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	02/11/2026

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

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview and record review, the facility failed to ensure that one of three sampled residents (Resident 2) was free from the use of physical restraints when the resident's bed was positioned against the wall in a manner that restricted the resident's voluntary movement. This deficient practice had the potential to limit Resident 2's freedom of movement, interfere with the resident's right to be free from physical restraints, and compromise the resident's right to be treated with dignity and respect.Findings: During a review of Resident 2's undated, admission Record, the admission Record indicated the facility admitted the resident on 10/1/2025 with diagnoses including cerebral infarction (occurs when the blood flow to part of the brain was blocked), unstageable PU (a deep wound where the true depth cannot be determined because the base was covered by dead tissues) to right upper back, and presence of gastrostomy (a small tube placed directly into the stomach through a tiny surgical opening in the belly skin) tube. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 1/8/2026, the MDS indicated Resident 2's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were severely impaired. During a concurrent observation and interview on 2/10/2026 at 10:56 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's bed was observed positioned directly against the wall. LVN 1 stated she was not sure if Resident 2 had a physician order to have the bed against the wall. During a follow up interview on 2/10/2026 at 11:25 a.m. and a concurrent record review of Resident 2's medical record, with LVN 1, LVN 1 stated there was no space between Resident 2's left side of the bed and the wall sufficient to allow Resident 2 or nursing staff access on that side. LVN 1 acknowledged the bed placement was considered a restraint and confirmed there was no physician order authorizing this positioning. LVN 1 also indicated review of Resident 2's care plans revealed no interventions addressing bed placement against the wall. During an interview on 2/10/2026 at 1:29 p.m. with Registered Nurse (RN) 1, RN 1 stated a bed positioned against the wall was considered a form of restraint and lack of access to one side of the bed had the potential to limit Resident 2's movement. During an interview on 2/10/2026 at 2:55 p.m. with the Director of Nursing (DON), the DON stated a bed placed less than one foot from the wall was considered a restraint. The DON stated Resident 2's bed placement against the wall was considered a restraint. The DON stated Resident 2's bed placement against the wall had the potential to restrain the restrict the resident's movement in bed. The DON stated the facility failed to ensure Resident 2's bed was not placed against the wall. During a review of the facility's policy and procedure titled, Restraints, last reviewed on 11/19/2025, the PnP indicated the purpose to ensure that all restraints are used properly and only when necessary on residents at the facility. The policy indicated the facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. Restraints require a physician order and are used as a last resort measure to be used only when deemed necessary by the Interdisciplinary Team (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(IDT) and in accordance with the resident's assessment and plan of care.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards of nursing practice for one of three sampled residents (Resident 1) by failing to ensure that licensed nurses appropriately monitored the resident's medical status following a documented change of condition (COC) on 1/18/2026. The record revealed there was no evidence that Resident 1's COC status was monitored for five consecutive shifts. This deficient practice had the potential to result in the failure to identify continued or worsening clinical deterioration, thereby placing Resident 1 at risk for adverse health outcomes and compromised safety. Findings: During a review of Resident 1's undated admission Record, the admission Record indicated the facility admitted the resident on 9/4/2024 with diagnoses including asthma (inflammation and narrowing of the small airways in the lungs), depression (a common, serious mood disorder characterized by persistent, intense, and long-lasting feeling of sadness or a loss of interest in activities), and overactive bladder (a sudden urge to urinate that may be hard to control). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/11/2025, 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 an interview and concurrent record review on 2/10/2026 at 1:29 p.m with Registered Nurse (RN) 1, RN 1 reviewed Resident 1's Change in Condition Evaluation, dated 1/18/2026. The evaluation indicated Resident 1 complained of a burning sensation during urination. RN 1 stated the resident should have been monitored every shift for 72 hours following the identified change in condition. RN 1 stated Resident 1's Progress Notes indicated there was no documented evidence that the resident was monitored on the following shifts:On 1/18/2026 (11 p.m. to 7 a.m. shift),On 1/19/2026 (11 p.m. to 7 a.m. shift),On 1/20/2026 (7 a.m. to 3 p.m. shift and 11 p.m. to 7 a.m. shift), [NAME] 1/21/2026 (7 a.m. to 3 p.m. shift).RN 1 stated that care not documented is considered not provided. RN 1 further stated that failure to document monitoring of the resident's condition could result in a failure to identify worsening symptoms. During an interview on 2/10/2026 at 2:55 p.m. the Director of Nursing (DON), stated Resident 1 should have been monitored every shift for at least 72 hours following the COC. The DON stated there was no confirmed documented evidence of monitoring on the identified shifts. The DON stated failure to monitor the resident every shift after a COC could result in missed signs of improvement or decline. The DON acknowledged and stated the facility failed to ensure Resident 1's health status was monitored every shift following the resident's COC. During a review of the facility's policy and procedure titled, Change in Condition, last reviewed on 11/19/2025, the policy indicated the licensed nurse will communicate any changes in required interventions to the care team members involved in the resident care.The policy further indicated the licensed nurse will document each shift for at least seventy-two (72) hours when there is a change in the resident's condition.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) received care consistent with professional standards of practice to prevent pressure ulcers (PU, a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) by failing to ensure Resident 2's low air-loss mattress (LALM - a mattress composed of inflatable air cushions used to relieve pressure on body parts) was set to appropriate settings per Physician Orders. This deficient practice placed Resident 2 at risk for the development of pressure ulcers. Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) received care consistent with professional standards of practice to prevent pressure ulcers (PU, a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) by failing to ensure Resident 2's low air-loss mattress (LALM - a mattress composed of inflatable air cushions used to relieve pressure on body parts) was set to according to the physician's orders and the resident's weight. This deficient practice placed Resident 2 at risk for worsening of an existing pressure injury and development of additional pressure injuries. Findings: During a review of Resident 2's undated admission Record (undated), the record indicated the facility admitted the resident on 10/1/2025 with diagnoses including cerebral infarction (occurs when the blood flow to part of the brain was blocked), an unstageable PU (a deep wound where the true depth cannot be determined because the base is covered by dead tissues) of the right upper back, and presence of gastrostomy (a small tube placed directly into the stomach through a tiny surgical opening in the abdominal wall skin). During a review of Resident 2's Care Plan related to pressure injury management, last revised on 11/4/2025, the Care Plan indicated the resident had an unstageable pressure injury on the right back. The Care Plan indicated Resident 2 was at risk for .further skin breakdown and delayed wound healing. The Care Plan Interventions indicated to use LALM for pressure injury management. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 1/8/2026, the MDS indicated Resident 2's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were severely impaired. During a concurrent observation and interview on 2/10/2026 at 10:56 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 2's LALM setting was programmed between 300 pounds (lbs. - unit of measurement) and 350 lbs. LVN 1 stated Resident 2's weight was less than 300 lbs. During a follow up interview on 2/10/2026 at 11:25 a.m. with concurrent record review of Resident 2's medical record, with LVN 1, LVN 1 stated the LALM was an intervention intended to prevent the development or progression of pressure ulcers. LVN 1 stated Resident 2's Wound Assessment and Plan, dated 1/22/2026, indicated Resident 2 had a Stage 4 pressure ulcer (a severe, deep, and dangerous open wound exposing underlying muscle, tendon, or bone) on the right back. LVN 1 stated Resident 2's Monthly Weight Report, dated 2/2026, indicated the resident's weight was 161 lbs. A review of Resident 2's Physician Orders, dated 10/23/2025, indicated licensed nurses were to calibrate the LALM setting to 180 lbs. for pressure injury management. LVN 1 stated the LALM setting should have been set at 180 lbs. per the physician's order. LVN 1 further stated an incorrect LALM setting had the potential to cause Resident 2's pressure ulcer to worsen. During an interview on 2/10/2026 at 2:55 p.m. with the Director of Nursing (DON), the DON stated a LALM is a pressure-relieving mattress used to aid in the healing of pressure ulcers and wounds. The DON acknowledged and stated the physician's order for the LALM setting was not followed and confirmed the facility failed to ensure the mattress setting was adjusted based on the resident's weight and physician's order. During a review of the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's policy and procedure titled, Pressure Injury Prevention, last reviewed on 11/19/2025, the policy indicated the purpose is to prevent the development of pressure injury in residents identified at risk. The policy indicated it will implement interventions identified in the plan of care which may include. pressure redistributing devices for bed. During a review of the facility's policy titled, Mattresses, last reviewed on 11/19/2025, the policy indicated the purpose is to provide a mattress appropriate to residents' needs. The policy further indicated the facility will provide mattresses capable of meeting the following needs of residents: a. to provide pressure reduction to residents at risk for skin breakdown. d. to reduce pressure and evenly distribute body weight over a larger area of body surface.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain an effective prevention and control program related to Enhanced Barrier Precautions (EBP-an infection control intervention designed to reduce transmission or multi[drug -resistant organisms through targeted gown and glove use during high-contact resident care activities) for one of three sampled residents (Resident 2). This deficient practice placed Resident 2 at risks for potential exposure to transmission of infectious organisms. Findings:During a review of Resident 2's undated admission Record the admission Record indicated the facility admitted the resident on 10/1/2025 with diagnoses including cerebral infarction (occurs when the blood flow to part of the brain was blocked), unstageable (a deep wound where the true depth cannot be determined because the base is covered by dead tissues) pressure ulcer (PU, a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) of the right upper back, and presence of gastrostomy (a small tube placed directly into the stomach through a tiny surgical opening in the abdominal skin).During a review of Resident 2's Physician Order dated 10/1/2025, the order indicated the resident was to be paced on Enhanced Barrier Precautions secondary to the presence of an indwelling medical device (gastrostomy tube). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 1/8/2026, the MDS indicated Resident 2's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were severely impaired. During a review of Resident 2's Care Plan related to Enhanced Barrier Precautions, last revised on 1/23/2026, the Care Plan indicated the resident was on EBP due to the presence of a gastrostomy tube and stage 4 (a severe, deep, and dangerous open wound exposing underlying muscle, tendon, or bone) pressure ulcer. During a concurrent observation and interview on 2/10/2026 at 11:55 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 2 was on EBP due to the gastrostomy tube and pressure ulcer. There was no posted EBP sign observed outside Resident 2's room. LVN 1 stated an EBP sign identifies the required precautions and personal protective equipment (PPE - equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) to be used when providing care. LVN 1 stated the Infection Preventionist Nurse (IPN) was responsible for ensuring the EBP signage was posted. LVN 1 further stated failure to post the signage could result in staff not wearing appropriate PPE, increasing the risk for transmission of infection. During an interview on 2/10/2026 at 1:10 p.m. with the IPN, the IPN confirmed and stated Resident 2 was on Enhanced Barrier Precautions (EBP). The IPN stated EBP signs were available at the nurses' stations and accessible to licensed nursing staff. The IPN further stated if signage was not posted outside the resident's room, staff may not implement appropriate PPE use, potentially contributing to the spread of infection among residents and staff. During an interview on 2/10/2026 at 2:55 p.m. with the Director of Nursing (DON), the DON stated an EBP sign should be posted outside Resident 2's room to notify staff and visitors of required precautions prior to providing direct care. The DON acknowledged that failure to post the signage could result in staff and visitors not following required precautions, thereby increasing the risk of infection transmission. The DON confirmed and stated the facility failed to ensure the EBP signage was posted outside Resident 2's room. During a review of the facility's policy and procedure, titled, Enhanced Barrier Precautions, last reviewed on 11/19/2025, the policy indicated the purpose was to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. The policy further directed staff to post the appropriate Enhanced Barrier Precautions sign on the resident's room door to inform caregivers of the appropriate tasks requiring the use of PPE.