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	06/13/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure an eye drop (liquid solutions you put on the surface of your eyes) was not left at bedside table and resident was assessed for self-administration of medication for one of three sampled residents (Resident 1). This deficient practice placed Resident 1 at risk for a negative outcome and the potential for another resident to take and misuse the medication (eye drop). Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 2/8/2025, with a diagnosis of diabetes mellitus (condition where blood sugar levels are too high) and chronic obstructive pulmonary disease (long-term lung disease that makes it hard to breathe). During a review of Resident 1' History and Physical, dated 6/10/2025, the History and Physical indicated that Resident 1 did not have capacity to made decisions at this time. During a review of Resident 1's Order Summary Report, with order date of 6/3/2025, the Order Summary report indicated to instill one drop in both eyes four times a day. During a concurrent observation, interview, and record review on 6/11/2025 at 3:05 p.m., with License Vocational Nurse (LVN) 1, observed inside Resident 1's room that there was a box of eye drops on the top of Resident 1's bedside table. LVN 1 stated that there was a box of eye drops place on the top of Resident 1's bedside table. LVN 1 stated that eye drops must be placed in the medication cart because Resident 1 could possibly lose it and another resident could just take it, and they could not know what could possibly happen to the eye drops. During a concurrent review of Resident 1's assessment and care plan, LVN 1 stated that there was no self-administration of medication assessment and no care plan about self-administration of medication. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview, and record review on 6/11/2025 at 3:10 p.m. with Registered Nurse (RN) 2, observed inside Resident 1's room that there was a box of eye drops place on the top of Resident 1's bedside. RN 2 stated she observes Resident 1's box of eye drop was placed on the top of Resident 1's bedside table and further stated that RN 2 did not notice the box of eye drop this morning when she started her shift. During a concurrent review of Resident 1's assessment, RN 2 stated there was no assessment and care plan for self-administration of medication and there was no physician order. RN 2 stated the facility staff should take away the eye drops from Resident 1's table because Resident 1 was not assessed if Resident 1 was capable to self-administering the eye drops. During an interview on 6/12/2025 at 10:18 a.m., with Director of Nursing (DON), the DON stated that Resident 1 must have a self-administration assessment, care plan and physician's order to be able to self-administer Resident 1's medication to ensure the capability of Resident 1 to self-administer and to follow the directions. The DON further stated that the eye drops should be stored in a locked storage because another resident could take it. During a review of the facility policy and procedure titled, Medication - Self Administration, last review date 1/29/2025, the policy and procedure indicated, If a resident wants to self-administer medication, the IDT (Interdisciplinary Team) will assess the resident's cognitive, physical, and visual ability to carry out this responsibility based on a review of an assessment by a Licensed Nurse as follows: A. The Licensed Nurse uses the Assessment for Self-Administration of Medications for the assessment and submits the results to the IDT. B. The resident will be asked to read and understand the directions on the pharmacy label, as well as how to administer his/her medications in the presence of a License Nurse to demonstrate the ability to take the medications according to Facility policy. For a final determination of the resident's ability to self - administer medications, the assessment for self-administration of medications will be presented to the resident's Attending Physician. Based on observation, interview, and record review, the facility failed to ensure an eye drop (liquid solutions you put on the surface of your eyes) was not left at bedside table and resident was assessed for self-administration of medication for one of three sampled residents (Resident 1). This deficient practice placed Resident 1 at risk for a negative outcome and the potential for another resident to take and misuse the medication (eye drop). Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 2/8/2025, with a diagnosis of diabetes mellitus (condition where blood sugar levels are too high) and chronic obstructive pulmonary disease (long-term lung disease that makes it hard to breathe). During a review of Resident 1' History and Physical, dated 6/10/2025, the History and Physical indicated that Resident 1 did not have capacity to made decisions at this time. (continued on next page)

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