STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555791	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Gardens Healthcare Center	17650 Devonshire Street Northridge, CA 91325

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 - Few	Ensure that residents are free from significant medication errors. (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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(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 - Few	Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free of any significant medication errors when Resident 1's medications were left above a meal tray cart parked in the hallway and documented as administered in the Medication Administration Record (MAR - a report detailing the medication administered to a resident by a healthcare professional).This deficient practice had the potential for Resident 1's condition to worsen. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 11/17/2025 with diagnoses including hypertension (high blood pressure) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/20/2025, the MDS indicated Resident 1 was moderately impaired with thought process and was dependent on facility staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 1's Physician's Orders, dated 11/17/2025, the Physician's Orders indicated to administer the following:- Give one tablet of Eliquis (also known as apixaban, a blood thinner) five milligrams (mg - unit of weight) twice a day for pulmonary embolism (sudden, serious blockage in lung artery, usually from a blood clot that traveled a deep vein in the leg, cutting off blood flow to part of the lung, causing symptoms like shortness of breath, chest pain, and rapid heart rate.)- Give one tablet of multivitamins once a day for supplement.- Give one tablet of Coenzyme Q10 (supplement used for energy production and cell protection) 50 mg one time a day for supplement.- Give one tablet of losartan potassium (medication used to treat high blood pressure) 50 mg twice a day for hypertension.- Give one tablet of metoprolol (medication used to treat high blood pressure) 100 mg once a day for hypertension. During a concurrent observation and interview on 12/16/2025 at 11:42 a.m. with Licensed Vocational Nurse (LVN) 1, observed Resident 1's breakfast meal tray parked in the hallway with a medication cup and five pieces of medications inside. LVN 1 stated that there was a medication cup with five medications on top of Resident 1 breakfast meal tray parked in the hallway. LVN 1 stated that the nurse administering medications to Resident 1 should have observed Resident 1 take all of her (Resident 1) medications before leaving Resident 1 to make sure the medication was administered properly.During a concurrent observation and interview on 12/16/2025 at 11:47 a.m. with Registered Nurse (RN) 1, observed a medication cup with five medications on the top of Resident 1's breakfast tray parked in the hallway. RN 1 stated that there was a medication cup on Resident 1's breakfast meal tray parked in the hallway.During a concurrent observation, interview, and record review on 12/16/2025 at 11:52 a.m. with RN 1, Resident 1's MAR), dated 12/16/2025, was reviewed. Resident 1's MAR indicated that Eliquis, Multivitamins, Coenzyme Q10, Losartan potassium, and Metoprolol was given on 12/16/2025 at 9:52 a.m. by RN 1. RN 1 stated that he (RN 1) signed it, and it means this medication was given to Resident 1. RN 1 stated that the therapeutic effect of Resident 1's medication will not take effect if Resident 1 misses a dose. During a concurrent interview and record review on 12/16/2025 at 12:05 p.m. with RN 2, Resident 1's MAR, dated 12/16/2025, was reviewed. Resident 1's MAR indicated that Eliquis, multivitamins, Coenzyme Q10, losartan potassium, and metoprolol were administered to Resident 1 on 12/16/2025 at 9:52 a.m. by RN 1. RN 2 stated Resident 1's MAR indicated all of Resident 1's morning medications were administered to the resident on 12/16/2025. RN 2 stated that RN 1 should not sign the MAR if the medication was not given to Resident 1 because Resident 1 could possibly have hypertension and tachycardia (fast heart rate).During an interview on 12/16/2025 at 1:47 p.m. with RN 1, RN 1 stated that RN 1 should witness Resident 1 take her medications to ensure that she (Resident 1) swallowed all her (Resident 1) medications. RN 1 stated that Resident 1's blood pressure could increase if Resident 1's losartan and metoprolol were missed.During an interview on 12/16/2025 at 2:21 p.m. with the Director of Nursing (DON). The DON stated that Resident 1's blood pressure could be affected by missing her (Resident 1) medication. The DON stated that RN 1 should not have documented that Resident 1's medication was administered on 12/16/2025 at 9:52 a.m. During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, last review date 1/2025, the policy and procedure indicated, The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate.