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	10/24/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure that one of three sampled residents (Resident 1) and or conservator (appointed by a judge to act or make decisions for the person who needs help) was informed of Resident 1's change in condition on 10/22/2025.This failure had violated conservator's right to be informed.Findings:During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 8/8/2025, with diagnoses that included metabolic encephalopathy (a condition where the brain's function is impaired due to disturbances in the body's metabolism [the process where your body converts food and drink into energy]), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life). The admission Record indicated Resident 1 had a conservator. During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 8/9/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions.During a review of Resident 1's Order Summary Report, dated 8/19/2025, the Order Summary Report indicated Resident 1 was incapable of making healthcare decisions. The Order Summary Report indicated that Resident 1 was under Conservatorship healthcare decision maker (a legal authority granted by a judge, allowing the conservator to consent to or withhold medical treatment, choose doctors and hospitals, and manage other health-related matters).During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool,) dated 8/20/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired.During a review of Resident 1's eInteract Change in Condition Evaluation, dated 10/22/2025, the eInteract Change in Condition Evaluation indicated alleged sexual interaction. The eInteract Change in Condition Evaluation indicated the physician was notified at 7:16 p.m. with an order for room change, psychiatrist (medical practitioner specializing in the diagnosis and treatment of mental illness) and psychologist (a person who specializes in the study of mind and behavior) consult. The eInteract Change in Condition Evaluation indicated Resident 1 was notified at 5:06 p.m.During a review of Resident 1's Multidisciplinary Care Conference, dated 10/23/2025, the Multidisciplinary Care Conference indicated Resident 1's Conservator attended the meeting on 10/23/2025, at 12 noon via phone to discuss alleged sexual encounter between Residents 1 and 2.During an interview on 10/24/2025, at 10:59 a.m. with Registered Nurse 1 (RN 1), RN 1 stated on 10/22/2025, she (RN 1) did not call and did not notify Resident 1's Conservator because Resident 1 was self-responsible (actively and proactively engaging in one's own health through actions like making healthy lifestyle choices, managing symptoms, and partnering with healthcare professionals). RN 1 stated Resident 1 seemed to be alert and understood the situation, so she (RN 1) just asked the physician to do the H&P again.During a concurrent interview and record review on 10/24/2025 at 11:08 a.m., with the Director of Nursing (DON), facility's policy and procedure (P&P), titled, Change of Condition Notification, dated 8/25/2022, was reviewed. The P&P indicated, The facility will promptly inform the resident, consult with the resident's Physician, and notify the residents legal representative or an interested family member, if known, when the resident endures a significant change in their condition caused by, but not limited to:A. An accidentB. A significant change in the resident's physical, mental or psychosocial status (how factors like emotions, thoughts, and behaviors are influenced by social elements such as family, relationships, and culture), and orC. A significant change in treatment.II. Change in Condition related to the Physician notification is defined as when the Physician must be notified when any sudden and marked adverse (unfavorable, harmful or negative) change in the residents condition which is manifested by signs and symptoms different that usual denote a new problem, complication or permanent change in status and require a medical assessment, coordination and consultation with the Physician and a change in the treatment plan. The DON stated RN 1 should have called the Conservator. The DON stated conservators are the decision makers of the Residents. The DON stated Conservator should have been notified to inform them of the alleged sexual interaction. The DON stated their policy indicated notification should be prompt. The DON stated Conservator should have been called on 10/22/2025. The DON stated there was a delay in notification.During an interview on 10/24/2025, at 11:38 a.m., with the MDS Nurse (MDSN), the MDSN stated Conservator acts on Resident 1's behalf and was appointed to make healthcare decisions for Resident 1. The MDSN stated that attempts to

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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. Based on interview and record review the facility failed to maintain an accurate and complete medical record for one of three sampled residents (Resident 2) by failing to ensure accurate time of notification was documented in Resident 2's medical record.This failure had the potential to cause confusion in care and the medical records containing inaccurate documentation.Findings:During a review of Resident 2‘s admission Record, the admission Record indicated the facility admitted Resident 2 on 2/6/2025, with diagnoses that included unspecified (unconfirmed) epilepsy (repeatedly uncontrolled electrical activity in the brain, which may produce a jerking movement of a part or the entire body), chronic pain syndrome (a condition where persistent pain lasts for at least three months) and unspecified depression (a serious mood disorder that goes beyond temporary sadness, causing a persistent feeling of emptiness, hopelessness, and loss of interest in life).During a review of Resident 2's History and Physical (H&P-a medical examination that involves a doctor taking a Resident's medical history, performing a physical exam, and documenting their findings), dated 2/7/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS-a Resident assessment tool), dated 8/14/2025, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired.During a review of Resident 2's eInteract Change in Condition Evaluation, dated 10/22/2025, timed at 5:16 p.m., the eInteract Change in Condition Evaluation indicated alleged sexual interaction. The eInteract Change in Condition Evaluation indicated the Physician was notified on 10/22/2025, at 7:16 p.m., and the Responsible Party (party responsible for making health care decisions when the principal party is unable to) was notified on 10/22/2025, at 1:18 a.m.During a concurrent interview, and record review on 10/24/2025, at 11:08 a.m., with the Director of Nursing (DON), Resident 2's eInteract Change in Condition Evaluation, dated 10/22/2025, was reviewed. The eInteract Change in Condition Evaluation indicated Resident 2's Responsible Party was notified on 10/22/2025 at 1:18 a.m. The DON stated the alleged sexual encounter happened on 10/22/2025, at 5 p.m. The DON stated the documentation for the Responsible Party notification was wrong. The DON stated they could not call ahead before the incident happened. The DON stated wrong documentation can create confusion at the time of the incident.During an interview on 10/24/2025, at 11:31 p.m., with the Administrator (ADM), the ADM stated the incident happened on 10/22/2025, at 5 p.m., The ADM stated he (ADM) was in his (ADM) office when he (ADM) was notified of the alleged sexual encounter.During a review of facility's policy and procedure (P&P), titled, Change in Condition dated 8/25/2022, was reviewed. The P&P indicated, Documentation:a. Licensed Nurse will document the following: .iii. the time the family/responsible person was contacted and name of individual notified.