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	05/08/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure two of three sampled residents (Resident 1 and Resident 2) received treatment and care in accordance with professional standards of practice by:1. Failing to ensure Resident 1 received Methadone (a medication used to treat severe pain), as ordered by the physician on 4/27/2026. 2. Failing to ensure Resident 2 received Apixaban (a medication used to assist with preventing a stroke [blood flow to part of the brain is blocked]), Losartan Potassium (a medication used to treat high blood pressure), Famotidine (a medication used to decrease the amount of stomach acid produced in the body) and Modafinil (a medication used to treat excessive sleepiness), as ordered by the physician on 4/22/2026 and 4/27/2026. These deficient practices placed Resident 1 at risk for unmanaged pain and diminished quality of life, and placed Resident 2 at risk for adverse clinical outcomes, including stroke, uncontrolled blood pressure, excessive sleepiness, and diminished quality of life. 1. During a review of Resident 1's admission Record dated 12/6/2023, the admission Record indicated the facility admitted Resident 1 on 12/6/2023 with diagnoses that included cerebral infarction (stroke, loss of blood flow to a part of the brain), hypertension (HTN- high blood pressure), glaucoma (eye condition that damages the optic nerve [the connection that lets your eyes send signals to your brain describing what they detect]), and malignant neoplasm of stomach (stomach cancer). During a review of Resident 1's Physician Order Summary dated 8/25/2025, the Physician Order Summary indicated Resident 1 had a physician's order for Methadone Hydrochloride tablet five milligrams (mg- unit of measurement) every eight hours for right knee aching pains. During a review of Resident 1's History and Physical (H&P - a comprehensive medical document completed by a physician upon a resident's admission) dated 12/16/2025, the H&P indicated Resident 1 was able to make decisions regarding activities of daily living (ADL- routine self-care tasks or activities such as bathing, dressing and toileting, a person performs daily to care for themselves). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 2/4/2026, the MDS indicated Resident 1's cognition (ability to think and make decisions) was moderately impaired. The MDS further indicated Resident 1 required moderate assistance with eating and maximum assistance from staff with oral hygiene, toileting and personal hygiene.During a review of Resident 1's Physician Order Summary with a start date of 8/25/2025, the Physician Order Summary indicated to give one tablet by mouth every eight hours for right knee aching pains. During a review of Resident 1's Medication Administration Record (MAR - a report detailing the medications administered to a resident by a health care professional) dated April 2026, the MAR indicated that nursing staff did not sign off that Resident 1 received the scheduled Methadone five mg dose on 4/27/2026 at 5:00 a.m. During an interview on 5/1/2026 at 10:55 a.m., with Resident 1, Resident 1 stated that nursing staff were occasionally late administering his (Resident 1) pain medication during the night shift (11 p.m. to 7 a.m.). During a concurrent interview and record review on 5/8/2026 at 1:30 p.m., with the facility Administrator (ADM), Resident 1's MAR for April 2026 was reviewed. The ADM confirmed that the MAR entry for Resident 1's Methadone five mg dose scheduled on 4/27/2026 was left blank and had not been signed off by nursing staff. The (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADM further stated that Resident 1 should have received the medication as ordered by the physician.2. During a review of Resident 2's admission Record dated 9/18/2023, the admission Record indicated the facility admitted Resident 2 on 9/18/2023, with the most recent readmission on [DATE] with diagnoses that included hemiplegia (paralysis [a condition in which you are unable to move all or part of your body] affecting one side of the body) affecting the right side, narcolepsy (a sleep disorder that causes extreme daytime sleepiness), atrial fibrillation (an abnormal heart rhythm), dementia (a progressive state of decline in mental abilities) and hypertension. During a review of Resident 2's H&P dated 5/13/2025, the H&P indicated Resident 2 does not have the capacity to understand and make decisions. During a review of Resident 2's Physician Order Summary dated 12/24/2024, the Physician Order Summary indicated Resident 2 had physician orders for the following medications: Apixaban oral tablet 2.5 mg, give one tablet two times a day for cerebrovascular accident (CVA - known as stroke, a sudden interruption of blood flow to the brain) prophylaxis (preventive care or treatment to preserve health and stop disease before it starts). Famotidine oral tablet 20 mg, give one tablet two times a day for Gastroesophageal Reflux Disease (GERD- a disorder where the contents of your stomach flow back into your esophagus [a hollow, muscular tube that connects your throat to your stomach]) Losartan Potassium oral tablet 25 mg, give one tablet two times a day for hypertension Modafinil oral tablet 100 mg, give one tablet in the morning for narcolepsy. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was dependent on staff for activities of daily living. During a review of Resident 2's MAR dated April 2026, the MAR indicated nursing staff failed to document administration of the following scheduled medications: Apixaban 2.5mg on 4/22/2026 and 4/27/2026 at 6:30 a.m. Famotidine 20mg on 4/22/2026 and 4/27/2026 at 6:00 a.m. Losartan Potassium 25mg on 4/22/2026 and 4/27/2026 at 6:00 a.m. Modafinil 100mg oral tablet on 4/22/2026 and 4/27/2026 at 6:00 a.m.During a concurrent interview and record review on 5/8/2026 at 1:30 p.m. with the ADM, Resident 2's MAR dated April 2026 was reviewed. The ADM confirmed that Resident 2's scheduled morning doses for Apixaban 2.5 mg due at 6:30 a.m. on 4/22/2026 and 4/27/2026, Famotidine 20 mg due at 6:00 a.m. on 4/22/2026 and 4/27/2026, Losartan Potassium 25 mg due at 6:00 a.m. on 4/22/2026 and 4/27/2026, and Modafinil 100mg oral tablet due at 6:00 a.m. on 4/22/2026 and 4/27/2026 were left blank and had not been signed off by nursing staff as administered. The ADM further confirmed that nursing staff are required to document on the MAR immediately following administration of the medication to verify that the medications were administered as ordered by the physician. During a review of the facility policy and procedure (P&P) titled Administering Medications last reviewed on 11/20/2025, the P&P indicated medications are administered in a safe and timely manner, and as prescribed.staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with the prescribers orders.The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.