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	12/23/2025

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 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. (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

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure the medical records of one of three sampled residents (Resident 1) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to ensure licensed nurses documented Resident 1's change of condition (COC) in Resident 1's medical records. This deficient practice resulted in incomplete and inaccurate information on Resident 1's medical records and had the potential for delayed medical interventions.Findings: During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 5/22/2019 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), other specified disorders of the brain, and convulsions (a medical event involving sudden, violent, involuntary muscle contractions and relaxations, causing uncontrollable shaking or stiffening of the body linked to unusual brain activity). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 10/22/2025, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were moderately impaired. During a review of Resident 1's Physician Orders, dated 12/16/2025, the Physician Orders indicated to monitor and document for episodes of seizure activity every shift and notify the attending physician of seizure presence. During an interview on 12/23/2025 at 3:51 p.m. and concurrent record review of Resident 1's Progress Notes, dated 12/18/2025, reviewed with Registered Nurse (RN) 1, the Progress Notes indicated Resident 1 experienced three consecutive seizure episodes . at 8:45 a.m. for ten seconds, at 11:11 a.m. for one minute, and at 12 p. m. for two minutes. RN 1 stated licensed nurses should document the assessment done on Resident 1 after the resident's COC. RN 1 stated there was no documented evidence that a Situation, Background, Appearance, and Review (SBAR) Form was created for the three seizure episodes of Resident 1 on 12/18/2025. RN 1 stated Resident 1's COC documentations were incomplete. During an interview on 12/23/2025 at 3:55 p.m. with the Director of Nursing (DON), the DON stated the licensed nurse that witnessed Resident 1's seizure or the RN supervisor should document the seizure episodes and the assessment done on the resident. The DON stated complete documentation was important for communicating Resident 1's condition to the attending physician and the resident's care team. The DON stated the facility failed to ensure proper documentation of Resident 1's assessment was completed. During a review of the facility's policy and procedure (PnP) titled, Change in Condition, last reviewed on 9/25/2025, the PnP indicated the licensed nurse will document the following . i. date, time, and pertinent details of the event and the subsequent assessment in the medical record. ii. The time the Physician was contacted. iii. The time the family or responsible person was contacted. During a review of the facility's policy and procedure (PnP) titled, Completion and Correction, last reviewed on 9/25/2025, 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. any person making observations or rendering services to the resident will document in the record. The PnP indicated documentation will reflect medically relevant information concerning the resident and will be documented in a professional manner.