STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055755	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Care Center	8167 West Third St. Los Angeles, CA 90048

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 2), was not billed for a single room during the time another resident was on bed hold (bed at the facility is held for a resident during hospitalization up to seven days and paid for), in the same room as the resident. This failure resulted in the resident not receiving the single room they were paying for. Findings: During a review of Resident 2's Admission Record, dated 7/2/24, indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses including left artificial hip joint, muscle weakness, abnormal posture, abnormalities of gait and mobility, hypertension (high blood pressure) and type two diabetes mellitus (a condition were your body has trouble controlling the level of sugar in the blood). During a review of Resident 2 ' s Minimum Data Set (MDS, a standardized assessment and screening tool), dated 4/15/24, the MDS indicated, Resident 2 was independent in decision making, and required set-up assistance from staff for eating and oral hygiene, as well as, partial to moderate assistance for bed mobility, toileting, dressing and personal hygiene. During an interview with concurrent record review on 7/2/24 at 12:48 pm, with Business Office Assistant (BOA), Resident 2 ' s census (list of residents at the nursing facility) list dated 7/2/24 and financial statement dated 7/1/24 were reviewed. The census list indicated Resident 2 was admitted on [DATE], had a room change on 4/11/24 and was discharged on [DATE]. The financial statement indicated an amount due of ($5, 684.00). The BOA verified the information and stated the process for private (single) room would be to give the resident a daily price then they get billed, and it is recommended they pay weekly. For the single room cost, the resident would have to pay for the extra bed in the room, so if their insurance pays for the semi-private room rate the resident would be responsible to pay for the other bed in the room. During a follow up interview with BOA on 7/2/24 at 1:35 pm, the BOA stated there was no documentation of the agreement for Resident 2 ' s single room, so the resident will not be liable and requested a refund of what they paid. BOA further stated the resident has a credit so they will be refunding that as well. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and a concurrent record review on 7/11/24 at 11:20 am with Director of Nursing (DON), the facility censuses dated 4/10/24 through 4/15/24 were reviewed. The DON verified the censuses indicated Resident 2 was in a semi-private (two beds) room with a resident on bed hold in the room ' s second bed for those dates. The DON stated the resident should not have been charged if there was a resident on bed hold on the census.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review the facility failed to follow Registered Dietician (RD) recommendations made during the interdisciplinary team (IDT, different health care disciplines get together to review the plan of care of the resident) meeting to change the residents gastrostomy (G-tube, a tube inserted through the belly that brings nutrition directly to the stomach) feeding formula (nutrition) for one of five sampled residents (Resident 1). This failure resulted in recommendations for a change in Resident 1's G-tube formula to be delayed for 51 days and the resident losing six pounds (4% of their weight). Findings: During a review of Resident 1's Admission Record dated 7/2/24, indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), type two diabetes mellitus (a condition were your body has trouble controlling the level of sugar in the blood), heart failure (condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), muscle weakness, dysphagia (difficulty swallowing), and encephalopathy (disturbance in brain function). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and screening tool), dated 4/28/24, the MDS indicated, Resident 1 had cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions), and was dependent on staff for eating, toileting, bed mobility, bathing, dressing, and personal hygiene. During an interview with concurrent record review on 7/11/24 at 11:20 am with Director of Nursing (DON), Resident 1's weight change notes dated 6/1/23, 6/23/23, 7/6/23, were reviewed. The noted indicated the following: 1. The note dated 6/1/23, indicated, a current weight of 143 lbs (pounds), and a G-tube feeding of Jevity 1.2 calorie per milliliter (cal/ml) at a rate of 40 milliliters per hour (ml/hr) with a recommendation to change tube feeding to Glucerna 1.5 cal/ml at a rate of 65 ml/hr. 2. The note dated 6/23/23, indicated, a current weight of 140 lbs, and a G-tube feeding of Jevity 1.2 cal/ml at a rate of 40 ml/hr (same as previous order) with recommendation to change the feeding to Jevity 1.2 cal/ml at a rate of 50 ml/hr. 3. The note dated 7/6/23, indicated, a current weight of 137 lbs and a G-tube feeding of Jevity 1.2 cal/ml at rate of 40 ml/hr (same as previous order) with recommendation to increase the feeding to Jevity 1.2 cal/ml at a rate of 50 ml/hr. The DON verified the note entries and stated the recommendations should have been followed up by the licensed nurse, they are supposed to call the doctor and get the order for the recommendation made by the registered dietitian and the G-tube feeding was not changed until 7/21/23 when it was ordered as Glucerna 1. 2 calories per milliliter at a rate of 50 milliliters per hour. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedures titled Physician Orders, reviewed 3/1/22, indicated, orders will be accepted only from authorized, credentialed physicians . a physician my delegate the tasks of writing dietary orders to a qualified Dietitian or other clinically qualified nutrition professional.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 1): 1. had and initial care plan developed for G-tube dislodgment and revised after the second dislodgement, to include new interventions. 2. had Interdisciplinary team meetings completed in a timely manner after G-tube dislodgement. This failure resulted in seven instances where Resident 1 ' s G-tube was dislodged and required replacement. Findings: 1. During a review of Resident 1's Admission Record, dated 7/2/24, indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including hypertension (high blood pressure), type two diabetes mellitus (a condition were your body has trouble controlling the level of sugar in the blood), heart failure (condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), muscle weakness, dysphagia (difficulty swallowing), and encephalopathy (disturbance in brain function). During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and screening tool), dated 4/28/24, the MDS indicated, Resident 1 had cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions), and was dependent on staff for eating, toileting, bed mobility, bathing, dressing, and personal hygiene. During a concurrent interview and record review, on 9/27/23 at 2:45 pm with Director of Nursing (DON), Resident 1's, admission and hospital leave report dated 9/27/23 was reviewed. The report indicated: 4/11/23 initial admitted to the facility, 5/11/23 hospital leave, 5/15/23 return to facility, 5/28/23 hospital leave, 6/1/23 return to facility, 6/14/23 hospital leave, 7/6/23 return to facility, 7/10/23 hospital leave, 8/3/23 return to facility, 8/8/23 hospital leave, 9/8/23 return to facility, 9/14/23 hospital leave, 9/19/23 return to facility. The DON stated and verified there were six instances between the initial admitted [DATE] and the most recent readmitted [DATE] where Resident 1 was transferred to the hospital. During an interview with concurrent record review on 7/11/24 at 11:20 am with DON, Resident 1's, Progress notes dated 5/9/23, 5/15/23, 7/24/23, 9/20/23, 9/22/23, 10/17/23, and 12/24/23 were reviewed. The DON verified those entries were for G-tube dislodgment that required replacement. The DON further stated the resident had comorbidities and the G-tube was sometimes leaking requiring a change of site. During an interview with concurrent record review on 7/11/24 at 11:20 am with DON, Resident 1's, Care plan for G-tube, dated 7/25/23 was reviewed. The DON verified there was no care plan for G-tube dislodgement with new interventions developed before this date and there should have been one made. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an interview with concurrent record review on 7/11/24 at 11:20 am with DON, Resident 1's progress notes dated 5/8/23 through 1/5/24 were reviewed. The progress note indicated no entries for interdisciplinary team (IDT) meeting notes for the G-tube dislodgement. The DON verified there were no IDT meeting notes in the medical record regarding G-tube dislodgement until 1/5/24. A review of the facility 's policy and procedures titled, Person-Centered Care Plan, reviewed 10/24/22, indicated, purpose . to attain or maintain the patient ' s highest practicable physical, mental, and psychosocial well being . to eliminate or mitigate triggers that may cause re-traumatization of the patient . the care plan must be customized to each individual patient ' s preferences and needs .Care plans will be: communicated to appropriate staff, patient, patient representative, family; reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals.