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	06/30/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the pad call light (a specialty alerting device that have ultra-sensitive touch surface for patients with limited mobility for nurses or other nursing personnel to assist a patient when in need) was within reach for one (1) of five (5) sampled residents (Resident 5) during an observation on 6/30/3036 at 10 a.m.This deficient practice had the potential to result in a delay in care and services, unmet needs, and possible injury to Resident 5 when the resident was unable to call for assistance.Findings:During a review of Resident 5's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility admitted Resident 5 on 7/25/2025 with diagnoses including paraplegia (loss of movement and/or sensation, to some degree, of the legs), dementia (a progressive state of decline in mental abilities), and aphasia (a disorder that makes it difficult to speak).During a review of Resident 5's History and Physical (H&P), dated 7/28/2025, the H&P indicated Resident 5 was unable to make his own decisions, but was able to make needs known.During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 5/1/2026, the MDS indicated Resident 5 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 5 was dependent (helper does all of the effort) with activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive) such as eating, toileting, personal and oral hygiene, and upper and lower body dressing.During a review of Resident 5's Order Summary Report, for the active orders as of 7/1/2026, the Order Summary Report indicated a physician's order for a touch pad as call light with an order date of 5/19/2026.During a concurrent observation and interview on 6/30/3036 at 10 a.m. inside Resident 5's room with Certified Nursing Assistant (CNA) 1, Resident 5 was observed lying in bed with contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of both upper arms. Resident 5 was positioned on his right side, and the pad call light was placed on the far-left corner of the pillow, out of his (Resident 5) reach. CNA 1 stated that Resident 5's pad call light was placed far from the resident and that the pad call light was not within Resident 5's reach. CNA 1 stated that Resident 5 had contractures of both upper arms and was unable to reach the pad call light. CNA 1 stated the pad call light should have been placed on the right side of Resident 5's pillow close to the face, prior to leaving the room, as the improper placement placed Resident 5 at risk of being unable to call for assistance and experiencing delays in having his needs met. CNA 1 stated that pad call lights are used for residents who are unable to move their bilateral upper extremities to operate a regular call light, and that with pad call light, residents can activate it by touching it with their face or head.During an interview on 6/30/2026 at 2:30 p.m. with the Director of Staff Development (DSD), the DSD stated that the staff are supposed to ensure that the pad call lights for residents who are unable to use a regular call light were placed next to the resident's head or face prior to leaving the room so they can call for assistance when needed. The DSD stated that Resident 5's pad call light should have been placed on the right side of Resident 5's pillow, as close as possible to his (Resident 5) face, so the resident can call for assistance with slight movement of the head. The DSD stated if the pad call light was not within Resident 5's reach, it placed Resident 5 at risk for (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	delays in receiving needed assistance and having his needs met in a timely manner.During an interview on 6/30/2026 at 4:06 p.m. with the Director of Nursing (DON), the DON stated staff are supposed to ensure that the call lights are placed within the residents' reach after providing care and prior to leaving the room. The DON stated Resident 5's touch pad call light should have been placed on the right side of the pillow, as close to the resident's face as possible, while he (Resident 5) was turned towards the right side, as Resident 5 has paraplegia and contracture of both upper arms. The DON stated that if the touch pad call light was not within reach, Resident 5 would not be able to ask for assistance, placing Resident 5 at risk of a delay in receiving help and the care he needed.During a review of the facility's policy and procedure (P&P) titled, Communication - Call System, last reviewed on 6/24/2026, the P&P indicated that the call alert device will be placed within resident's reach, and the facility staff will answer call alerts promptly. The P&P indicated that an adaptive call alert system will be provided to residents who are unable to utilize the general call alert system.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to notify and provide a written notification to the resident and/or resident's representative(s) at least 30 days prior to a planned discharge for one (1) of three (3) sampled residents (Resident 1).This failure had the potential for incomplete information to be conveyed to Resident 1 and could have violated Resident 1's right to appeal the discharge (a formal, legally protected process that allows a resident to challenge a facility's decision to discharge or transfer them).Findings:During a review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility admitted Resident 1 on 2/21/2025, with diagnoses including urinary tract infection (UTI - an infection caused by bacteria [germ] entering the urinary system), radiculopathy in the lumbar region (a condition caused by a pinched nerve in the spine of the lower back), and generalized muscle weakness. The Face Sheet indicated Resident 1 was self-responsible.During a review of Resident 1's History and Physical (H&P), dated 5/23/2026, the H&P indicated Resident 1 had the capacity to make decisions for healthcare purposes and was able to make his needs known. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/18/2026, the MDS indicated Resident 1 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make his needs known. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff with toileting hygiene, shower, and lower body dressing.During a review of Resident 1's Order Summary Report, for the active orders as of 7/1/2026, the Order Summary Report indicated a physician order for Resident 1's discharge to the Assisted Living Facility (ALF - a residential housing option for people who need help with daily tasks, such as bathing, dressing, and medication management allowing individuals to maintain independence in a secure, homelike setting) 1 on 7/2/2026 with Durable Medical Equipment (DME - it refers to the medical devices and supplies a resident needs to safely continue recovery or management after discharge), with an order date of 7/1/2026.During a review of Resident 1's Social Services Progress Notes, dated 5/15/2026 and 6/15/2026, the Social Services Progress Notes indicated that Resident 1 was referred to a lower level of care.During a review of Resident 1's Interdisciplinary Team (IDT - a group of health care professionals with various areas of expertise who work together toward resident's goals) Note, dated 6/24/2026, the IDT Note indicated that the IDT met with Resident 1 to discuss possible accepting facilities. The IDT note indicated that Resident 1 will be discharged to ALF 1. The IDT Note indicated that social services will conduct a 5-day post discharge follow up and that Resident 1 needs to see his (Resident 1) primary care provider within five days post discharge. During a review of Resident 1's Social Services Progress Note, dated 6/26/2026, the Social Services Progress Note indicated that Social Services Designee (SSD) 1 spoke with Resident 1's representatives regarding discharge planning and provided them with information on a possible accepting facility.During a concurrent observation and interview on 6/30/2026 at 9:35 a.m. with Resident 1 in Resident 1's room, Resident 1 stated that he did not know if he was given enough notice regarding the discharge to a lower level of care, but the facility had been discussing the discharge plan with him (Resident 1). Resident 1 stated that last week (unspecified date) he (Resident 1) was given the name of the receiving facility and thought he (Resident 1) would be discharged after two (2) days. Resident 1 stated that the discharge date was not clearly explained to him. Resident 1 stated that he (Resident 1) felt that he, as well as his family, should have been provided with 30 days' notice prior to scheduled discharge so he can prepare for the discharge.During an interview on 6/30/2026 at 10:36 a.m. with MDS Nurse (MDSN) 1, MDSN 1 stated that the IDT discusses residents' discharge planning based on the residents' goals for discharge. MDSN 1 stated that the social services department was in charge of the discharge planning. MDSN 1 stated that if the IDT deemed discharge appropriate, they notify the nursing staff of the discharge (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan to obtain an order from the physician.During a concurrent interview and record reviews on 6/30/2026 at 10:53 a.m., 12:09 p.m., and 1:18 p.m., Resident 1's social services progress notes and IDT notes were reviewed with SSD 1. SSD 1 stated that the discharge planning for Resident 1 with referral to a lower level of care started on 5/15/2026 and another referral was sent on 6/15/2026. SSD 1 stated that she (SSD 1) provided Resident 1's representatives (unspecified) with the name of ALF 1 and phone number but was unable to remember the date. SSD 1 stated that MDSN 1 and social services staff notifies nursing staff of resident's discharge plan to obtain an order from the physician for the discharge on ce arrangements have been made with the accepting facility. SSD 1 stated that the Notice of Proposed Transfer/Discharge (a formal written notice given to the resident at least 30 days before the proposed moved or discharge date) is provided to the resident and/or family member once arrangements have been made and there is a physician's order for discharge. SSD 1 stated that she (SSD 1) did not provide Resident 1 with the Notice of Proposed Transfer/Discharge as there was no physician's order yet. SSD 1 stated that the 30 days' notice gives Resident 1 and/or family member time to appeal the discharge.During a concurrent interview and record review on 6/30/2026 at 4:06 p.m., the facility's policy and procedure (P&P) titled, Transfers and Discharge, was reviewed with the Director of Nursing (DON). The DON stated that the P&P indicated that if the IDT and attending physician determine that the resident may be appropriate for discharge, the social services staff will coordinate the discharge with the IDT, the resident, and the responsible party. The DON stated that the P&P indicated that the facility should provide at least 30 days' notice before the resident is transferred or discharged . The DON stated that less than 30 days' notice may be made as soon as practicable before transfer or discharge if the safety and health of other residents in the facility would be endangered, the resident's health improves sufficiently, and immediate transfer or discharge is needed due to urgent medical needs. The DON stated the notification will be documented in the Notice of Transfer/Discharge, by the resident or responsible party, and a copy will be provided to the resident or responsible party. The DON stated that the P&P for Transfers and Discharge was not followed and Resident 1 or the family member would not be able to appeal the discharge and ensure that an adequate preparation and assistance was provided.During a review of the facility's P&P titled, Transfer and Discharge, last reviewed on 6/24/2026, the P&P indicated the purpose of the policy is to ensure that adequate preparation and assistance is provided to residents prior to transfer or discharge from the facility. The P&P indicated:The social services staff will participate in assisting the resident with transfers and discharges.If the IDT and the attending physician determine that the resident may be appropriate for discharge, social services staff will coordinate the discussion of discharge with IDT, the resident, and the responsible party.The social services staff will communicate with the facility staff, the resident, and responsible party as the time of discharge approaches.Social services staff will orient the resident to the impending discharge.Social services staff may coordinate a care conference to discuss discharge needs, plans, and teaching, and will involve other IDT members as appropriate.The Notice of discharge indicated that the facility should provide at least 30 days' notice before the resident is transferred or discharged . The Notice of discharge indicated:Less than 30 days' notice may be made as soon as practicable before transfer or discharge when the safety of individuals in the facility would be endangered due to clinical or behavioral status, the health of the individuals on the facility would be endangered, the resident's health improves sufficiently, and an immediate transfer or discharge is required by the resident's medical needs.The notification will be documented on SS - 13 - Form B - Notice of Proposed Transfer and Discharge.The Notice of Proposed Transfer and Discharge will be signed by the resident.If the resident does not have the capacity or ability to sign, the responsible party may sign the document.If the responsible party is not available to sign, contact should be made by phone and documented on the Notice of Proposed Transfer and Discharge form.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility did not accurately code the Minimum Data Set (MDS - a resident assessment tool) by failing to ensure the MDS assessment for one (1) of five (5) sampled residents (Resident 1) was reflected accurately when Resident 1's quarterly assessment under discharge planning indicated there was no active discharge planning.This deficient practice had the potential to create confusion regarding Resident^1's discharge plan and delay the timely coordination of necessary care and services needed to support a safe and appropriate transition.Findings:During a review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility admitted Resident 1on 2/21/2025, with diagnoses including urinary tract infection (UTI - an infection caused by bacteria [germ] entering the urinary system), radiculopathy in the lumbar region (a condition caused by a pinched nerve in the spine of the lower back), and generalized muscle weakness.During a review of Resident 1's History and Physical (H&P), dated 5/23/2026, the H&P indicated Resident 1 had the capacity to make decisions for healthcare purposes and was able to make his needs known.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 5/18/2026, the MDS indicated Resident 1 did not have active discharge planning occurring.During a review of Resident 1's Social Services Progress Note, dated 5/15/2026, and Social Service Assessment, dated 5/26/2026, the Social Services Progress Note and Social Services Assessment indicated that there is an active discharge plan in place for Resident 1 to return to the community.During a concurrent interview and record review on 6/30/2026 at 1:34 p.m., reviewed Resident 1's MDS assessment, Social Services Progress Notes, and Social Services Assessment with the MDS Coordinator (MDSC). The MDSC stated that the social services designee who attends the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the resident's goals) meeting is responsible in completing the discharge planning section of the MDS assessment. The MDSC stated that Resident 1's MDS assessment discharge planning section indicated that there was no discharge planning occurring for Resident 1 to return to the community. The MDSC stated that Resident 1's Social Service Progress Notes and Social Services Assessment indicated that there was an active discharge planning in place. The MDSC stated that Resident 1's MDS assessment was not coded accurately. The MDSC stated that Resident 1's MDS assessment should have been coded accurately as it presents the clinical picture of the resident for all members of the IDT and placed Resident 1 at risk for a delay in receiving the care the resident needs.During an interview on 6/30/2026 at 4:06 p.m. with the Director of Nursing (DON), the DON stated that the designated social services designee who attends the IDT meetings, complete the discharge planning section of the MDS assessments based on the social services documentations in the electronic health record (EHR - a digital, real-time, resident-centered record). The DON stated that MDS assessments should be coded accurately by reviewing the residents' EHR as it presents the clinical picture of the resident to ensure resident receives the care needed. The DON stated that Resident 1's MDS assessment should have been coded accurately to indicate that there was a discharge planning occurring for Resident 1. During a review of the facility provided Centers for Medicare and Medicaid Services (CMS, a federal agency that administers the nation's major healthcare programs) Resident Assessment Instrument (RAI - a standardized, comprehensive assessment framework to gather accurate clinical date about residents, mandated by CMS) Version 3.0 Manual, last updated 10/2025, Chapter 1, Section 1.3, indicated the RAI process requires that the assessment accurately reflects the resident's status. The RAI manual indicated that an accurate assessment requires collecting information from multiple sources and nursing homes are responsible for ensuring that all participants in the assessment process have the knowledge to complete an accurate assessment.

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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 follow infection prevention and control practices for one (1) of three (3) sampled residents (Resident^1) by failing to ensure Resident^1's urinal (a handheld container designed for collecting urine) was labeled with the resident's name and room number as required by facility policy and procedure (P&P).This failure had the potential to result in cross^contamination, the transfer of harmful bacteria from one person, object, or place to another, which may lead to the development of urinary tract infections (UTI - an infection of the urinary tract.Findings:During a review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility admitted Resident 1 on 2/21/2025, with diagnoses including urinary tract infection (UTI - an infection caused by bacteria [germ] entering the urinary system), radiculopathy in the lumbar region (a condition caused by a pinched nerve in the spine of the lower back), and generalized muscle weakness.During a review of Resident 1's History and Physical (H&P), dated 5/23/2026, the H&P indicated Resident 1 had the capacity to make decisions for healthcare purposes and was able to make his needs known.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/18/2026, the MDS indicated Resident 1 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make his needs known. The MDS indicated Resident 1 required substantial/maximal assistance from staff with toileting hygiene, shower, and lower body dressing.During an observation on 6/30/2026 at 9:35 a.m., inside Resident 1's room, observed Resident 1 lying in bed with the over-bed table in front of him while he (Resident 1) watched his computer. A urinal was observed next to the computer without a label.During a concurrent observation and interview on 6/30/2026, at 9:40 a.m., with Registered Nurse (RN) 1, inside Resident 1's room, RN 1 stated that Resident 1's urinal, which was placed on top of the over-bed table, did not indicate the resident's name and/or room number. RN 1 stated that the staff are required to label the urinals or any resident care items with the resident's name and/or room number upon providing them to the residents. RN 1 stated that Resident 1's urinal should have been labeled to prevent switching of urinals among residents that can cause cross-contamination.During an interview on 6/30/2026, at 9:45 a.m., with the Director of Staff Development (DSD), the DSD stated the practice in the facility when providing urinals to the resident was to label the urinal with the resident's name or initials and room number to prevent switching of urinals among residents that can cause cross-contamination and residents can acquire infection. The DSD stated that Resident 1's urinal should have been labeled with the name or initials and room number to prevent switching as it placed Resident 1 and other residents at risk for acquiring infections such as UTI due to cross-contamination.During an interview on 6/30/2026, at 4:10 p.m., with the Director of Nursing (DON), the DON stated per facility policy and procedure (P&P) for Prevention of Cross-Contamination: Resident Care Items, the urinals and any other resident care items should be labeled with the resident's initials/name and room number when provided to the residents. The DON stated the purpose of labeling the urinal is to prevent switching the urinals with other residents in the room. The DON stated that Resident 1's urinal should have been labeled with the resident's name/initials and room number per facility P&P as it can cause cross-contamination leading to development of UTI on the residents.During a review of the facility's policy and procedure (P&P) titled, Prevention of Cross-Contamination: Resident Care Items, last reviewed on 6/24/2026, the P&P indicated that resident care items will be clearly labeled with the resident's name and/or room number upon placing them into service for the resident to prevent cross-contamination from use of another resident's/unidentified personal care items/belongings and prevent healthcare associated infection. The P&P indicated that personal care items include wash basins, bedpans, urinals, toothpaste, toothbrushes/holders, shampoo/conditioner, lotions, and any other single use resident care items.