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	05/13/2026

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 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 interview and record review the facility failed to ensure facility staff notified the resident representative after one of three sampled residents (Resident 1) had a change of condition after being found on the floor next to the bed with an injury.This deficient practice resulted in Resident 1's representative not being notified of Resident 1's change of condition and had the potential for of the resident representative to be unable to make informed decisions regarding Resident 1's treatment and plan of care. Findings:During a review of Resident 1's Face Sheet, the Face Sheet indicated that the facility originally admitted Resident 1 on 9/15/2025 and most recently readmitted Resident 1 on 9/27/2025 with diagnoses that included type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, need for assistance with personal care, dysphagia (difficulty swallowing), urinary tract infection (UTI-an infection in the bladder [a hollow, muscular organ that stores urine or urinary tract [the body's drainage system designed to produce, store and remove urine [liquid waste and extra water]), history of falling and depression.During a review of Resident 1's History and Physical (H&P) dated 9/16/2025, the H&P indicated Resident 1 has the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/23/2026, the MDS indicated Resident 1's cognition (ability to think and make decisions) was severely impaired. The MDS further indicated Resident 1 required setup assistance with eating and oral hygiene, and supervision with toileting hygiene, upper and lower body dressing and personal hygiene, and dependent on staff for showering. During a review of Resident 1's Change of Condition form (COC-a form used by the facility to document changes in resident's condition including actions taken and notification of the physician and responsible party) dated 4/29/2026, the COC form indicated at approximately 1:15 a.m., Resident 1 was found in the room on the floor mat next to the bed after hearing the resident (Resident 1) yelled for help, resident (Resident 1) was on floor mat (a mat placed next to a residents bed to prevent injury in case of a fall or accident) and verbalized, she slid from bed because she wanted to go to the restroom.resident (Resident 1) noted to have a skin tear (a wound often occurring in older adults or those with fragile skin) of 3 centimeters (cm-unit of measurement) on the right upper arm near elbow. treatment rendered.Resident 1 is self-responsible. During an interview on 5/13/2026 at 10:10 a.m. with Responsible Party (RP) 1, RP 1 stated that the facility did not inform RP 1 that Resident 1 had a fall in the facility. RP 1 stated that RP 1 called on 4/29/2026 around 8:30 a.m. to check on Resident 1's status and was informed Resident 1 had a fall in the middle of the night. RP 1 stated that RP 1 should have been informed at the time of the fall by facility staff. During an interview on 5/13/2026 at 2:30 p.m. with the Director of Nursing (DON), the DON confirmed Resident 1 was found on the floor mat next to Resident 1's bed on 4/29/2026 around 1:15 a.m. The DON confirmed that facility staff should have notified RP 1 at the time Resident 1 was found next to Resident 1's bed. During a review of the facility's policy and procedure (P&P) titled Change of Condition or Status last reviewed on 11/20/2025, the P&P indicated Our facility promptly notifies the resident, his or her attending physician, the resident representative of changes in the resident's medical/mental condition and/or status.Unless otherwise instructed by the resident, a nurse will notify the resident's representative (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when the resident is involved in any accident or incident that results in an injury including injuries of an unknown source, there is a significant change in the resident's physical, mental, or psychological status.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) laboratory results were communicated with the physician in a timely manner.This deficient practice had the potential for Resident 1 to have a delay in care and services, increased risk for worsening infection and decrease in overall health status.Findings: During a review of Resident 1's Face Sheet, the Face Sheet indicated that the facility originally admitted Resident 1 on 9/15/2025 and most recently readmitted Resident 1 on 9/27/2025 with diagnoses that included type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, need for assistance with personal care, dysphagia (difficulty swallowing), urinary tract infection (UTI-an infection in the bladder [a hollow, muscular organ that stores urine or urinary tract [the body's drainage system designed to produce, store and remove urine [liquid waste and extra water]), history of falling and depression (mood disorder that causes persistent feeling of sadness, emptiness and a loss of interest in activities). During a review of Resident 1's History and Physical (H&P) dated 9/16/2025, the H&P indicated Resident 1 has the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/23/2026, the MDS indicated Resident 1's cognition (ability to think and make decisions) was severely impaired. The MDS further indicated Resident 1 required setup assistance with eating and oral hygiene, and supervision with toileting hygiene, upper and lower body dressing and personal hygiene, and dependent on staff for showering. During a review of Resident 1's laboratory results report dated 4/28/2026, the laboratory results for complete blood count (CBC- a blood test that measures the number and size of the different cells in your blood) and a basic metabolic panel (BMP-a blood test that checks the levels of different substances in your blood) indicated the laboratory work was completed on 4/28/2026 at 2:45 p.m. The laboratory report further indicated that the laboratory results were sent to the facility on 4/28/2026 at 9:41 p.m. and Registered Nurse 3 (RN 3) reviewed the laboratory results on 4/29/2026 at 6:59 a.m. During an interview and concurrent record review on 5/13/2026 at 1:00 p.m. with RN 3, the CBC and BMP results for Resident 1 on 4/28/2026 were reviewed with RN 3. RN 3 stated he works during the 7 a.m. to 3 p.m. shift. RN 3 confirmed that he reviewed Resident 1's CBC and BMP results, on 4/29/2026 at 6:59 a.m. and that he sent the results to Resident 1's physician. During an interview and concurrent record review on 5/13/2026 at 2:30 p.m. with the Director of Nursing (DON), Resident 1's laboratory results for CBC and BMP, dated 4/28/2026, were reviewed with the DON. The DON confirmed that Resident 1's laboratory results were received by the facility on 4/28/2026 at 9:41 p.m. The DON stated that the laboratory results should be sent to the physician in a timely manner, as soon as possible. The DON stated that the licensed nurse should not have waited until 4/29/2026 to inform Resident 1's physician regarding the laboratory results. During a review of the facility's policy and procedure (P&P) titled Test Results with a last reviewed date of 11/20/2025, the P&P indicated The resident's attending physician will be notified of the results of diagnostic tests.Results of laboratory, radiological and diagnostic tests shall be reported in writing to the resident's attending physician or to the facility. Should the test results be provided to the facility, the attending physician shall be promptly notified of the results. The director of nursing services, or charge nurse receiving the test results, shall be responsible for notifying the physician or such test results.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) had complete information documented on the change of condition form (COC-a form used by the facility document changes in resident's condition including actions taken and notification of the physician and responsible party) by failing to document Resident 1's physician's response to Resident 1's change of condition.This deficient practice had the potential to delay necessary treatment, care and services, placing Resident 1 at risk for a decline in overall health status.Findings:During a review of Resident 1's Face Sheet, the Face Sheet indicated that the facility admitted Resident 1 on 9/15/2025 and most recently readmitted Resident 1 on 9/27/2025 with diagnoses that included type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, need for assistance with personal care, dysphagia (difficulty swallowing), urinary tract infection (UTI-an infection in the bladder [a hollow, muscular organ that stores urine or urinary tract [the body's drainage system designed to produce, store and remove urine [liquid waste and extra water]), history of falling and depression (mood disorder that causes persistent feeling of sadness, emptiness and a loss of interest in activities).During a review of Resident 1's History and Physical (H&P) dated 9/16/2025, the H&P indicated Resident 1 has the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/23/2026, the MDS indicated Resident 1's cognition (ability to think and make decisions) was severely impaired. The MDS further indicated Resident 1 required setup assistance with eating and oral hygiene, and supervision with toileting hygiene, upper and lower body dressing and personal hygiene, and dependent on staff for showering. During a review of Resident 1's COC form dated 4/28/2026, the COC form indicated resident (Resident 1) unable to sit up with chills and febrile (elevated body temperature), denied pain or discomfort, but general weakness.All due meds (medications) given with acetaminophen (medication used to treat mild pain and elevated body temperatures) 325 milligrams (mg-unit of measurement) 2 tablets.MD (medical doctor/physician) being informed.During an interview and concurrent record review on 5/12/2026 at 3:20 p.m. with Licensed Vocational Nurse (LVN) 1, the COC form for Resident 1, dated 4/28/2026 was reviewed. LVN 1 confirmed that LVN 1 completed the COC form dated 4/28/2026 for Resident 1. LVN 1 stated that Resident 1 experienced weakness and had an elevated body temperature on 4/28/2026. LVN 1 confirmed that acetaminophen 325 milligrams (mg-unit of measurement) 2 tablets were provided to Resident 1. LVN 1 stated that LVN 1 informed Registered Nurse Supervisor (RNS) 1. LVN 1 stated that RNS 1 informed Resident 1's physician of the change of condition. LVN 1 confirmed that LVN 1 did not document Resident 1's physician's response to Resident 1's change of condition.During an interview on 5/13/2026 at 11:20 a.m. with RNS 1, RNS 1 stated that LVN 1 informed RNS 1 of the change of condition for Resident 1 on 4/28/2026. RNS 1 stated that RNS 1 informed Resident 1's physician and that Resident 1's physician instructed RNS 1 to continue to monitor Resident 1. RNS 1 stated that she informed LVN 1 of Resident 1's physician's instructions. RNS 1 stated that RNS 1 did not document the communication between RNS 1 and Resident 1's physician.During an interview and concurrent record review of 5/13/2026 at 2:30 p.m. with the Director of Nursing (DON), the COC form for Resident 1, dated 4/28/2026 was reviewed. The DON confirmed Resident 1's COC form dated 4/28/2026 indicated that the physician was informed. The DON confirmed that the nursing staff should have documented Resident 1's physician's response on the COC form to ensure continuity of care for Resident 1.During a review of the facility's policy and procedure (P&P) titled Change in a Resident's Condition or Status with a last reviewed date of 11/20/2025, the P&P indicated Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.The nurse will notify the resident's attending physician or physician on call when there has been.significant change in the resident's (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical/emotional/mental condition.The nurse will record in the resident's medial record information relative to changes of in the resident's medical/mental condition or status.