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	06/25/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a call light (a device used by a resident to signal his/her need for assistance from staff) was within reach of a resident while the resident was in bed for one of three sampled residents (Resident 1). This deficient practice had the potential to delay the resident's ability to request assistance, which could result in delayed staff response, delayed provision of necessary care and services, and unmet resident needs. During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted the resident on 7/10/2025 and was readmitted on [DATE] with diagnoses that included encephalopathy (brain disorder that affect brain function), type 2 diabetes mellitus (DM-a chronic condition in which the body does not use insulin [a vital hormone produced by the pancreas that regulates blood sugar] effectively, resulting in elevated blood sugar levels) with foot ulcer (an open sore or wound on the foot that may involve the skin and underlying tissue) and chronic respiratory failure (a long-term condition in which the lungs cannot adequately oxygenate the body, resulting in low oxygen levels) with hypoxia (a medical condition where your body's tissues and organs do not receive enough oxygen to function properly). During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 4/14/2026, the MDS indicated Resident 1 was cognitively (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) intact and required maximal assistance from staff for toileting hygiene, sit-to-lying, and lying-to-sitting on the side of the bed. During a concurrent observation and interview on 6/23/2026 at 10:00 a.m., with Licensed Vocational Nurse 1 (LVN 1) observed Resident 1 lying in bed with the call light placed on top of the bedside table (a small, accessible piece of furniture placed next to a resident's bed) and not within the resident's reach. LVN 1 stated the call light should have been within Resident 1's reach so the resident could request staff assistance. LVN 1 further stated that if the call light was not within reach, the resident could experience a delay in receiving needed care and services. During an interview on 6/25/2026 at 3:45 p.m., with the Director of Nursing (DON), the DON stated the call light should have been kept within Resident 1's reach while the resident was in bed so the resident could request assistance as needed. The DON further stated that failure to ensure the call light was within reach could result in a delay in providing the care and services the resident needed. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, dated 11/20/2025, the P&P indicated to ensure timely responses to the resident's requests and needs. The P&P further indicated to ensure that the call light is accessible to the resident when in bed or wheelchair in room, from the toilet or shower room if necessary.

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 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 staff failed to follow up with the physician after notification of a change of condition (COC- a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) when a resident had an abnormal laboratory result and failed to monitor the resident after a change of condition for one of five sampled residents (Resident 5). This deficient practice had the potential result to negatively affect the provision of necessary care and services.Findings: a. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 2/14/2026 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one entire side of the body) following cerebral infarction (refers to tissue death in the brain caused by a blocked blood vessel) affecting left dominant side, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and cerebral infarction unspecified During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 2/17/2026, the MDS indicated that Resident 5 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), and dependent on staff with toileting hygiene, shower/bathe self, lower body dressing, and lying to sitting on side of bed. During a review of Resident 5's laboratory results for Comprehensive Metabolic Panel (CMP- type of blood test) and CBC differential (a standard blood test that provides a specific breakdown of distinct types of blood cells) dated 2/16/2026 19:08, the document indicated abnormal labs result. During a review of Resident 5's Change of Condition (COC-/ Interact Assessment Form Situation, Background, Assessment, Recommendation [SBAR]- a form filled out by licensed nursing staff for the purpose of communicating information about a resident's condition or other issue to other members of the health care team, including a resident's physician) effective date 2/16/2026 20:00, the document indicated under licensed nurse note, physician notified, awaiting response for new orders. There was no follow up documentation indicating if there was a physician order or not. During a concurrent interview and record review on 6/23/2026 at 4:10 p.m., with the Director of Nursing (DON), reviewed Resident 5's lab results dated 2/16/2026 19:08 and Resident 5's COC/ Interact Assessment Form SBAR effective date 2/16/2026 20:00. The DON stated the nurse should have followed up with the physician regarding Resident 5's abnormal lab results. The DON stated that it can negatively affect and delay providing the necessary care and services that the residents need. b. During a record review of Resident 5's COC/ Interact Assessment Form SBAR effective date 2/16/2026 20:00, the document indicated under licensed nurse note that the physician was notified. During a review of Resident 5's Licensed Nurse Note Type: Change of condition notes, the documents indicated there was no documented evidence that Resident 5's Licensed Nurse Note Type: Change of condition note for 2/17/2026 3 p.m. to 11:00 p.m. shift was completed. During a concurrent interview and record review on 6/24/2026 at 4:15 p.m., with Licensed Vocational Nurse 4 (LVN 4), reviewed Resident 5' COC/ Interact Assessment Form SBAR effective date 2/16/2026 20:00. LVN 4 stated on 2/17/2026 during the 3 p.m. to 11:00 p.m. shift he missed Resident 5' Licensed Nurse Note Type: Change of condition note because he got busy helping other residents that night. LVN 4 also stated he should have completed Resident 5's Licensed Nurse Note Type: Change of condition note, and by not completing the Licensed Nurse Note Type: Change of condition note it can delay providing the necessary care and services that Resident 5 needs. During an interview on 6/25/2026 at 3:45 p.m., with the DON, the DON stated that the licensed nurse should have completed the Licensed Nurse Note Type: Change of condition on 2/17/2026 for the 3 p.m. to 11:00 p.m. shift because there should have been 72 hour monitoring and documentation every shift after Resident 5's 2/16/2026 COC to monitor the resident's condition because it can negatively affect and delay providing the necessary care and services that the resident needs. During a review of the facility's policy and procedure titled, Change in a Resident's Condition or Status, last reviewed on 11/20/2025, the policy indicated the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse will notify the residents attending physician or physician on call when there has been a need to alter the resident's medical significantly. The nurse will record in the resident's medical record information relative to changes in the residents medical/mental condition or 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the clinical record was accurately documented for one of five sampled residents (Resident 4), consistent with accepted standards of professional practice and the care and services provided. This deficient practice had the potential to adversely affect the resident's plan of care, and the delivery of necessary care and services. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included traumatic subdural hemorrhage (a life-threatening collection of blood between the brain and its tough outer covering [the dura], caused by a head injury) without loss of consciousness (a temporary state in which a person in unaware of themselves and their surroundings and cannot respond to stimuli), acute pulmonary edema (sudden buildup of fluid in the lungs), and contusion (bruise) of scalp (the skin on the top and back of your head where your hair grows). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool) dated 2/21/2026, the MDS indicated Resident 4 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), and was dependent on staff for toileting hygiene, showering/bathing, lower body dressing, and rolling left and right. During a review of Resident 4's Census List dated 2/21/2026, the Census List indicated Resident 4 was discharged to the general acute care hospital (GACH) on 2/21/2026 at 3:36 p.m. During a review of Resident 4's Weights and Vitals (clinical measurements used to assess the body's basic functions) Summary dated 2/22/2026, the Vitals Summary indicated a temperature (the degree of hotness or coldness of the body) of 97.1 degrees Fahrenheit (ˆ - a temperature scale used to measure body temperature), obtained using a non-contact forehead thermometer (a device used to accurately measure human body temperature), was documented on 2/22/2026 at 4:07 a.m. During a concurrent interview and record review on 6/23/2026 at 4:00 p.m., with the Director of Nursing (DON), Resident 4's Census List dated 2/21/2026 and Weights and Vitals Summary dated 2/22/2026 were reviewed. Resident 4's Census List indicated the resident (Resident 4) was transferred to GACH on 2/21/2026 at 3:36 p.m., and the Weights and Vitals Summary dated 2/22/2026 documented a temperature on 2/22/2026 at 4:07 a.m., after Resident 4 had been discharged from the facility. The DON stated the temperature entry had been documented in error and should have been documented accurately. The DON further stated inaccurate documentation could negatively affect the accuracy of the resident's clinical records and could delay the delivery of necessary care and services. During a review of the facility`s policy and procedure (P&P) titled, Charting and Documentation last reviewed on 11/20/2025, the facility P&P indicated all services provided to the resident, progress toward care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The following information is to be documented in the resident medical record: objective observations, treatments or services performed.