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	05/20/2026

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 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's licensed nurses failed to accurately complete Fall Risk Evaluation assessment for one of four sampled residents (Resident 1). This deficient practice had the potential to place the resident at increased risk for falls and fall-related injuries due to the failure to appropriately identify and evaluate fall risk factors.During a review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated that the facility originally admitted Resident 1 on 10/10/2020 and readmitted on [DATE] with diagnoses that included congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hypertension (high blood pressure), and diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). 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, reason, and function) was intact. The MDS further indicated that Resident 1 required setup or clean-up assistance from staff for all Activities of Daily Living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Change of Condition (COC - an acute, abnormal alteration in a resident's physical or mental baseline) Assessment Form dated 5/2/2026, timed at 10:33 p.m., the COC Assessment Form indicated that on 5/2/2026, at 10:30 p.m., Registered Nurse 1 (RN 1) saw Resident 1 sitting on the floor. The COC Assessment Form indicated that Resident 1 reported seeing a roach on the floor while lying in bed, attempted to reach for the roach, fell out of bed, and broke the footboard (upright, flat, or rigid support attached perpendicular to the end of a resident's bed). During a review of Resident 1's Fall Risk Evaluation dated 5/4/2026, the Fall Risk Evaluation indicated the following: Under 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. History of falls (past three [3] months) was marked as ?No falls in past three (3) months' despite the COC Assessment Form (dated 5/2/2026) documentation of a fall. During a review of Resident 1's Fall Risk Evaluation dated 5/4/2026, the FRE indicated a total fall risk score of seven (7), which did not identify/consider Resident 1 as being at high risk for falls. During a concurrent interview and record review on 5/20/2026 at 2:53 p.m., with the Director of Nursing (DON), the DON reviewed Resident 1's COC Assessment Form dated 5/2/2026 and Fall Risk Evaluation dated 5/4/2026. The DON stated that she (DON) completed the Fall Risk Evaluation dated 5/4/2026. The DON further stated that the Fall Risk Evaluation was completed on 5/4/2026 after the fall incident that occurred on 5/2/2026 to identify the root causes of the fall incident and implement measures to prevent future falls. The DON stated that the 5/2/2026 fall should have been included in the 5/4/2026 assessment when responding to the question regarding history of falls within the previous three months. The DON stated the omission occurred because she was confused when completing that (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	portion of the assessment. During a review of the facility's policy and procedures (P&P) titled Assessing Falls and Their Causes last reviewed on 11/20/2025, the P&P indicated, Purpose: The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. When a resident falls, the following information should be recorded in the resident's medical record. Completion of a falls risk assessment. Appropriate interventions taken to prevent future falls.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on interview and record review, the facility failed to provide radiology (a branch of medicine that uses imaging technology to look inside the body) services in accordance with the physician's order for one of four sampled residents (Resident 2), following a fall incident. The facility failed to ensure timely completion of a radiology service to evaluate Resident 2's left foot, which was noted to have swelling and pain rated four (4) out of 10 (on a scale where zero indicates no pain and 10 indicates the worst pain imaginable). This deficient practice had the potential to result in a delay in diagnosis and treatment of the resident's condition.During a review of Resident 2's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated that the facility admitted Resident 2 on 1/30/2026 with diagnoses that included right arm fracture (broken bone), epilepsy (a chronic brain disorder that causes a person to have recurring seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), dementia (a progressive state of decline in mental abilities), and history of falling. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 2/3/2026, the MDS indicated Resident 2's cognition (ability to think, reason, and function) was severely impaired. The MDS further indicated that Resident 2 was dependent on staff for toileting hygiene, showering/bathing and upper body dressing, and required maximal assistance for eating, oral and personal hygiene, and lower body dressing, and required moderate assistance for sit-to-stand and chair/bed-to-chair transfers. During a review of Resident 2's Change of Condition (COC - an acute, abnormal alteration in a resident's physical or mental baseline) Assessment Form dated 5/19/2026, the COC Assessment Form indicated the following:At 3:30 a.m., staff found Resident 2 sitting on a landing pad (a cushioned floor pad designed to help prevent injury should a person fall) on the left side of the bed.At 4:20 p.m., Resident 2 reported left foot pain, and swelling noted to the left dorsal (towards the back) foot upon skin assessment. Resident 1 stated that the resident had slid from the bed last night (5/19/2026) at 3:30 a.m. and landed on the left foot with the full body weight. Pain was rated four (4) out of 10. Resident 1's physician was notified and a stat (immediately) order was obtained for an x-ray (a painless, noninvasive medical imaging test that uses a small, safe amount of electromagnetic radiation to produce pictures of the inside of your body) of the left foot. During a review of Resident 2's Physician Order dated 5/19/2026, timed at 4:21 p.m., the Physician Order indicated an order for a stat x-ray of Resident 2's left foot. During a review of Resident 2's radiology results report dated 5/20/2026, the report indicated the following:Examination Date: 5/20/2026 at 9:49 a.m.Reported Date: 5/20/2026 at 10:17 a.m.Conclusion: No acute osseous (bony or made of bone) findings. Recommend a repeat multi-view imaging in one (1) week or sooner if clinically warranted especially if symptoms continue to persist or progress. During a review of Resident 2's Progress Notes dated 5/20/2026, timed at 7:53 a.m., the Progress Notes indicated the Director of Nursing (DON) notified Resident 2's physician that the stat x-ray order for Resident 2's left foot had not yet been completed. During a concurrent interview and record review on 5/20/2026 at 2:25 p.m., with the DON, the DON reviewed Resident 2's COC Assessment Form dated 5/19/2026 and the Physician's stat Order for the left foot x-ray. When the DON was asked how soon the facility was required to provide radiology services for a stat order, the DON stated there was no specific timeframe; however, the service such as x-ray should be completed as soon as possible, typically within four (4) hours of the order. The DON further stated that if the service was not completed within that timeframe, nursing staff should notify the physician regarding the delay; however, this notification was not completed for Resident 2. The DON stated that the stat x-ray order was obtained on 5/19/2026 at 4:21 p.m. and the radiology service was completed on 5/20/2026 at 9:49 a.m. The DON further stated that a stat x-ray may be ordered to rule out a possible fracture or injury related to a fall incident that occurred on 5/19/2026 at approximately 3:30 a.m. During a review of the facility's (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy and procedures (P&P) titled Request for Diagnostic Services last reviewed on 11/20/2025, the P&P indicated, Orders for diagnostic services will be promptly carried out as instructed by the physician's order. Emergency requests must be labeled stat to assure that prompt action is taken. During a review of the facility's P&P titled Change in a Resident's Condition or Status, last reviewed on 11/20/2025, the P&P indicated, The nurse will notify the resident's attending physician or physician on call when there has been a(an). need to alter the resident's medical treatment significantly. specific instruction to notify the physician of changes in the resident's condition.

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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. Based on interview and record review, the facility failed to implement and maintain an effective infection prevention and control program when Certified Nursing Assistant 1 (CNA 1) failed to report the presence of roaches observed in a resident's room for one of four sampled residents' rooms (Resident 3's room). This deficient practice had the potential to create unsanitary conditions and contribute to cross-contamination (the transfer of harmful germs from one surface, object, or food to another), placing residents, staff, and visitors at increased risk for infection.During a review of Resident 3's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated that the facility admitted Resident 3 on 5/13/2026 with diagnoses that included left total hip replacement, osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 3's History and Physical (H&P - a comprehensive medical document that includes a detailed account of a resident's medical history, a physical examination, a clinical assessment, and a care plan) Evaluation dated 5/15/2026, the H&P Evaluation indicated, Resident 3 had the capacity to make decisions and communicate needs. During a review of the Pest Control Service Report dated 4/29/2026, the service report indicated that the facility Maintenance Supervisor (MS) reported concerns regarding American roaches (an average length around four centimeters [cm - a unit of measurement], and these cockroaches may move indoors, seeking warmer environments and food. Cockroaches may enter houses via wastewater plumbing, underneath doors, or via air ducts or other openings in the walls, windows or foundation). The Technician 1, from the pest control services, found live roach activity in drains and recommended that drains be kept clean. The report further indicated that increased pest activity, including potential activity within the facility, could be expected for several days following treatment. During an interview on 5/20/2026 at 11:30 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she (CNA) observed a roach crawling on the wall in Resident 3's room. CNA 1 stated she (CNA 1) while wearing gloves, captured and killed the roach on the floor. CNA 1 described the roach as brownish in color and approximately one and one-half inches (in- unit of measurement) in length. CNA 1 stated a family member was present at the bedside at the time of the incident. During a concurrent interview on 5/20/2026 at 11:42 a.m., with Resident 3 and Family Member 1 (FM 1), in Resident 3's room, FM 1 stated that a couple of days ago, they observed a roach on the ceiling and notified staff. FM 1 stated staff entered the room and killed the roach. FM 1 described the roach as large, brownish in color, and noted it was moving on the wall and ceiling. During an interview on 5/20/2026 at 12:30 p.m., with the MS, the MS stated that no reports - verbal or written, including through maintenance logs, had been received regarding roach activity from staff, including CNA 1. During a follow-up interview on 5/20/2026 at 12:35 p.m., with CNA 1, CNA 1 stated, that after killing the roach in Resident 3's room approximately two days earlier, she (CNA 1) intended to report the incident to the MS but forgot and subsequently left the facility without notifying anyone. When asked why staff should report pest sightings, CNA 1 stated that reporting is necessary so the facility can investigate pest activity and take corrective action. CNA 1 further stated that roaches can carry germs and pose a risk to resident health. During a concurrent interview and record review on 5/20/2026 at 2:14 p.m., with Technician 1, Technician 1 reviewed the Pest Control Service Report dated 4/29/2026 and stated that while no roaches were observed inside the building during the visit, roach activity was identified in exterior drains. Technician 1 stated treatment was completed and stated that increased roach activity including potential movement into the building through drains, cracks or gaps, may occur following treatment. During an interview with the Director of Nursing (DON) on 5/20/2026 at 2:45 p.m., the DON stated when CNA 1 observed and killed a roach in Resident 3's room, the incident should have been reported immediately to supervisory and maintenance personnel for follow-up. The DON further stated that cockroaches pose a risk of transmitting germs and that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	failure to follow reporting procedures and pest control protocols could negatively impact residents and the facility environment. During an interview with the Infection Control Preventionist (ICP) on 5/20/2026 at 3:09 p.m., the ICP stated that any sighting of live or dead roaches should be reported promptly to supervisory staff or maintenance personnel for communication with pest control services. The ICP further stated that staff were aware roaches can carry pathogens (any disease-producing agent or organism) that may negatively impact resident health and contaminate environments. The ICP stated that failure to report such sightings is inconsistent with the facility's infection prevention and control program. During a review of the facility's policy and procedures (P&P) titled Infection Control last reviewed on 11/20/2025, the P&P indicated, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The objectives of our infection control policies and practices are to: a. prevent, detect, investigate, and control infections in the facility; b. maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public, During a review of the Centers for Disease Control and Prevention (CDC - the primary United States federal agency responsible for protecting public health and safety) Guidelines titled Environmental Infection Control in Health-Care Facilities last updated July 2019, the CDC guidelines indicated, E. Environmental Services. 6. Pest Control. Cockroaches, flies and maggots, ants, mosquitoes, spiders, mites, midges, mice are among the typical arthropods (any creature with no backbone, a hard outer shell, and jointed legs) and vertebrate (any animal that has a backbone) pest populations found in health-care facilities. Insects can serve as agents for the mechanical transmission of microorganisms, or as active participants in the disease transmission process by serving as a vector. From a public health and hygiene perspective, arthropod and vertebrate pests should be eradicated from all indoor environments, including health-care facilities,

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on interview and record review, the facility failed to maintain a pest-free environment by not ensuring effective pest control in one of four sampled residents' rooms (Resident 3's room). This deficient practice placed the residents at risk for vector-borne diseases (illnesses caused by viruses or bacteria transmitted through the bites of infected living organisms, primarily blood-feeding insects).During a review of Resident 3's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated that the facility admitted Resident 3 on 5/13/2026 with diagnoses that included left total hip replacement, osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 3's History and Physical (H&P - a comprehensive medical document that includes a detailed account of a resident's medical history, a physical examination, a clinical assessment, and a care plan) Evaluation dated 5/15/2026, the H&P Evaluation indicated Resident 3 had the capacity to make decisions and communicate needs. During a review of the Pest Control Service Report dated 4/29/2026, the service report indicated that the facility Maintenance Supervisor (MS) reported concerns regarding American roaches (an average length around four centimeters [cm - a unit of measurement], and these cockroaches may move indoors, seeking warmer environments and food. Cockroaches may enter houses via wastewater plumbing, underneath doors, or via air ducts or other openings in the walls, windows or foundation). The Technician 1, from the pest control services, found live roach activity in drains and recommended that drains be kept clean. The report further indicated that increased pest activity, including potential activity within the facility, could be expected for several days following treatment. During an interview on 5/20/2026 at 11:30 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she (CNA) observed a roach crawling on the wall in Resident 3's room. CNA 1 stated she (CNA 1) while wearing gloves, captured and killed the roach on the floor. CNA 1 described the roach as brownish in color and approximately one and one-half inches (in- unit of measurement) in length. CNA 1 stated a family member was present at the bedside at the time of the incident. During a concurrent interview on 5/20/2026 at 11:42 a.m., with Resident 3 and Family Member 1 (FM 1), in Resident 3's room, FM 1 stated that a couple of days ago, they observed a roach on the ceiling and notified staff. FM 1 stated staff entered the room and killed the roach. FM 1 described the roach as large, brownish in color, and noted it was moving on the wall and ceiling. During a concurrent interview and record review on 5/20/2026 at 2:14 p.m., with Technician 1, Technician 1 reviewed the Pest Control Service Report dated 4/29/2026 and stated that while no roaches were observed inside the building during the visit, roach activity was identified in exterior drains. Technician 1 stated treatment was completed and stated that increased roach activity including potential movement into the building through drains, cracks or gaps, may occur following treatment. During an interview with the Infection Control Preventionist (ICP) on 5/20/2026 at 3:09 p.m., the ICP stated that any observed live or dead roaches should be reported to the supervisory or maintenance staff for communication with pest control services. The ICP further stated that staff were aware roaches can carry pathogens (any disease-producing agent or organism) and may negatively impact resident health. During a review of the facility's policy and procedures (P&P) titled Pest Control last reviewed on 11/20/2025, the P&P indicated, Our facility shall maintain an effective pest control program. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.