STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055932	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Healthcare & Wellness Center, LP	5335 Laurel Canyon Blvd. North Hollywood, CA 91607

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. Based on interview and record review, the facility failed to ensure a resident was provided supervision to prevent elopement (the act of leaving a facility unsupervised and without prior authorization) for one of three sampled residents (Resident 1). On 6/7/2025, at 12:27 p.m., Resident 1, who was assessed as a high risk for elopement, walked out of the facility unassisted and without permission. Resident 1 exited the facility building through the main facility entrance door with the Receptionist (REC) 1 at the reception desk who stated he (REC 1) did not see Resident 1 go out of the facility main door. REC 1 stated the reception area had a list of residents on elopement risk and one of his responsibilities was to ensure the residents do not go out of the main facility door unassisted and without permission. This deficient practice resulted to Resident 1 ' s elopement and can potentially place Resident 1 at risk for serious health problems and accidents. Findings: During a review of Resident 1 ' s admission Record (undated), the admission Record indicated the facility admitted the resident on 5/21/2025, with diagnoses including type 2 diabetes mellitus (DM - a chronic condition that affects the way the body processes blood sugar [glucose]), epilepsy (a condition that affects the brain and causes frequent seizures [sudden, uncontrolled body movements and changes in behavior that occurs because of abnormal electrical activity in the brain]), and schizophrenia (mental disorder in which people interpret reality abnormally). During a review of Resident 1 ' s Elopement Evaluation, dated 5/21/2025, the Elopement Evaluation indicated the resident had a history of elopement or attempted to leave the facility without informing the staff. The Elopement Evaluation indicated a score value of one or higher indicated risk of elopement. During a review of Resident 1 ' s Care Plan on wandering and elopement, initiated on 5/22/2025, the Care Plan indicated the resident was at risk for elopement related to elopement score of one. Resident 1 ' s Care Plan Goal indicated the resident will not leave facility unattended. The Care Plan Interventions indicated to identify if there were triggers for wandering and elopement. During a review of Resident 1 ' s Initial Psychiatric (related to the study of mental illness) Interview, dated 5/26/2025, the Initial Psychiatric Interview indicated Resident 1 ' s thought process was tangential (erratic) and illogical. The Initial Psychiatric Interview indicated Resident 1 had poor judgment and insight. (continued on next page)

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
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool), dated 5/28/2025, the MDS indicated Resident 1 ' s cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. The MDS indicated Resident 1 required moderate assistance (helper lifts, holds, or supports trunk or limbs but provides less than half the effort) on shower and bathe. The MDS indicated Resident 1 required staff supervision on toileting hygiene, dressing the lower body, putting on and taking off footwear, sit to stand activity, chair transfer, toilet transfer, and shower transfers. During a review of Resident 1 ' s Medication Administration Record (MAR), dated 6/1/2025 to 6/30/2025, the MAR indicated the resident did not receive the scheduled 5 p.m. medications that included levetiracetam (a medication used in the treatment of epilepsy) 750 milligrams (mg - unit of measurement) tablet two times a day for seizures, metformin hydrochloride (a medication used to manage blood sugar in people with type 2 DM) 1000 mg tablet two times a day to be given with food, and risperidone (a medication used to treat a variety of mental health conditions) two mg tablet two times a day for schizophrenia. During a review of Resident 1 ' s Change in Condition Evaluation (CIC), dated 6/8/2025, timed 4:26 a.m., the CIC indicated on 6/7/2025 at 9:25 p.m., Licensed Vocational Nurse (LVN) was not able to locate Resident 1 in the facility. The Director of Nursing (DON) and the staff were alerted. The CIC indicated at 9:28 p.m., staff looked for Resident 1 inside the facility, at the surrounding areas of the facility, and called General Acute Care Hospitals (GACH) 1. The CIC indicated at 10:15 p.m., the physician was notified. The CIC indicated at 10:30 p.m., law enforcement was notified. During a review of Resident 1 ' s Progress Notes, dated 6/8/2025, the progress Notes indicated the resident was self-admitted at GACH 1. The Progress Notes indicated Resident 1 did not have injuries or change in condition at the time of arrival at GACH 1. During an interview on 6/10/2025 at 9:40 a.m. and concurrent record review of the facility ' s video surveillance footage with the recording date of 6/7/2025, reviewed with the Administrator (ADM) and the Central Supply Director (CSD). The ADM stated he was not familiar with the functions of the video surveillance and the CSD will navigate the video surveillance footage. The CSD stated the following video surveillance cameras and time stamps indicated: a. On 6/7/2025 at 12:15:42 p.m., video surveillance camera 6 indicated Resident 1 was walking in the hallway between Nursing Station 1 and Nursing Station 2. b. On 6/7/2025 at 12:16:01 p.m., video surveillance camera 6 indicated Resident 1 entered the patio adjacent to Nursing Station 1. c. On 6/7/2025 at 12:16:20 p.m., video surveillance camera 29 indicated Resident 1 went to the area of the patio that was not visible to the video surveillance due to the location of the camera. The ADM stated there was no facility staff present in the patio as observed in the video surveillance. d. On 6/7/2025 at 12:22:52 p.m., video surveillance camera 29 indicated a black line (unable to identify) appeared on the ground at the left side of the patio beside the black planter box. The ADM stated the black line was Resident 1 ' s wander guard (a brand name of a device used to ensure safety while allowing freedom to move within secure boundaries). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 6/7/2025 at 12:27:04 p.m., video surveillance camera 6 indicated Resident 1 entered the door from the patio that lead to Nursing Station 1. f. On 6/7/2025 at 12:27:24 p.m., video surveillance camera 10 indicated Resident 1 walked in the hallway at station 1. g. On 6/7/2025 at 12:27:46 p.m., video surveillance camera 2 indicated Resident 1 walked to the facility lobby. Receptionist (REC) 1 was at the reception desk facing the facility lobby and REC 1 ' s face was visible to the video surveillance. h. On 6/7/2025 at 12:27:55 p.m., video surveillance camera 2 indicated Resident 1 opened the main facility entrance door and walked out of the facility. ADM stated REC 1 did not stand up or looked at the facility main entrance. i. On 6/7/2025 at 12:27:59 p.m., video surveillance camera 24 indicated Resident 1 was outside the facility walking on the sidewalk along Street A. The CSD stated Resident 1 walked towards Street B. During a telephone interview on 6/10/2025 at 10:58 a.m. with REC 1, REC 1 stated a facility staff is required be at the reception area at all times to answer calls and monitor the activities in the lobby. REC 1 stated the reception area had a list of residents on elopement risk. REC 1 stated one of his responsibilities was to ensure the residents do not go out of the main facility door unassisted and without permission. REC 1 stated on 6/7/2025, he was at the facility ' s reception desk, studying with his laptop open in front of him. REC 1 stated he did not see Resident 1 go out of the facility main door. REC 1 stated Resident 1 had the potential for accidents due to the facility located in front of a high traffic street. During an interview on 6/10/2025 at 12:34 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 6/7/2025 between 4 p.m. to 5 p.m., she saw Resident 1 walking in the hallway between Nursing Station 1 and Nursing Station 2. CNA 1 stated at 6:30 p.m., she looked for Resident 1 to prepare the resident for dinner. CNA 1 stated she notified LVN 2 that she was not able to locate Resident 1. CNA 1 stated she was informed that between 4 p.m. to 5 p.m., CNA 2 saw Resident 1 in the smoking patio. CNA 1 stated at 8 p.m., three hours after the last time the Resident was observed in the facility, LVN 2 called a code yellow (the facility ' s code indicating a missing resident). During an interview on 6/10/2025 at 1 p.m. with the ADM, the ADM stated the video surveillance footage time was accurate and current. During an interview on 6/10/2025 at 3:05 p.m. with LVN 3, LVN 3 stated that residents ' whereabouts should be checked every one to two hours to ensure the residents were inside the facility premises. LVN 3 stated Resident 1 verbalized (no documented evidence provided) to her that the resident wanted to leave and visit someone. LVN 3 stated she offered Resident 1 to use the facility phone to call the person the resident wanted to visit. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/10/2025 at 3:20 p.m. with Registered Nurse (RN) 1, RN 1 stated Resident 1 was an elopement risk resident. RN 1 stated Resident 1 paced inside the facility and would sit on the couch at the lobby. RN 1 stated high risk for elopement residents ' location should be monitored every hour. RN 1 stated she could not remember if she saw Resident 1 that day. RN 1 stated on 6/7/2025 at 9:30 p.m., she saw LVN 2 walking to Nursing Station 3 and looked worried. RN 1 stated LVN 2 informed her the staff was not able to locate Resident 1 ' s whereabouts. RN 1 stated she instructed the facility staff to search for Resident 1 inside the facility and in the surrounding areas. RN 1 stated the street in front of the facility was a busy street and Resident 1 had the potential for accidents. RN 1 stated Resident 1 was not given the 5 p.m. scheduled seizure medication and had the potential for seizures. RN 1 stated Resident 1 did not eat dinner and had the potential for hypoglycemia (low blood sugar). During an interview on 6/10/2025 at 3:55 p.m. with LVN 2, LVN 2 stated Resident 1 was ambulatory (able to walk or move around) and was always seen standing by the facility lobby door. LVN 2 stated stated Resident 1 was an elopement risk resident. LVN 2 stated on 6/7/2025 at 3:50 p.m., she did not see Resident 1 in the resident ' s room. LVN 2 stated between 5 p.m. to 6 p.m., she went inside Resident 1 ' s room to give the resident the scheduled medications but the resident was not inside the room. LVN 2 stated she asked CNA 1 to look for Resident 1 in the facility and LVN 2 continued to pass the other residents ' medications. LVN 2 stated at 7 p.m. she asked CNA 1 the whereabouts of Resident 1 and CNA 1 informed LVN 2 that she was still searching for the resident. LVN 2 stated at 9 p.m., she notified RN 1 that she was not able to locate Resident 1 ' s whereabouts. LVN 2 stated she started her shift at 3:15 p.m. and had not seen Resident 1 since the start of her shift. LVN 2 stated Resident 1 had the potential for accidents due to the busy street in front of the facility and a risk for hypoglycemia and seizures due to the resident not receiving the scheduled 5 p.m. medications. During a telephone interview on 6/11/2025 at 2:39 p.m. with LVN 1, LVN 1 stated Resident 1 was an elopement risk resident. LVN 1 stated she last saw Resident 1 at 11:30 a.m. on 6/7/2025. LVN 1 stated she did not ask and looked for Resident 1 ' s whereabouts from 11:30 a.m. to 3 p.m. (end of LVN 1 ' s shift). During an interview on 6/11/2025 at 3:43 p.m. with the DON, the DON stated Resident 1 should be monitored at the beginning of every shift and every two hours after. The DON stated Resident 1 had an elopement history from another facility. The DON stated she was not sure if the receptionist ' s responsibility included watching residents and visitors coming in and out of the facility. The DON stated all residents were at risk for elopement. The DON defined elopement as a resident leaving the facility without permission. The DON stated the receptionists had a list of high elopement risk residents. The DON stated checking for the whereabouts of an elopement risk resident was the responsibility of all facility staff. The DON stated Resident 1 did not have a potential for harm since the resident was homeless and the resident ' s home is the streets. The DON stated Resident 1 would have the same risks of hypoglycemia and seizures in the facility and outside since the resident had been refusing the medications. The DON stated the street in front of the facility was a busy street. The DON stated Resident 1 ' s risk for accidents was the same for anyone. The DON stated the facility staff should do better in monitoring the location of the residents. The DON stated the facility failed to ensure Resident 1 was supervised. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (PnP) titled, Wandering and Elopement, last reviewed on 1/29/2025, the PnP indicated the purpose to enhance the safety of residents of the facility. The PnP defined elopement as a behavior that may lead to the resident leaving the facility unsupervised and without permission. The PnP indicated if facility staff observes a resident leaving the premises unaccompanied or without having followed proper procedures . try to prevent the departure in a courteous manner . if the resident exits the facility despite the efforts to stop the resident, a staff member will accompany or follow the resident to ensure the resident ' s safety until assistance arrives.

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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 - Some	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 medical records of three of three sampled residents (Resident 1, Resident 2, and Resident 3) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to: 1. Ensure Certified Nursing Assistants (CNAs) documented Residents 1, 2, and 3 ' s percentage (% - per one hundred) of food eaten on the correct time. 2. Ensure CNA 1 accurately documented Resident 1 ' s bowel movement (defecation). 3. Ensure Registered Nurse (RN) 1 completed and signed Resident 1 ' s Change in Condition Evaluation (CIC). These deficient practices resulted in inaccurate information on Residents 1, 2, and 3 ' s medical records and had the potential for delayed and inaccurate medical interventions. Findings: During a review of Resident 1 ' s admission Record (undated), the admission Record indicated the facility admitted the resident on 5/21/2025, with diagnoses including type 2 diabetes mellitus (DM - a chronic condition that affects the way the body processes blood sugar [glucose]), epilepsy (a condition that affects the brain and causes frequent seizures [sudden, uncontrolled body movements and changes in behavior that occurs because of abnormal electrical activity in the brain]), and schizophrenia (mental disorder in which people interpret reality abnormally). During a review of Resident 1 ' s Care Plan on Nutrition, initiated on 5/22/2025, the Care Plan indicate the resident had nutritional risk due to DM, hypertension (high blood pressure), epilepsy and schizophrenia. The Care Plan Interventions indicated to monitor intake and record every meal. During a review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool), dated 5/28/2025, the MDS indicated Resident 1 ' s cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. During an interview on 6/11/2025 at 2 p.m. and concurrent record review of Resident 1 ' s Bowel Elimination Task, dated 5/29/2025 to 6/8/2025, reviewed with CNA 1, the Bowel Elimination Task indicated on 6/7/2025 at 4:18 p.m., Resident 1 had a medium sized, formed bowel movement. CNA 1 stated she did not observe Resident 1 ' s stool appearance. CNA 1 stated she intended to ask Resident 1 upon the resident ' s return to the room. CNA 1 stated she should not document the description of Resident 1 ' s stool until it was verified. During an interview on 6/11/2025 at 3:11 p.m. and concurrent record review of Resident 1 ' s Nutritional Task, dated 5/29/2025 to 6/8/2025, reviewed with the Director of Staff Development (DSD), the Nutritional Task section indicated the meal (breakfast, lunch, and dinner) intake amount the resident had eaten in percentage. Resident 1 ' s Nutritional Task indicated the following: (continued on next page)

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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 - Some	a. On 5/30/2025, Resident 1 ' s documented breakfast and lunch meal intake were 75% to 100%, both at 12:09 p.m. b. On 6/1/2025, Resident 1 ' s documented breakfast and lunch meal intake were 75% to 100%, both at 11:24 a.m. c. On 6/2/2025, Resident 1 ' s documented breakfast and lunch meal intake were 75% to 100%, both at 12:05 p.m. d. On 6/5/2025, Resident 1 ' s documented breakfast and lunch meal intake were 75% to 100%, both at 12:03 p.m. e. On 6/6/2025, Resident 1 ' s documented breakfast meal intake was 75% to 100% at 10:58 a.m. and lunch meal intake was 75% to 100% at 11 a.m. f. On 6/7/2025, Resident 1 ' s documented breakfast and lunch meal intake were 75% to 100%, both at 12:08 p.m. The DSD stated the documented time of Resident 1 ' s percentage of meal intake were inaccurate. The DSD stated Resident 1 ' s meal intake should be documented after the meal had been consumed. During an interview on 6/11/2025 at 3:43 p.m. and concurrent record review of Resident 1 ' s CIC Evaluation, dated 6/8/2025, timed 4:26 a.m., the CIC Evaluation indicated on 6/7/2025 at 9:25 p.m., Licensed Vocational Nurse (LVN) was not able to locate Resident 1 in the facility. The documented CIC was indicated as pending and did not have RN 1 ' s signature. The DON stated documentation should be accurate and timely. The DON stated incomplete and inaccurate documentation had the potential for residents ' inaccurate plan of care and treatment. The DON stated the facility failed to ensure complete, accurate, and timely documentation of Resident 1 ' s meal intake percentage, bowel movement, and CIC Evaluation. During a review of Resident 2 ' s admission Record (undated), the admission Record indicated the facility admitted the resident on 9/28/2021, with diagnoses including metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), vascular dementia (a type of dementia that occurs when there is damage to the blood vessels in the brain, leading to problems with cognition and memory), and dysphagia (a condition that makes it difficult to swallow). During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognition was severely impaired. The MDS indicated Resident 2 required supervision on eating. During an interview on 6/11/2025 at 3:11 p.m. and concurrent record review of Resident 2 ' s Nutritional Task, dated 5/29/2025 to 6/11/2025, reviewed with the DSD, the Nutritional Task section indicated the meal (breakfast, lunch, and dinner) intake amount the resident had eaten in percentage. Resident 2 ' s Nutritional Task indicated the following: a. On 6/1/2025, Resident 2 ' s documented breakfast meal intake was 75% to 100% at 2:22 p.m. and lunch meal intake was 75% to 100% at 2:23 p.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 6/6/2025, Resident 2 did not have a documented breakfast meal intake. c. On 6/7/2025, Resident 2 ' s documented breakfast meal intake was 75% to 100% at 12:09 p.m. and lunch meal intake was 75% to 100% at 12:10 p.m. d. On 6/9/2025, Resident 2 ' s documented breakfast meal intake was 75% to 100% at 11:58 a.m. and lunch meal intake was 75% to 100% at 12:03 p.m. e. On 6/10/2025, Resident 2 ' s documented meal intake was 75% to 100% at 10:48 a.m. and 6 p.m. The DSD stated the documented time of Resident 2 ' s percentage of meal intake were inaccurate. The DSD stated Resident 2 ' s meal intake should be documented after the meal had been consumed. During a review of Resident 3 ' s admission Record (undated), the admission Record indicated the facility admitted the resident on 5/20/2025, with diagnoses including toxic encephalopathy (a brain damage or dysfunction caused by exposure to harmful substances), dysphagia, and schizophrenia. During a review of Resident 3 ' s MDS, dated [DATE], the MDS indicated Resident 3 ' s cognition was severely impaired. The MDS indicated Resident 3 required supervision on eating. During an interview on 6/11/2025 at 3:11 p.m. and concurrent record review of Resident 3 ' s Nutritional Task, dated 5/29/2025 to 6/11/2025, reviewed with the DSD, the Nutritional Task section indicated the meal (breakfast, lunch, and dinner) intake amount the resident had eaten in percentage. Resident 3 ' s Nutritional Task indicated the following: a. On 5/30/2025, Resident 3 ' s documented breakfast meal intake was 51% to 75% at 11:15 a.m. and lunch meal intake was 51% to 75% at 11:17 a.m. b. On 6/1/2025, Resident 3 ' s documented breakfast meal intake was 51% to 75% at 12:13 p.m. and lunch meal intake was 51% to 75% at 1:16 p.m. c. On 6/6/2025, Resident 3 did not have a documented breakfast meal intake. d. On 6/10/2025, Resident 3 did not have a documented dinner meal intake. The DSD stated the documented time of Resident 3 ' s percentage of meal intake were inaccurate. The DSD stated Resident 3 ' s meal intake should be documented after the meal had been consumed. During an interview on 6/11/2025 at 3:43 p.m. with the DON, the DON stated documentation should be accurate and timely. The DON stated incomplete and inaccurate documentation had the potential for residents ' inaccurate plan of care and treatment. The DON stated the facility failed to ensure complete, accurate, and timely documentation of Resident 2 and Resident 3 ' s meal intake percentage. During a review of the facility ' s policy and procedure (PnP), last reviewed on 1/29/2025, the PnP indicated the purpose to ensure that medical records are complete and accurate. The PnP indicated entries will be recorded promptly as the events or observations occur . entries will be complete, legible, descriptive, and accurate. The PnP indicated entries will include . signature and professional designation. The PnP indicate an event is never to be documented before it occurs.