor for adverse effects on the use of Erythromycin Ethyl succinate. RN 2 stated the Progress Notes and Nursing Assessments from 12/2025 to 1/2026 did not indicate specific monitoring for adverse effects on the use of the antibiotic. However, RN 2 stated documenting no change of (continued on next page)

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	01/29/2026

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	condition means that the adverse effects of all medications including the antibiotics were monitored for adverse effect already. RN 2 stated it is okay to be vague in documenting the monitoring for adverse effects of the antibiotics. RN 2 stated she (RN 2) learned her practice from the previous educator but cannot remember his/her name. RN 2 also stated she (RN 2) learned them from nursing school that documenting no change in condition as assessing and monitoring for adverse effects of antibiotics. During an interview on 1/28/2026, at 6:57 a.m., with RN 9, RN 9 stated when she (RN 9) administers antibiotics to residents, she (RN 2) makes sure that the indication is correct for the medication, there is an end date, and the monitoring for adverse effect is specified in the order. RN 9 stated they are supposed to document the antibiotic administered and document if the resident had tolerated the medication or had an adverse effect on the resident. RN 9 stated the licensed nurse who received the order should have clarified with the physician what adverse effects should the nurse be monitoring for Resident 39. RN 9 stated it was important to monitor for the adverse effect of administering antibiotics to resident and document specific reactions so the primary physician can intervene appropriately and to keep resident free from undue harm of the medication. During an interview on 1/28/2029, at 7:05 a.m., with the Manager of Pediatrics (MP), the MP stated when they have residents with antibiotic used as prophylaxis, they monitor for laboratory results and monitor for its adverse effects on the resident. The MP stated the licensed staff should have documented every shift on the progress notes or Nursing Assessment every shift to indicate what antibiotic is given and to monitor for resident's tolerance to the medication or if the resident had an adverse effect on the resident. The MP stated they were not asking the physicians what adverse effect to monitor on the use of the antibiotic, and he (MP) would have to start educating the staff and the physicians to indicate in their orders what specific adverse effects to report and watch for. The MP stated antibiotics are significant medications that needed to be monitored for adverse effects and should be documented every shift. The MP stated the failure of the licensed staff to monitor for specific adverse effect on the use of antibiotics increases the risk of antibiotic resistance on Resident 39. The MP stated the Adult/Pediatrics Subacute RN and Licensed Vocational Nurse (LVN) Annual Skills List includes medication administration; however, it does not cover specific antibiotic monitoring and documentation of adverse effects. During an interview on 1/29/2026, at 8:37 a.m., with the Director of Nursing (DON), the DON stated the staff should check if antibiotics were prescribed to residents if they have the proper indication, the correct duration, and to ensure the MD provided what adverse effects to monitor and report to ensure its safe use. The DON stated not monitoring for specific adverse effects of the antibiotics could lead to antibiotic resistance on Resident 39. During a concurrent interview and record review on 1/29/2026, at 9:29 a.m., with the Director of Staff Development (DSD), reviewed RN 2's Adult/Pediatrics Subacute RN and LVN Annual Skills List, dated 10/16/2025. The DSD stated RN 2's Adult/Pediatrics Subacute RN and LVN Annual Skills List did not indicate specific competency done for antibiotic administration and adverse effects monitoring. During an interview on 1/29/2026, at 12:17 p.m., with the Infection Preventionist (IP), the IP stated the licensed staff should monitor for the adverse effect of the antibiotic medication even though it is used as a prophylaxis and it needed to be documented in the narrative the specific antibiotic given and the adverse reaction observed or no reactions noted because they need the information during the interdisciplinary team meeting (IDT, is a group of healthcare professionals from various fields who work together to assess the resident's needs, develop a single, coordinated plan of care, and ensure all needs are being met). The antibiotic for prophylaxis is not a routine medication it has an end date of 60 days.ˆThe IP stated the staff should have monitored for specific adverse effects on the use of Erythromycin Ethyl Succinate on Resident 39 and document to prevent antibiotic resistance. During a review of the facility's recent policy and procedure (P&P) titled, Employee Performance and Skills Evaluation, last reviewed 1/21/2025, theˆP&PˆindicatedˆPurpose: .ˆThe purpose of this policy is to provide guidelines to perform employee performances and skills evaluation. Policy: Annual performance and skills evaluations will be done for all clinical employees. Procedures: . 1. All clinical (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	employees will receive annual skills and performance evaluations. 2. The evaluations will be done by the unit or department manager.ˆ4. Each EMPLOYEE PERFORMANCE AND SKILLS EVALUATION will be based on the individual employee's license and job description. 5. The Performance Evaluation form will include the following: . e. Job Performance. m. Job Knowledge. Safety.ˆ6. The Performance Evaluation will be used as a tool for employee development.ˆ During a review of the facility-provided, Job Duty Statement (JDS), for Registered Nurse/Licensed Vocational Nurse Adult and Pediatric Units, undated, the JDS indicated under Duties and Responsibilities: 9. Chart nurses' notes in an informative and descriptive manner that reflects the care provided, as well as the Resident's/patient's response to the care. During a review of the facility's recent P&P titled, Antibiotic Stewardship Program,ˆlast reviewed on 1/21/2025, the P&P indicated this policy, and procedure promotes reduction in unnecessary use of Antibiotics while optimizing pertinent infection treatment, which in turn will help reduce potential adverse reaction risk. During a review of the facility-provided Pharmacy Services Consultant (PSC) 1 Service Job Description, revised on 10/2018, indicated the pharmacist will present a quality assurance report and work with the I.D. (interdisciplinary) Team to identify medications that require special study based on (but not limited to): 6. Adverse drug reactions and medication errors. During a review of the facility-provided Erythromycin (Systemic) (Children's Hospital of LA) Information, undated, the Information indicated: Adverse Reactions Gastrointestinal: Abdominal pain, anorexia, diarrhea, nausea, vomiting Hypersensitivity: Hypersensitivity reaction (including anaphylaxis) Cardiovascular: Cardiac arrhythmia (including torsade's de pointes, ventricular arrhythmia, ventricular tachycardia), prolonged QT interval ECG 2. During a review of Resident 71's AR, the AR indicated the facility admitted the resident on 3/9/2017, and readmitted the resident on 3/21/2017, with diagnoses including acute upper respiratory tract infection (a short-term, contagious bug (usually a virus, like a cold or flu) that hits your nose, sinuses, and throat, causing classic symptoms like a runny nose, sore throat, sneezing, and cough, and typically resolves on its own with rest and fluids within a few days to a couple of weeks), gastrostomy, and otitis media (is a common medical term forˆan ear infection in the middle ear). During a review of Resident 71's H&P, dated 1/27/2025, the H&P indicated the resident was well nourished, no acute distress, and opens his eyes without tracking. The H&P also indicated the resident was non-verbal, with spasticity (a condition in which muscles become stiff, tight, or rigid, preventing normal, fluid movement), hypertonicity with (w/) clonus bilat (a person hasˆabnormally high muscle tension or stiffnessˆ(hypertonicity) accompanied byˆinvoluntary, rhythmic, and rapid muscle jerkingˆ(clonus) inˆboth sides of the bodyˆ(bilat). During a review of Resident 71's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a person has a serious loss of mental abilities-like thinking, remembering, and making decisions-so significant that they are unable to live an independent life and require substantial assistance with daily activities). The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 71's OSR, dated 11/24/2025, the OSR indicated an order for Metronidazole 18.7 milligrams (mg, a unit of weight)/milliliters (ml, a unit of volume) susp. Give 187 mg via g-tube every eight hours for ethylmalonic encephalopathy (a rare, severe, inherited metabolic disorder that causesˆbrain damage and affects multiple body systemsˆfrom a very young age) for six months. During a review of Resident 71's CP Report titled, At risk for adverse effects due to long term use of antibiotic therapy, initiated on 6/3/2025, the CP indicated an intervention to assess for s/s of adverse reactions and report to MD. During a concurrent interview and record review on 1/27/2026, at 9:49 a.m., with RN 2, reviewed Resident 71's Medical Diagnosis, OSR, Progress Notes, and Nursing Assessments. RN 2 stated there was no order from the physician to monitor for adverse effects on the use of Metronidazole. RN 2 stated the Progress Notes and Nursing Assessments from 12/2025 to 1/2026 did not indicate specific monitoring for adverse effects on the use of the antibiotic. However, RN 2 stated documenting no change of condition means that the adverse effects of all medications including the (continued on next page)

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	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antibiotics were monitored for adverse effect already. RN 2 stated it is okay to be vague in documenting the monitoring for adverse effects of the antibiotics. RN 2 stated she (RN 2) learned her practice from the previous educator but cannot remember his/her name. RN 2 also stated she (RN 2) learned them from nursing school that documenting no change in condition as assessing and monitoring for adverse effects of antibiotics. During an interview on 1/28/2026, at 6:57 a.m., with RN 9, RN 9 stated when she (RN 9) administers antibiotics to residents, she (RN 9) makes sure that the indication is correct for the medication, there is an end date, and the monitoring for adverse effect is specified in the order. RN 9 stated they are supposed to document the antibiotic administered and document if the resident had tolerated the medication or had an adverse effect on the resident. RN 9 stated the licensed nurse who received the order should have clarified with the physician what adverse effects should the nurse be monitoring for. RN 9 stated it was important to monitor for the adverse effect of administering antibiotics to Resident 71 and document specific reactions so the primary MD can intervene appropriately and to keep resident free from undue harm of the medication. During an interview on 1/28/2029, at 7:05 a.m., with the MP, the MP stated when they have residents with antibiotic used as prophylaxis, they monitor for laboratory results and monitor for its adverse effects on the resident. The MP stated the licensed staff should have documented every shift on the progress notes or Nursing Assessment every shift to indicate what antibiotic was given and to monitor for resident's tolerance to the medication or if the resident had an adverse effect on the resident. The MP stated they were not asking the physicians what adverse effect to monitor on the use of the antibiotic, and he (MP) would have to start educating the staff and the physicians to indicate in their orders what specific adverse effects to report and watch for. The MP stated antibiotics are significant medications that needed to be monitored for adverse effects and should be documented every shift. The MP stated the failure of the licensed staff to monitor for specific adverse effect on the use of antibiotics increases the risk of antibiotic resistance on Resident 71. The MP stated the Adult/Pediatrics Subacute RN and LVN Annual Skills List includes medication administration, however it does not cover specific antibiotic monitoring and documentation of adverse effects. During an interview on 1/29/2026, at 8:37 a.m., with the DON, the DON stated the staff should check if antibiotics were prescribed to residents if they have the proper indication, the correct duration, and to ensure the MD provided what adverse effects to monitor and report to ensure its safe use. The DON stated not monitoring for specific adverse effects of the antibiotics could lead to antibiotic resistance on Resident 71. During an interview and record review on 1/29/2026, at 9:29 a.m., with the DSD, reviewed RN 2's Adult/Pediatrics Subacute RN and LVN Annual Skills List, dated 10/16/2025. The DSD stated RN 2's Adult/Pediatrics Subacute RN and LVN Annual Skills List did not indicate specific competency done for antibiotic administration and adverse effects monitoring. During an interview on 1/29/2026, at 12:17 p.m., with the IP, the IP stated the licensed staff should monitor for adverse effect of the antibiotic medication even though it is used as a prophylaxis and it needed to be documented in the narrative the specific antibiotic given and the adverse reaction observed or no reactions noted because they need the information during IDT. The antibiotic for prophylaxis is not a routine medication it has an end date of 60 days.ˆThe IP stated the staff should have monitored for specific adverse effects on the use of Metronidazole on Resident 71 and document to prevent antibiotic resistance. During a review of the facility P&P titled, Employee Performance and Skills Evaluation, last reviewed 1/21/2025, theˆP&Pˆindicated, Purpose: .ˆThe purpose of this policy is to provide guidelines to perform employee performances and skills evaluation. Policy: Annual performance and skills evaluations will be done for all clinical employees. Procedures: . 1. All clinical employees will receive annual skills and performance evaluations. 2. The evaluations will be done by the unit or department manager.ˆ4. Each EMPLOYEE PERFORMANCE AND SKILLS EVALUATION will be based on the individual employee's license and job description. 5. The Performance Evaluation form will include the following: . e. Job Performance. m. Job Knowledge. Safety.ˆ6. The Performance Evaluation will be used as a tool for employee development.ˆ During a review of the facility-provided, (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Job Duty Statement (JDS), for Registered Nurse/Licensed Vocational Nurse Adult and Pediatric Units, undated, the JDS indicated under Duties and Responsibilities: 9. Chart nurses' notes in an informative and descriptive manner that reflects the care provided, as well as the Resident's/patient's response to the care. During a review of the facility's recent P&P titled, Antibiotic Stewardship Program,ˆlast reviewed on 1/21/2025, the P&P indicated this policy, and procedure promotes reduction in unnecessary use of Antibiotics while optimizing pertinent infection treatment, which in turn will help reduce potential adverse reaction risk. During a review of the facility-provided PSC 1 Service Job Description, revised on 10/2018, indicated the pharmacist will present a quality assurance report and work with the I.D. (interdisciplinary) Team to identify medications that require special study based on (but not limited to): 6. Adverse drug reactions and medication errors. During a review of the facility-provided Metronidazole (Flagyl, Likmez)- Uses, Side Effects, and More Information, dated 10/23/20214, the Information indicated while less common, the most serious side effects of metronidazole are described below, along with what to do if they happen. - Severe Allergic Reactions - Breathing problems or wheezing - Racing heart - Fever or general ill feeling - Swollen lymph nodes - Swelling of the face lips, mouth, tongue, or throat Etc 3. During a review of Resident 71's admission Record (AR), the AR indicated the facility admitted the resident on 3/9/2017, and readmitted the resident on 3/21/2017, with diagnoses including gastrostomy, abdominal hernia (when an internal body part, like fatty tissue or a piece of the intestine, pushes through a weak spot or a small hole in the strong muscle wall that's supposed to hold it in, creating a bulge, often in the belly or groin area, that can be painful when straining or lifting), constipation (a problem with passing stool). During a review of Resident 71's History and Physical (H&P), dated 1/27/2025, the H&P indicated the resident was well nourished, no acute distress, and opens his eyes without tracking. The H&P also indicated the resident was non-verbal, with spasticity, hypertonicity w/ clonus bilat. During a review of Resident 71's Minimum Data Set (MDS, a resident assessment tool), dated 11/30/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition. The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs). The MDS indicated the resident had a feeding tube. During a review of Resident 71's Order Summary Report (OSR), dated 3/31/2018, the OSR indicated an order may vent g-tube continuously every shift. During a review of Resident 71's Care Plan (CP) Report titled, Presence of NG/JT/g-tube. At risk for potential or actual: Infection related to aspiration and or g-tube/JT opening or stoma, initiated on 6/2/2025, the CP indicated a goal of resident will not have any irritation or infection on NGT/JT/g-tube site at all times and an intervention to render NGT/g-tube/JT care as ordered every shift and if needed (PRN). During an observation on 1/26/2026, at 10:05 a.m., observed Resident 71, with 60-cubic centimeters (cc, a basic unit for measuringˆvolume, essentially the space inside a tiny cube that's one centimeter long, one centimeter wide, and one centimeter high) syringe (a small tube with a plunger, like a tiny pump, used to push liquids in or pull liquids out of something, often a person's body for medicines or blood tests) hanging at the resident's head board without a plunger (the rod you push or pull to move liquid in or out of the syringe) open to air with 60-cc of formula. The syringe was labeled vent syringe with the resident's name and room number. During a concurrent observation and interview on 1/26/2026, at 10:14 a.m., with RN 1, inside Resident 71's room, observed Resident 71's vent syringe with 60-cc of formula without a plunger open to air, hanging at the resident's headboard. RN 1 stated the feeding should be on a closed system and leaving the syringe open to air can lead to gastric infection to the resident. RN 1 stated it was the night shift nurse who hang the syringe with the feeding formula open to air and she was not able to catch them on shift change. During a concurrent interview and record review on 1/27/2026, at 9:58 a.m., with RN 2, reviewed Resident 71's Medical Diagnoses, OSR, and CP. RN 2 stated there was an order for may vent g-tube continuously every shift. RN 2 stated the 60-cc syringe hanging at the headboard of the resident with feeding formula is meant for g-tube venting. RN 2 stated the presence of feeding formula on the 60-cc syringe open to air can result to GI (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection when introduced to the g-tube of the resident. RN 2 stated RN 1 should have ensured there were no backflow of feeding formula on the 60-cc syringe to prevent infection to set in on the resident. RN 2 stated the purpose of g-tube venting is to release the gas from the gut of the resident and not for feeding. During an interview on 1/29/2026, at 7:49 a.m., with the MP, the MP stated RN 1 should have caught the issue on change of shift report with another licensed nurse. The MP stated the purpose of the manual g-tube venting was to decompress the gut with air not for feeding. RN 1 stated the failure of RN 1 to ensure there were no feeding formula that back flowed to the 60-cc syringe can lead to gastric infection when introduced to the stomach. The MP stated the formula back flowed to the syringe probably due to incorrect clamping on the Y connection site (Y-port for feeding is a small, Y-shaped access point on a feeding tube or the attached tubing that allows for a second connection without interrupting the main flow of nutrition). The MP stated that the Adult/Pediatrics Subacute RN and LVN Annual Skills List had g-tube, but it does not discuss in full details the process for gastric venting. The MP also stated he does not have any lesson plan to show regarding what topics was discussed during the Adult/Pediatrics Subacute RN and LVN Annual Skills List on g-tube. During an interview on 1/29/2026, at 8:37 a.m., with the DON, the DON stated the 60-cc syringe that was hanging on Resident 71's headboard was for manual g-tube venting and was not intended for feeding. The DON stated the failure of the staff to intervene during shift change when a 60-cc syringe for g-tube venting had a feeding formula that back flow to the 60-cc syringe can cause infection to the resident as the formula was open to air and exposed to environmental contaminants. During a concurrent interview and record review on 1/29/2026, at 9:45 a.m., with the DSD, reviewed RN 1's Adult/Pediatrics Subacute RN and LVN Annual Skills Checklist, dated 10/16/2025. The DSD stated there was no specific training or in-service offered regarding gastric venting, the staff learns them on the floor. During a review of the facility P&P titled, Employee Performance and Skills Evaluation, last reviewed 1/21/2025, theˆP&Pˆindicated, Purpose: .ˆThe purpose of this policy is to provide guidelines to perform employee performances and skills evaluation. Policy: Annual performance and skills evaluations will be done for all clinical employees. Procedures: . 1. All clinical employees will receive annual skills and performance evaluations. 2. The evaluations will be done by the unit or department manager.ˆ4. Each EMPLOYEE PERFORMANCE AND SKILLS EVALUATION will be based on the individual employee's license and job description. 5. The Performance Evaluation form will include the following: . e. Job Performance. m. Job Knowledge. Safety.ˆ6. The Performance Evaluation will be used as a tool for employee development.ˆ During a review of the facility-provided, Job Duty Statement (JDS), for Registered Nurse/Licensed Vocational Nurse Adult and Pediatric Units, undated, the JDS indicated under Duties and Responsibilities: 14. Administer professional service such as: .tube feedings. 16. Assure that established infection control and aseptic techniques are followed as per facility policies. During a review of the facility's recent P&P titled, Gastrostomy Tube Venting, last reviewed on 1/21/2025, the P&P indicated the purpose of this policy is to provide a guideline on the venting of gastrostomy tubes (GT) to alleviate abdominal distention and bloating in tube feeding residents. Bolus feeding with venting: 2. Once the bolus feeding is completed, clamp GT (see Physician's orders for duration of clamping) to allow feeding and medications to absorb. During a review of the facility's recent P&P titled, Infection Control Program, last reviewed on 1/21/2025, the P&P indicated the facility shall establish an infection control program designed to provide a safe, sanitary and comfortable environment for Residents and staff to help prevent the development and transmission of disease and infection.ˆ

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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. Based on observation, interview, and record review the facility failed to: 1. Reconcile (the process of comparing transactions and activity to supporting documentation) one (1) medication emergency kit ([eKIT] - kit containing medications needed to be used during emergencies) containing narcotics (medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as Controlled Medication [CM] or Controlled Drug [CD]) for January 2026, in one (1) of two (2) inspected medication storage areas (Medication storage Nursing Station 1.) 2. Include the verifying signatures of either the Director of Nursing (DON) or a Registered Nurse (RN) along with Licensed Vocational Nurse (LVN) on the Controlled Drug Record accountability logs for two (2) of two (2) narcotics awaiting disposal (removal, destroying) in the CD locked cabinet. As a result, control and accountability of CDs, and medications awaiting final disposition (process of returning and/or destroying unused medications) did not follow state and federal regulations and facility policy and procedures. These deficient practices increased the opportunity for CD diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) and increased the risk that residents in the facility could have accidental exposure to harmful medications possibly leading to physical and psychosocial harm, and hospitalization. Findings: During an observation and concurrent interview on 1/26/2026 at 12:21 p.m., with Registered Nurse (RN) 10, in Medication storage Nursing Station 1 there was: 1. One (1) medication eKIT stored in the refrigerator and labeled 13503 containing narcotics without an accountability log for the reconciliation of narcotic inventory at every shift change for January 2026.ˆ During a concurrent interview, RN 10 stated that all narcotics, including medication eKITs containing narcotics should be reconciled at every shift. RN 10 stated the eKIT labeled 13503 containing narcotics in Medication storage Nursing Station 1 was not reconciled at every shift in January 2026, and it was important to account for all narcotics to ensure accountability and prevent narcotic diversion.ˆˆ During an observation and record review in the Director of Nursing (DON) office, on 1/26/2025 at 2 p.m., in the presence of the DON, there were two (2) Controlled Drug Record accountability logs for narcotics awaiting final disposition/destruction in a locked cabinet without containing verifying signatures of either the DON or an RNˆalong with a Licensed Vocational Nurseˆ(LVN). During a concurrent interview, the DON acknowledged the two (2) Controlled Drug Record accountability logs for narcotics awaiting final disposition did not contain verifying signatures.ˆ The DON stated the DON was unable to locate the verifying signatures of RN/DON and LVN.ˆ The DON stated the DON and the LVNs failed to sign theˆaccountability logs upon receipt of the narcotics from the LVNs.ˆ The DON stated the DON counts the narcotics with the LVN upon receipt of the accountability log; however, they overlooked to sign and date the two (2) logs.ˆ The DON stated the DON understood the importance of narcotic accountability to ensure each narcotic dose was accounted for until disposed.ˆ The DON stated it was important to verify and sign these logs to prevent narcotic diversions and accidental exposure of harmful substances to residents.ˆˆˆ During an interview on 1/28/2026 at 11 a.m., with the DON, the DON stated that medication eKITs containing narcotics needed to be counted and reconciled at every shift change to ensure accountability and prevent narcotic diversion.ˆ The DON stated the eKIT labeled 13503 containing narcotics in Medication storage Nursing Station 1 was not reconciled at every shift in January 2026. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKits containing narcotics. During a review of the Policy and Procedures (P&P,) titled Narcotics, last reviewed 1/21/2025, the P&P indicated the purpose of the policy: To ensure narcotics are accurately accounted for and administered safely. 1. A licensed nurse will perform all change of shift narcotic counts with another licensed nurse (RN or LVN.) During a review of the P&P titled Disposal of Narcotics, last reviewed 1/21/2025, the P&P indicated: For controlled medications submitted to the DON or appointed designee to store pending destruction with (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pharmacist and DON, a separate log is recommended to be used for the accountability and auditing purposes. During a review of the log titled Narcotic Disposal log, last revised October 2018, the log indicated a column for DON and Licensed Nurse signatures.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure that resident's drug regimen was free from unnecessary drugs (medication that is not needed for the current medical condition) for one (1) of two (2) sampled residents (Resident 97) reviewed for anticoagulant use by failing to monitor the resident for signs and symptoms of bleeding for the use of Eliquis (also known as apixaban, an AC used to treat and prevent blood clots). This deficient practice had the potential for Resident 97 to receive suboptimal (less than the highest standard or quality) care leading to the use of unnecessary medications causing potential side effects and negatively impacting their physical, mental, and psychosocial well-being. Cross-reference F656.Findings: During a review of Resident 97's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted the resident on 4/30/2025, and readmitted in the facility on 6/16/2025, with diagnoses including gastrostomy (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (HTN-high blood pressure). During a review of Resident 97's History and Physical (H&P) dated 6/18/2025, the H&P indicated Resident 97 did not have the capacity to understand and make decisions. During a review of Resident 97's Minimum Data Set (MDS, a resident assessment tool), dated 11/5/2025, the MDS indicated Resident 97 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make his needs known. The MDS further indicated Resident 97 required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 97 received anticoagulant. During a review of Resident 97's Order Summary Report dated 1/29/2026, the Order Summary Report indicated a physician's order dated 7/5/2025 for Eliquis oral tablet 2.5 milligrams (mg - a unit of measurement) give 2.5 mg via GT every 12 hours for deep vein thrombosis (DVT - a blood clot that forms in the veins located deep within a limb, usually the lower leg or thigh) prophylaxis (a measure taken to maintain health and prevent the spread of disease). The Order Summary Report did not indicate a monitoring for signs and symptoms of bleeding for the use of Eliquis. During a review of Resident 97's care plan (CP) titled, Potential for injury or bleeding, initiated on 12/10/2025, the CP did not indicate monitoring for signs and symptoms of bleeding as one of the interventions for the use of Eliquis. During a concurrent interview and record review on 1/27/2026 at 2:25 p.m., Resident 97's physician's orders, CP, and medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 11/2025, 12/2025, and 1/2026 were reviewed with Registered Nurse (RN) 7. RN 7 stated that Resident 97 had a physician's order for Eliquis but there was no physician's order to monitor Resident 97 for signs and symptoms of bleeding. RN 7 stated that monitoring for signs and symptoms of bleeding is every shift and documented in the MAR. RN 7 stated that the MAR did not contain documentation for monitoring for signs and symptoms of bleeding and bruising with the use of Eliquis. RN 7 stated a CP was initiated on 12/10/2025 but did not indicate monitoring signs and symptoms of bleeding as one of the interventions for the use of Eliquis. RN 7 stated there should have been a physician's order to monitor Resident 97 for signs and symptoms of bleeding for the use of Eliquis so the nurses would check the resident for any signs of bleeding and report to the physician immediately. RN 7 stated if Resident 97 was not monitored routinely for signs and symptoms of bleeding, Resident 97 could have signs of bleeding not seen by staff, delaying notification of the physician, leading to a delay in the necessary care the resident need. During a concurrent interview and record review on 1/28/2026 at 3:39 p.m. Resident 97's physician's orders, CP, and MAR for 11/2025, 12/2025, and 1/2026 were reviewed with the MDS Coordinator (MDSC). The MDSC had a physician's order for Eliquis but there was no order to monitor Resident 97 for signs and symptoms of bleeding every shift. The MDSC stated that monitoring for (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	signs and symptoms of bleeding is done by the nurses every shift and documented in the MAR and notify the physician right away if there are signs present. The MDSC stated that there should have been a physician's order to monitor Resident 97 for signs and symptoms of bleeding. The MDSC stated if there was no monitoring for signs and symptoms of bleeding in place for the use of Eliquis for Resident 97, there is no way for the nurses to notice any symptoms which can delay notification of the physician and placed Resident 97 at risk for a delay in receiving the care needed. During a review of the facility's policy and procedure (P&P) titled, Monitoring of Anticoagulant Therapy, last reviewed on 1/21/2025, the P&P indicated that patients receiving anticoagulation therapy should be assessed for bruising, swelling, and/or redness every shift and as needed. The P&P further indicated that the physician should be notified immediately for any abnormalities. During a review of the facility's P&P titled, Anticoagulant Therapy, last reviewed on 1/21/2025, the P&P indicated that patients shall be assessed for signs and symptoms of adverse effects including unusual bruising or bleeding, hematuria (blood in the urine), bleeding gums, sudden headache, dizziness, or weakness, shortness of breath or chest pain, and swelling at the injection site.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%.) Three (3) medication errors out of 30 total opportunities contributed to an overall medication error rate of 10% affecting one (1) of two (2) residents observed for medication administration (Resident 61.) The medication errors were as follows: 1. Licensed Vocational Nurse (LVN) 5 failed to wait at least five (5) minutes in between administration of brimonidine tartrate (a medication used for glaucoma [a condition of increased pressure in the eyeball,]) dorzolamide hydrochloride (a medication used for glaucoma,) and refresh tears (a medication used to moisturize dry eyes) ophthalmic (eye) drops to Resident 61. These failures had the potential to result in Resident 61 not absorbing the full medication dose resulting in Residents 61's health and well-being to be negatively impacted. Findings: During an observation on 1/26/2026 at 10 a.m., in Medication Cart 9, LVN 5 was observed administering brimonidine one (1) drop to both eyes, immediately followed by administering dorzolamide one (1) drop to left eye, immediately followed by administering refresh tears to both eyes to Resident 61. During an interview on 1/26/2026 at 10:15 a.m., with LVN 5, LVN 5 acknowledged LVN 5 administered brimonidine one (1) drop to both eyes, immediately followed by administering dorzolamide one (1) drop to the left eye, immediately followed by administering refresh tears to both eyes to Resident 61, during the morning medication administration that day (1/26/2026) at 10 a.m. LVN 5 stated according to the directions on the brimonidine ophthalmic prescription label, the label indicated to wait three (3) to five (5) minutes between drops to same eye. LVN 5 stated the reason for waiting three (3) to five (5) minutes between drops to same eye was to ensure each drop of medication had enough time to be fully absorbed before another drop was administered, that could flush out both drops. LVN 5 stated LVN 5 failed to wait three (3) to five (5) minutes between administering brimonidine, dorzolamide and refresh tears to Resident 61 likely flushing out each drop and not allowing full absorption of each medication potentially worsening Resident 61's glaucoma and dry eyes. LVN 5 stated these were considered medication administration errors. During an interview on 1/28/2026 at 11 a.m., with the Director of Nursing (DON,) the DON stated according to manufacturer guidelines and facility policy and procedures (P&P,) when administering eye drops there needs to be a three (3) to five (5) minutes lapse between administrations of more than one (1) drop or more than one (1) medication to each eye to allow the medication to be fully absorbed and not flushed out. The DON stated LVN 5 failed to wait three (3) to five (5) minutes between administration of brimonidine, dorzolamide and refresh tear eye drops to Resident 61 on 1/26/2026 at 10 a.m. The DON stated these were considered medication administration errors. During a review of Resident 61's admission Record (a document containing demographic and diagnostic information,) dated 1/28/2026, the record indicated that Resident 61 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including hypertension (high blood pressure.) During a review of Resident 61's Medication Administration Record ([MAR] - a record of mediations administered to residents), for January 2026, the MAR indicated Resident 61 was prescribed: 1. brimonidine tartrate one (1) drop in both eyes three (3) times a day for Glaucoma, to be administered at 9 a.m., 1 p.m. and 5 p.m. 2. dorzolamide one (1) drop in left eye three (3) times a day for Glaucoma, to be administered at 9 a.m., 1 p.m. and 5 p.m. 23. refresh tears one (1) drop in both eyes two (2) times a day for dry eyes, to be administered at 9 a.m. and 5 p.m. During a review of the facility's P&P titled Medication Error Policy and Record Completion, last reviewed 1/21/2025, the P&P indicated that A Medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm or no harm while the medication is in control of the health care professional. During a review of the facility's P&P, titled Medication Administration Techniques, last reviewed 1/21/2025, the P&P indicated: 6. Observe 10 Medication Rights: 5. Right Time 4. Verify direction on the Med Sheet with the directions on the prescription label. (continued on next page)

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	01/29/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P, titled Eye Medication Administration, last reviewed 1/21/2025, the P&P indicated: 8. Wait 3-5 minutes between more than 1 drop or more than one medication. This will allow the medication time to be absorbed. During a review of manufacturer's guidelines titled Highlights of Prescribing Information for brimonidine tartrate, last revised May 2025, the document indicated: Brimonidine tartrate ophthalmic solution may be used concomitantly with other topical ophthalmic drug products to lower intraocular pressure. If more than one topical ophthalmic product is to be used, the different products should be instilled at least 5 minutes apart. During a review of manufacturer's guidelines titled Highlights of Prescribing Information for dorzolamide hydrochloride, last revised December 2024, the document indicated: Dorzolamide hydrochloride ophthalmic solution may be used concomitantly with other topical ophthalmic drug products to lower intraocular Sections or subsections omitted from the full prescribing information are not listed. pressure. If more than one topical ophthalmic drug is being used, the drugs should be administered at least five minutes apart.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (meaning the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for one (1) of one (1) sampled resident (Resident 6) reviewed for anticoagulant (a substance that is used to prevent and treat blood clots in blood vessels and the heart) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) heparin (an anticoagulant) administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of heparin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (a condition in which clumps of abnormal proteins called amyloids build up in the skin). Findings: During a review of Resident 6's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted the resident on 1/21/2025, and readmitted in the facility on 5/31/2025, with diagnoses including dependence on respirator (also known as ventilator - a machine used to help a person breath when they are unable to do so on their own) status , tracheostomy (an opening a surgeon makes through the neck and into the trachea [also known as windpipe] to help a patient breathe), and type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 6's History and Physical (H&P) dated 5/31/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 10/29/2025, the MDS indicated Resident 6 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make his needs known. The MDS further indicated Resident 6 had impairment of both upper and lower extremities and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 6's Order Summary Report dated 1/29/2026, the Order Summary Report indicated a physician's order dated 5/31/2025 for: - Heparin sodium injection solution 5000 unit per milliliter (unit/ml - a unit of measurement) inject one ml subcutaneously every 12 hours for deep vein thrombosis (DVT - a blood clot that forms in the veins located deep within a limb, usually the lower leg or thigh) prophylaxis (a measure taken to maintain health and prevent the spread of disease). During a review of Resident 6's Location of Administration Report for heparin sodium for the months of 12/2025 and 1/2026, the Location of Administration Report indicated the heparin sodium was administered on the following dates, times, and sites: - 12/09/25 9 p.m. 12/09/25 8:45 p.m. subcutaneously abdomen - right lower quadrant (RLQ) - 12/10/25 9:00 a.m.12/10/25 8:53 a.m. subcutaneously abdomen - RLQ - 1/22/26 9:00 p.m. 1/22/26 9:51 p.m. subcutaneously abdomen - left lower quadrant (LLQ) - 1/23/26 9:00 a.m. 1/23/26 9:38 a.m. subcutaneously abdomen - LLQ - 1/24/26 9:00 p.m. 1/24/26 8:21 p.m. subcutaneously arm - left - 01/25/26 9:00 a.m.1/25/26 8:09 a.m. subcutaneously arm - left During a concurrent interview and record review on 1/27/2026 at 4:47 p.m., Resident 6's physician's order, medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), and Location of Administration Reports for 12/2025 and 1/2026 were reviewed with Registered Nurse (RN) 7. RN 7 stated there were multiple instances the licensed nurses did not rotate the subcutaneous injection sites of heparin on 12/9/2026, 12/10/2026, 1/22/2026, 1/23/2026, 1/24/2026, and 1/25/2026. RN 7 stated administration sites for subcutaneous injection should be rotated per standards of practice and according to the manufacturer's guideline to prevent excessive bruising and lipodystrophy on the injection site. During an interview on 1/28/2026 at 3 p.m. with the Director of Nursing (DON), the DON (continued on next page)

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	01/29/2026

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she was made aware of multiple instances of not rotating the subcutaneous injection sites for heparin for Resident 6. The DON stated the staff are able to see in the MAR the previous administration sites for the heparin and are supposed to rotate according to professional standards of practice and the manufacturer's guideline. The DON stated there should be no reason for the licensed staff to repeat the administration sites for all subcutaneous injections, not just heparin. The DON stated Resident 6's injection site for heparin should have been rotated as it can place Resident 6 at risk for discomfort or irritation at the injection site, excessive bruising, or lipodystrophy which can affect the absorption of the medication. The DON stated that not following the professional standards of practice and manufacturer's guideline to rotate heparin injection sites can be considered a medication error. During a review of the facility provided Highlights of Prescribing Information on the use of heparin sodium injection, last revised on 9/2019, the Highlights of Prescribing Information indicated that a few of the adverse reactions for heparin included but not limited to hemorrhage (any type of internal or external loss of blood from a damaged blood vessel [tubes that carry blood throughout the body]), and injection site irritation. The Highlights of Prescribing Information further indicated that for therapeutic anticoagulant effect a different site should be used for each injection to prevent the development of massive hematoma (a localized collection of blood outside of blood vessels and should be administered as a deep subcutaneous injection. During a review of the facility's policy and procedure (P&P) titled, Subcutaneous Medication Administration, last reviewed on 1/21/2025, the P&P indicated a purpose to ensure safe and effective administration of medications via the subcutaneous route, reducing the risk of infection, and tissue injury. The P&P further indicated: - Site Selection: approved sites include abdomen, upper outer arms, rotate injection sites to prevent tissue damage, avoid areas with bruising, scars, inflammation, edema or infection. - Post administration: observe the patient for adverse reactions. - Documentation: document medication name, dose, route, time, and site of administration; note site rotation as required. During a review of the facility's P&P titled, Adverse Drug Reactions, last reviewed on 1/21/2025, the P&P indicated that the purpose of the policy is to establish written standards for monitoring, reporting, and analyzing real or potential adverse drug reactions. The P&P further indicated an adverse drug reaction is defined as any unexpected, unintended, undesired, or excessive response to a drug that results in temporary or permanent harm, disability, or death. During a review of the facility's P&P titled, Medication Error Policy and Record Completion, last reviewed on 1/21/2025, the P&P indicated a medication error is any preventable event that may cause or [NAME] to inappropriate medication use or patient harm or no harm while the medication is in the control of the healthcare professional.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to store medications in accordance with manufacturer specifications, professional principles and facility policy and procedures by failing to: 1. Monitor and record medication storage area room temperature on a temperature monitoring log for January 2026, for one (1) of two (2) inspected medication storage areas (Medication storage Nursing Station 1.) 2. Label and store one (1) levalbuterol (a generic name for medication used to treat and prevent shortness of breath) inhalation solution foil pouch (a package made of foil protecting the inhalation solution from light and degradation) for Resident 79 at room temperature in accordance with the manufacturer's requirements in one (1) of ten (10) inspected Medication Carts (Medication Cart room [ROOM NUMBER].) 3. Ensure nasal sprays were stored separately from orally administered medications, in one (1) of ten (10) inspected Medication Carts (Medication Cart 3.) 4. Ensure eye drops and nasal sprays were stored separately from orally administered medications, in one (1) of ten (10) inspected Medication Carts (Medication Cart 2.) ^ These deficient practices increased the risk for Resident 79 and others to receive medication that had become ineffective or toxic due to improper storage or labeling and increase the risk of contamination and receiving medications via the wrong route (internal versus external routes,) possibly leading to adverse health consequences resulting in in the negative impact to their health and well-being, hospitalization or death. Findings: During an observation and concurrent interview on 1/26/2026 at 12:21 p.m., with Registered Nurse (RN) 10, the medication storage cabinets in Nursing Station 1 contained medication bottles for facility stock and residents. The room temperature monitoring log for the storage of medications in Nursing Station 1 for January 2026 was not available. RN 10 stated the room temperature log for the storage of medications in Nursing Station 1 for January 2026 was not available, and without a log containing documentation for room temperatures, it was implied that the room temperature for medication storage area in Nursing Station 1 was not monitored. RN 10 stated the room temperature should be monitored and documented every day during all shifts to ensure medications are properly maintained at an acceptable temperature range, and their potency (the strength of medication required to produce an effect) not affected. RN 10 stated if the room temperature was not monitored it was unknown if the temperatures were maintained within the acceptable range and if the medications were affected negatively. RN 10 stated using improperly stored medications can harm the residents and not help in treating their condition. During an observation on 1/27/2026 at 10:27 a.m., in Medication Cart room [ROOM NUMBER] with Licensed Vocational Nurse (LVN) 7, the following medication was found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: 1. One (1) open levalbuterol inhalation solution foil pouch containing several unused solutions/vials for Resident 79, was found stored at room temperature and not labeled with a date indicating when the foil pouch was opened. According to the manufacturer's product storage and labeling, opened foil pouch of levalbuterol inhalation solutions should be stored between 68 to 77 degrees Fahrenheit and once the foil pouch is opened to be used within two (2) weeks. During a concurrent interview, LVN 7 stated the levalbuterol inhalation solution foil pouch for Resident 79 in Medication Cart room [ROOM NUMBER] was not labeled with a date indicating when the foil pouch was opened. LVN 7 stated that per facility policy multi-dose (containing more than one dose) products such as inhalation solutions should be labeled with the date when first opened to know when they expire. LVN 7 stated that expired medications have lost potency and will not be effective in treating residents' condition. LVN 7 stated according to the manufacturer guidelines, the inhalation solutions should be used within two (2) weeks of opening the pouch. LVN 7 stated failing to record the date of (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	first use could lead to Resident 79 receiving potentially expired and ineffective levalbuterol. LVN 7 stated this could cause Resident 79 harm by not treating or preventing the shortness of breath, making breathing more difficult, requiring immediate treatment and potential hospitalization. During an observation on 1/27/2026 at 11:05 a.m., in Medication Cart 3, with RN 11, the following medications were stored in a manner contrary to the facility's P&P: 1. One (1) fluticasone (a medication used for allergies) nasal spray, and one (1) azelastine (a medication used for allergies) nasal spray was stored with one (1) melatonin (a medication used to regulate sleep cycles) oral tablet bottle, in the same bin/compartment of the medication cart. During a concurrent interview, RN 11 stated that internally administered medications, such as oral tablets, and externally administered medications, such as nasal sprays, should be stored separately in their own sections/bins and not together, to prevent errors in wrong route administration and possible infections/contaminations. RN 11 acknowledged one (1) medication bin contained one (1) fluticasone nasal spray, one (1) azelastine nasal spray and one (1) melatonin oral tablet bottle. RN 11 stated the facility failed not to separate and store fluticasone and azelastine nasal sprays from melatonin oral tablets. During an observation on 1/27/2026 at 11:45 a.m., in Medication Cart 2, with LVN 8, the following medications were stored in a manner contrary to the facility's P&P: 1. One (1) fluticasone (a medication used for allergies) nasal spray, and one (1) refresh tears (a medication used for dry eyes) eye drop was stored with one (1) Tylenol (a medication used for fever and/or pain) oral tablet bottle, in the same bin of the medication cart. During a concurrent interview, LVN 8 stated that nasal sprays and eye drops should be stored separately from oral medications, to prevent errors in wrong route administration and possible infections/contaminations. LVN 8 acknowledged one (1) medication bin contained one (1) fluticasone nasal spray, one (1) refresh tears eye drops and one (1) Tylenol oral tablet bottle. LVN 8 stated the facility failed not to separate and store nasal spray and eye drops from oral tablets. During an interview, on 1/28/2026 at 11 a.m., with the Director of Nursing (DON,) the DON stated that the temperature of medication storage areas should be monitored and documented twice daily. The DON stated not knowing the temperature of the medication storage areas from lack of monitoring, may result in medications being stored in unacceptable temperature ranges and lose efficacy, and when used they will not be effective in treating the residents' conditions. The DON acknowledged that the medication storage area in Nursing Station 1 contained several medication bottles for facility stock and residents and did not have a temperature monitoring log for January 2026. During the same interview the DON stated that breathing inhalation solutions stored in foil pouches should be labeled with a date when removed from pouch to know when the solutions expire, otherwise would be unable to determine the expiration date. The DON stated levalbuterol inhalation solutions expire within two (2) weeks of opening the foil pouch. The DON stated that expired inhalation solutions have lost effectiveness and when administered in error will not treat the shortness of breath further causing respiratory (related to breathing) distress (discomfort) and stoppage of breathing for Resident 79 requiring immediate treatment and hospitalization. The DON stated the facility failed to label the levalbuterol inhalation solution pouch with the date when first opened for Resident 79. During the same interview the DON stated internally (such as oral) and externally (such as eyes, ears, nose, skin) administered medications should be stored separately to prevent wrong route administration, infections and contaminations. The DON stated the facility failed to store nasal sprays in Medication Cart 3 separate from oral medications and failed to store nasal and eye drops in Medication Cart 2 separate from oral medications. During a review of facility's Policy and Procedures (P&P) titled, Multiple-Use Medications, last reviewed on 1/21/2025, the P&P indicated that Multiple-Use medications maybe used for individual patients only and must be handled in a manner that prevents contamination, medication errors, and infection transmission. 1. LABELING a. All multiple-use medications must be labeled with iii. Date opened b. Unlabeled medications must be discarded immediately. 2. STORAGE a. Medications must be stored according to manufacturer recommendations. During a review of facility's P&P titled, Medication Storage for Internal and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	External Medications, last reviewed on 1/21/2025, the P&P indicated To prevent cross contamination by ensuring that medications intended for external use are stored separately from medications intended for internal use. All medications intended for external use will be stored separately from medications intended for internal use at all times to minimize the risk of medication errors. Definitions: Internal Medications: Medications intended for administration inside the body, including oral, sublingual, injectable, inhaled, rectal, and vaginal medications. External Medications: Medications intended for external use only, including topical creams, ointments, lotions, patches, eye drops, ear drops, nasal sprays, and medicated shampoos. Procedures: Medication carts must have separate compartments for internal and external medications. During a review of facility's P&P titled, Temperature of Medications, last reviewed on 1/21/2025, the P&P indicated Drugs shall be stored in appropriate temperatures. A. Drugs required to be stored at room temperature shall be stored at a temperature between 59 degrees Fahrenheit (F) and 86 degrees F. 1)Recommend a temperature log for daily documentation, saving records for a minimum of 1 year. During a review of facility's P&P titled, Medication Room Temperature and Monitoring, last reviewed on 1/21/2025, the P&P indicated Room temperature shall be monitored and documented at least twice daily. Temperature readings shall be recorded on a designated Medication room Temperature Log. During a review of facility's P&P titled, Expiration Dates after Opening, last reviewed on 1/21/2025, the P&P indicated: Xopenex (brand name for levalbuterol) foil pouch inhalation solution - expiration 14 days at room temperature. a. Be sure to document Date when opened on . multi-dose medications with a shortened shelf life once seal is broken. During a review of manufacturer's guide Highlights of Prescribing Information for levalbuterol inhalation dated July 2019, the guide indicated ?Store Levalbuterol Inhalation Solution, USP in the protective foil pouch at 20 - 25 C (68 - 77 F). Protect from light and excessive heat. Keep unopened vials in the foil pouch. Once the foil pouch is opened, the vials should be used within 2 weeks.

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	056407	A. Building B. Wing	01/29/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure to store, prepare, and serve food in accordance with professional standards for food service safety for 19 out of 109 residents by failing to ensure: 1. The facility discarded the bag of deli bread and an unopened bag of deli hot dog buns with the best by date of 1/20/2026. 2. The facility did not hang a spoodle (is a hybrid kitchen utensil that combines the features of aˆspoonˆand aˆladle) with butter residues on the clean rack near the steam table. These deficient practices had the potential to cause food-borne illnesses. Findings: During a concurrent observation and interview on 1/26/2026, at 8:09 a.m., with Dietary Supervisor/Registered Dietician (DS/RD), during Kitchen Facility Task, observed the following inside the facility's walk-in refrigerator: 1. A bag of opened deli bread with best by date of 1/20/2026, no open date. 2. A bag of unopened deli hot dog buns with best by date of 1/20/2026. Observed a spoodle hanging on the clean rack near the steam table with butter residues on them. The DS/RD stated it was the responsibility of all the kitchen staff to ensure the food products in the facility were not used after its best by date to ensure food quality and palatability is maintained. The DS/RD stated the staff should ensure the food products has their delivery date, and open date to make sure they are not going past the expiration date of the food products. The DS/RD also stated there is a potential for food-borne illnesses on residents served with food past their best by dates. The DS/RD also stated the spoodle should not have any butter residues in them because it is contaminated and when used to stir/prepare food, it can cause food-borne illnesses. During an interview on 1/29/2026, at 8:37 a.m., with the Director of Nursing (DON), the DON stated the kitchen staff should have discarded the deli buns without the open date, with best by date of 1/20/2026 and the deli hot dog buns with the best by date of 1/20/2026 because it is past due of their best by dates. The DON stated serving the buns to resident can affect the food palatability and worse can cause food-borne illnesses on residents. The DON stated the kitchen staff should inspect and ensure kitchen utensils such as the spoodle should be free from food residues as it can contaminate the food and can cause gastrointestinal (GI, having to do with the gastrointestinal (GI) tract or GI system) infections to residents. During a review of the facility's recent policy and procedure (P&P) titled, Food and Formula Storage, last reviewed on 1/21/2025, the P&P indicated proper food and formula storage procedure are followed to allow for effective, safe, and sanitary kitchen operations.ˆ During a review of the facility's recent P&P titled, Labeling and Dating of Foods, last reviewed on 1/21/2025, the P&P indicated newly opened food items will need to be closed and labeled with an open date and use by date that follow manufacturer's guideline.

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	056407	A. Building B. Wing	01/29/2026

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review the facility failed to ensure garbage and refuse in the facility were disposed of properly. The deficient practice had the potential to attract pests that can bring diseases to the residents. Findings: During an observation on 1/26/2026, at 7:30 a.m., near the facility's trash bin area, observed a racoon lurking around the trash bins. During a concurrent observation and interview on 1/26/2026 at 8:09 a.m. with the Dietary Supervisor/ Registered Dietician (DS/RD), observed multiple black and blue trash bins opened and overflowing with trash and cannot be shut closed. The DS/RD stated the trash bins were not totally shut. The DS/RD stated they were already aware of the issue because they dispose more trash and the bins were not enough to store them without overflowing. The DS/RD stated they had requested for an extra bin and they were awaiting for the delivery. The DS/RD stated that it was not appropriate to leave the trash bins open as it attracts pests such as rats and rodents that can carry diseases to the facility causing the residents to get sick. During a concurrent interview and record review on 1/29/2026 at 8:37 a.m. with the Director of Nursing (DON), reviewed the pictures of the trash bins taken on 1/26/2026 at 7:09 a.m., with the DON. The DON stated the bins on the pictures were showing their trash bins were not closed and overflowing. The DON stated it was not acceptable to have trash bins left open because it can attract pests, rodents, rats that carry diseases causing the residents to get sick. During a review of the facility's recent policy and procedure (P&P) titled, Grounds, last reviewed on 1/21/2025, the P&P indicated facility grounds shall be maintained in a safe and attractive manner. Policy Interpretation and Implementation 4. Facility outdoor trash bins will remain covered at all times, unless during times when being emptied or filled.

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	056407	A. Building B. Wing	01/29/2026

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its antibiotic stewardship program (a coherent set of actions which promote using antimicrobials responsibly) that includes antibiotic (ATB, a medicine that fights bacterial infections by killing bacteria or stopping them from multiplying) use protocols and a system to monitor antibiotic use for two of three sampled residents (Residents 39 and 71) reviewed for antibiotic use by failing to ensure: 1. Resident 39's Erythromycin Ethyl succinate Oral Suspension Reconstituted (a commonˆantibiotic medicationˆused to treat a wide variety of bacterial infections) 200 milligrams (mg, a unit of weight)/5 milliliters (ml, a unit of volume) (Erythromycin Ethyl succinate) via gastrostomy tube (g-tube, a soft, flexible tube that a doctor places directly into the stomach through a small, surgically created opening in the skin of the belly) every six (6) hours due to (d/t) delayed gastric emptying for 6 months had monitoring for its adverse effects (an undesired, harmful, or unexpected result caused by a medical treatment, such as a drug, surgery, or intervention). 2. Resident 71's Metronidazole (a prescription antibiotic that kills certain bacteria and parasites, especially those that do not need oxygen) 18.7 mg/ml susp for ethylmalonic encephalopathy (a severe, rare, inherited disorder that causes damage to several body systems, particularly the brain, nerves, and blood vessels) for 6 months had monitoring for its adverse effects. The deficient practices had placed the residents at risk for adverse effects and multidrug resistant organisms (MDRO) resistance (means that a germ, like a bacteria or fungus, has evolved to a point where multiple drugs that once killed it are no longer effective) to antibiotics. Findings: 1. During a review of Resident 39's admission Record (AR), the AR indicated the facility admitted the resident on 12/3/2015, and readmitted the resident on 3/15/2023, with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), acute tracheitis (an inflammation or, more commonly, a seriousˆbacterial infection of the windpipe [trachea]), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 39's History and Physical (H&P), dated 1/27/2025, the H&P indicated the resident was delayed (a general term used when a child does not reach common age-appropriate skills, known as developmental milestones, at the expected time), spastic (muscles that are stiff, tight, and hard to control, leading to jerky, involuntary movements or spasms, often due to brain or nerve damage) with upper extremity flexion contracture (a condition where a joint, like a knee, hip, or finger, gets stuck in a bent (flexed) position and cannot be fully straightened, either by the person themselves or with help from another person), and non-verbal. During a review of Resident 39's Minimum Data Set (MDS, a resident assessment tool), dated 11/10/2025, the MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 39's Order Summary Report (OSR), dated 11/24/2025, the OSR indicated an order of Erythromycin Ethyl succinate Oral Suspension Reconstituted 200 mg/5 ml (Erythromycin Ethyl succinate). Give 70 mg via g-tube every 6 hours d/t delayed gastric emptying for 6 months. Give 70 mg via g-tube every 6 hours for gastric motility (theˆautomatic muscle movementsˆof the stomach that mix, break down, and move food through the digestive system). During a review of Resident 39's Care Plan (CP) Report titled, At risk for adverse effects due to long term use of antibiotic therapy, last revised on 8/12/2025, the P&P indicated an intervention to monitor for signs and symptoms (s/s) of side effects and adverse reactions to antibiotics and intervene appropriately. During a concurrent interview and record review on 1/27/2026, at 9:49 a.m., with Registered Nurse (RN) 2, Resident 39's Medical Diagnosis, OSR, Progress Notes, and Nursing Assessments were reviewed. RN 2 stated there was no order from the physician to monitor for adverse effects on the use of Erythromycin Ethyl succinate. RN 2 stated the (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Progress Notes and Nursing Assessments from 12/2025 to 1/2026 did not indicate specific monitoring for adverse effects on the use of the antibiotic however, RN 2 stated documenting no change of condition means that the adverse effects of all medications including the antibiotics were monitored for adverse effect already. RN 2 stated it is okay to be vague in documenting the monitoring for adverse effects of the antibiotics. During an interview on 1/28/2026 at 6:57 a.m. with RN 9, RN 9 stated when she (RN 9) administers antibiotics to residents, she (RN 9) makes sure that the indication is correct for the medication, there is an end date, and the monitoring for adverse effect is specified in the order. RN 9 stated they are supposed to document the antibiotic administered and document if the resident had tolerated the medication or had an adverse effect on the resident. RN 9 stated the licensed nurse who received the order should have clarified with the physician what adverse effects should the nurse be monitoring for Resident 39. RN 9 stated it was important to monitor for the adverse effect of administering antibiotics to resident and document specific reactions so the primary MD can intervene appropriately and to keep resident free from undue harm of the medication. During an interview on 1/28/2026 at 7:05 a.m. with the Manager of Pediatrics (MP), the MP stated that when the facility has residents with antibiotic used as prophylaxis (any action taken to prevent a disease or illness before it happens), the facility monitor for laboratory results and monitor for its adverse effects on the resident. The MP stated the licensed staff should have documented every shift on the progress notes or Nursing Assessment every shift to indicate what antibiotic is given and to monitor for resident's tolerance to the medication or if the resident had an adverse effect. The MP stated the facility was not asking the physicians what adverse effect to monitor on the use of the antibiotic. The MP stated antibiotics are significant medications that needed to be monitored for adverse effects and should be documented every shift. The MP stated the failure of the licensed staff to monitor for specific adverse effect on the use of antibiotics increases the risk of antibiotic resistance (occurs when bacteria develop defenses against the antibiotics designed to kill them) on residents. During an interview on 1/29/2026 at 8:37 a.m. with the Director of Nursing (DON), the DON stated the staff should check if antibiotics were prescribed to residents if the orders have the proper indication, the correct duration, and to ensure the MD provided what adverse effects to monitor and report to ensure its safe use. The DON stated not monitoring for specific adverse effects of the antibiotics could lead to antibiotic resistance on Resident 39. During an interview on 1/29/2026 at 12:17 p.m. with the Infection Preventionist (IP), the IP stated the licensed staff should monitor for the adverse effect of the antibiotic medication even though it is used as a prophylaxis and it needed to be documented in the narrative the specific antibiotic given and the adverse reaction observed or no reactions noted because the facility needs the information during the interdisciplinary team meeting (IDT, a group of healthcare professionals and staff who work together to create, implement, and review the care plan for each resident). The antibiotic for prophylaxis is not a routine medication and has an end date of 60 days.ˆThe IP stated the staff should have monitored for specific adverse effects on the use of Erythromycin Ethyl Succinate on Resident 39 and document to prevent antibiotic resistance. During a review of the facility's recent policy and procedure (P&P) titled, Antibiotic Stewardship Program,ˆlast reviewed on 1/21/2025, the P&P indicated this policy and procedure promotes reduction in unnecessary use of Antibiotics while optimizing pertinent infection treatment, which in turn will help reduce potential adverse reaction risk. During a review of the facility provided Pharmacy Services Consultant (PSC) 1 Service Job Description, revised on 10/2018, indicated the pharmacist will present a quality assurance report and work with the I.D. (interdisciplinary) Team to identify medications that require special study based on (but not limited to): 6. Adverse drug reactions and medication errors. During a review of the facility provided Erythromycin (Systemic) Information, undated, the Information indicated: Adverse Reactions Gastrointestinal: Abdominal pain, anorexia (a type of eating disorder), diarrhea, nausea, vomiting Hypersensitivity: Hypersensitivity reaction (including anaphylaxis [a severe, potentially life-threatening, and fast-acting allergic reaction]) Cardiovascular: Cardiac arrhythmia (an abnormal (continued on next page)

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	01/29/2026

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

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	heart rhythm), prolonged QT interval (an abnormal heart rhythm) ECG (electrocardiogram - a test to the electrical signals traveling through the heart) 2. During a review of Resident 71's AR, the AR indicated the facility admitted the resident on 3/9/2017, and readmitted the resident on 3/21/2017, with diagnoses including acute upper respiratory tract infection (viruses and bacteria that infect the respiratory tract above the vocal cords), gastrostomy, and otitis media (aˆmiddle ear infectionˆor inflammation). During a review of Resident 71's H&P, dated 1/27/2025, the H&P indicated the resident was well nourished, no acute distress, and opens his eyes without tracking. The H&P also indicated the resident was non-verbal, with spasticity, hypertonicity with (w/) clonus bilat (a condition involving abnormally tight or stiff muscles that also experience rapid, involuntary, rhythmic jerking movements, occurring on both sides of the body). During a review of Resident 71's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a person has a serious loss of mental abilities-like thinking, remembering, and making decisions-that is significant enough to prevent them from living independently and managing their daily life). The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 71's OSR, dated 11/24/2025, the OSR indicated an order for Metronidazole 18.7 mg/ml susp. Give 187 mg via g-tube every 8 hours for ethylmalonic encephalopathy for 6 months. During a review of Resident 71's CP Report titled, At risk for adverse effects due to long term use of antibiotic therapy, initiated on 6/3/2025, the CP indicated an intervention to assess for s/s of adverse reactions and report to MD. During a concurrent interview and record review on 1/27/2026 at 9:49 a.m. with RN 2, Resident 71's Medical Diagnosis, OSR, Progress Notes, and Nursing Assessments were reviewed. RN 2 stated there was no order from the physician to monitor for adverse effects on the use of Metronidazole. RN 2 stated the Progress Notes and Nursing Assessments from 12/2025 to 1/2026 did not indicate specific monitoring for adverse effects on the use of the antibiotic however, RN 2 stated documenting no change of condition means that the adverse effects of all medications including the antibiotics were monitored for adverse effect already. RN stated it is okay to be vague in documenting the monitoring for adverse effects of the antibiotics. During an interview on 1/28/2026, at 6:57 a.m., with RN 9, RN 9 stated when she administers antibiotics to residents, she makes sure that the indication is correct for the medication, there is an end date, and the monitoring for adverse effect is specified in the order. RN 9 stated staff are supposed to document the antibiotic administered and document if the resident had tolerated the medication or had an adverse effect on the resident. RN 9 stated the licensed nurse who received the order should have clarified with the physician what adverse effects should the nurse be monitoring for Resident 71. RN 9 stated it was important to monitor for the adverse effect of administering antibiotics to Resident 71 and document specific reactions so the primary MD can intervene appropriately and to keep resident free from undue harm of the medication. During an interview on 1/28/2026 at 7:05 a.m. with the MP, the MP stated that when the facility has residents with antibiotic used as prophylaxis, the facility monitors for laboratory results and monitor for its adverse effects on the resident. The MP stated the licensed staff should have documented every shift on the Progress Notes or Nursing Assessment every shift to indicate what antibiotic is given and to monitor for resident's tolerance to the medication or if the resident had an adverse effect. The MP stated they were not asking the physicians what adverse effect to monitor on the use of the antibiotic and he (MP) would have to start educating the staff and the physicians to indicate in their orders what specific adverse effects to report and watch for. The MP stated antibiotics are significant medications that needed to be monitored for adverse effects and should be documented every shift. The MP stated the failure of the licensed staff to monitor for specific adverse effect on the use of antibiotics increases the risk of antibiotic resistance on Resident 71. During an interview on 1/29/2026 at 8:37 a.m. with the DON, the DON stated the staff should check if antibiotics were prescribed to residents if the orders have the proper indication, the correct duration, and to ensure the MD provided what adverse effects to monitor and report to ensure its safe use. The DON stated not (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitoring for specific adverse effects of the antibiotics could lead to antibiotic resistance on Resident 71. During an interview on 1/29/2026 at 12:17 p.m. with the IP, the IP stated the licensed staff should monitor for adverse effect of the antibiotic medication even though it is used as a prophylaxis and it needed to be documented in the narrative the specific antibiotic given and the adverse reaction observed or no reactions noted because the facility needs the information during the IDT. The antibiotic for prophylaxis is not a routine medication it has an end date of 60 days.ˆThe IP stated the staff should have monitored for specific adverse effects on the use of Metronidazole on Resident 71 and document to prevent antibiotic resistance. During a review of the facility's recent P&P titled, Antibiotic Stewardship Program,ˆlast reviewed on 1/21/2025, the P&P indicated this policy and procedure promotes reduction in unnecessary use of antibiotics while optimizing pertinent infection treatment, which in turn will help reduce potential adverse reaction risk. During a review of the facility provided PSC 1 Service Job Description, revised on 10/2018, indicated the pharmacist will present a quality assurance report and work with the I.D. (interdisciplinary) Team to identify medications that require special study based on (but not limited to): 6. Adverse drug reactions and medication errors. During a review of the facility provided Metronidazole (Flagyl, Likmez) - Uses, Side Effects, and More Information, dated 10/23/2024, the Information indicated while less common, the most serious side effects of metronidazole are described below, along with what to do if they happen. - Severe Allergic Reactions - Breathing problems or wheezing - Racing heart - Fever or general ill feeling - Swollen lymph nodes (body parts that filter fluid in the body for harmful substances or cells) - Swelling of the face lips, mouth, tongue, or throat Etc

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	056407	A. Building B. Wing	01/29/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care in a manner that promoted dignity and respect for one of one sampled resident (Resident 23) reviewed under dignity care area by failing to ensure that Housekeeping (HSK) 1 moved Resident 23's wheelchair to create adequate space when bringing the large gray bin (storage bin container used to store used reusable gowns [a personal protective equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses]) into the room, which resulted in the bin colliding with the foot of Resident 23's bed and bedside table, as observed on 1/28/2026. This deficient practice had the potential to affect Resident 23's self-esteem and self-worth. Findings: During a review of Resident 23's admission Record (AR), the AR indicated that the facility originally admitted Resident 23 on 4/14/2016 and readmitted on [DATE] with diagnoses including chronic respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood), convulsions (n abnormal violent and involuntary contraction or series of contractions of the muscles), and cerebral palsy (a group of conditions that affect movement and posture). During a review of Resident 23's History and Physical (H&P), dated 10/16/2025, the H&P indicated that Resident 23 had assay to understand and make a decision. During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool), dated 1/21/2026, the MDS indicated Resident 23 had clear speech and adequate vision, makes self-understood, and had the ability to understand others. The MDS indicated Resident 23 was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). During a review of Resident 23's Care Plan (CP) focused on potential for hypotension (low blood pressure), dated 5/20/2025, the CP indicated the resident with goal of blood pressure will be within range. The care plan with intervention was to provide resident with an environment conductive to rest and free from obnoxious stimuli. During an interview on 1/26/2026 at 9:46 a.m. with Resident 23, Resident 23 stated HSK 1 comes in the morning and wakes her (Resident 23) due to the banging the bed with the broom, the mop while cleaning her (Resident 23) room. Resident 23 stated she (Resident 23) has lost sleep in the morning. During an observation on 1/28/2026 at 8:51 a.m., Resident 23 was asleep in bed.^ During an observation on 1/28/2026 at 8:56 a.m., in front of Resident 23's room, HSK 1 entered Resident 23's room and brought in a gray bin, with lid and wheels, to the restroom. Resident 23's foot of the bed was in front of the restroom door. HSK 1 opened the restroom door and crashed gray bin into Resident 23's foot of the bed and overbed table. HSK 1 placed the gray bin inside the restroom, closed the restroom door, and exited the room. During an interview on 1/28/2026 at 9:03 a.m. with HSK 1, HSK 1 stated she (HSK 1) picked up the gray bin from the restroom, and she (HSK 1) did not have enough space to move because Resident 23's wheelchair was in the way. HSK 1 stated her (HSK 1) gloves were dirty and she (HSK 1) was touching the barrel, so she (HSK 1) did not move the wheelchair. HSK 1 stated she (HSK 1) should have used alcohol sanitizer and put on new gloves and moved Resident 23's wheelchair. HSK 1 stated when the gray bin collided with Resident 23's bed, the resident was alert and became upset. During an interview on 1/29/2026 at 2:54 p.m. with the Director of Nursing (DON), the DON stated HSK 1 should be told to be careful and to apologize to the resident for the incident. The DON stated she (DON) will make sure her (Resident 23) concerns are addressed and what she (Resident 23) wants is addressed. The DON stated she (DON) can change the assignment to avoid this issue. The DON stated if it continues, it will cause friction and would cause a problem. The DON stated she (DON) will talk to Resident 23 for her concern and will address it. The DON stated HSK 1 should not have done that because this is the resident's home, they need to give their respect. The DON stated the residents are to be treated with respect because it is their residents' rights. During a review of the facility's policy and procedures (P&P) titled, Resident Rights, last reviewed on 1/21/2025, the P&P indicated that the purpose of this policy is to ensure that (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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All Saints Healthcare Subacute	11810 Saticoy Street North Hollywood, CA 91605

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents rights and dignity are ensured. Policy: Employees shall treat all residents with kindness, respect, and dignity. Procedure: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the pad call light (a specialty alerting device that have ultra-sensitive touch surface for patients with limited mobility for nurses or other nursing personnel to assist a patient when in need) was within reach for one (1) of one (1) sampled resident (Resident 6) reviewed under the environment task. This deficient practice had the potential to result in a delay of care and services and possible injury to Resident 6 when the resident was unable to call for assistance. Findings: During a review of Resident 6's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted the resident on 1/21/2025, and readmitted in the facility on 5/31/2025, with diagnoses including dependence on respirator (also known as ventilator - a machine used to help a person breath when they are unable to do so on their own) status , tracheostomy (an opening a surgeon makes through the neck and into the trachea [also known as windpipe] to help a patient breathe), and type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 6's History and Physical (H&P) dated 5/31/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 10/29/2025, the MDS indicated Resident 6 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make his needs known. The MDS further indicated Resident 6 had impairment of both upper and lower extremities and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 6's fall risk assessment dated [DATE], the fall risk assessment indicated Resident 6 was at a high risk for falls. During a review of Resident 6's care plan (CP) on potential for falls and injury initiated on 4/28/2025, and last revised on 6/6/2025, the CP indicated to place call light within reach as one of the interventions to keep the resident free from falls and injury at all times. During a concurrent observation and interview on 1/26/2025 at 11:48 a.m. inside Resident 6's room with Registered Nurse (RN) 6, Resident 6 was observed lying in bed and asleep. RN 6 stated Resident 6's call light was at the foot of the bed on the left side. RN 6 stated that the staff should ensure that the call light was within the residents' reach prior to leaving the room so they can call for assistance. RN 6 stated that Resident 6's pad call light should have been within reach at least next to the hand as Resident 6 was able to slightly move the hands and touch the pad call light for assistance. RN 6 stated if the call light was not within Resident 6's reach, it placed the resident at risk for a delay in providing the care and services the resident needed. During a concurrent interview and record review on 1/28/2026 at 1:40 p.m. Resident 6's fall risk assessment, and CP were reviewed with RN 7. RN 7 stated that the fall risk assessment indicated that Resident 6 is at a risk for falls. RN 7 stated Resident 6`s CP on potential for falls indicated to place call light within reach as one of the interventions to keep Resident 6 free from falls and injury. RN 7 stated that staff are supposed to ensure that the call lights are placed within the residents' reach after providing care and prior to leaving the room. RN 7 stated Resident 6's call light should have been placed within reach and not by the foot of the bed as the resident was unable to move both lower extremities and it placed Resident 6 at risk for a delay in receiving the care he needed. RN 7 stated Resident 6 can slightly move both hands and if the call light was placed near the hands, he would be able to call for assistance when needed. During a review of the facility's policy and procedure (P&P) titled, Call Lights, last reviewed on 1/21/2025, the P&P indicated a purpose to enable residents to call for assistance and to enable staff to respond to call lights in a timely and efficient manner. The P&P further indicated: - All residents on the adult unit have a working call light to enable them to call for assistance. - Procedure: - All residents will be given a call light. - (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The call light will be placed within their reach. - Patients who are unable to use the standard call light will be given an adaptive call light to enable them to call for assistance. - Call lights will be answered timely and efficiently. - Call lights will be monitored for positioning by licensed nurses and Certified Nursing Assistance (CNA) during rounds and after treatments.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to notify the primary physician and responsible party of a significant change in condition (major decline or improvement in a resident's status that will not resolve itself without intervention) for one (1) of one (1) sampled resident (Resident 13) reviewed for change of condition by failing to notify the responsible party when the resident was transferred to the hospital. This deficient practice had violated the resident's responsible party's right to be informed of the care services provided. Findings: During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was originally admitted in the facility on 9/9/2025 and readmitted in the facility on 10/20/2025, with diagnoses including respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and dependence on respirator (also known as ventilator - a machine used to help a person breath when they are unable to do so on their own) status. During a review of Resident 13's History and Physical (H&P) dated 10/22/2025, the H&P indicated Resident 13 did not have the capacity to understand and make decisions. During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool) dated 12/30/2025, the MDS assessment indicated Resident 13 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs- routine tasks/activities. The MDS indicated Resident 13 required suctioning (mechanical removal of a patient's secretions with artificial airway such as tracheostomy). During a review of Resident 13's Discharge Summary notes dated 9/10/2025, the Discharge Summary notes indicated that during routine patient care, a large amount of blood was noticed by the Certified Nursing Assistants (CNAs) from the rectum (end part of the large intestine that connects to the anus [opening at a person's bottom] where the stools accumulate) and bleeding in the trachea during suctioning of secretions (process of removing fluids or mucus from a person's body using a suction device) by the respiratory therapist. The discharge summary notes further indicated the nurse practitioner was notified and ordered to transfer Resident 13 to the nearest emergency room (ER) via paramedics (healthcare professionals trained to respond in emergency calls for medical help outside the hospital). The discharge summary notes did not indicate that Resident 13's representative was notified of the change in condition. During a review of Resident 13's eINTERACT SBAR Summary form (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 9/10/2025, the eINTERACT SBAR Summary form indicated Resident 13 had bleeding in the rectum and trachea during routine patient care. The eINTERACT SBAR Summary form further indicated the nurse practitioner was notified and ordered to transfer Resident 13 to the nearest emergency room via paramedics. The eINTERACT SBAR Summary form did not indicate that Resident 13's representative was notified of the change in condition. During a concurrent interview and record review on 1/29/2026 at 8:39 a.m., Resident 13's physician's order, eINTERACT SBAR Summary form, and discharge summary notes were reviewed with the Minimum Data Set Coordinator (MDSC). The MDSC stated that Resident 13 was transferred to the ER for bleeding on the rectum and trachea on 9/10/2025. The MDSC stated the discharge summary notes and eINTERACT SBAR Summary form did not indicate Resident 13's family was notified of the transfer to the nearest ER via paramedics. The MDSC stated the eINTERACT SBAR Summary form entails identifying the changes in a resident's health status, obtaining vital signs, assessment for mental status or behavior, documentation of skin changes, immediate action taken, and the notification of the primary physician and the resident representative of the change in condition of the resident. The MDSC stated it was important to complete Resident 13's eINTERACT SBAR Summary form to have a complete account of what (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	happened that day including notification of the resident's representative to honor the resident representative's right for informed care of their family member and be aware of Resident 13's plan of care. During an interview on 1/29/2026 at 10:06 a.m., with the Director of Nursing (DON), the DON stated the licensed staff are supposed to complete the eINTERACT SBAR Summary form to include the notification of the resident's representative of any changes in condition of the resident and what are the plans to address the resident's change in condition. The DON stated resident representatives have the right to be notified of any change in condition. The DON stated if a resident was transferred to the ER via paramedics, the family can be notified at the soonest time possible or after the resident had left the facility for them to be aware of what had happened to the resident. The DON stated Resident 13's representative should have been notified by the nurses of Resident 13's transfer to the hospital via paramedics to respect their right to be aware of the informed care. During a review of the facility's policy and procedure (P&P) titled, Reporting Changes in Condition, last reviewed on 1/21/2025, the P&P indicated that the facility shall notify the family or responsible party and physician or nurse practitioner of resident's change in condition. The P&P further indicated: - The nursing staff will report changes in a resident's condition or status to the resident's family/responsible party in a timely manner. - The licensed nurse who reported change of condition to the physician or nurse practitioner and family/responsible party will document it in the nurse's notes.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a baseline care plan (an initial, temporary care document that is developed within 48 hours of a resident's admission, providing essential, person-centered care instructions to staff to ensure safety and continuity of care while a more comprehensive plan is developed) for one (1) of five (5) sampled resident (Resident 6) reviewed for unnecessary medications review when Resident 6 was readmitted to the facility on [DATE]. This deficient practice placed Resident 6 at risk of not receiving the appropriate care and treatment specific to the residents' needs. Findings: During a review of Resident 6's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted the resident on 1/21/2025 and readmitted in the facility on 5/31/2025, with diagnoses including dependence on respirator (also known as ventilator - a machine used to help a person breath when they are unable to do so on their own) status , tracheostomy (an opening a surgeon makes through the neck and into the trachea [also known as windpipe] to help a patient breathe), and type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 6's History and Physical (H&P) dated 5/31/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 10/29/2025, the MDS indicated Resident 6 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make his needs known. The MDS further indicated Resident 6 had impairment of both upper and lower extremities and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 6's baseline care plans (CP), the baseline CP indicated the following baseline CP were initiated on 6/3/2025: - Physical Therapy (PT - a therapy that is used to preserve, enhance, or restore movement and physical function impaired or threatened by disease, injury, or disability) Care Plan - Resident has arteriovenous fistula (AV fistula - created by directly connecting a person's artery and vein to provide a good blood flow during dialysis [a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney/s have failed]) on left upper arm. - Potential for falls and injury related to impaired cognition and balance - Potential for hypoglycemia (low blood sugar) or hyperglycemia (increased blood sugar) related to DM 2 - The resident has DM 2 - The resident is on anticoagulant therapy - The resident is on oxygen therapy. During a concurrent interview and record review on 1/28/2026 at 1:50 p.m., Resident 6's admission Record, physician orders, and baseline care plans (CP) were reviewed with Registered Nurse (RN) 7. RN 7 stated Resident 6 was readmitted in the facility on 5/31/2025 and the resident`s baseline CPs were initiated on 6/3/2025. RN 7 stated that the charge RNs are supposed to initiate the baseline CP upon admission or within 48 hours of the admission. RN 7 stated Resident 6's baseline CP was not initiated and implemented timely. RN 7 stated Resident 6's baseline CP should have been initiated between 5/31/2025 to 6/2/2025 so the staff would know how to provide the immediate care and prevent delay in providing the care Resident 6 need. During a concurrent interview and record review on 1/29/2026 at 9:01 a.m., Resident 6's admission Record, physician orders, and baseline care plans (CP) with the MDS Coordinator (MDSC). The MDSC stated Resident 6 was readmitted in the facility on 5/31/2025 and that the baseline CPs were initiated on 6/3/2025. The MDSC stated that the charge RNs or admitting nurse are supposed to develop a baseline CP upon admission or within 48 hours of admission and then comprehensive care plan will be developed by the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) seven (7) days after completion of the comprehensive assessment or 21 days after admission or readmission date. The (continued on next page)

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	01/29/2026

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDSC stated Resident 6's baseline CP was not initiated and implemented timely. The MDSC stated Resident 6's baseline CP should have been initiated on 5/31/2025 or 6/2/2025 so the staff would be aware of the care the resident needed upon admission so the care would not be delayed. During a review of the facility's policy and procedure (P&P) titled, Baseline Care Plans, last reviewed on 1/21/2025, the P&P indicated that the IDT shall develop and implement a baseline CP for each resident that includes instructions needed to provide effective and person-centered care of the resident within 48 hours of admission. The P&P further indicated the baseline CP include the minimum healthcare information necessary to properly care for a resident immediately upon admission which is to address resident-specific health and safety concerns to prevent decline or injury, such as elopement (refers to a situation where a patient leaves a facility without permission or the proper level of supervision) or fall risk, and to identify needs for supervision, behavioral interventions, and assistance with ADLs, as necessary.

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	01/29/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive care plan (CP, a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and function needs) by failing to: 1. Develop and implement a CP for the resident's use of Eliquis (also known as apixaban - an anticoagulant [AC] medication used to treat and prevent blood clots) included measurable goals and outcomes for monitoring signs and symptoms of bleeding for one of two sampled residents (Resident 97) reviewed for AC medications. 2. Develop and implement a CP for a resident who was identified with a Moisture-Associated Skin Damage (MASD - inflammation [becomes reddened, swollen or hot] or skin erosion [breakdown of outer layers of skin] caused by prolonged exposure to moisture-like urine, stool, sweat) and at risk for pressure ulcer/injuries (a skin and tissue injury caused by prolonged pressure on the skin, often over bony areas) for one of four sampled residents (Resident 18) reviewed for pressure ulcer. These deficient practices had the potential to result in miscommunication among interdisciplinary (a group of health care professionals with various areas of expertise who work together toward the goals of their clients) staff, residents, and resident representatives resulting in a delay of necessary care and services. Findings: a. During a review of Resident 97's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted the resident on 4/30/2025 and readmitted in the facility on 6/16/2025, with diagnoses including gastrostomy (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (HTN-high blood pressure). During a review of Resident 97's History and Physical (H&P) dated 6/18/2025, the H&P indicated Resident 97 did not have the capacity to understand and make decisions. During a review of Resident 97's Minimum Data Set (MDS, a resident assessment tool), dated 11/5/2025, the MDS indicated Resident 97 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make his needs known. The MDS further indicated Resident 97 required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 97 received anticoagulant. During a review of Resident 97's Order Summary Report dated 1/29/2026, the Order Summary Report indicated a physician's order dated 7/5/2025 for Eliquis oral tablet 2.5 milligrams (mg – a unit of measurement) give 2.5 mg via GT every 12 hours for deep vein thrombosis (DVT - a blood clot that forms in the veins located deep within a limb, usually the lower leg or thigh) prophylaxis (a measure taken to maintain health and prevent the spread of disease). During a review of Resident 97's care plan (CP) titled, Potential for injury or bleeding, initiated on 12/10/2025, the CP did not indicate monitoring for signs and symptoms of bleeding as one of the interventions for the use of Eliquis. During a concurrent interview and record review on 1/27/2026 at 2:25 p.m., Resident 97's physician's orders, CP, and medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 11/2025, 12/2025, (continued on next page)

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	01/29/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and 1/2026 were reviewed with Registered Nurse (RN) 7. RN 7 stated that Resident 97 had a physician's order for Eliquis and a CP was initiated on 12/10/2025. However, the CP did not indicate to monitor for signs and symptoms of bleeding as one of the interventions for the use of Eliquis. RN 7 stated monitoring for signs and symptoms should be included in the care plan as one of the interventions. RN 7 stated Resident 97's care plan for the use of Eliquis should have included monitoring for signs and symptoms of bleeding as one of the interventions to ensure staff are aware of what is in Resident 97's plan of care so they would know how to properly care for the resident. RN 7 stated if the proper interventions are not in place such as monitoring for signs and symptoms of bleeding, it placed Resident 97 at risk unmonitored bleeding which may lead to a delay in receiving the necessary care and services needed. During a concurrent interview and record review on 1/28/2026 at 3:39 p.m. Resident 97's physician's orders, CP, and MAR for 11/2025, 12/2025, and 1/2026 were reviewed with the MDS Coordinator (MDSC). The MDSC stated that there is a physician's order for Eliquis, and the CP for the use of Eliquis did not indicate monitoring signs and symptoms of bleeding as one of the interventions. the MDSC stated CP should be comprehensive and person-centered and must include complete interventions to properly car for the residents. The MDSC stated Resident 97's CP for the use of Eliquis should have included monitoring signs and symptoms of bleeding as one of the interventions so the staff would be aware what are the interventions in place to properly care for the resident, especially monitor for signs and symptoms of bleeding to prevent delay in providing the care the resident needs. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, last reviewed on 1/21/2025, the P&P indicated a comprehensive person-centered care plan for each resident must be developed and implemented for each resident consistent with the resident rights, that include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The P&P further indicated that the care plans will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. b. During a review of Resident 18's AR, the AR indicated that the facility originally admitted the resident on 12/7/2023 and readmitted on [DATE], with diagnoses including chronic respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood), nontraumatic intracerebral hemorrhage (bleeding into the substance of the brain in the absence of trauma or surgery) in hemisphere (sides of the cerebrum- area that controls movement, sensation, language, and thinking), dysphagia (difficulty swallowing) following cerebral infarction (stroke- loss of blood flow to a part of the brain), and hydrocephalus (the buildup of fluid in cavities called ventricles deep within the brain). During a review of Resident 18's Clinical admission Screener (CAS), dated 10/28/2025, the CAS indicated Resident 18 had left buttock MASD. During a review of Resident 18's admission Progress Notes (APN- a comprehensive, written, or electronic document created by a provider upon a resident's entry into an inpatient facility that includes gathering a thorough medical history from the resident and performing a physical examination to assess their overall health and identify any potential medical concern) dated 10/29/2025, the APN indicated Resident 18 did not have the capacity to understand and make decisions. The APN indicated that Resident 18's skin had no erythema (redness of skin). (continued on next page)

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	01/29/2026

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 18's MDS, dated [DATE], the MDS indicated that Resident 18 had the ability to understand others sometimes and rarely or never makes self-understood. The MDS indicated Resident 18 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 18 was dependent on staff for bed mobility including rolling to the left and right. The MDS indicated Resident 18 had no unhealed pressure ulcer but was identified as being risk for developing pressure ulcers. During a review of Resident 18's Assessment of Decubitus Ulcer Potential (ADUP- a scoring tool used to predict resident's risk of developing pressure ulcer, the higher the score, the greater is the potential to develop decubitus ulcers), the ADUP indicated the resident with a score above 12 should be considered at risk: - Score of 23, dated 12/24/2024. - Score of 25, dated 12/26/2025. During a concurrent interview and record review on 1/27/2026 at 1:41 p.m., with TN 1, reviewed Resident 18's care plans. TN 1 stated there was no care plan developed for Resident 18's MASD on the left buttock on 10/28/2025. TN 1 stated that she (TN 1) forgot to add it and should have been added on the day it was identified.ˆTN 1 stated she (TN 1) will include in the interventions the treatment orders because they evaluate the wound every 14 or 30 days depending on the order if it is working or not. TN 1 stated she (TN 1) would also include repositioning and turning the resident every two hours and as needed. LVN stated the purpose of care plan is to manage the wound and ensure the resident does not develop infection.ˆTN 1 stated that she (TN 1) reviews the care plan interventions (approaches) and so do the LVNs and Registered Nurses (RNs) taking care of Resident 18. During a concurrent interview and record review on 1/27/2026 at 2:10 p.m., with RN 8, reviewed Resident 18's physician orders and care plans. RN 8 stated that when Resident 18 was readmitted on [DATE], she (RN 8) assessed the resident, TN 2 and LVN 4 checked the skin, and she (RN 8) checked the skin as well. RN 8 stated TN 2 measures the wounds, develops care plans related to skin and wounds, reaches out to the wound doctor, MD 2, and places wound treatment orders, if there is any. RN 8 stated TN 2 should have developed a care plan addressing Resident 18's MASD on the left buttock and placed Resident 18's treatment orders. During a concurrent interview and record review on 1/27/2026 at 4:56 p.m., with TN 2, reviewed Resident 18's physician orders, care plans, and nursing progress notes. TN 2 stated that when she (TN 2) finds wounds, redness, skin discoloration on the resident, the charge nurse (RN) and the primary nurse (LVN), documents it in the admission Notes, and the charge nurse places the orders for any skin issue. TN 2 stated she (TN 2) does not have to document, only the primary nurse and the charge nurse, does the documentation for the admission.ˆTN 2 stated she (TN 2) helps with wound measurement, wound treatment, and depends on the order.ˆTN 2 stated the charge nurse or whoever enters the order would also develop the care plan. TN 2 stated she (TN 2) does not have any documentation because RN 4 and LVN 4 document on their notes and she (TN 2) provides them with the wound measurements and details. TN 2 stated she (TN 2) did not call the wound doctor on 10/28/2025 for Resident 18. During a concurrent interview and record review on 1/29/2026 at 3:25 p.m., with the Director of Nursing (DON), reviewed the facility's P&P titled, Decubitus Ulcer Prevention. The DON stated that the TN is responsible for developing the care plan upon identification of any skin issues. The DON stated (continued on next page)

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	01/29/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she (DON) was not aware of Resident 18's left buttock open blister and stage two (2) pressure ulcer, and the MASD on admission. The DON stated TN 2 should have communicated to RN 4 regarding a need for calling the wound doctor and she (TN 2) should have documented. The DON stated TN 2 should have developed the care plan right away and followed through. The DON stated because TN 2 did not develop a care plan, MD 2 was not notified, and Resident 18's wounds were not followed through. The DON stated the care plan should have been updated to reflect the current approaches and wound treatments are usually every two weeks and skin/wound is assessed weekly. The DON stated if there is no care plan developed, the resident's wounds will become worse, it has not been noted, and the wound doctor has not been called. During a review of the facility's P&P titled, Decubitus Ulcer Prevention, last reviewed on 1/21/2025 that indicated that: Policy: 1. The Registered Nurse will evaluate the Residents/Patients on admission and then on a daily basis to establish the presence of any pressure sores. Preventive Measures:. 5. Any Resident/Patient admitted with a pressure sore will have immediate and appropriate action to treat the problem. Proper documentation of the presence, location, size and description of the pressure sore will be recorded in the Resident/Patient health record. 6. Proper documentation of the treatment performed via the Physician Orders will be in the treatment book. Special Observations: All pressure points, especially bony prominences, should be assessed for redness, irritated or lacerated skin:. Buttocks, Sacrum. Residents/Patients Most Vulnerable: 1. Residents/Patients required to lie in one position due to immobilization or restrictive appliances (cast, traction, infusion board, etc.) 2. Residents/Patients incapable of voluntary movement (comatose, stuporous, paralyzed, heavily sedated). 3. Residents/Patients who are abnormally thin, elderly, debilitated, incontinent. 4. Diabetics and Residents/Patients with poor circulation or peripheral vascular disease. During a review of the facility's P&P titled, Comprehensive Care Plans, last reviewed on 1/21/2025, the P&P indicated that a comprehensive person-centered care plan for each resident must be developed and implemented for each resident consistent with he resident rights, that include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The P&P further indicated that the care plans will be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

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	01/29/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to revise one of four sampled residents (Resident 18) care plan when Resident 18's care plan was not updated to reflect current left buttock stage 2 pressure ulcer interventions addressing Resident 18's risk for worsening PU. This deficient practice had the potential to result in inconsistent implementation of the care plan that may lead to a delay in or lack of delivery of care and services. Findings: During a review of Resident 18's admission Record (AR), the AR indicated that the facility originally admitted Resident 18 on 12/7/2023 with diagnoses including chronic respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood), nontraumatic intracerebral hemorrhage (bleeding into the substance of the brain in the absence of trauma or surgery) in hemisphere (sides of the cerebrum [area that controls movement, sensation, language, and thinking]), dysphagia (difficulty swallowing) following cerebral infarction (also known as stroke, loss of blood flow to a part of the brain), and hydrocephalus (the buildup of fluid in cavities deep within the brain called ventricles). During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool), dated 10/2/2025, the MDS indicated Resident 18 had the ability to understand others sometimes and rarely or never makes self understood. The MDS indicated Resident 18 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 18 was dependent on staff for bed mobility including rolling to the left and right. The MDS indicated Resident 18 had no unhealed pressure ulcer but was identified as being at risk for developing pressure ulcers. During a review of Resident 18's Clinical admission Screener (CAS - a pre-admission document used to evaluate a prospective resident's medical and physical needs to ensure the facility can provide appropriate care) form, dated 10/28/2025, the CAS form indicated Resident 18 had left buttock MASD. During a review of Resident 18's admission Progress Notes (APN - a comprehensive, written, or electronic document created by a provider upon a resident's entry into an inpatient facility that includes gathering a thorough medical history from the resident and performing a physical examination to assess their overall health and identify any potential medical concern), dated 10/29/2025, the APN indicated Resident 18 did not have the capacity to understand and make decisions. The APN indicated that Resident 18's skin had no erythema (superficial reddening of the skin as a result of injury or irritation). During a review of Resident 18's Assessment of Decubitus Ulcer Potential (ADUP - a scoring tool used to predict a resident's risk of developing pressure ulcer, the higher the score, the greater the potential to develop decubitus ulcers), dated 12/24/2025, the ADUP indicated residents with a score above 12 should be considered at risk for developing pressure ulcers. The ADUP indicated Resident 18 scored 23. During a review of Resident 18's ADUP, dated 12/26/2025, the ADUP indicated Resident 18 scored 25. During a review of Resident 18's Physician Order, dated 1/19/2026, the Physician Order indicated the following treatment : Cleanse the Left Buttock open blister (bubble on the skin filled with clear, watery liquid or blood, usually caused by friction, rubbing, or burns) with normal saline (NS - sterile water used to cleanse and moisten wounds), apply moist gauze (a wound care product designed to absorb wound drainage and protect the wound), pat dry with dry gauze, apply xeroform (a moist yellow dressing that covers the wound and promotes wound healing) and cover with a foam dressing every day shift for one (1) Day, with the Wound Doctor to reassess on 1/20/2026. During a review of Resident 18's wound care Progress Note Details (PND), dated 1/20/2026, the wound care PND indicated that Resident 18 had the following wound: Left buttock open blister, measuring 1.6 centimeters (cm- a unit of measure) in length x (by) 1.5 cm in width x 0.1 cm in depth, with a small amount of serous (clear, thin, watery fluid that's typically pale yellow in color) drainage noted. During a review of Resident 18's Physician Order, dated 1/20/2026, the Physician Order indicated the following treatment: Cleanse the Left Buttock open blister with NS, apply moist gauze, pat dry with dry gauze, apply xeroform and cover with a foam (continued on next page)

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	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing every day shift for 14 Days. During a review of Resident 18's wound care PND, dated 1/27/2026, the wound care PND indicated that Resident 18 had the following wound: Left buttock stage 2 pressure ulcer, measuring 1.2 cm in length x 0.8 cm in width x 0.2 cm in depth, with a moderate amount of serous drainage, and a wound bed (exposed tissue surface within a wound) 76 to 100 percent (%). During a review of Resident 18's Physician Order, dated 1/27/2026, the Physician Order indicated the following treatment: Cleanse the Left Buttock Stage 2 Pressure Ulcer with NS, apply moist gauze, pat dry, apply xeroform and cover with a foam dressing every day and as needed for 30 days. During a concurrent interview and record review on 1/27/2026 at 1:41 p.m., with Treatment Nurse (TN) 1, Resident 18's care plans were reviewed. TN 1 stated the care plan focused on Wound Management, revised on 1/20/2026, did not include Resident 18's stage two (2) pressure ulcer on the left buttock. TN 1 stated that she (TN 1) forgot to add it and should have been added on the day it was identified.ˆ TN 1 stated the purpose of the care plan is to manage the wound and make sure there are no infections for the resident.ˆTN 1 stated that she (TN 1), the licensed vocational nurses (LVNs), and Registered Nurses (RNs) taking care of Resident 18 reviews the care plan interventions (approaches). During a concurrent interview and record review on 1/29/2026 at 3:25 p.m. with the DON, the facility's policy and procedure (P&P) titled, Decubitus Ulcer Prevention, last reviewed 1/21/2025, was reviewed. The DON stated the TN is responsible for developing the care plan upon identification. The DON stated the care plan should have been updated to reflect the current approaches and wound treatments are usually every two weeks and skin/wound is assessed weekly. The DON stated if there is no care plan developed, the resident's wounds will become worse, it has not been noted, and the wound doctor has not been called. During a review of the facility's policy and procedure (P&P) titled, Decubitus Ulcer Prevention, last reviewed on 1/21/2025 that indicated that: Policy: 1. The Registered Nurse will evaluate the Residents/Patients on admission and then on a daily basis to establish the presence of any pressure sores. Preventive Measures:. 5. Any Resident/Patient admitted with a pressure sore will have immediate and appropriate action to treat the problem. Proper documentation of the presence, location, size and description of the pressure sore will be recorded in the Resident/Patient health record. 6. Proper documentation of the treatment performed via the Physician Orders will be in the treatment book. Residents/Patients Most Vulnerable: 1. Residents/Patients required to lie in one position due to immobilization or restrictive appliances (cast, traction, infusion board, etc.) 2. Residents/Patients incapable of voluntary movement (comatose, stuporous, paralyzed, heavily sedated). 3. Residents/Patients who are abnormally thin, elderly, debilitated, incontinent. 4. Diabetics and Residents/Patients with poor circulation or peripheral vascular disease. During a review of the facility's P&P titled, Long Term and Short Term Care Plans, last reviewed on 1/21/2025, the P&P indicated that the purpose of this policy is To have a written plan of nursing care for the resident/patient from admission to discharge. Policy. 1. All Diagnoses or Diagnosis that cannot be resolved within one month will be considered long term and will be included in the Long Term Care Plan. 2. All Diagnoses or Diagnosis that cannot be resolved within one month or less will be considered short term and included in the Short Term Care Plan. Care Plans will be updated and revised throughout the resident/patient stay. Dependent on progress, change in condition, or as new Diagnosis arises and are identified. Long Term Care Plans will be re-evaluated quarterly, annually, and as needed. Short Term Care Plans will be re-evaluated if the goals are not met within the target date.

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	01/29/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide needed care and services that are resident centered in accordance with the resident's goals for care and professional standards of practice for two of two sampled residents (Residents 65 and 81), reviewed under quality of care, by failing to ensure: 1. Resident 65's bilateral sequential compression devices (SCD's, are medical devices used to prevent blood clots in patients who are immobile) were applied to the lower extremities at all times. 2. Resident 81's water flush was administered via gastrostomy tube (g-tube) gavage (a medical term for giving liquid food, fluids, or medicines directly into the stomach through a special, surgically placed tube) per physician`s order. The deficient practices had the potential for residents to receive substandard quality of care that cannot meet the resident's physical, mental, and psychosocial needs. Findings: 1. During a review of Resident 65's admission Record (AR), the AR indicated the facility admitted the resident on 4/5/2024, with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), spastic quadriplegic cerebral palsy (a severe form of CP that causes stiff, tight muscles and poor control inˆall four limbs (arms and legs) and the trunk, making movement, speech, and swallowing very difficult, often requiring lifelong support for daily activities like walking, eating, and talking), and hydrocephalus (ˆmedical condition where too much cerebrospinal fluid (CSF) builds up within the normal cavities (ventricles) of the brain). During a review of Resident 65's History & Physical (H&P), dated 10/3/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 65's Minimum Data Set (MDS, a resident assessment tool), dated 1/11/2026, the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had moderately impaired cognition (noticeable memory or thinking problems, like forgetting things or words more often, that are worse than normal aging butˆnotˆsevere enough to stop someone from doing daily tasks like managing finances, cooking, or shopping independently). The MDS indicated the resident was dependent to needing supervision assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 65's Order Summary Report (OSR), dated 4/1/2025, the OSR indicated an order of SCD to bilateral lower extremities at all times, every shift for deep vein thrombosis (DVT, aˆblood clot that forms in a large, deep vein, most commonly in the legs) prophylaxis (any action or treatment taken toˆpreventˆa disease or condition from happening in the first place, rather than treating it after it starts). During a review of Resident 65's Care Plan (CP) Report titled, Potential for alteration in blood circulation related to medical diagnosis such as DVT. At risk for pulmonary embolism (a blood clot that develops in a blood vessel elsewhere in the body (often the leg), travels to an artery in the lung, and suddenly forms a blockage of the artery), initiated on 4/9/2025, the CP indicated an intervention to ensure SCD's are applied to bilateral lower extremities at all times (DVT prophylaxis). During a concurrent observation, interview, and record review on 1/26/2026, at 10:41 a.m., with Registered Nurse (RN) 4, inside Resident 65's room, observed Resident 65's SCD machine was turned off, and the sleeves were not applied on the resident's bilateral lower extremities. RN 4 reviewed Resident 65's Medical Diagnosis, OSR, and CP. RN 4 stated there was an order to place SCD's to bilateral lower extremities at all times, every shift for DVT prophylaxis. RN 4 stated the resident refuses the SCD. RN 4 stated there was no care plan for refusing the SCD in Resident 65`s electronic healthcare record. RN 4 stated the SCD's should have been placed at all times to prevent DVT to Resident 65 since the resident was immobile and dependent in most ADL's. During an interview on 1/29/2026, at 7:49 a.m., with the Manager of Pediatrics (MP), the MP stated Resident 65's bilateral SCD's should have been applied to the resident at all times per physician's order to prevent DVT. The MP stated if the resident was refusing to wear the SCDs, the licensed staff should have brought it to the attention (continued on next page)

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	01/29/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the interdisciplinary team (IDT, a group of various healthcare professionals who work together to create, implement, and manage a unified and person-centered care plan for each resident) to develop a care plan for the refusal after explaining the risk and benefits of its application. During an interview on 1/29/2026, at 8:37 a.m., with the Director of Nursing (DON), the DON stated the SCD's should be on at all times per MD order to prevent DVT to Resident 65. The DON stated if the resident refuses it has to be escalated to the IDT to care plan. During a review of the facility's recent policy and procedure (P&P) titled, Sequential Compression Device, last reviewed on 1/21/2025, the P&P indicated sequential compression device is used to limit the development of deep vein thrombosis and/or prevent blood clot formation. Procedure: 3. Nursing will implement use of this device following manufacturer's guidelines. 7. Nursing will apply the device as per MD's orders. During a review of the facility's recent P&P titled, Physician's/FNP Orders, last reviewed on 1/21/2025, the P&P indicated to accurately ensure the proper procedures for physician's/FNP orders.ˆ Procedure: 4. The primary nurse is responsible for carrying out the physician's/FNP orders with proper documentation. 2. During a review of Resident 81's AR, the AR indicated the facility admitted the resident on 6/15/2023, with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), gastro-esophageal reflux disease (GERD, isˆa chronic condition whereˆstomach contents, including acid, frequently flow back up into the esophagusˆ(the tube connecting your mouth and stomach)), and constipation (a problem with passing stool). During a review of Resident 81's H&P, dated 10/3/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 81's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (used to describe a person's ability to think, learn, and remember clearly without any significant decline or impairment in their mental functions). The MDS indicated the resident was mostly dependent on mobility and activities of daily living (ADLs). The MDS indicated the resident has a feeding tube. During a review of Resident 81's OSR, dated 6/17/2025, the OSR indicated an order of Enteral Feed (a method of providingˆliquid nutrition directly to the stomach or small intestine through a flexible tube). Five times a day. Encourage oral (PO) water flush 400 cubic centimeters (cc, one of the standard units of volume, the amount of space occupied by an object) water, may give gavage via g-tube if not able to finish everything PO (hydration). During a review of Resident 81's Care Plan (CP) Report titled, Alteration in nutrition and hydration, last revised on 9/3/2025, the CP indicated an intervention to give water flushes via tube as ordered. During an observation on 1/26/2026, at 9:37 a.m., observed Resident 65 with a water feeding flush bag running at 195 milliliters (ml, a unit of volume)/ hour (hr,) with a volume of 400 ml set at the feeding pump (a small medical machine that acts like an automated feeding hand, delivering liquid food and nutrients into a person's stomach or small intestine through a tube at a controlled, steady rate). During a concurrent interview and record review on 1/27/2026, at 9:35 a.m., with RN 2, reviewed Resident 81's Medical Diagnosis, OSR, and CP. RN 2 stated there was an order for Enteral Feed for Resident 81, five times a day. RN 2 stated the order indicated to encourage PO water flush 400cc water, and to give gavage via g-tube if not able to finish everything PO (hydration). RN 2 stated the licensed staff did not follow the physician's order because the water flush was given via pump. RN 4 stated the licensed staff should have clarified the order to prevent confusion. RN 4 stated the failure of the staff to identify irregularities in the order and executing the order inappropriately can lead to resident dehydration or errors in provision of therapy. During an interview on 1/29/2026, at 8:37 a.m., with the DON, the DON stated RN 2 should have followed the physician's order to give g-tube gavage of water flush 400 cc five times a day instead of placing them on a pump that cannot give 400 cc bolus at a time. The DON stated the feeding pumps are programmed to a maximum infusion of 195 ml/hr. so to infuse 400 cc, it will take more than 2 hours to complete the water hydration. The DON stated the failure of the staff to follow the physician's order can result to resident dehydration (a condition caused by the loss of too much fluid from the body). (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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All Saints Healthcare Subacute	11810 Saticoy Street North Hollywood, CA 91605

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's recent P&P titled, Physician's/FNP Orders, last reviewed on 1/21/2025, the P&P indicated to accurately ensure the proper procedures for physician's/FNP orders.ˆ Procedure: 4. The primary nurse is responsible for carrying out the physician's/FNP orders with proper documentation.

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	056407	A. Building B. Wing	01/29/2026

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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 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 residents received adequate supervision to prevent accidents by failing to: 1. Ensure mupirocin calcium external cream (a topical medication used to treat bacterial skin infections) was not left unattended and readily available in the residents shared room for one of one sampled resident (Resident 114) reviewed during the Accidents care area. 2. Ensure a resident`s medications were not left unattended on the bedside table without a physician's order for one randomly sampled resident (Resident 61). This deficient practice had the potential to result in residents obtaining medication without staff knowledge resulting in unsupervised self-administration and accidental ingestion causing harm to residents. Findings: a. During a review of Resident 114's admission Record (AR), the AR indicated the facility admitted the resident on 4/3/2025, and most recently admitted the resident on 6/6/2025, with diagnoses that included chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood), tracheostomy (trach - opening surgically created through the front of the neck and into the trachea [windpipe]), anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), and depression (persistent feelings of sadness and loss of interest that can interfere with daily living). During a review of Resident 114's Minimum Data Set (MDS – resident assessment tool) dated 1/11/2026, the MDS indicated the resident was able to understand others and was able to make herself understood. During a review of Resident 114's Physician Orders, the Physician's orders indicated mupirocin calcium external cream two (2) percent (%), apply to percutaneous endoscopic gastrostomy (PEG - a surgical procedure to insert a flexible tube directly into the stomach through the abdominal wall used for medications and feedings) tube stoma (opening) topically every day shift for status post PEG removal for 14 days, supervised self-administration. Cleanse with normal saline (NS – a sterile liquid), pat dry, apply medication and cover with a dry dressing until 2/3/2026, then re-evaluate, dated 1/20/2026. During a concurrent observation and interview on 1/26/2026 at 10:02 a.m., Resident 114 was observed sitting in bed eating a sandwich with numerous cups of liquid placed on the bedside rolling table. Observed a clear plastic medication cup with ointment placed on a stand directly next to the right side of the resident's bed. Resident 114 stated the clear medication cup contained cream to help with itching. During a concurrent observation and interview on 1/26/2026 at 10:24 a.m., with Certified Nursing Assistant (CNA) 3, CNA 3 entered Resident 114's room and spoke with the resident. CNA 3 stated there was a used medication cup on Resident 114's bedside stand that still contained a little cream. During a concurrent observation and interview on 1/26/2026 at 10:27 a.m., with Registered Nurse (RN) 5, observed RN 5 entered Resident 114's room. RN 5 stated she (RN 5) applied mupirocin cream to Resident 114 during the morning on 1/26/2026 and left the cup on the resident's stand. RN 5 stated it was not her normal practice to leave used cups at bedside, but she (RN 5) forgot to dispose of the medication cup containing some remaining cream. During a follow-up interview on 1/26/2026 at 10:32 a.m. with RN 5, RN 5 stated the used topical (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication cup should not have been left at Resident 114's bedside because anyone could grab the used medication cup. RN 5 stated another resident should not apply the mupirocin cream because the medication was prescribed only for Resident 114 and should only be applied to Resident 114. RN 5 stated she (RN 5) should have thrown out the used medication cup, but she (RN 5) did not. During a concurrent interview and record review on 1/29/2026 at 12:50 p.m., with the Director of Nursing (DON), the DON reviewed the facility policy and procedures (P&P) regarding medication administration and accidents. The DON stated the facility process for topical medication administration is to follow the physician's order, ensure all of the medication is applied to the resident, and to dispose of the used medication cup after the treatment is applied. The DON stated used medication cups containing any residual medication should never be left at a resident's bedside to ensure the medication is not accidentally ingested by that resident, or any other resident. The DON stated topical medication is not meant to be ingested and could potentially result in poisoning of the resident when ingested. The DON stated RN 5 did not follow the facility P&P when RN 5 left the used medication cup with cream at Resident 114's bedside. During a review of the facility P&P titled, Bedside Medication, last reviewed 1/21/2025, the P&P indicated, Drugs stored at the bedside shall be stored in a manner that shall prevent access by other residents . During a review of the facility P&P titled, Administration of Topical Medications, last reviewed 1/21/2025, the P&P indicated, Purpose: The purpose of this policy is to ensure the safe, accurate, and consistent administration of topical medications by nursing staff. Policy: All topical medications shall be administered in accordance with the physician's order, manufacturer's guidelines, and nursing standards of practice . Procedures: . Dispose of used materials according to infection control and hazardous waste policies. During a review of the facility P&P titled, Accident Prevention, last reviewed 1/21/2025, the P&P indicated, Policy Statement. Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation. Facility-Oriented Approach to Safety. 1. Our facility-oriented approach to safety addresses risks for groups of residents. 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; and a facility-wide commitment to safety at all levels of the organization.Individualized, Resident-Centered Approach to Safety. 1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. Systems Approach to Safety. 1. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. b. During a review of Resident 61's AR, the AR indicated the facility admitted the resident on 3/31/2014, and readmitted the resident on 7/17/2017, with diagnoses including chronic respiratory failureˆwith ventilator (a medical device to help support or replace breathing) dependence,ˆmorbid obesityˆ(a serious health condition that results from an abnormally high body mass)ˆand (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anxietyˆdisorder.ˆ During a review ofˆResidentˆ61'sˆHistory and Physical (H&P) dated 8/13/2025 the H&Pˆindicatedˆthatˆtheˆresidentˆhadˆdecision making capacity.ˆˆ During a review of Resident 61's MDS, dated [DATE],ˆthe MDS indicatedˆresidentˆrequiredˆsupervisionˆor touching assistance of staff toˆperformˆactivitiesˆof daily livingˆ(ADLs - basic tasks that must be accomplished every day for an individual to thrive)ˆand indicated Residentˆ61 was up in the wheelchair dailyˆwith the assistance of staff.ˆˆ Duringˆaˆconcurrentˆobservationˆand interviewˆonˆ1/26/2026 at 9:56 a.m., Residentˆ61 wasˆobservedˆwithˆVicksˆVapor Rub (an over-the-counter topical ointment designed to temporarily relieve coughs and minor aches/pains),ˆNatural Breezeˆaerosolˆairˆfreshener, and arthritisˆpain relief topical sprayˆ(labeledˆin Spanish)ˆon the bedside table.ˆResident 61 stated herˆ(Resident 61)ˆhusbandˆbroughtˆthe itemsˆtoˆuse whenever she (Resident 61) needs them.ˆˆˆˆˆ During a concurrentˆobservation and interview on 1/28/2026 atˆ7:30ˆa.m.,ˆobservedˆon Residentˆ61's overbed tableˆVicks Vapor Rub, Natural Breeze aerosol air freshener, and arthritis pain relief sprayˆ(labeledˆin Spanish). The DONˆstatedˆthe VicksˆandˆArthritisˆspray should not beˆat the resident's bedsideˆas Resident 61 has no physicians order forˆthe medicationsˆandˆResident 61 has not been assessed toˆself-administerˆmedications.ˆThe DONˆstatedˆstaffˆdid notˆknowˆResident 61 had medications at her bedside.ˆ During a review of theˆfacility'sˆP&PˆtitledˆBedside Medication,ˆ last reviewed 1/21/2025, the P&P indicated, theˆ(P&P)ˆindicated,ˆMeds shall be kept at the bedsideˆforˆself-administrationˆonly on a MD order.ˆDrugsˆstored at the bedside shall be storedˆin a mannerˆshall prevent access by otherˆresidentsˆsuch as in a locked drawer or locked box) no foreign products (mustˆbe approved in the USA)ˆ Duringˆaˆreviewˆofˆtheˆfacility'sˆP&PˆtitledˆSelf-Administration of Medications, last reviewed 1/21/2025, the P&P indicated,ˆP&Pˆindicatedˆifˆdeemedˆappropriate aˆphysician'sˆorder will be obtained forˆself-administratorˆof medication upon resident's request, nursingˆwillˆmonitorˆusage of medication every shift.ˆ

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	056407	A. Building B. Wing	01/29/2026

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All Saints Healthcare Subacute	11810 Saticoy Street North Hollywood, CA 91605

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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 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide specialized rehabilitative services by qualified personnel, when ordered for a resident by a doctor. Based on observation, interview, and record review, the facility failed to ensure Respiratory Therapists (a specialized healthcare professional who treats, manages, and cares for residents of all ages who have trouble breathing) demonstrated training and competency to perform tracheostomy (trach - opening surgically created through the front of the neck and into the trachea [windpipe] that is held open by a specialized tube [cannula]) care treatments for one of three sampled residents (Resident 93) reviewed under the Respiratory care area by failing to: 1. Ensure Respiratory Therapist (RT) 4 provided tracheostomy care per the physician's orders by cleaning the resident's stoma (actual physical opening in the skin at the front of the neck) with hydrogen peroxide (H2O2 - a liquid chemical used to clean wounds and reduce risk of infection from a wide variety of microorganisms). 2. Ensure RT 4 performed hand hygiene (process of cleaning one's hands to prevent the spread of infectious diseases) before and after glove use during tracheostomy care. 3. Ensure RT 4 performed tracheostomy care per the facility policy and procedure (P&P) by cleaning the neck and stoma prior to inserting the sterile inner cannula (a smaller, removable tube that fits inside the main outer tracheostomy tube). These deficient practices placed Resident 93 at risk for respiratory infections resulting in hospitalization and death. Findings: During a review of Resident 93's admission Record (AR), the AR indicated the facility admitted the resident on 9/20/2022 and most recently admitted the resident on 10/8/2024 with diagnoses including chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood), tracheostomy, dependence of respirator (ventilator - a medical device to help support or replace breathing), unspecified intracranial brain injury (a brain injury that is caused by an outside force) with loss of consciousness of unspecified duration, and sepsis (a life-threatening blood infection). During a review of Resident 93's Minimum Data Set (MDS - resident assessment tool), dated 12/16/2025, the MDS indicated the resident rarely/never was able to understand others and rarely/never was able to make himself understood. The MDS further indicated that the resident was dependent on staff for bathing, toileting, dressing, oral and personal hygiene, and mobility. The MDS indicated while in the facility the resident was on an invasive mechanical ventilator and received tracheostomy care. During a review of Resident 93's Order Summary Report, the Order Summary Report indicated the following orders: - Dated 2/18/2025, tracheostomy care every shift and as needed (PRN): cleanse stoma with H202. Rinse with normal saline (NS - a sterile solution). - Dated 2/18/2025, ventilator dependent resident: change inner cannula daily and PRN, every day shift. - Dated 10/21/2025, suction tracheostomy secretions every two hours and PRN. During a review of Resident 93's Care Plan (CP) titled, Presence of tracheostomy: ineffective airway clearance related to inability to expel excess secretions.potential for infection., initiated 4/13/2025, the CP indicated a goal that the resident would remain free from signs and symptoms of infection at all times. The CP indicated interventions that included suction tracheal secretions every two hours and render trach care every shift. During a review of Resident 93's CP titled, Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics (medication used to treat infections caused by bacteria)] that uses targeted gown and glove use during high contact resident care activities)., initiated 7/30/2025, the CP indicated a goal that the resident would remain free from infections. The CP indicated interventions that included to observe good hand washing before and after contact with residents or resident equipment. During a tracheostomy care observation on 1/28/2026 at 11:15 a.m. with RT 4 and Licensed Vocational Nurse (LVN) 2, observed RT 4 and LVN 2 enter Resident 93's room and performed HH. RT 4 donned (put on) clean (non-sterile) blue gloves. RT 4 then suctioned Resident 93's mouth with a yankauer (disposable medical tool used to suction), doffed (took off) the blue gloves, and donned a new pair of blue gloves. Observed RT 4 did not perform HH between glove (continued on next page)

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes. RT 4 then opened a pair of sterile gloves and placed a sterile glove over the top of the left-hand blue glove. LVN 2 stated do not double glove (practice of wearing two pairs of gloves simultaneously). RT 4 then removed both sets of gloves, opened a new sterile glove package, and donned the sterile gloves. Observed RT 4 did not perform HH between changing gloves. RT 4 then suctioned Resident 93's trach and inserted the sterile inner cannula wearing sterile gloves, doffed the sterile gloves, and donned blue gloves. Observed RT 4 did not perform HH between glove changes. RT 4 then used NS to clean Resident 93's neck around the stoma, changed gloves, and then applied a new dressing at the stoma. Observed RT 4 did not use H2O2 to clean around the stoma, did not perform HH between glove changes, and performed the insertion of the sterile inner cannula before cleaning the area around the stoma. RT 4 exited the resident's room and performed HH. During an immediate follow-up interview with RT 4, RT 4 stated she (RT 4) usually double gloves to perform the sterile procedure of suctioning and placing a sterile inner cannula. RT 4 stated LVN 2 told her not to double glove, so she stopped and removed all the gloves. RT 4 then stated she (RT 4) changed gloves multiple times during Resident 93's trach care and did not perform HH between glove changes. RT 4 stated she (RT 4) only performs HH before and after resident care and not between glove changes. RT 4 further stated RT 4 did not use H2O2 to cleanse around Resident 93's stoma. RT 4 proceeded to review Resident 93's physician's orders and stated the order indicated to use H2O2 and rinse with NS. RT 4 stated the RT Manager (RTM) told her (RT 4) to use only NS to clean around the stoma so she only used NS and not H2O2. During a concurrent interview and record review on 1/28/2026 at 12:02 p.m., with the RTM and RT 4, the RTM reviewed Resident 93's physician orders. The RTM stated it was important to clean around the stoma during tracheostomy care to prevent infection. The RTM stated that tracheostomy care should be provided per the physician's orders. The RTM stated Resident 93's order indicates to use H2O2 to cleanse around the stoma, and RT 4 should have used H2O2 during trach care for Resident 93. RT 4 stated she was nervous and did not use H2O2 for Resident 93's trach care. The RTM then stated HH should be performed between glove changes and the RT should not double glove. The RTM stated HH between glove changes prevents contamination from any bacteria from the used gloves transferring to the new gloves. The RTM stated RT 4 should have performed HH between glove changes and she (RT 4) did not. The RTM stated when RT 4 did not perform HH between glove changes and did not use H2O2 per the physician's orders, there was the potential to result in a respiratory infection in Resident 93. The RTM stated RT 4 has had in-services regarding HH and tracheostomy care. The RTM stated RT 4 had a competency issue and should have known to perform HH between glove changes and to follow the physician's orders, but she (RT 4) did not. During a follow-up concurrent interview and record review on 1/28/2026 at 1:03 p.m. with the RTM, the RTM reviewed the P&P regarding trach care. The RTM stated the facility's P&P for trach care indicates to first provide cleaning of the area around the stoma, then change to sterile gloves and replace the inner cannula to prevent infection. The RTM stated RT 4 did not follow the P&P when RT 4 replaced the sterile cannula before cleaning the area around the stoma. During a concurrent interview and record review on 1/29/2026 at 9:20 a.m. with the Director of Nursing (DON), the DON reviewed RT 4's Respiratory Therapist Annual Skills List and Returned Demonstration, dated 6/16/2025, and the facility's P&P regarding hand hygiene and trach care. The DON stated proper technique during trach care is very important because bad practices could introduce infections to residents. The DON stated sterile procedures are completed after clean procedures because everything has to be removed and cleaned per physician's orders with H2O2 before inserting the inner cannula during a sterile procedure. The DON stated this process prevents the growth of microorganisms at the stoma site from entering the airway. The DON stated double gloving during trach care is a bad practice and only protects the staff performing trach care and not the resident. The DON stated when RT 4 attempted to double glove and did not perform HH between glove changes, there was the potential for cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful (continued on next page)

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	01/29/2026

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All Saints Healthcare Subacute	11810 Saticoy Street North Hollywood, CA 91605

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F 0826 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effect). The DON stated RT 4 did not demonstrate professional standards of practice for trach care and did not follow the facility P&Ps potentially leading to pneumonia (infection that causes inflammation in one or both lungs, specifically filling the tiny air sacs with fluid or pus) and other respiratory infections resulting in hospitalization and death in the resident. The DON stated RT 4 has a competency issue. The DON stated the RTM completed a competency check list for RT 4 on 6/18/2025 that included the evaluation of RT 4's tracheostomy care for residents. The DON stated the competency evaluation was not effective because RT 4 did not provide competent trach care to Resident 93 and needed further training. The DON stated the RTM is responsible for providing continued monitoring to evaluate and identify any retraining needs in the RT staff. The DON stated the P&P was not followed because the RTM did not follow through to ensure RT 4 was competent to safely provide trach care to facility residents. During a review of the facility P&P titled, Hand Washing and Sanitizing, last reviewed 1/21/2025, the P&P indicated, Purpose: . The purpose of this policy and procedure is to minimize transmission of microorganisms in the healthcare setting. Compliance with this policy also provides a clean, healthy environment for patients and staff. Hand washing and the use of alcohol-based hand rub are the most effective techniques for preventing spread of infection. Hand washing or the use of alcohol-based hand rub should be done before and after resident contact, and between clean and dirty procedures. Hand washing or alcohol-based hand rub will be done at any time when hands are visibly soiled or contaminated. Hand washing will be done even when staff has donned gloves during a procedure. (Rationale: hands may become contaminated even with glove use, and may transfer organisms to a fresh set of gloves). During a review of the facility P&P titled, Tracheostomy Care / Routine Daily Care / Inner Cannula Care, last reviewed 1/21/2025, the P&P indicated, Standard of Care:. Tracheostomies will be kept clean and the airway clear of mucus. Tracheostomy care will be done daily and PRN. Purpose. I. To maintain an adequate airway and to clear excessive secretion. 2. To prevent encrustation of the tracheostomy tube inner cannula (if used). 3. To prevent breakdown or irritation of the surrounding skin. 4. To maintain patency, placement, and security of the tracheostomy. Equipment Needed: . 1. NS . 2. Hydrogen peroxide. 3. Gauze. 6. Inner cannula if applies. 7. Plastic bag for waste. Procedure Steps: . 1. Remove old gauze and place in waste bag. 2. Remove trach tie. 3. Clean around stoma with NS and Hydrogen Peroxide moist gauze. 4. Clean around neck with NS moist gauze. 5. Pat dry neck and stoma with dry gauze. 6. Place new trach tie to secure trach tube. 7. Place new 4x4 [a four inch by four inch square gauze dressing] around stoma. 8. If applies remove old inner cannula. 9. Change gloves to sterile and insert new inner cannula. During a review of the facility P&P titled, Employee Performance and Skills Evaluation, last reviewed 1/21/2025, the P&P indicated, Purpose:. The purpose of this policy is to provide guidelines to perform employee performances and skills evaluation. Policy: Annual performance and skills evaluations will be done for all clinical employees. Procedures: . 1. All clinical employees will receive annual skills and performance evaluations. 2. The evaluations will be done by the unit or department manager. 4. Each EMPLOYEE PERFORMANCE AND SKILLS EVALUATION will be based on the individual employee's license and job description. 5. The Performance Evaluation form will include the following: . e. Job Performance. m. Job Knowledge. Safety. 6. The Performance Evaluation will be used as a tool for employee development. During a review of the facility Job Duty Statement for Respiratory Therapist Adult and Pediatric, undated, the Job Duty Statement indicated, Scope: Must be able to demonstrate practical application and competency in respiratory therapy, mechanics, theory, . airway and ventilator management, . medication delivery. Duties and Responsibilities: . 2. Suction patients every two hours, prn, or as ordered throughout the shift. 4. Perform routine trach changes. 10. Maintain, clean, and handle all equipment in a safe and responsible manner. 17. Ensure that individualized approaches to plan of care are implemented. 18. Follow all policies and procedures. 19. When providing bedside respiratory care, always follow infection control practices in addition to utilizing PPE (personal protective equipment - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) .

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	056407	A. Building B. Wing	01/29/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases (infectious diseases that can be transmitted from one individual, or species, to another) and infections by failing to: 1. Ensure suction canisters (a disposable container connected by tubing to a device used to suction respiratory secretions) were changed and labeled per facility Policy and Procedure (P&P) for one of three sampled residents (Resident 93) reviewed during the Respiratory care area. 2. Ensure residents gastrostomy tube (g-tube or GT, a soft tube placed directly through the belly skin into the stomach to deliver food, fluids, and medicine when someone can't eat enough by mouth, providing essential nutrition or relieving stomach pressure) venting syringe (a tube with a plunger and often a needle, used to push liquids into or pull liquids out of something, like giving a shot (medicine) or taking blood) did not back flow the feeding formula for one of four sampled residents (Resident 71) reviewed for tube feeding. These deficient practices had the potential to result in the spread of infectious microorganisms resulting in respiratory and gastric infections in residents. Findings: a. During a review of Resident 93's admission Record (AR), the AR indicated the facility admitted the resident on 9/20/2022, and most recently admitted the resident on 10/8/2024, with diagnoses that included chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood), tracheostomy (opening surgically created through the front of the neck and into the trachea [windpipe]), dependence of respirator (ventilator - a medical device to help support or replace breathing), unspecified intracranial brain injury (a brain injury that is caused by an outside force) with loss of consciousness of unspecified duration, and sepsis (a life-threatening blood infection). During a review of Resident 93's Minimum Data Set (MDS – resident assessment tool) dated 12/16/2025, the MDS indicated the resident rarely/never was able to understand others and rarely/never was able to make himself understood. The MDS further indicated that the resident was dependent on staff for bathing, toileting, dressing, oral and personal hygiene, and mobility. During a review of Resident 93's Order Summary Report, the Order Summary Report indicated suction tracheostomy secretions every two hours and as needed, dated 10/21/2025. During a review of Resident 93's Care Plan (CP) titled, Presence of tracheostomy: ineffective airway clearance related to inability to expel excess secretions.potential for infection., initiated 4/13/2025, the CP indicated a goal that the resident would remain free from signs and symptoms of infection at all times. The CP indicated interventions that included suction tracheal secretions every two hours and as needed. During a concurrent observation and interview on 1/26/2026 at 11:30 a.m., with Registered Nurse (RN) 5, observed Resident 93 lying in bed. Observed a clear plastic suction canister mounted on the wall behind the resident's head of the bed. RN 5 stated suction canisters should be labeled with the resident's name and the date of when the canister was last changed. RN 5 stated there was no sticker on the suction canister and the canister was not labeled. Observed the canister was not labeled. RN 5 stated she (RN 5) did not know how long Resident 93's suction canister had been there because it was not labeled. RN 5 stated the canisters should be changed twice a week by the Respiratory Therapists (RT). (continued on next page)

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	01/29/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/26/2026 at 11:30 a.m. with RT 1, RT 1 stated suction canisters are changed twice a week by the night shift and labeled with the resident's name, room number, and the date the canister was changed. RT 1 stated it was important to label the canisters so the suction set up is not used on the wrong resident in a shared room and for sanitary reasons because secretions in the canister can grow organisms potentially leading to respiratory infections in residents if not changed twice a week. RT 1 stated if the canister is not labeled with the date, then she (RT 1) did not know when Resident 93's suction canister was last changed. During an interview on 1/28/2026 at 12:02 p.m., with the RT Manager (RTM), the RTM stated suction canisters should be labeled with the date changed and the room number of the resident to prevent cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) between residents and to ensure the canister is changed per P&P. The RTM stated it was important to change the suction canisters, so bacteria does not grow. RTM stated if bacteria grow in the canister there is the potential that the bacteria could transfer to the resident causing an infection. The RTM stated when Resident 93's suction canister was not labeled the facility P&P was not followed. During a concurrent interview and record review on 1/29/2026 at 9:20 a.m. with the Director of Nursing (DON), the DON reviewed the facility P&P regarding suction canister and tubing change. The DON stated the P&P indicates to change the suction canister twice a week and label the canister with the resident's name and date. The DON stated suction canisters need to be labeled because it prevents the spread of infection in residents. The DON stated it was important to use one suction set up and canister per resident to prevent cross contamination. The DON stated it was also important to ensure suction canister and tubing were not left in use for too long because microorganisms could grow in the canister. The DON stated the microorganisms could potentially transfer to the resident through the attached tubing used to suction the resident. The DON stated the transfer of microorganisms may lead to respiratory infections. The DON stated the facility P&P was not followed when Resident 93's suction canister was not labeled. During a review of the facility P&P titled, Suction Canister and Tubing Changed, last reviewed 1/21/2025, the P&P indicated, Purpose: .The purpose of this policy is to provide a guideline for the routine and PRN change of suction canisters and their tubing. Policy: . The suction canisters will be changed routinely twice per week . Procedures: . 2. The suction canisters will be labeled with the resident's name and the date the canister was changed. During a review of the facility P&P titled, Respiratory Equipment Maintenance, last reviewed 1/21/2025, the P&P indicated, Purpose: . To maximize the prevention of infections and control communicable diseases to patients and personnel associated with respiratory care equipment and procedures within patient Care areas. Guidelines: . b. For Adults: . 1v. Suction canister and tubing changed twice per week and PRN. During a review of the facility's recent P&P titled, Infection Control Program, last reviewed on 1/21/2025, the P&P indicated the facility shall establish an infection control program designed to provide a safe, sanitary and comfortable environment for Residents and staff to help prevent the development and transmission of disease and infection.ˆ b. During a review of Resident 71's admission Record (AR), the AR indicated the facility admitted the resident on 3/9/2017, and readmitted the resident on 3/21/2017, with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to (continued on next page)

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	056407	A. Building B. Wing	01/29/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the stomach common for people with swallowing problems), abdominal hernia (any protrusion of intestine or other tissue through a weakness or gap in the abdominal wall), constipation (a problem with passing stool). During a review of Resident 71's History and Physical (H&P), dated 1/27/2025, the H&P indicated the resident was well nourished, no acute distress, and opened his eyes without tracking. The H&P also indicated the resident was non-verbal, with spasticity (a condition that causes muscles to be unusually stiff, tight, or rigid, which prevents normal, fluid movement), hypertonicity w/ clonus bilat (a condition of tight, stiff muscles with involuntary, rhythmic jerking on both sides of the body). During a review of Resident 71's MDS dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (having major problems with thinking, remembering, and making decisions that make it impossible to live an independent life and require full-time care). The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had a feeding tube. During a review of Resident 71's Order Summary Report (OSR), dated 3/31/2018, the OSR indicated an order may vent g-tube continuously every shift. During a review of Resident 71's Care Plan (CP) Report titled, Presence of nasogastric (NG, Nasogastric is a medical term that simply describes the pathway from the nose (Naso-) to the stomach (-gastric))/jejunostomy tube (JT, a soft, flexible tube that a doctor places through the skin of the belly directly into the middle part of the small intestine)/g-tube. At risk for potential or actual: Infection related to aspiration and or GT/JT opening or stoma, initiated on 6/2/2025, the CP indicated a goal of resident will not have any irritation or infection on NGT/JT/GT site at all times and an intervention to render NGT/GT/JT care as ordered every shift and if needed (PRN). During an observation on 1/26/2026 at 10:05 a.m., observed Resident 71, with a 60-cubic centimeters (cc, a basic unit for measuring volume, essentially the space inside a tiny cube that's one centimeter long, one centimeter wide, and one centimeter high, like a small sugar cube) syringe hanging at the resident's head board without a plunger (the rod you push or pull to move liquid in or out of the syringe) open to air with 60-cc of formula. The syringe was labeled vent syringe with the resident's name and room number. During a concurrent observation and interview on 1/26/2026, at 10:14 a.m., with RN 1, inside Resident 71's room, observed Resident 71's vent syringe with 60-cc of formula without a plunger open to air, hanging at the resident's headboard. RN 1 stated the feeding should be on a closed system and leaving the syringe open to air can lead to gastric infection to the resident. RN 1 stated it was the night shift nurse who hang the syringe with the feeding formula open to air and she was not able to catch them on shift change. During a concurrent interview and record review on 1/27/2026, at 9:58 a.m., with Registered Nurse (RN) 2, reviewed Resident 71's Medical Diagnoses, OSR, and CP. RN 2 stated there was an order for may vent g-tube continuously every shift. RN 2 stated the 60-cc syringe hanging at the headboard of the resident with feeding formula is meant for g-tube venting. RN 2 stated the presence of feeding formula on the 60-cc syringe open to air can result to gastrointestinal infection when introduced to the g-tube of the resident. RN 2 stated RN 1 should have ensured there were no backflow of feeding formula on the 60-cc syringe to prevent infection to set in on the resident. RN 2 stated the purpose of (continued on next page)

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	01/29/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g-tube venting is to release the gas from the gut of the resident and not for feeding. During an interview on 1/29/2026, at 7:49 a.m., with the Manager of Pediatrics (MP), the MP stated RN 1 should have caught the issue on change of shift report with another licensed nurse. The MP stated the purpose of the manual g-tube venting was to decompress the gut with air not for feeding. The MP stated the failure of RN 1 to ensure there were no feeding formula that back flowed to the 60-cc syringe can lead to gastric infection when introduced to the stomach. The MP stated the formula back flowed to the syringe probably due to incorrect clamping on the Y connection site (is a port on medical tubing that looks like the letter Y, allowing healthcare providers to add a second fluid or medication without having to use a new access point on the patient's body). During an interview on 1/29/2026, at 8:37 a.m., with the Director of Nursing (DON), the DON stated the 60-cc syringe that was hanging on Resident 71's headboard was for manual g-tube venting and was not intended for feeding. The DON stated the failure of the staff to intervene during shift change when a 60-cc syringe for g-tube venting had a feeding formula that back flow to the 60-cc syringe can cause infection to the resident as the formula was open to air and exposed to environmental contaminants. During a review of the facility's recent policy and procedure (P&P) titled, Gastrostomy Tube Venting, last reviewed on 1/21/2025, the P&P indicated the purpose of this policy is to provide a guideline on the venting of gastrostomy tubes (GT) to alleviate abdominal distention and bloating in tube feeding residents. Bolus feeding with venting: 2. Once the bolus feeding is completed, clamp GT (see Physician's orders for duration of clamping) to allow feeding and medications to absorb. During a review of the facility's recent P&P titled, Infection Control Program, last reviewed on 1/21/2025, the P&P indicated the facility shall establish an infection control program designed to provide a safe, sanitary and comfortable environment for Residents and staff to help prevent the development and transmission of disease and infection.

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	056407	A. Building B. Wing	01/29/2026

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure two of four sampled residents (Resident 85 and Resident 41) reviewed under the infection control facility task were screened for, administered, or obtained and documented refusal or medical contraindication for the pneumonia (a lung infection that causes inflammation in one or both lungs, specifically filling the tiny air sacs with fluid or pus) vaccine (medication that teaches the immune system to recognize and fight off dangerous viruses or bacteria) for Resident 85 and Resident 41. This deficient practice placed residents at risk for acquiring pneumococcal disease and related complications. Findings: During a review of Resident 85's admission Record (AR), the AR indicated the facility admitted Resident 85 on 12/16/2025 with diagnoses including chronic respiratory failure (a long-term, ongoing condition where the lungs cannot properly move oxygen into the blood or remove carbon dioxide), tracheostomy (a surgically made opening that allows for breathing in and out through a tube in the neck), gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and ventilator dependent (a medical device to help support or replace breathing). During a review of Resident 85's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 12/16/2025, the H&P indicated Resident 85 lacked the capacity to understand and make decisions. During a review of Resident 85's Minimum Data Set (MDS - a resident assessment tool), dated 12/28/2025, the MDS indicated Resident 85 lacked the capacity to understand and was dependent upon staff to complete all areas of activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 85's Immunization Record, undated, the immunization record indicated Prevnar 13 (a vaccine that protects against 13 types of pneumococcal bacteria and other serious infections) was administered to Resident 85 on 12/27/2012. During a review of Resident 41's AR, the AR indicated the facility admitted the resident on 6/17/2025 and was originally admitted on [DATE], with diagnoses including chronic respiratory failure, tracheostomy, gastrostomy tube, and cerebral palsy (a lifelong condition caused by early brain damage that affects movement and muscle control). During a review of Resident 41's H&P, dated 6/18/2025, the H&P indicated, Resident 41 did not have the capacity to understand or make decisions. During a review of Resident 41's MDS, dated [DATE], the MDS indicated Resident 41 lacked the capacity to understand and was dependent upon staff to complete all activities of daily living. During a review of Resident 41's immunization record, the immunization record indicated, Pneumovax 23 (a vaccine that protects against 23 types of pneumococcal bacteria that can cause pneumonia or other serious infections) was administered to Resident 41 on 5/9/2003. During a review of the facility's Flu (also known as influenza, a highly contagious respiratory illness caused by viruses that infect the nose, throat, and lungs), Pneumonia, and Covid (also known as COVID-19, a highly contagious respiratory illness caused by the virus SARS-CoV-2) consent tracker, dated 2025-2026, the tracker did not list Resident 85 and documented Resident 41 as completed for the pneumonia vaccine. During an interview with the Infection Preventionist (IP) on 1/29/2026 at 3:00 p.m., the IP stated per current Center for Disease Control and Prevention (CDC) and Advisory Committee on Immunization Practices (ACIP) adult immunization guidelines, Resident 85 and Resident 41, previously vaccinated with PCV13 and Pneumovax 23, are eligible for and recommended to receive updated pneumococcal conjugate vaccines. During an interview with the Director or Nurses (DON) on 1/29/2026 at 3:30 p.m., the DON stated not offering vaccines to residents upon admission was not aligned with the facility's policy and stated not doing so put the immunocompromised residents at risks for pneumonia and other infections and indicated each resident should be screened by the Infection Preventionist. During a review of the facility's policy and procedure (P&P) titled, Pneumococcal Pneumonia Vaccine, reviewed 1/2025, the P&P indicated, all residents admitted to the facility will be offered the pneumococcal pneumonia vaccine. (continued on next page)

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	01/29/2026

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Vaccinations, last reviewed 1/2025, the P&P indicated all new residents shall be assessed for current vaccination status upon admission. The P&P indicated all vaccinations will need a consent/declination from the resident or responsible part before administration of vaccines. The P&P further indicated if vaccines are refused, the refusal shall be documented in the resident's medical record.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review the facility failed to ensure one of four sampled residents (Resident 85) reviewed under the infection control facility task was screened for the Covid-19 (a highly contagious respiratory illness caused by the virus SARS-CoV-2) vaccine (medication that teaches the immune system to recognize and fight off dangerous viruses or bacteria) upon admission. This deficient practice placed residents at risk for acquiring Covid-19 and other related complications. Findings: During a review a of Resident 85's admission Record (AR), the AR indicated the facility admitted Resident 85 on 12/16/2025 with diagnoses including chronic respiratory failure (a long-term, ongoing condition where the lungs cannot properly move oxygen into the blood or remove carbon dioxide), tracheostomy (a surgically made opening that allows for breathing in and out through a tube in the neck), gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and ventilator dependent (a medical device to help support or replace breathing). During a review of Resident 85's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 12/16/2025, the H&P indicated Resident 85 lacked the capacity to understand and make decisions. During a review of Resident 85's Minimum Data Set (MDS - a resident assessment tool), dated 12/28/2025, the MDS indicated Resident 85 lacked the capacity to understand and was dependent upon staff to complete all areas of activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 85's Immunization Record, undated, the immunization record indicated no documentation of when or if the COVID Vaccine was offered or administered to Resident 85. There was no documentation that Resident 85 had declined the covid vaccination available in the clinical record. During a review of the facility's Flu (also known as influenza, a highly contagious respiratory illness caused by viruses that infect the nose, throat, and lungs), Pneumonia (lung infection that causes inflammation in one or both lungs, specifically filling the tiny air sacs with fluid or pus), and Covid consent tracker, dated 2025-2026, the tracker did not list Resident 85. During an interview on 1/29/2026 at 1:51 p.m. with Licensed Vocation Nurse (LVN) 6, LVN 6 stated that she (LVN 6) assists the Infection Prevention Nurse in data entry for vaccines. LVN 6 stated that there was no documentation in Resident 85's clinical record that Resident 85 was offered, declined, or was administered the Covid vaccine upon admission. During an interview with the Director or Nurses (DON) on 1/29/2026 at 3:30 p.m., the DON stated not offering vaccines to residents upon admission was not aligned with the facility's policy and stated not doing so put immunocompromised (having a weakened immune system that does not function at full capacity) residents at risks for infections and indicated each resident should be screened by the Infection Preventionist upon admission. During a review of the facility's policy and procedure (P&P) titled, Vaccinations, last reviewed 1/2025, the P&P indicated, all new residents shall be assessed for current vaccination status upon admission. The P&P indicated all vaccinations will need a consent/declination from the resident or responsible part before administration of vaccines. The P&P further indicated if vaccines are refused, the refusal shall be documented in the resident's medical record.