POC Accepted 5/20/2025
Evaluator Number 51104

PRINTED: 05/06/2025
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055932	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/24/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 5/22/1968 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: TWO STORY, TYPE III, FULLY SPRINKLERED The following reflects the findings of the California Department of Public Health during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. The facility is not in substantial compliance with 42 CFR 483.90 for Long Term Care (LTC) Facilities. Resident Certified Beds: 201 Census: 174	K 000	K355 Portable Fire Extinguishers How the corrective action will be accomplished for those residents found to have been affected by this practice • On 04/23/25 the Maintenance Director and Designees started immediately remounted the PFE near room 54, and nurse station 2 no more than five feet from the floor. How will the facility identify the other residents having potential to be affected by the same deficient practice and what corrective action will be taken. • On 04/23/25 the Maintenance Director and Designees completed a sweep of all PFE in the building. 38 PFE in the building and a total of 5 had to remounted to be no more than five feet from the floor.	05.16.25 05.16.25
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to install a portable fire extinguisher (PFE) at the required height range in accordance with NFPA 10, 2010 Edition Section 6.1.3, affecting one of eight smoke compartments	K 355	What Measures will be put in place or what systemic changes will you make to ensure the deficient practice does not recur • On 05/07/25 the Administrator conducted an in-service with the Maintenance Department. Regarding the Policy and Procedure titled, "Extinguishing a Fire." This in-service was completed on 05/07/25. • On 05/14/25 the Maintenance Department started to conduct a random weekly audit on all PFE in the building to ensure they are no more than five feet from the floor. This audit will continue x3 months.	05.16.25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 05/16/25

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055932	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/24/2025**

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**

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K 355	Continued From page 1 (space within a building separated from other interior areas of the building by smoke barriers, including interior walls and doors). This deficient practice has the potential to hinder access to the PFE and delay the extinguishing of a fire in the event of an emergency. Findings: During a concurrent observation and interview on 4/23/2025 at 10:49 a.m. with the Maintenance Supervisor (MS), the PFE mounted on the wall by Resident Room 54 was measured from the top of the PFE to the floor and the MS stated it was 65 inches and mounted too high. During a concurrent observation and interview on 4/23/2025 at 10:52 a.m. with the Maintenance Supervisor (MS), the PFE mounted on the wall by Nurse Station 2 was measured from the top of the PFE to the floor and the MS stated it was 67 inches and mounted too high. During a review of the facility's policy and procedure (P&P) titled, "Extinguishing a Fire" (Revised 1/1/2012), the P&P indicated, " ... C. Fire extinguishers are mounted so that the top of the extinguisher is no more than five (5) feet from the floor."	K 355	What does the facility plan to monitor its performance to make sure solutions are sustained and to ensure deficient practice will not recur • The Administrator will conduct a monthly random observation of the PFE to ensure all PFE are no more than five feet from the floor. This audit started on May 16, 2025 and will continue x3months. • The Administrator or Designee will present the results of the audits to the Quality Assurance Performance Improvement Committee for review and recommendations monthly for 3 months or until substantial compliance is achieved. • The Administrator will be responsible for monitoring and sustaining compliance. Completion Date: 05/16/25	05/16/25

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	055932	A. BUILDING _____ B. WING _____	04/24/2025

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

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. The facility is in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care (LTC) Facilities. Census: 174	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/6/25

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.