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	05/26/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 3) was free of any significant medication error when on 5/18/2026 Resident 3 did not get her prescribed medication as ordered. This deficient practice had the potential to negatively affect Resident 3.Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 9/4/2024 and readmitted Resident 3 on 11/13/2026 with diagnoses including morbid (severe) obesity (a medical condition defined by the buildup of excess body fat) due to excess calories, and muscle weakness. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 3/12/2026, the MDS indicated Resident 3 had the ability to understand and was understood.During a review of Resident 3's Physician History and Physical (H&P- a process used by doctors to understand patients' health it combines medical history and a physical examination), dated 4/2/2026, the H&P indicated Resident 3 had the capacity to understand and make decisions.During a review of Resident 3's Order Summary Report (OSR) dated 4/23/2026, the ORS indicated Wegovy (Semaglutide- is a prescription medication used to help people lose weight and keep it off long-term) oral tablet 1.5 milligrams (mg- a unit of measurement) give one tablet by mouth one time a day for related to weight management until 5/23/2026. During a review of Resident 3's Progress notes titled, Order Note, dated 5/17/2026 at 1:09 p.m. the Prgoress Note indicated Resident 3 came up to writer stating she (Resident) called pharmacy for her Wegovy tablets. Resident 3 stated that it should come later today but was upset she had to call the pharmacy herself to confirm that it was coming by the end of the day. The Progress Noted indicated that per pharmacy the refill request was made on 5/11/26 and also mentioned that this request was sent but insurance could not authorize until today was noted and made Resident 3 aware.During a review of Resident 3's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for May 2026, the MAR indicated:-On 5/18/2026 at 9 a.m. for the scheduled Wegovy 1.5 mg give one tablet by mouth one time a day for related to weight management was documented as 9 (other/see progress notes)-On 5/18/2026 at 2:35 p.m. Wegovy 1.5 mg give one tablet by mouth one time only for related to weight management was documented as given. During a review of Resident 3's Progress notes titled, Case Management, dated 5/18/2026 at 1:57 p.m. the Progress Notes indicated Resident 3 was very fixated on a medication claiming a whole month's supply was sent over to the facility, but writer informed her that it was only actually five tablets that was sent. During an interview on 5/26/2026 at 10:41 a.m. with Resident 3, Resident 3 stated she had been on Wegovy tablets for one month and on 5/18/2026 she did not get her Wegovy medications. Resident 3 stated she asked staff and did not get an answer, so she called the pharmacy. Resident 3 stated the pharmacy informed her (Resident 3) that they had already delivered the medication. Resident 3 stated Registered Nurse (RN) 1 had stated to Resident 3 that she (RN 1) signed for the medication and stated the Wegovy medication was missing. Resident 3 stated RN 1 then reordered the medication, and the pharmacy re-delivered the medication. Resident 3 stated she received that day (5/18/2026) in the afternoon. Resident 3 stated she is not upset about it because her pills were covered but is concerned that staff have sticky fingers, and stole her (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications. During an interview on 5/26/2026 at 11:52 a.m. with RN 1, RN 1 stated she worked on 5/17/2026 and took care of Resident 3. RN 1 stated Resident 3's Wegovy was scheduled at 9 a.m. and RN 1 stated she was able to give Resident 3 her morning Wegovy and that was the last dose available. RN 1 stated then on 5/17/2026 around 5 p.m. the facility received Resident 3's Wegovy and she (RN 1) signed off Resident 3's Wegovy and three other medications for other residents as received. RN 1 stated the Wegovy was in a bubble pack of only 7 days' worth. RN 1 stated she placed the medications in the cart, cart 2-C. RN 1 stated the next day (5/18/2026) she (RN1) came back to work but was not assigned to Resident 3, she found out from Resident 3's nurse (Licensed Vocational Nurse [LVN] 1) that the Wegovy medication was missing. RN1 stated she looked for the medication but could not find it and she (RN 1) had signed off for it. RN 1 stated the Wegovy medication was reordered, and Resident 3 was given the medication when the medication arrived. RN 1 stated the next bubble pack came in that day. RN 1 stated she thought the assigned nurse was LVN 1 on 5/18/2026. RN 1 stated she was sure she (RN1) put the medication in the correct cart. RN 1 stated it is always just 7 days' worth of medication. RN 1 stated she was not aware of having issues with missing medications before. RN 1 stated she did not take the medication and was not aware of who could have taken the medication.During an interview on 5/26/2026 at 12:35 p.m. with LVN 1, LVN 1 stated she worked on 5/18/2026 from 7 a.m. to 3 p.m. and took care of Resident 3. LVN 1 stated when she was going to give Resident 3 her medication in the morning, Resident 3's Wegovy medication was not in the medication cart. LVN 1 stated she called pharmacy to request for the Wegovy medication and the pharmacy had informed LVN 1 that it had been delivered on 5/17/2026 around 2 p.m. LVN 1 stated she then looked throughout the cart and could not find the Wegovy medication. LVN 1 stated then communicated with the doctor to get a one-time dose and Resident 3 got the medication later. LVN 1 stated she was not aware of what happened to the medication. LVN 1 stated the Director of Nursing (DON) was also aware of the missing medication and was looking for it.During an interview on 5/26/2026 at 1:06 p.m. with the DON, the DON stated she reviewed the cameras in the facility. The DON stated RN 1 did sign off the medications but did not verify what medications were delivered and the p.m. nurse (LVN 2) was the one that placed the medication away and reviewed them. During an interview on 5/26/2026 at 1:49 p.m. with the DON, the DON stated the facility followed its policy and procedure (P&P) titled, Unavailable Medication. The DON stated staff notifies the doctor, then call pharmacy then we get another order for the medication. The DON stated she informed Resident 3 that the medication is not covered by insurance but Resident 3 would still get the medication. The DON stated she was notified by an RN that Resident 3's Wegovy medication was missing. The DON stated she looked for the medication, reviewed the cameras to see how many medications were delivered. The DON stated LVN 1 then called the doctor to get an order and notify the doctor of the situation. The DON stated RNs and the DON can sign the medications but normally the DON can sign off the medication through the system. The DON stated she signed it via computer pharmacy system. The DON stated that she was not sure if she signed it on 5/17/2026 when it was delivered. The DON stated RN 1 signed off as received, and the DON stated if it is signed off as received then it means the medication was received at the facility. The DON stated she spoke to LVN 2 and stated not sure what medications they were and that she (LVN 2) placed the medications away prior to counting but could not recall for who or how many medications. The DON stated there is a potential for residents to have medication administration issues, medications can be late, and cause medication administration issues. The DON stated there can be a potential for theft. The DON stated there was a possible misplacement of medications. The DON stated when pharmacy delivers the medication the RN will review the medication then sign off that they were delivered and then will place the received medication into the designated cart. The DON stated RN 1 received the medication and signed off on the medication and LVN 2 was the one that put the medication away. The DON stated this is not the correct process.During a review of the facility provided Prescription History, dated 5/17/2026, the Prescription History indicated Resident 3's Wegovy 1.5 mg tablet, quantity five (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(5) was delivered on 5/17/2026 at 3:13 p.m. and RN 1 signed off as received. During a review of the Facility P&P titled Medication Administration, last reviewed on 4/22/2026 the P&P indicated all medications shall be administered by licensed nursing staff according to physician order, current best practice, and federal and state regulations. The facility shall ensure residents receive the correct medications in timely, safe, and documented manner.iii. Medications must be administered within one hour before or one hour after the schedule time, unless as specific clinical reason requires a more rigid schedule.During a review of the Facility P&P titled Medication Ordering and Receiving from Pharmacy, last reviewed on 4/22/2026 the P&P indicated medications, and related products are received form the dispensing pharmacy on timely basis. The facility maintains accurate records of medication order and receipts. B. Receiving Medications from the Pharmacy 1. A licensed nurse:1. Receives medication delivery to the facility and documents that the delivery was received and was secure on the medication delivery receipt, or other documentation system.2. Verifies medications received and directions for use with the medication order form.3. Promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor. 4. Immediately delivers the medications to the appropriate secure storage area or a designee under the direct supervision of the licensed nurse.5. Assure medications are incorporated into the resident's specific allocation prior to the next medication pass.