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	05/15/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement its written abuse policy and procedures (P&P) titled, Abuse Prevention and Management, when one of three sampled residents (Resident 2) had an allegation of physical abuse (includes, but is not limited to, hitting, slapping, punching, biting, and kicking) on 3/31/2026 and the facility did not report this to the State Survey Agency (SSA) and did not conduct a thorough investigation. This failure had the potential to subject Resident 2 to further physical abuse. Cross-reference F609 and F610. Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 1/8/2026 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting right side dominant side, dementia (a progressive state of decline in mental abilities), depression (feeling of sadness, emptiness, and loss of interest in activities). During a review of Resident 2's Minimum Data set (MDS - a resident assessment tool), dated 4/13/2026, the MDS indicated that Resident 2's cognition (the mental process of acquiring knowledge and understanding through thought, experience, and senses) was moderately impaired. The MDS indicated that Resident 2 required maximal assistance (helper does more than half the effort) with oral hygiene, lower body dressing and personal hygiene. The MDS indicated that Resident 2 was dependent (helper does all of the effort) with toileting and showers. During a review of Resident 2's History and Physical (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 1/8/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During an interview on 5/14/2026 at 10:37 a.m. with Resident 2's Responsible Party (RP), the RP stated that he (RP) arrived around 7 a.m. on 3/31/2026 to visit Resident 2 during breakfast and observed a bruise and scratch on the right side of Resident 2's cheek. The RP stated that he had visited Resident 2 the previous night during dinner and had not observed any bruising on the right side of Resident 2's cheek. The RP stated that Resident 2 said, he hit me, and demonstrated how she (Resident 2) was struck by making a fist with her (Resident 2) left hand and motioning toward the right side of her (Resident 2) face. The RP stated that he (RP) reported the incident to Registered Nurse (RN) 1 that same morning (3/31/2026). The RP stated that the Director of Nursing (DON) visited Resident 2 while the RP was present, and Resident 2 demonstrated to the DON how she (Resident 2) had been hit. The RP stated he (RP) spoke with the DON and Administrator (Admin) regarding his (RP) concerns, and the facility decided to contact law enforcement to interview Resident 2 regarding the allegation of physical abuse. During a concurrent interview and record review on 5/15/2026 at 12:24 p.m. with the DON, the facility's P&P titled, Abuse Prevention and Management, dated 3/25/2026, was reviewed. The DON stated that the facility did not report Resident 2's allegation of abuse to the SSA because she (DON) believed no abuse had occurred. The DON stated that the facility should have reported the allegation of physical abuse because the state agency will investigate to determine whether abuse occurred or not. The DON further stated that the facility did not follow their Abuse Prevention and Management policy because they did not report the allegation to the Ombudsman (advocates for residents of nursing homes, board and care homes, and assisted living facilities) or SSA and did not conduct a thorough investigation. During a review of the facility's P&P titled, Abuse Prevention and Management, dated 3/25/2026, the (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P&P indicated, 5. Administrator as Abuse Prevention Coordinator. a. Allegations of abuse . are to be reported to the Administrator or designated representative immediately. b. When the Administrator or designated representative receives a report of an allegation of resident abuse . the Administrator or designated representative, will initiate an investigation immediately 7. Notification of Outside Agencies for All Allegations of Abuse. a. The Administrator or designated representative will . send a written SOC 341 [Report of Suspected Dependent Adult/Elder Abuse] report to the Ombudsman, . and CDPH [California Department of Public Health] Licensing and Certification within (2) hours 11. Providing State Survey Agency and Other Agencies of the Results. a. The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken, to the [CDPH] Licensing and Certification and others that may be required by state or local laws, within five (5) working days of the reported allegation.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation of physical abuse (includes, but is not limited to, hitting, slapping, punching, biting, and kicking) within two hours for one of three sampled residents (Resident 2) when on 3/31/2026, there was an allegation that Resident 2 was punched in the face. This deficient practice had the potential to place Resident 2 at an increased risk for further abuse and additional unreported incidents. Cross-reference F607 and F610. Findings: During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 1/8/2026 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting right side dominant side, dementia (a progressive state of decline in mental abilities), depression (feeling of sadness, emptiness, and loss of interest in activities). During a review of Resident 2's Minimum Data set (MDS - a resident assessment tool), dated 4/13/2026, the MDS indicated that Resident 2's cognition (the mental process of acquiring knowledge and understanding through thought, experience, and senses) was moderately impaired. The MDS indicated that Resident 2 required maximal assistance (helper does more than half the effort) with oral hygiene, lower body dressing and personal hygiene. The MDS indicated that Resident 2 was dependent (helper does all of the effort) with toileting and showers. During a review of Resident 2's History and Physical (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 1/8/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 2's Change of Condition (COC - recording of a significant, unpredicted improvement or decline in a resident's health, mental status, or functional ability compared to their established baseline), dated 3/31/2026, the COC indicated [Resident 2] observed with bruise to right jaw. [Responsible Party (RP)] present at bedside during assessment. During an interview on 5/14/2026 at 10:37 a.m. with Resident 2's Responsible Party (RP), the RP stated that he (RP) arrived around 7 a.m. on 3/31/2026 to visit Resident 2 during breakfast and observed a bruise and scratch on the right side of Resident 2's cheek. The RP stated that he had visited Resident 2 the previous night during dinner and had not observed any bruising on the right side of Resident 2's cheek. The RP stated that Resident 2 said, he hit me, and demonstrated how she (Resident 2) was struck by making a fist with her (Resident 2) left hand and motioning toward the right side of her (Resident 2) face. The RP stated that he (RP) reported the incident to Registered Nurse (RN) 1 that same morning (3/31/2026). The RP stated that the Director of Nursing (DON) visited Resident 2 while the RP was present, and Resident 2 demonstrated to the DON how she (Resident 2) had been hit. The RP stated he (RP) spoke with the DON and Administrator (Admin) regarding his (RP) concerns, and the facility decided to contact law enforcement to interview Resident 2 regarding the allegation of physical abuse. During an interview on 5/14/2026 at 12:01 p.m. with RN 1, RN 1 stated that Resident 2's RP reported concerns that night-shift staff had handled Resident 2 roughly, which allegedly caused bruising to Resident 2's right cheek. RN 1 stated that he (RN 1) informed the RP he (RN 1) would investigate the allegation. RN 1 stated that he (RN 1) notified the DON and the Admin because the allegation involves physical abuse. RN 1 stated that the facility must investigate and report all abuse allegations to state agency within two hours. RN 1 stated that he (RN 1) did not submit a report because he (RN 1) was not sure if it was abuse. During an interview on 5/14/2026 at 1:12 p.m. with the DON, the DON stated Resident 2's RP expressed concerns about bruising on Resident 2's right cheek. The DON stated the Admin and RP spoke with Resident 2 and Resident 2 informed them she (Resident 2) was punched in the face. The DON stated that the facility did not report the allegation to the state agency because she (DON) believed no abuse had occurred and the bruise on Resident 2's right side of the cheek was from a fall Resident 2 had on 3/29/2026. The DON further stated the facility should have reported the allegation of physical abuse because the state agency will investigate to determine whether abuse occurred or (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not. During an interview on 5/14/2026 at 1:42 p.m. with the Admin, the Admin stated that he was aware of Resident 2 having some marks. The Admin stated Resident 2's RP requested an investigation. In response, the facility contacted law enforcement because the Admin wanted an outside agency to investigate. The Admin stated that he (Admin) did not consider the allegation to be abuse. The Admin stated that Resident 2's RP did not want the state agency to get involved and the Admin stated that he (Admin) would conduct the investigation. The admin further stated that he (Admin) did not investigate allegation of Resident 2's physical abuse. During a review of the facility's Policy and Procedure (P&P) titled, Reporting Abuse, dated 3/25/2026, the P&P indicated, The facility will report known or suspected instances of physical abuse to the proper authorities by telephone or through a confidential tool as required by state and federal regulations.report shall be made to the local Ombudsman, California Department of Public Health within two (2) hours of the observation, knowledge, or suspicion of physical abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to thoroughly investigate and submit the investigation report of all allegations of abuse to the California Department of Public Health (CDPH) within five days of the incident for one of three sampled residents (Resident 2) when the facility failed to thoroughly investigate and submit investigative reports to CDPH when an allegation of abuse was made on 3/31/2024 by Resident 2's Responsible party (RP) that an unidentified staff member hit Resident 2 on right side of the cheek. This deficient practice resulted in CDPH's inability to investigate the allegation of abuse timely and had the potential for other allegations of abuse to go unreported. Cross-reference F607 and F609. Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 1/8/2026 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting right side dominant side, dementia (a progressive state of decline in mental abilities), depression (feeling of sadness, emptiness, and loss of interest in activities). During a review of Resident 2's Minimum Data set (MDS - a resident assessment tool), dated 4/13/2026, the MDS indicated that Resident 2's cognition (the mental process of acquiring knowledge and understanding through thought, experience, and senses) was moderately impaired. The MDS indicated that Resident 2 required maximal assistance (helper does more than half the effort) with oral hygiene, lower body dressing and personal hygiene. The MDS indicated that Resident 2 was dependent (helper does all of the effort) with toileting and showers. During a review of Resident 2's History and Physical (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 1/8/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During an interview on 5/14/2026 at 10:37 a.m. with Resident 2's Responsible Party (RP), the RP stated that he (RP) arrived around 7 a.m. on 3/31/2026 to visit Resident 2 during breakfast and observed a bruise and scratch on the right side of Resident 2's cheek. The RP stated that he had visited Resident 2 the previous night (3/30/2026) during dinner and had not observed any bruising on the right side of Resident 2's cheek. The RP stated that Resident 2 said, he hit me, and demonstrated how she (Resident 2) was struck by making a fist with her (Resident 2) left hand and motioning toward the right side of her (Resident 2) face. The RP stated that he (RP) reported the incident to Registered Nurse (RN) 1 that same morning (3/31/2026). The RP stated that the Director of Nursing (DON) visited Resident 2 while the RP was present, and Resident 2 demonstrated to the DON how she (Resident 2) had been hit. The RP stated he (RP) spoke with the DON and Administrator (Admin) regarding his (RP) concerns, and the facility decided to contact law enforcement to interview Resident 2 regarding the allegation of physical abuse. During an interview on 5/14/2026 at 1:42 p.m. with the Admin, the Admin stated that he (Admin) was aware of Resident 2 having some marks. The Admin stated Resident 2's RP requested an investigation. In response, the facility contacted law enforcement because the Admin wanted an outside agency to investigate. The Admin stated that he (Admin) did not consider the allegation to be abuse. The Admin stated that Resident 2's RP did not want the state agency to get involved and the Admin stated that he (Admin) would conduct the investigation. The admin further stated that he (Admin) did not investigate allegation of Resident 2's physical abuse. During an interview on 5/15/2026 at 12:24 p.m. with the DON, the DON stated that the facility did not report the allegation to CDPH because she (DON) believed no abuse had occurred. The DON stated that the facility should have reported the allegation of physical abuse because CDPH will investigate to determine whether abuse occurred or not. The DON further stated that the facility did report the allegation to CDPH within five days because an investigation was not done for the allegation of physical abuse. During a review of the facility's policy and procedure (P&P) titled, Reporting Abuse, dated 01/2014, the P&P indicated The administrator or his or her designee, shall provide the appropriate agencies or individuals with a written report of the findings of the investigation within five (5) working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken and documented.

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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 maintain accurate clinical records in accordance with acceptable professional standards and practices for one of three sampled residents (Resident 1) when on 5/11/2026, Licensed Vocational Nurse (LVN) 5 failed to accurately document in Resident 1's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) when LVN 5 documented in Resident 1's MAR as if Resident 1 was still in the facility when Resident 1 was already discharged to General Acute Care Hospital (GACH) 1. This deficient practice resulted in inaccurate documentation of Resident 1's records.Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 3/10/2026 Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), hydrocephalus (an abnormal buildup of cerebrospinal fluid deep within the brain's cavities [ventricles]), venous insufficiency (occurs when the tiny, one-way valves in your leg veins are damaged or weakened), and peripheral vascular disease (a slow and progressive circulation disorder). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/16/2026, the MDS indicated Resident 1 had the ability to understand and be understood. During a review of Resident 1's History and Physical (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 4/4/2026, the H&P indicated Resident 1 did not have the capacity to understand or make medical decisions. During a review of Resident 1's Order Summary Report (OSR), dated 3/10/2026, the OSR indicated the following orders:- Famotidine oral tablet 20 milligrams (mg - a unit of measurement) give one tablet by mouth two times a day for Gastroesophageal Reflux Disease (GERD - a chronic condition where stomach acid frequently flows back up into the tube connecting your mouth and stomach) administered two times a day before meals.- fluticasone propionate suspension 50 micrograms (mcg- a unit of measurement) one spray in each nostril two times a day for allergic rhinitis (the inflammation of the inside of the nose caused by an allergic reaction).During a review of Resident 1's OSR, dated 3/11/2026, the OSR indicated an order for Culturelle oral capsule (lactobacillus rhamnosus- good bacterium naturally found in the human gut and urinary tract) give one capsule by mouth two times a day for supplement.During a review of Resident 1's OSR, dated 5/1/2026, the OSR indicated Lasix (also known as furosemide, water pill that helps your body get rid of extra salt and water by increasing the amount of urine produced) oral tablet 20 mg give two tablets by mouth two times a day for pitting edema (a type of swelling caused by excess fluid trapped in your body's tissues) on bilateral lower extremities (BLE) give two tablets for a total of 40 mg. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR - a standard tool used to communicate critical information), dated 5/11/2026, the SBAR indicated bilateral (two-sided) swelling of upper eyelids and Medical Doctor made aware with new orders to transfer to GACH 1 for bilateral eye swelling and pain. During a review of Resident 1's Skilled Nursing Facility (SNF) to Hospital Transfer Form, dated 5/11/2026, the SNF to Hospital Transfer Form indicated Resident 1 was transferred to GACH 1 on 5/11/226 at 11:20 a.m. During a review of Resident 1's MAR for May 2026, the MAR indicated the following:- 5/11/2026 at 4:30 p.m. Famotidine oral tablet 20 mg give one tablet by mouth two times a day for GERD administered two times a day before meals, was administered by LVN 5.- 5/11/2026 at 5p.m. Culturelle Oral capsule give one capsule by mouth two times a day for supplement, was administered by LVN 5.- 5/11/2026 at 5p.m. fluticasone propionate suspension 50 mcg 1 spray in each nostril two times a day for allergic rhinitis, was administered by LVN 5.- 5/11/2026 at 5 p.m. Lasix oral table 20 mg give two tablets by mouth two times a day for pitting edema on BLE give two tablets for a total of 40 mg, was administered by LVN 5. During an interview on 5/13/2026 at 3:20 p.m. with LVN 5, LVN 5 stated she (LVN 5) worked on 5/11/2026 from 3 p.m. to 11 p.m. and Resident 1 was not in the facility when she (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(LVN 5) came in to work at 3 p.m. LVN 5 stated when doing medication pass, she (LVN 5) must go into the resident's room, check vital signs (core measurements that show how well your body is functioning), explain what she (LVN 5) is going to do, explain each medication prior to giving the mediation, then once the medications are taken by the resident, will then document in the MAR that the medications were given. LVN 5 stated for Resident 1, she (LVN 5) must have signed off the medication by accident. LVN 5 stated she (LVN 5) should be signing the mediations off when she (LVN 5) is in front of the resident and not after. During a concurrent interview and record review on 5/13/2026 at 3:44 p.m. with the Director of Nursing (DON), Resident 1's May 2026 MAR was reviewed. The DON stated medication pass can be done one-hour before or after the scheduled time. The DON stated staff must follow protocol for medication pass that includes the right resident, time, route, order, must explain the medications to the residents and the residents have the right to refuse medications. The DON stated medications should be administered at the bedside with the resident and signed off immediately when given on the MAR. The DON reviewed Resident 1's MAR and stated LVN 5 signed off medications as given when Resident 1 was not in the facility. The DON stated LVN 5 should have documented on the MAR with 6, indicating Resident 1 is in the hospital. The DON stated believes this is willful LVN 5 was not following the facility protocol of pour, pass, and sign. The DON stated if the nurse is doing this it will give the wrong documentation this is not accurate condition of the resident which will cause confusion. The DON stated the oncoming shift may think Resident 1 was still in the facility when in fact Resident 1 was not. The DON stated this can cause confusion with documentation and communication.During a review of the facility's policy and procedure (P&P) titled, Medication Administration, last reviewed on 4/29/2026, the P&P indicated to establish standardized procedures for the safe, effective, and accurate administration of medications in compliance with state and federal regulations and best practices standards. d. License Nurse will verify the resident's identity before administering the medication using the six (6) rights of medications.During a review of the facility's P&P titled, Falsification and Omission, last reviewed on 4/29/2026, the P&P indicated entries in a medical record at the facility will be factual and will accurately reflect the services provided to the resident, the condition of the resident, and the resident's response to services provided.