

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/07/2026
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. Based on interview and record review, the facility failed to document the administration of a PRN (as needed) dose of Tylenol (pain medication) in the resident's medical record after the medication was administered for one of three sampled residents (Resident 1). This failure had the potential to result in inaccurate clinical records, duplicate medication administration, ineffective assessment of Resident 1's pain management, and impaired continuity of care. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 6/23/2025 with diagnoses including dysphagia (inability to swallow), type 2 diabetes (body's inability to process sugar), and heart failure (when the heart muscle does not pump as well as it should). During a review of Resident 1's History and Physical (H&P), dated 6/24/2026, the H&P indicated Resident 1 had the capacity to understand and make their own decisions. During an observation and interview with Resident 1 on 7/2/2026 at 10:30 am, Resident 1 stated he had been trying to call a nurse for assistance, but his call light was not working. Resident 1 stated last night he was having pain, and he had to ask his roommate to press his call light. Resident 1 stated a nurse came in around 3 a.m., and administered Tylenol (pain medication) for generalized pain. During an interview with Licensed Vocational Nurse (LVN 1) on 7/2/2026 at 11:15 a.m., LVN 1 stated, he was not aware that Resident 1's call light was not working. LVN 1 stated a certified nurse assistant called him around 3 a.m. and reported that Resident 1 was having pain. LVN 1 stated he administered pain medication but forgot to chart the administration in Resident 1's Medication Administration Record. During an interview with Registered Nurse (RN 1) on 7/2/2026 at 2:20 p.m., RN 1 stated, residents use their call light to request for assistance. RN 1 stated she was not aware that Resident 1's call light was not functioning. RN 1 stated it is important for residents to have a functioning call light because this is the way they can request help. RN 1 stated, LVN 1 needed to document that he gave Tylenol for pain as soon as the medication was administered. RN 1 stated a failure to document can lead to duplicate administration of the medication and Resident 1 not being assessed properly for pain. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, revised on 6/26/2025, the P&P indicated, All medications shall be administered by licensed nursing staff according to physician orders, current best practices, and federal and state regulations. The facility shall ensure residents receive the correct medications in a timely, safe and documented manner 5. Documentation. a. The time and dose of the medication or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the medication		

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

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 07/07/2026
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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure Resident 1 had a functioning call light for one of three sampled residents (Resident 1). This failure had the potential to delay Resident 1's ability to call staff for assistance, increasing the risk of unmet care needs and compromising the resident's safety. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 6/23/2025 with diagnoses including dysphagia (inability to swallow), type 2 diabetes (body's inability to process sugar), and heart failure (when the heart muscle does not pump as well as it should). During a review of Resident 1's History and Physical (H&P), dated 6/24/2026, the H&P indicated Resident 1 had the capacity to understand and make their own decisions. During a review of Resident 1's Plan of Care (PC), dated 6/24/2026, the PC indicated Resident 1 had activity of daily living self-care performance deficit related to disease process and limited mobility. Interventions included to encourage the resident to use the call light for assistance. During a concurrent observation and interview with Resident 1 on 7/2/2026 at 10:30 am, observed Resident 1's call light was not working. Resident 1 stated he had been trying to call a nurse for assistance, but his call light was not working. Resident 1 stated last night he was having pain, and he had to ask his roommate to press his call light. Resident 1 stated a nurse came in around 3 a.m. and administered Tylenol (pain medication) for generalized pain. Resident 1 stated his call light was not working. During an interview with Licensed Vocational Nurse (LVN 1) on 7/2/2026 at 11:15 a.m., LVN 1 stated, he was not aware that Resident 1's call light was not working. LVN 1 stated a certified nurse assistant called him around 3 a.m. and reported that Resident 1 was having pain. LVN 1 stated he administered pain medication but forgot to chart it in the Medication Administration Record. During an interview with Registered Nurse (RN 1) on 7/2/2026 at 2:20 p.m., RN 1 stated residents use their call light to request assistance. RN 1 stated she was not aware that Resident 1's call light was not functioning. RN 1 stated it is important for residents to have a functioning call light because this is the way they can request help. RN 1 stated, not having a functioning call light can lead to a delay of treatment. During a review of the facility's policy and procedure (P&P) titled, Communication-Call System, revised on 8/24/2024, the P&P indicated, If the call alert system is defective, it will be reported to maintenance for immediate repair. If the call system cannot be repaired immediately, an alternative call alert process will be put in place		