

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055932	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2025
NAME OF PROVIDER OR SUPPLIER Four Seasons Healthcare & Wellness Center, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to keep the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) within reach of the resident for one of five sampled residents (Resident 1) reviewed under accommodation of needs. This deficient practice had the potential for Resident 1 to be unable to summon health care workers for help as needed. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 9/12/2017, with diagnoses including dementia (a progressive state of decline in mental abilities), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition that causes weakness on one side of the body), and parkinsonism (a group of movement disorders that cause slow, stiff, and shaky movements). During a review of Resident 1's History and Physical (H&P), dated 11/29/2024, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/26/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a person has major problems with their mental abilities-such as thinking, remembering, learning, making decisions, and using judgment-to the point where they can no longer live independently and require significant help with everyday activities). The MDS indicated the resident was dependent to requiring substantial assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Fall Risk Evaluation (FRE), dated 9/4/2025, the FRE indicated the resident was at risk for falls. During a review of Resident 1's Care Plan (CP) Report regarding Resident 1 being at risk for fracture (broken bone) and alteration in musculoskeletal (the body's system of muscles, bones, and joints, along with the tendons, ligaments, and cartilage that connect them, which all work together to provide structure, support, and movement) function, last revised on 10/13/2025, the CP indicated an intervention to anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. During a concurrent observation and interview on 11/13/2025 at 8:32 a.m. with Certified Nursing Assistant (CNA) 1, inside Resident 1's room, observed Resident 1's call light cord was hanging on the wall, and the call button was at the foot part of Resident 1's bed. CNA 1 stated she hung the call light cord on the wall, and the call button was placed at the foot part of Resident 1's bed because the resident throws them away. CNA 1 stated Resident 1 will not be able to use the call light to ask for help and could fall while reaching for the call light button. During a concurrent interview and record review on 11/13/2025 at 3:45 p.m. with the Director of Nursing (DON), a picture of Resident 1's location of the call light button during observation was reviewed. The DON stated the call light button was on the foot part of Resident 1. The DON stated Resident 1 will not be able to call for help when needed. The DON stated it was everyone's responsibility in the facility to ensure the call light was within reach of the resident. The DON stated the staff should check the placement of the call lights every two hours. The DON also stated the failure of the staff to keep the call light within reach can result in injuries such as bruises, bumps, skin tears and potential falls. The DON reviewed the policy and procedure (P&P) titled Communication- Call System, last reviewed 9/25/2024, and stated the staff did not follow the P&P as they did not ensure the call light was within reach of Resident 1. During a review of the facility's recent P&P titled Communication- Call System, last reviewed on 9/25/2024, the P&P indicated call cords will be placed within the resident's reach in the resident's room.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to ensure the resident's environment was free of accident hazards for one of five sampled residents (Resident 2) reviewed for accidents by failing to ensure Resident 2's fall/floor mats (a cushioned floor pad designed to help prevent injury should a person fall) did not have any furniture or medical equipment on top of them. The deficient practice increased the risk of accidents such as falls with injuries on residents. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted the resident on 8/7/2020, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (a condition that causes weakness or a partial loss of strength on one side of the body), and muscle weakness. During a review of Resident 2's History and Physical (H&P), dated 6/4/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 8/5/2025, the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had impaired cognition (problems with thinking, learning, memory, and decision-making that are worse than what is considered normal for a person's age). The MDS indicated that the resident requires substantial to set up assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 2's Order Summary Report (OSR), dated 5/29/2025, the OSR indicated an order of floor mat on the right side of the bed to decrease potential injury every shift. During a review of Resident 2's Fall Risk Evaluation (FRE), dated 9/1/2025, the FRE indicated the resident was at risk for falls. During a review of Resident 2's Care Plan (CP) Report titled, Risk for injury: Fall occurred related to non-compliance with the call light, last revised on 4/22/2025, the CP indicated an intervention to educate on the importance of maintaining a safe environment, free of potential fall hazards. During a concurrent observation and interview on 11/13/2025 at 8:32 a.m. with Certified Nursing Assistant (CNA) 1, inside Resident 2's room, observed Resident 2's floor/fall mat had a side table and a trash can on top of them. CNA 1 stated there should be no furniture or equipment on top of the floor/fall mat because when the resident falls on them, they will hit the hard objects that is on top of the mat that can cause injuries to residents. CNA 1 stated it is everyone's responsibility to ensure there were no objects placed on top of the fall mat. During a concurrent interview and record review on 11/13/2025 at 3:45 p.m. with the Director of Nursing (DON), a picture of Resident 2's floor/fall mat the right side of the resident's bed was reviewed. The DON stated there was a side table and a trash can on top of the floor mat. The DON stated there should be no objects placed on top of the floor mat as it defeats the purpose of the floor mat to have a safe, soft-landing space when the resident falls from the bed. The DON stated it was everyone's responsibility to ensure floor mats were placed correctly at the bedside of the residents, free from any accident hazards. The DON stated the failure of the staff to ensure there was no furniture or equipment on top of the fall mat can lead to bruising, bumps, skin discoloration, and potential fractures (broken bone) to residents. The DON reviewed the following policies and procedures (P&P) provided by the facility: Fall Prevention and Management Program, and Resident Safety; facility-provided Floor Mat (FM) 1 User Instructions. The DON stated the staff did not follow the P&Ps by failing to ensure the environment was free from hazards and the facility-provided FM 1 User Instructions purpose of reducing the incidence of resident trauma and severity by having equipment or furniture on top of the floor mat. During a review of the facility's recent P&P titled, Fall Prevention and Management Program, last reviewed on 9/25/2025, the P&P indicated the facility will implement a Fall Prevention and Management Program that supports providing an environment free from the hazards over which the facility has control. During a review of the facility's recent P&P titled Resident Safety, last reviewed on 9/25/2025, the P&P indicated to provide a safe and hazards free environment. Any facility staff member who identifies an unsafe situation, practice or environmental risk factors should immediately notify their supervisor or charge nurse. During a review of the facility-provided FM 1 User Instructions (UI), undated, the UI indicated the impact reduction fall mats placed alongside the bed have become a cost-effective means to help reduce the incidence of resident trauma and severity of injury by providing a cushioned, slide resistant surface.</p>		