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	06/29/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 2) was free from medications errors by failing to: 1.Ensure the scheduled 9 p.m. dose of atorvastatin calcium (a medication used to lower cholesterol) was administered as ordered or, if not administered, that the omission and reason were documented in the Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). 2.Ensure that the licensed nurse who administered the resident's medications accurately documented the medication administration in the MAR. This deficient practice resulted in an inability to determine whether Resident 2 received the prescribed medication and had the potential to result in medication errors, compromise medication safety, and create confusion regarding the delivery of resident care and services.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 Seet indicated that the facility originally admitted the resident on 12/30/2022 and readmitted the resident on 11/01/2025 with diagnoses that included Type 2 diabetes (T2D - a chronic condition in which the body either resists the effects of insulin [an essential hormone that regulates the body's blood sugar {BS} levels] or does not produce enough to maintain normal BS levels), atherosclerotic heart disease (the clogging of the arteries with sticky, fatty deposits called plaque), glaucoma (a group of eye diseases that damage the eye nerve, usually due to abnormally high pressure inside the eye), anemia (a condition where the body does not have enough healthy red blood cells), polyneuropathy (occurs when multiple nerves are damaged simultaneously throughout the body), and seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 4/6/2026, the MDS indicated Resident 2 had intact cognition (ability to think, understand, and make decisions). The MDS indicated Resident 2 required moderate assistance from staff with toileting hygiene, supervision or touching assistance with lower body dressing, transferring and walking, and required setup or clean-up assistance with eating, oral/personal hygiene, and bed mobility (movement). During a review of Resident 2's Order Summary Report, the Order Summary Report indicated the following physician orders: Atorvastatin calcium tablet 40 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth at bedtime for hyperlipidemia (excessive fat in the blood), ordered 11/2/2025. Netarsudil dimesylate ophthalmic solution (a prescription eye drop medication used to lower elevated intraocular pressure [IOP - the measurement of the fluid pressure inside the eyes]) 0.02 percent (% - the strength or concentration of the medicine), instill (to put a liquid drop by drop into eyes) one (1) drop in left eye at bedtime for glaucoma, ordered 4/11/2026. Xalatan ophthalmic solution (a medication used to reduce high IOP) 0.005 %, instill one (1) drop in both eyes at bedtime for glaucoma, ordered 11/03/2025. Brimonidine tartrate ophthalmic solution (a prescription eye drop medication used to lower elevated intraocular pressure) 0.15 %, instill one (1) drop in left eye two times a day for glaucoma, ordered 3/9/2026. Cosopt ophthalmic solution (a prescription eye drop medication that combines two medications - dorzolamide and timolol - to lower high IOP) 22.3- 6.8 mg per milliliter (ml - a metric unit of volume, used to measure small amounts of liquid), instill one (1) drop in left eye two times a day for (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	06/29/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	glaucoma, wait five (5) minutes between administration of eye drops to the same eye, ordered 5/18/2026. Gabapentin (a medication used to treat seizures or pain), give 300 mg by mouth two times a day for neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), ordered 11/1/2025. Keppra (a medication used to control seizures) oral solution 100 mg/ml, give five (5) ml by mouth two times a day for seizure prophylaxis (any preventive treatment or action taken to guard against a disease or health problem before it happens), ordered 11/2/2025. Oyster shell calcium (a medication used to prevent or treat calcium deficiencies) tablet 500 mg, give one (1) tablet by mouth two times a day for nail growth for 60 days, ordered 5/5/2026. Insulin glargine (a long-acting insulin used to treat type 1 and type 2 diabetes) subcutaneous (fatty tissue between the skin and muscle) solution 100 unit/ml, inject 10 units subcutaneously at bedtime for T2D, hold if BS is lower than 70 milligrams per deciliter (mg/dL - a unit of measurement), ordered 11/3/2025. Insulin Humalog (insulin lispro - a fast-acting insulin used to manage blood sugar) injection solution 100 unit/ml, inject four (4) units subcutaneously before meals for diabetes mellitus (DM - disorder characterized by difficulty in BS control and poor wound healing), give medication three times a day before meals, ordered 11/4/2025. Insulin lispro injection solution 100 unit/ml, inject as per sliding scale (a method of managing blood sugar where the dose insulin is adjusted based on a resident's pre-meal or bedtime blood glucose level) subcutaneously before meals for T2D, ordered 11/4/2026. During a review of Resident 2's MAR for the month of 5/2026, the MAR indicated the following: On 5/2/2026, atorvastatin calcium tablet 40 mg, scheduled for 9 p.m., was not documented as administered and was left blank. On 5/2/2026, Licensed Vocational Nurse 1 (LVN 1) documented the following scheduled 9 p.m. medications: Insulin glargine 10 units, netarsudil dimesylate ophthalmic solution, and insulin lispro three (3) units. On 5/23/2026, LVN 1 documented the following scheduled 9 p.m. medications: atorvastatin calcium tablet 40 mg, insulin glargine 10 units, netarsudil dimesylate ophthalmic solution, Xalatan ophthalmic solution, brimonidine tartrate ophthalmic solution, cosopt ophthalmic solution, gabapentin 300 mg, Keppra five (5) ml, oyster shell calcium 500 mg, ticagrelor (a medication used to prevent blood clots) 90 mg, and insulin lispro four (4) units. During an interview on 6/25/2026 at 12:29 p.m., with Resident 2, the resident stated that Registered Nurse 1 (RN 1) mostly administered the resident's medications (unable to specify) when LVN 1 was on duty (unable to recall exact date). During a concurrent interview and record review on 6/26/2026 at 1:58 p.m., with LVN 2, LVN 2 reviewed Resident 2's MAR for 5/2/2026 and stated that the scheduled 9 p.m. atorvastatin 40 mg was not documented as administered and was left blank. LVN 2 stated that the licensed nurses should document the appropriate reason using the designated codes and should not leave the MAR blank. If a resident was out of the facility or unavailable to receive the medications, a code should be documented. Otherwise, it could not be determined whether Resident 2 received the medication. During a concurrent interview and record review on 6/29/2026 at 3:42 p.m., with LVN 1, LVN 1 reviewed Resident 2's MAR for 5/2026 and the Nursing Staffing Assignment and Sign-in Sheet for 3 p.m. to 11 p.m. shift (3-11 shift) on 5/2/2026 and 5/23/2026. LVN 1 stated that LVN 1 did not administer Resident 2's medications during the 3 -11 shift on 5/2/2026 and 5/23/2026, LVN 1 stated that Resident 2 had refused LVN 1's services, and therefore LVN 1 was not allowed to observe other nurses preparing or administering Resident 2's medications, including eye drops and insulin. LVN 1 stated that RN 1 was on duty on both dates (5/2/2026 and 5/23/2026), and RN 1 administered Resident 2's medications, but LVN 1 documented the administration in the MAR. LVN 1 was unable to recall at that time why the documentation was completed on behalf of RN 1. LVN 1 further stated that, at times, RN 1 had an emergencies to address and became busy after administering Resident 2's medications; however, the nurse who prepared and administered the medications should document the administration in the MAR immediately after the medications are given. During an interview on 6/29/2026 at 4:15 p.m., with the Director of Nursing (DON), the DON reviewed Resident 2's MAR for 5/2026 and the Nursing Staffing Assignment and Sign-in Sheet for 3 p.m. to 11 p.m. shift on 5/2/2026 and 5/23/2026. The DON stated that on 5/2/2026, the scheduled 9 (continued on next page)

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	06/29/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m. atorvastatin entry contained no reason code and was left blank in the MAR. The DON stated that licensed nurses should not leave any medication entry blank and should document whether the medication was offered and declined, the resident was unavailable to receive the medication, or any other applicable reason. The DON further stated that the licensed nurse who prepared and administered the resident's medications should document the medication administration in the MAR to prevent medication errors. During a review of the facility's 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. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) . If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and document the reason. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. As required or indicated for medication, the individual administering the medication records in the resident's medical record:a. the date and time the medication was administered;b. the dosage;c. the route of administration;d. the injection site (if applicable);e. any adverse or undesired result;f. any results achieved and when those results were observed; andg. the signature and title of the person administering the drug.