STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	07/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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. (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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(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	Based on interview and record review, the facility failed to ensure the medical records of one of three sampled residents (Resident 1) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to: 1. Ensure Registered Nurse (RN) 1 completed and signed Resident 1's Discharge Planning Review Form.2. Ensure the Licensed Nurses documented the level of care provided to Resident 1 before the resident's discharge from the facility.3. Ensure the Licensed Nurses documented Resident 1's condition before the resident's discharge from the facility.4. Ensure the Licensed Nurses documented Resident 1's refusal to sign discharge documents. These deficient practices resulted in inaccurate information on Residents 1's medical records and had the potential for delayed and inaccurate medical interventions.Findings:During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted the resident on 1/5/2024, with diagnoses including anxiety disorder (persistent and excessive worry that interferes with daily activities), gastroesophageal reflux disease (a condition in which the stomach contents move up into the esophagus), and acute respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (low levels of oxygen in your body tissues). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 4/14/2025, the MDS indicated Resident 1's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. During an interview on 7/14/2025 at 10:27 a.m. and concurrent record review of Resident 1's medical records, reviewed with RN 1, RN 1 stated Resident 1 was discharged from the facility on 7/1/2025. During a review of Resident 1's Discharge Planning Review Form, dated 6/26/2025, the Discharge Planning Review Form did not indicate the licensed nurses' and the resident's signatures upon discharge. RN 1 stated Resident 1 refused to sign the Discharge Planning Review Form. RN 1 stated he did not document the resident's refusal to sign in the resident's medical records. During a review of Resident 1's Progress Notes, dated 4/12/2025 to 6/18/2025, RN 1 stated Resident 1's Progress Notes did not indicate the level of care, resident health status, and medical records provided to Resident 1 on the day of discharge. RN 1 stated Resident 1's information should be part of the resident's Progress Notes. RN 1 stated Resident 1 had an incomplete discharge documentation. During an interview on 7/14/2025 at 10:54 a.m. and concurrent record review of Resident 1's Progress Notes, dated 7/1/2025, reviewed with the Medical Records Director (MRD), the MRD stated on 7/1/2025, Licensed Vocational Nurse 2 documented discharge on Resident 1's Progress Notes. The MRD stated there was no documented evidence of the level of care, resident health status, and medical records provided to Resident 1 on the day of discharge. During an interview on 7/14/2025 at 2:13 p.m. and concurrent review of Resident 1's medical records, reviewed with the Director of Nursing (DON), the DON stated Resident 1's medical records did not indicate the resident's health status upon discharge. The DON stated Resident 1's Progress Notes did not indicate the resident's refusal to sign the Discharge Planning Review Form. The DON stated Resident 1's medical records were incomplete. The DON stated the facility failed to ensure the licensed nurses' documentation of Resident 1's discharge status were timely and complete. During a review of the facility's policy and procedure (PnP) titled, Progress Notes, last reviewed on 12/7/2024, the PnP indicated the purpose to provide an interdisciplinary record of each resident's progress. The PnP indicated II. Progress notes will reflect the resident's current status.and other relevant information. V. All progress notes must be legible and signed with the writer's name and title. VI. Progress notes are to be documented in a timely manner.