

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  03/26/2026
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)		
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.  **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medical records for one of four sampled residents (Resident 1) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to ensure accurate documentation of the Long Term Care Evaluation (weekly documentation of residents' progress) form. This deficient practice had the potential for inaccurate medical interventions for Resident 1. Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted Resident 1 on 2/4/2025 and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, osteoarthritis, and chronic pain syndrome. During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 4/23/2025, 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 2/12/2026, the MDS indicated Resident 1 had intact cognitive functioning (resident's mental abilities, impacting their ability to think, learn, remember, reason, and make decisions).The MDS indicated Resident 1 was with toileting hygiene, showers, upper and lower body dressing. The MDS indicated Resident 1 was independent with ambulating 150 feet (ft-unit of measurement). During a concurrent interview and record review on 3/26/2026 at 12:39 p.m. with the Interim Rehab Director (IRD), Resident 1's was discharged from Physical and Occupation Therapy on 5/19/2025. The IRD stated Resident 1 did not receive Occupational and Physical therapy after 5/19/2025. During a concurrent interview and record review on 3/26/2026 at 1:38 p.m. with the Director of Nursing (DON), Resident 1's Long Term Care Evaluation forms dated 6/8/2025 and 6/29/2025 were reviewed. The Long Term Care Evaluation forms dated 6/8/2025 and 6/29/2025 indicated that Resident 1 continued to participate in Occupational and Physical Therapy as ordered by the physician. The DON stated the Long Term Care Evaluation was a weekly assessment of resident's progress for continuation of care. The DON stated Resident 1 was not receiving Occupational and Physical therapy during the 6/8/2025 and 6/29/2025 evaluation period. The DON stated the evaluation forms were not documented accurately. During a review of the facility-provided policy and procedure titled, Completion and Correction, last reviewed on 1/26/2026, the P&P indicated, To ensure that medical records are complete and accurate. The Facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation. III. Entries will be complete, legible, descriptive, and accurate.		

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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