STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056412	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northridge Care Center	7836 Reseda Blvd Reseda, CA 91335

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39739 Based on interview and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior by one resident towards another) for one of six sampled residents (Resident 1) on 6/19/2024, when Resident 2 struck Resident 1 in the face with his closed fist. This deficient practice resulted in Resident 1 being subjected to physical abuse by Resident 2 while under the care of the facility and had the potential to cause emotional harm which could result to a feeling of embarrassment, low self-esteem, and self-worth. Findings: A review of Resident 1's Admission Record indicated Resident 1 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included alcoholic cirrhosis of the liver (overconsumption of alcohol that results in permanent scarring that damages the liver and interferes with its functioning), acute respiratory failure (when the air sacs of the lungs cannot release enough oxygen into the blood) and hypertension (high blood pressure). A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care planning tool) dated 4/22/2024 indicated Resident 1 had moderately intact cognition (ability to think and make decisions). The MDS indicated Resident 1 required moderate assistance from staff with oral hygiene, toileting hygiene, bathing, dressing and personal hygiene. A review of Resident 1's Situation - Background - Assessment - Recommendation (SBAR) Communication Form (SBAR - a form used to facilitate prompt communication regarding a change in a resident's health condition), dated 6/19/2024, indicated that on 6/19/2024 at around 1:00 p.m., Resident 1 was wheeling his (Resident 1) wheelchair inside the dining room when Resident 1 passed and wheeled beside Resident 2 and bumped on the wheelchair of Resident 2. Resident 2 got mad and punched Resident 1 in the face. A review of Resident 2's Admission Record indicated Resident 2 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), acute kidney failure (occurs when the kidneys suddenly become unable to filter waste products from the blood), and hypertension. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2's MDS dated [DATE] indicated Resident 2 had fully intact cognition. The MDS indicated Resident 2 required moderate assistance with oral hygiene and required maximum assistance from staff with toileting hygiene, bathing, dressing, and personal hygiene. A review of Resident 2's SBAR Communication Form dated 6/19/2024 indicated Resident 2 was involved in a resident-to-resident altercation in which Resident 2 got mad and punched another resident (Resident 1) in the face. A review of a letter written by Resident 2's Psychologist (a person who specializes in the study of mind and behavior or in the treatment of mental, emotional, and behavioral disorders) dated 6/20/2024 indicated Resident 2 was evaluated on 6/20/2024. The letter indicated Resident 2 displayed a high degree of anxiety (a feeling of fear, dread and uneasiness) and emotional dysregulation (an emotional response that is poorly regulated and does not fall within the traditionally accepted range of emotional reaction). The letter further indicated additional intervention was needed to calm Resident 2 down. During an interview with Resident 1 on 7/8/2024 at 9:45 a.m., Resident 1 stated he remembers the altercation with Resident 2 that took place on 6/19/2024. Resident 1 stated he bumped into Resident 2's wheelchair by accident, not intentionally. Resident 1 stated Resident 2 threw a punch at him, but he was not injured. During an attempted interview with Resident 2 on 7/8/2024 at 11:10 a.m., Resident 2 stated he did not want to be interviewed. During an interview with Certified Nursing Assistant 1 (CNA 1) on 7/8/2024 at 12:44 p.m., CNA 1 stated that on 6/19/2024, at around 12:00 p.m., CNA 1 was in the dining room assisting the residents with lunch. CNA 1 stated that around 1:00 p.m., Resident 1 finished lunch and was exiting the dining room in his wheelchair when he accidentally bumped into Resident 2's wheelchair. CNA 1 stated Resident 2 became upset and started to yell and threw his (Resident 2) right closed fist at Resident 1 and struck the left side of Resident 1's face as Resident 1 was wheeling himself out of the dining room. During an interview with the Social Services Director (SSD) on 7/8/2024 at 1:00 p.m., the SSD stated she spoke with Resident 2 on 6/20/2024, the day following the altercation. The SSD stated on 6/20/2024, Resident 2 was still upset about the altercation and admitted that he hit Resident 1 because Resident 1 provoked him by bumping into his wheelchair. During an interview with the Director of Nursing (DON) on 7/8/2024 at 1:40 p.m., the DON stated that the resident-to-resident altercation between Resident 1 and Resident 2 was reported to her. The DON stated staff (CNA 1) witnessed Resident 2 punch Resident 1 in the face while in the dining room, sometime after lunch. The DON stated that the act of Resident 2 punching Resident 1 in the face was considered abuse. The DON stated that it is the job of the facility to protect the residents from abuse and ensure residents are free from abuse. A review of the undated policy and procedure titled, Abuse & Mistreatment of Residents, indicated it is the policy of the facility to uphold a resident's right to be free from verbal, sexual, and mental abuse, corporal punishment, and involuntary seclusion.