STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2026
NAME OF PROVIDER OR SUPPLIER Northridge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to ensure staff monitored and documented intake (food and fluid consumption) and output (urine and stool amounts) in accordance with professional standards of practice and per the facility's policy and procedure (P&P) for one of six sampled resident (Resident 1), who had fluid restrictions. This deficient practice had the potential to result in unrecognized hydration needs and hypervolemia (fluid overload).Findings: During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted the resident on 12/11/2025 and readmitted the resident on 12/30/2025 with diagnoses including acute (sudden, intense flare-up) on chronic diastolic (pressure during the relaxing of the heart) congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic pulmonary edema (fluid in the lungs), and orthostatic hypotension (a sudden, temporary drop in blood pressure that occurs when standing up from a sitting or lying position). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/6/2026, the MDS indicated that Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was intact. The MDS indicated that Resident 1 was dependent on staff with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Registered Nurse (RN) Hospital to RN Facility admission Report, or admission Report, dated 12/30/2025 timed at 12:22 p.m., the admission Report indicated to restrict fluids 750 milliliters (ml - a unit of measurement) per day. During a review of Resident 1's Physician's Telephone Orders dated 12/30/2025, the Physician's Telephone Orders indicated an order for fluid restriction of 750 ml per day due to chronic pulmonary edema. During a review of Resident 1's Physician's Orders dated 1/7/2026, the Physician's Orders indicated not to leave a water pitcher at bedside. During a concurrent interview and record review on 2/25/2026 at 12:04 p.m., with Licensed Vocational Nurse 1 (LVN 1), reviewed Resident 1's Physician's Telephone Orders dated 12/30/2025, the physician order dated 1/7/2026, and Resident 1's Intake and Output (I/O) Record from 12/30/2025 to 1/7/2026. LVN 1 stated that the licensed nurses did not monitor or document Resident 1's I/O with the fluid restrictions since 1/7/2026. During a concurrent interview and record review on 2/25/2026 at 12:25 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 1's Physician's Telephone Orders dated 12/30/2025, the physician order dated 1/7/2026, and Resident 1's I/O Record from 12/30/2025 to 1/7/2026. RN 1 stated that since Resident 1 was under fluid restrictions of 750 ml per day with no water pitcher at bedside, the licensed nurses should continue to monitor I/O with close monitoring for any changes of condition especially since Resident 1 had heart problems with history of edema. During a review of the facility's P&P titled, Fluid Intake and Output, last reviewed on 11/20/2025, the P&P indicated, Fluid intake and output shall be recorded for residents with. and restricted fluids as ordered by physician. Daily intake and output shall be recorded for a minimum of 30 days as ordered by physician. During a review of the (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
	056412	A. Building B. Wing	02/25/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's P&P titled, Resident Hydration and Prevention of Dehydration, last reviewed on 11/20/2025, the P&P indicated, If potential inadequate intake and/or sign of symptoms of dehydration are observed, intake and output monitoring will be initiated and incorporated into the care plan. Nursing will monitor and document fluid intake and the dietician will be kept informed of status. The interdisciplinary team will update the care plan and document resident response to intervention until the team agrees that fluid intake and relating factors are resolved.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess and document a resident's fall risk assessment for two out of six sampled residents (Resident 1 and 2) by failing to: 1. Ensure Resident 1's Fall Risk Evaluation was completed thoroughly and accurately. 2. Ensure Resident 2's systolic blood pressure (SBP - the first number in a blood pressure reading, which measures the pressure in the arteries [pathway that carries blood away from the heart] when the heart beats) was completed lying and standing when performing Resident 2's Fall Risk Evaluation. These deficient practices had the potential to place the residents at risk of injury from falls.Findings: a. During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted the resident on 12/11/2025 and readmitted the resident on 12/30/2025 with diagnoses including acute (sudden, intense flare-up) on chronic diastolic (pressure during the relaxing of the heart) congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic pulmonary edema (fluid in the lungs), and orthostatic hypotension (a sudden, temporary drop in blood pressure that occurs when standing up from a sitting or lying position). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/6/2026, the MDS indicated that Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was intact. The MDS indicated that Resident 1 was dependent on staff with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Fall Risk Evaluation dated 12/30/2025, the Fall Risk Evaluation indicated the following:1) The section for history, current status, predisposing conditions.Upon admission and quarterly, at a minimum, thereafter, observe the resident status in the 11 clinical condition parameters listed below by assigning the corresponding score which best describes the resident. If the total score is 10 or greater, the resident should be considered at high risk for potential falls. Prevention protocol should be initiated immediately and documented on the care plan.Systolic blood pressure was marked as: No noted drop between lying and standing.2) The section for gait/balance.Observe the Resident's gait/balance, have them/they stand on both feet without holding onto anything, if safe to do so. If assistive devices are required, provide the device and then proceed. Walk straight forward; walk through a doorway; and make a turn. Check the response below that best describes the resident abilities.Not marked for any items including ‘not able to perform function'.3) The section for medications.Respond based on the following types of medications, but not marked for any items including ‘none of these medications taken currently or within last seven (7) days. During a review of Resident 1's Fall Risk Evaluation dated 12/30/2025, the FRE indicated a fall score of four (4 - not considered at high risk at potential falls). During a concurrent interview and record review on 2/24/2025 at 4:21 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 1's Fall Risk Evaluation dated 12/30/2025. RN 1 stated that he (RN 1) performed Resident 1's Fall Risk Evaluation on 12/30/2025 and stated Resident 1 was not able to stand up but RN 1 marked ‘no noted drop between lying and standing' for Resident 1's systolic blood pressure because there were no other options like a ‘non-applicable.' RN 1 stated RN 1 did not complete the sections of gait/balance and medications and stated the total score of four (4) with no risk of fall was not correct. When RN 1 was asked why the Fall Risk Evaluation should be done correctly, RN 1 stated that assessments were to establish the plan of care to reduce fall risks. b. During a review of Resident 2's admission Record, the admission Record indicated that the facility originally admitted the resident on 10/10/2020 and readmitted the resident on 12/29/2020 with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses including combined systolic and diastolic CHF, and hypertension (high blood pressure). During a review of Resident 2's MDS dated [DATE], the MDS indicated that Resident 2's cognition was intact. The MDS indicated that Resident 2 required moderate assistance with oral/personal hygiene, and supervision or touching assistance with toileting hygiene, upper/lower body dressing and toilet transfer. During a review of Resident 2's Fall Risk Evaluation dated 12/22/2025, the Fall Risk Evaluation indicated the following:1) The section for history, current status, predisposing conditions.Upon admission and quarterly, at a minimum, thereafter, observe the resident status in the 11 clinical condition parameters listed below by assigning the corresponding score which best describes the resident. If the total score is 10 or greater, the resident should be considered at high risk for potential falls. Prevention protocol should be initiated immediately and documented on the care plan.Ambulation/elimination status was marked as: Ambulatory (able to walk)/Continent (the ability to voluntarily control to urinate or have a bowel movement).Systolic blood pressure was marked as: No noted drop between lying and standing. During a review of Resident 2's Fall Risk Evaluation dated 12/22/2025, the Fall Risk Evaluation score indicated a score of eight (8 - not considered at high risk at potential falls). During an interview on 2/24/2026 at 11:20 a.m., in Resident 2's room, Resident 2 stated that sometimes Resident 2 went to the bathroom alone without staff's assistance and was able to self-clean. During a concurrent interview and record review on 2/25/2026 at 10:42 a.m., with Minimum Data Set Nurse 1 (MDSN), reviewed Resident 2's Fall Risk Evaluation dated 12/22/2025. MDSN 1 stated that MDSN 1 completed Resident 2's Fall Risk Evaluation. When MDSN 1 was asked how MDSN 1 obtained Resident 2's systolic blood pressure to compare lying and standing when performing the Fall Risk Evaluation, MDSN 1 stated that she (MDSN 1) did not measure Resident 2's systolic blood pressure when lying and standing. MDSN 1 stated that she used data with the blood pressure summaries done by the other nurses, but there were no records for Resident 2's standing blood pressures, so the Fall Risk Evaluation was not done correctly to assess Resident 2's fall risks. During a review of the facility's P&P titled, Promoting Safety, Reducing Falls, last reviewed on 11/20/2025, the P&P indicated, If caregivers are to prevent falls, they must have a working knowledge of the key factors that determine which residents are most at risk. Gait and balance disturbances. These are the second leading cause of falls, and it's important for caregivers to continually observe every resident's gait and balance. Changes in gait balance can be accompanied to prevent falls. Caregivers must constantly remind the residents to rise slowly from a lying or sitting position. This allows the circulatory system time to adjust to the change in position, preventing light-headedness.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interview and record review, the facility failed to ensure a physician telephone order indicated a signature and title of the licensed nurse who transcribed the information and failed to ensure a physician countersigned the telephone order per the facility's policy and procedure (P&P) for one of six sampled residents (Resident 1). This deficient practice had the potential to result in failure to deliver the necessary care and services.Findings: During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted the resident on 12/11/2025 and readmitted the resident on 12/30/2025 with diagnoses including acute (sudden, intense flare-up) on chronic diastolic (pressure during the relaxing of the heart) congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic pulmonary edema (fluid in the lungs), and orthostatic hypotension (a sudden, temporary drop in blood pressure that occurs when standing up from a sitting or lying position). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/6/2026, the MDS indicated that Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was intact. The MDS indicated that Resident 1 was dependent on staff with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Registered Nurse (RN) Hospital to RN Facility admission Report, or admission Report, dated 12/30/2025 timed at 12:22 p.m., the admission Report indicated to restrict fluids 750 milliliters (ml - a unit of measurement) per day. During a review of Resident 1's Physician's Telephone Orders dated 12/30/2025, the Physician's Telephone Orders indicated an order for fluid restriction of 750 ml per day due to chronic pulmonary edema. During a concurrent interview and record review on 2/24/2026 at 5:16 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 1's admission Report dated 12/30/2025 and Physician's Order Recap (a quick summary of the most important points) Report dated from 12/30/2025 through 1/1/2026. RN 1 stated that RN 1 was made aware of Resident 1's fluid restriction of 750 ml/day when RN 1 received the report from the hospital before Resident 1 arrived at the facility on 12/30/2025. RN 1 stated RN 1 missed inputting Resident 1's fluid restrictions of 750 ml per day on the physician's orders. During a concurrent interview and record review on 2/25/2026 at 12:19 p.m., with RN 1, reviewed Resident 1's physician order summary indicating active orders as of 2/1/2026 and Resident 1's Physician's Telephone Orders dated 12/30/2025 indicating to restrict fluids 750 ml per day. RN 1 stated that he did not transcribe the Physician's Telephone Orders for fluid restriction on 12/30/2025, and stated RN 1 could not tell who wrote the Physician's Telephone Orders because there was no name or signature of the person who carried the order. RN 1 stated Resident 1's Physician's Telephone Orders was incomplete and was not included in the physician orders until Resident 1 was transferred to the hospital on 2/8/2026. During a concurrent interview and record review on 2/25/2026 at 1:10 p.m., with the Assistant Director of Nursing (ADON) and the Medical Records Director (MRD), reviewed Resident 1's Physician's Telephone Orders dated 12/30/2025 written for ‘Fluid restriction of 750 ml per day due to chronic pulmonary edema.' The MRD stated that she could not locate the white color copy of Resident 1's Physician's Telephone Orders that should be returned to the facility within five days after Resident 1's physician signed the orders. The MRD reviewed Resident 1's current and discontinued physician's order for fluid restrictions of 750 ml per day, but there was no history of an entry in Resident 1's physician's orders for fluid restrictions of 750 ml per day. During a concurrent interview and record review on 2/25/2026 at 1:15 p.m., with the ADON, reviewed Resident 1's Physician's Telephone Orders dated 12/30/2025. The ADON stated that she could not tell who (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transcribed the Physician's Telephone Orders and stated that person should be a licensed nurse, and that person should include the physician orders in the charting system. The ADON stated that the fluid restriction of 750 ml per day was not noted in the physician order summary. The ADON stated whoever transcribed Resident 1's Physician's Telephone Orders on 12/30/2025 did not follow the protocol. The ADON stated the ADON could not tell if the person was authorized to carry out the physician order either. During a review of the facility's P&P titled, Telephone Orders, last reviewed on 11/20/2025, the P&P indicated, Verbal telephone orders may only be received by licensed personnel. Orders must be reduced to writing by the person receiving the order and recorded in the resident's medical record. The entry must contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information. Telephone orders must be countersigned by the physician during his or her next visit or electronically.