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	01/09/2026

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from physical abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) for one of four sampled residents (Resident 1) when on 12/22/2025 (time unknown) in the Station A hallway (near the smoking patio entrance and Station A dining room), Resident 2 used a wooden back scratcher (a handheld tool used to reach and relieve back itches) to hit the top of Resident 1's head. This deficient practice resulted in Resident 1 being subjected to physical abuse by Resident 2 while under the care of the facility. On 12/23/2025, Resident 1 sustained an acute (sudden or short-term) pain one out of 10 to Resident 1's top of scalp.Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 7/12/2010 and readmitted the resident on 2/3/2022 with diagnoses including functional quadriplegia (a complete inability to move limbs due to severe frailty or disability), multiple sclerosis (MS - a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), optic atrophy (degeneration of the optic nerve, leading to vision loss), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 12/25/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/17/2025, the MDS indicated Resident 1 had intact cognitive functioning (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS further indicated Resident 1 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 1's Change of Condition (COC - major decline or improvement in a resident's status that will not resolve without intervention) form, dated 12/23/2025, timed at 12:15 p.m., the COC form indicated on 12/23/2025 (time not indicated), Resident 1 was on monitoring for potential pain and emotional distress related to claimed physical altercation. The COC further indicated Resident 1 had 1 out of 10 pain level on the top of the scalp.During a review of Resident 1's Care Plan (CP) focused on potential for pain and emotional distress related to claimed physical altercation, dated 12/23/2025, the CP indicated Resident 1's goals included to be free of signs and symptoms of pain and emotional distress. The CP indicated interventions including monitor for pain and any changes, offer cold compress every two hours for 15 to 20 minutes for 24 hours, and assess/skin check. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 11/10/2025 with diagnoses including fracture (bone that is broken in at least two places) of one rib on the left side, metabolic encephalopathy (a condition where the brain does not work normally because of problems with the body's (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	metabolism [how the body manages food, energy, or chemicals]), and generalized muscle weakness. During a review of Resident 2's physician visit note, dated 11/13/2025, the physician visit note indicated Resident 2 as alert and oriented. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had intact cognitive functioning. The MDS further indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) on staff for activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) which included toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear; and with mobility which included sit to stand, chair/bed-to-chair transfer, and walk 10 feet (ft - a unit of measurement).During a review of Resident 2's Situation-Background-Appearance-Review (SBAR - also known as COC), undated, the SBAR indicated on 12/23/2025 (time unknown), Resident 2 claimed that Resident 1 was in his (Resident 2) way while attempting to get by in the hallway and Resident 1 did not move. The SBAR indicated Resident 2 claimed to lift his (Resident 2) own wheelchair to pass by Resident 1 and placed his (Resident 2) wheelchair on top of Resident 1's legs to get by, but Resident 1 made an inappropriate comment, called him (Resident 2) a Nazi, and made him (Resident 2) upset. The SBAR indicated Resident 2 went back and reached the back of the wheelchair and potentially hit Resident 1's back of the head with the back scratcher. The COC indicated Resident 2 stated that he (Resident 2) will avoid Resident 1. The COC further indicated that the primary care clinician was notified on 12/23/2025 at 12:45 p.m. and Resident 2 was self-responsible.During a review of Resident 2's CP focused on an altercation with another resident, dated 12/23/2025, the CP indicated Resident 2's goals included Resident 2 will not have any signs and symptoms of emotional distress or pain related to the altercation. The CP indicated interventions included Resident 2 to continue to be up in wheelchair and to continue with smoking as per resident's choice and socialization with others. During a review of Resident 3's AR, the AR indicated the facility admitted Resident 3 on 3/8/2021 with diagnoses including radiculopathy (a set of symptoms that occur from spinal nerve root compression aka pinched nerve) on the lumbar region (lower part of the back), atherosclerosis (a disease that develops when a sticky plaque [buildup of fats, cholesterol, and other substances] builds up in the arteries [a blood vessel that carries blood from the heart to tissues and organs in the body]), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage [a tough, flexible, rubbery tissue that acts as a natural cushion and shock absorber in your body, preventing bones from rubbing together in joints]) of the hip. During a review of Resident 3's H&P, dated 4/25/2025, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated that Resident 3 had intact cognitive functioning. The MDS further indicated Resident 3 required setup help or clean-up assistance from staff (resident completes activity) with ADLs including eating, oral hygiene, toileting hygiene, upper body dressing, and personal hygiene and required supervision in walking 150 ft and setup or clean-up assistance with sit to stand and chair/bed-to-chair transfer. During an interview on 1/8/2026 at 8:49 a.m. with Resident 1, Resident 1 stated that he (Resident 1) is a quadriplegic and he (Resident 1) cannot move his (Resident 1) arms and legs. Resident 1 stated Resident 2 hit him (Resident 1) on top of his (Resident 1) head with a wheelchair. Resident 1 stated Resident 2 stood up and lifted his (Resident 2) wheelchair and hit the back of his (Resident 1) head with the footrest. Resident 1 stated he (Resident 1) did not start the incident, Resident 2 called him (Resident 1) a bad word he (Resident 1) could not remember what it was and he (Resident 1) responded with something like German Nazi and that was when Resident 2 hit him (Resident 1). Resident 1 stated he (Resident 1) did not suffer any injuries. Resident 1 stated he (Resident 1) could not remember who was there, but he (Resident 1) (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remembered someone was there because when it happened, he (Resident 1) heard someone say, what are you doing or something like that. During an interview on 1/8/2026 at 9:05 a.m. with Resident 2, Resident 2 stated he (Resident 2) had an altercation with Resident 1. Resident 2 stated he (Resident 2) does not remember when or what time the altercation happened. Resident 2 stated he (Resident 2) went to go smoke and was trying to cross with his (Resident 2) wheelchair on the left hand side when Resident 1's wheelchair was in the way and he (Resident 2) carried his (Resident 2) wheelchair to get past him (Resident 1), and Resident 1 told him no and would not move. Resident 2 stated he (Resident 2) lifted his (Resident 2) wheelchair to get past Resident 1 and Resident 2's wheelchair legs may have touched Resident 1's legs. Resident 2 stated he (Resident 2) went and reached for his (Resident 2) wooden back scratcher and popped Resident 1's head three to four times with the back scratcher. Resident 2 stated popped means he (Resident 2) hit Resident 1's head. Resident 2 stated this happened in the hallway going to the smoking patio. Resident 2 stated the staff took his (Resident 2) wooden back scratcher that he (Resident 2) brought from home. Resident 2 stated that Resident 1 started the incident when the road was blocked and there was no way of getting past him (Resident 1). Resident 2 stated he (Resident 2) cannot say the incident was his (Resident 2) fault. Resident 2 stated Resident 1 blocked him (Resident 2) from getting to his (Resident 2) destination and that means the blocker (Resident 1) is in the wrong. During an interview on 1/8/2026 at 11:58 a.m. with the Administrator (ADM), the ADM stated Resident 1 named Resident 3 as a witness during the incident on 12/22/2025 and that there were no other witnesses. The ADM stated Resident 2 initially brought this to his (ADM) attention on 12/23/2025 and the investigation was done as a team effort by nursing and social services departments. During a concurrent interview and record review on 1/8/2026 at 12:09 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's Interdisciplinary (IDT - a team of healthcare professionals from different professional disciplines who work together to manage the physical, psychological and spiritual needs of the resident) Note, dated 12/23/2025, time stamped at 4:14 p.m., was reviewed and LVN 1 confirmed the IDT Note indicated that at approximately 4 p.m. near Station (Sta) C, Resident 1 was positioned in a manner that impeded Resident 2's path and would not move. Resident 2 stated his (Resident 2) wheelchair made contact with Resident 1's wheelchair and reports that he (Resident 2) lifted his (Resident 2) own wheelchair and moved the wheelchair over Resident 1's legs to get past. Resident 2 admits to reaching towards Resident 1 with a back wooden back scratcher during the interaction and reports making contact with wheelchair headrest. During a follow-up interview on 1/8/2026 at 12:55 p.m. with Resident 1, Resident 1 stated he (Resident 1) was wearing a hat and he (Resident 1) was hit on top of his head not the back of his (Resident 1) head. Resident 1 stated he (Resident 1) was wearing a hat and getting hit did not hurt. Resident 1 stated he (Resident 1) wanted to clarify that it was not a wheelchair that hit him (Resident 1), it was a wooden back scratcher. Resident 1 stated if he (Resident 1) was not wearing his (Resident 1) hat, the back scratcher would have hit his (Resident 1) skin directly. During an interview on 1/8/2026 at 1:10 p.m. with Resident 3, Resident 3 stated Resident 1 has MS and cannot move both upper and lower extremities and uses a special wheelchair that he (Resident 1) blows air into to move. Resident 3 stated he (Resident 3) saw the entire incident on 12/22/2025 between Resident 1 and Resident 2. Resident 3 stated he (Resident 3) was a few feet away from Resident 1 and Resident 2 in the hallway where the smoking patio entrance and Station A dining room are. Resident 3 stated what he (Resident 3) saw Resident 1 accidentally hit, with his wheelchair, Resident 2's wheelchair. Resident 3 stated Resident 2 stood up and moved his (Resident 2) wheelchair and passed by Resident 1 then grabbed what looked like a wooden back scratcher and hit Resident 1 on top of his (Resident 1) head. Resident 3 stated Resident 2 did not hit (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's wheelchair headrest. Resident 3 stated the incident was upsetting to see because Resident 1 could not move and even if Resident 1 hit Resident 2, it was accidental because Resident 1 cannot control how much the wheelchair moves when he (Resident 1) blows air into the wheelchair to move. Resident 3 stated he (Resident 3) told Resident 2, you're a tough guy? You're a tough guy? and Resident 2 responded he [Resident 1] hit me! Resident 3 stated he (Resident 3) responded to Resident 2, yes, he [Resident 1] hit you, but it was an accident because Resident 1 could not move his (Resident 1) arms or legs to move his (Resident 1) wheelchair. Resident 3 stated Resident 2 moved away after talking to Resident 3. Resident 3 stated Resident 1 did not yell in pain or looked like he (Resident 1) was in pain.During a follow-up interview on 1/8/2026 at 1:33 p.m. with Resident 2, Resident 2 stated he (Resident 2) did not hit Resident 1's wheelchair headrest. Resident 2 stated he (Resident 2) hit Resident 1 on the top of Resident 1's head. During an interview on 1/8/2026 at 3:50 p.m. with LVN 2, LVN 2 stated on 12/23/2025 she (LVN 2) was notified that there had been an alleged physical altercation between Resident 1 and Resident 2 on 12/22/2025, and she (LVN 2) did her (LVN 2) own investigation and went to the resident herself (LVN 2) and documented what she (LVN 2) had seen and done. LVN 2 stated there were multiple attendees who had spoken to Resident 1, and Resident 1 mentioned that the incident happened the day before, on 12/22/2025, and Resident 1 was in Station A dining room. LVN 2 stated she (LVN 2) was not in the facility the day when the alleged incident occurred. LVN 2 stated Resident 1 stated he (Resident 1) wanted to go around the facility and do his (Resident 1) activities in the Station A dining room. LVN 2 stated Resident 1 stated he was in the middle of the hallway and another resident in a wheelchair (Resident 2) forced his (Resident 2) way through and Resident 1 did not like that. LVN 2 stated Resident 1 has a history of blocking people and when she (LVN 2) asked him if he (Resident 1) had intentionally blocked the other residents, Resident 1 said he (Resident 1) did not. LVN 2 stated Resident 1 said that he (Resident 1) got hit by something on his (Resident 1) head and that it did not hurt, but he (Resident 1) knew something had hit him (Resident 1). LVN 2 stated she (LVN 2) asked him (Resident 1) if he (Resident 1) has pain and Resident 1 stated at first yes, then no, and then maybe a little. LVN 2 stated she (LVN 2) offered Resident 1 pain medication and cold compress (applying something cold to affected area to help reduce pain, swelling, and tenderness), and Resident 1 asked to put cold compress. LVN 2 stated when she (LVN 2) returned to Resident 1, Resident 1 did not want the cold compress. LVN 2 stated she (LVN 2) assured Resident 1 that if he (Resident 1) is in any pain, to ask for a cold compress and pain medication to his (Resident 1) charge nurse.During an interview on 1/9/2026 at 9:02 a.m. with the Director of Nursing (DON), the DON stated she (DON) discussed her (DON) findings with the ADM and interviewed Resident 1 and Resident 2. The DON stated both Resident 1 and Resident 2 said that an incident happened but the residents do not know the exact time and location. The DON stated Resident 1's wheelchair was in the way and Resident 2 was passing by Resident 1. The DON stated Resident 2 carried his (Resident 2) wheelchair and placed the wheelchair on Resident 1's legs as Resident 2 was passing. The DON stated Resident 2 felt like Resident 1's wheelchair touched him (Resident 2) and Resident 2 turned around and hit Resident 1. The DON stated during the first interview with Resident 1, Resident 1 stated he (Resident 1) was wearing a hat and heard a thump. The DON stated Resident 1 told her (DON) getting hit did not hurt because he (Resident 1) was wearing a hat. The DON stated the facility did a skin check and there was no redness and Resident 1 did not report the incident to anyone. The DON stated Resident 1 usually reports to her (DON) and to the ADM, usually about everything every day, but Resident 1 did not report anything on 12/22/2025. The DON stated she (DON) was not aware of the incident until Resident 2 reported the incident to the ADM. The DON stated the alleged physical altercation (continued on next page)

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