

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Los Feliz Healthcare & Wellness Center, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medical record of one of two sampled residents (Resident 1) was accurately documented in accordance with the facility's policy, when Licensed Vocational Nurse (LVN) 1 documented in advance that Resident 1 was transferred to a new isolation room (a room that is specifically assigned to a resident who is infected with a specific germ in order to prevent the spread of infection to other residents) when the transfer had not yet occurred. This deficient practice resulted in an inaccurate medical record for Resident 1. Findings: During a review of Resident 1's admission Record, dated 2/5/2026, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE], and re-admitted on [DATE]. The admission Record indicated Resident 1's diagnoses included cerebral ischemia (when blood flow to the brain is blocked or significantly reduced), spinal stenosis (when the space around the spinal cord becomes too narrow, which puts pressure on the nerves and spinal cord), and paroxysmal atrial fibrillation (when the heart pumps in an irregular and abnormally fast rhythm). During a review of Resident 1's History and Physical Examination (H&P - a comprehensive assessment of a resident's medical condition), dated 1/9/2026, the H&P indicated Resident 1 was re-admitted to the facility on [DATE] after being treated at an acute hospital for a urinary tract infection. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 1/14/2026, the MDS indicated Resident 1 needs maximal assistance for eating, personal hygiene, and upper body dressing (a helper does more than half the effort of the activity). The MDS also indicated Resident 1 is dependent for toileting hygiene and shower/bathe (a helper does all of the effort of the activity). During an interview on 2/4/2026 at 10:16 a.m. with LVN 1, LVN 1 stated the facility does not have a designated (specifically reserved) isolation room. LVN 1 stated that if a resident needs to be placed on isolation, the nursing staff will first assess if the resident can stay in their room or if they have to move. LVN 1 stated that as an example, residents who are on enhanced barrier precautions (when facility staff must wear gowns and gloves when providing direct contact care to residents who are at high risk of germs that are resistant to antibiotics) are not compatible and must be separated from residents who are on contact isolation (residents who are specifically separated because they have germs that spread through contact, such as touching the infected residents or items in their room). LVN 1 stated the facility currently has two residents on contact isolation and approximately 30 to 40 residents on enhanced barrier precautions. During a concurrent interview and record review on 2/4/2026 at 10:25 a.m. with LVN 1, Resident 1's electronic medical record was reviewed. LVN 1 stated that on 1/31/2026, Resident 1 had several episodes of diarrhea. LVN 1 stated a stool sample (sample of Resident 1's diarrhea) was collected for testing, and the results came back positive for c-diff (presence of clostridioides difficile which is a type of bacteria can cause infection in the intestine resulting in severe diarrhea) on 2/3/2026. LVN 1 stated that after receiving Resident 1's</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056380
		If continuation sheet Page 1 of 2

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>positive c-diff test results, Resident 1 had to be transferred to a new room and placed on contact isolation. LVN 1 stated Resident 1's new room was private (Resident 1 would not have to share the room with another resident) but still needed to be cleaned prior to Resident 1's transfer. LVN 1 stated: [The new room] was getting cleaned so we were waiting for it to be done. Around noon time, we put Resident 1 in [the new room]. During a concurrent interview and record review on 2/4/2026 at 11:11 a.m. with LVN 1, Resident 1's Infection Note, dated 2/3/2026 was reviewed. The Infection Note was documented at 9:07 a.m. and indicated that Resident 1 had been placed in a private room. When asked why the Infection Note that was documented at 9:07 a.m. indicated Resident 1 was already transferred to the private room, when LVN 1 previously stated that Resident 1 was transferred to the new room around noon time, LVN 1 stated: I probably did the note before [Resident 1] was transferred. LVN 1 stated the Infection Note that was documented at 9:07 a.m. was inaccurate at the time LVN 1 entered it in the facility's computer system. When asked why licensed nurses should not document in advance before an event occurs, LVN 1 stated: Some things might have happened differently, such as if Resident 1 was not transferred to the private room. During an interview on 2/4/2026 at 12:42 a.m. with Certified Nursing Assistant (CNA 1), CNA 1 stated CNA 1 recalls transferring Resident 1 on 2/3/2026. CNA 1 stated that housekeeping (facility staff whose job duties consist of cleaning and disinfecting) had to clean Resident 1's new, private room before Resident 1 could be transferred. CNA 1 stated that CNA 1 transferred Resident 1 to the private room right before CNA 1 went on lunch break at approximately 11:30 a.m. During an interview on 2/4/2026 at 3:21 p.m. with Director of Nursing (DON), DON stated licensed nurses should chart whatever they did. DON stated licensed nurses should not document an event in advance before the event actually occurs because anything can happen, such as the patient's condition can change. When asked about possible consequences of documenting an event ahead of time, DON stated, it's not reflecting the accurate condition of patient, and it is not an accurate record. DON stated it is important to make sure a resident's medical record is complete and accurate because it reflects the actual condition of the patient so that nursing staff can provide better care. During a review of the facility's policy and procedure (P&P) titled, Completion & Correction, dated 1/1/2012, the P&P indicated the purpose of the policy is to ensure that medical records are complete and accurate. The P&P indicated entries will be recorded as the events or observations occur. The P&P further indicated [a]n event is never to be documented before it occurs.</p>		