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	09/25/2024

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 43851 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had pressure ulcers (also known as a pressure injury, a localized area of damaged skin or tissue caused by prolonged pressure on the skin), was assessed quarterly using the Braden scale assessment (a tool used to assess a patient's risk of developing pressure ulcers). This deficient practice caused an increased risk in assessing a significant change to Resident 1's skin integrity. Findings: A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 4/15/2024 indicated the resident was at risk of developing pressure ulcers. A review of Resident 1's Admission Record indicated the facility readmitted the resident on 4/19/2024 with diagnoses including altered mental status, hemiplegia (severe or complete loss of strength or paralysis on one side of the body), hemiparesis (mild or partial weakness or loss of strength on one side of the body), muscle wasting and atrophy (the decrease in size or wasting away of a tissue, organ, or body part), and gastrostomy (G-Tube, a tube inserted through the abdomen that delivers nutrition directly to the stomach). A review of Resident 1's Wound Care Specialist Progress Note dated 4/23/2024, indicated Resident 1 had unstageable pressure induced tissue damage (also known as an unstageable pressure injury or pressure ulcer, a type of pressure sore that occurs when tissue is compressed for a long time resulting in tissue death. Unstageable pressure injuries are when the stage of the injury is not clear) on their sacral coccyx (tailbone area) extending to the left buttock. The progress note indicated Resident 1 also had a right lateral (side) heel vascular wound. A review of Resident 1's Care Plan initiated on 4/25/2024, indicated Resident 1 had unstageable pressure induced tissue damage on the sacral coccyx extending to the left buttock. The care plan indicated a goal for Resident 1's wound to heal as evidenced by a decrease in size, absence of erythema (skin redness caused by increase blood flow) and drainage, and/or the presence of granulation (the appearance of red, bumpy tissue in the wound bed as the wound heals). The care plan indicated an intervention of sacral coccyx extending to left buttock unstageable pressure induced tissue damage. There were no other listed interventions on the care plan. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Braden scale assessment form dated 5/18/2024, indicated the resident was at severe risk of developing a pressure ulcer with a score of 8. The Braden scale indicated Resident 1 had completely limited sensory perception (unresponsive to painful stimuli due to diminished level of consciousness or sedation), was constantly moist, was bedfast (confined to bed), was completely immobile, and had a problem with friction and shear (required moderate to maximum assistance in moving). According to a review of Resident 1's Wound Specialist Progress Note dated 6/18/2024, the wound specialist changed the classification of the resident's sacral coccyx wound that extended to the left buttock to a Stage IV pressure ulcer and noted the condition of the sacral coccyx wound was stable. The note further indicated Resident 1 had the right lateral heel vascular wound. During a concurrent interview and record review on 9/26/2024 at 3:44 PM, Resident 1's Braden scale form was reviewed with the Director of Nursing (DON). The DON stated the Braden scale assessment form should be completed quarterly and stated Resident 1 did not have had a Braden Scale completed on 8/15/2024. The DON stated the Braden scale was important to help prevent pressure ulcers and inform the staff of the type of care the resident needs and helped to improve the resident's health. The DON stated there was a potential for the staff to not be aware of the care Resident 1 needed which could potentially lead to the worsening of the resident's wounds as the Braden scale assessment was not completed quarterly. A review of the facility's policy and procedure titled, Skin Integrity and Wound Management, revised 5/1/2024, indicated A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influence skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed Complete risk evaluation on admission/readmission, weekly for the first month, quarterly, and with significant change in condition .Identify patient's skin integrity status and need for prevention or treatment interventions through review of all appropriate assessment information.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 43851 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who had a severe risk for developing a pressure ulcer (also known as a pressure injury, a localized area of damaged skin or tissue caused by prolonged pressure on the skin), received necessary treatment and services to promote healing of pressure sore by: -Failing to develop a care plan for Resident 1's right lateral (side) leg vascular wound (develop due to problems with blood circulation, often caused by peripheral vascular disease [PVD, a circulatory condition that occurs when blood vessels outside of the heart and brain narrow, spasm, or become blocked]). -Failing to revise the care plan for Resident 1's sacral coccyx (tailbone area) pressure ulcer when it was re-classified from an unstageable pressure ulcer (when the stage of the pressure injury is not clear) to a Stage IV (characterized by full-thickness skin loss that extends through the fascia and into the muscle, bone, tendon, or joint) pressure ulcer. -Failing to indicate services that were to be provided to Resident 1 in the care plan interventions for the resident's sacral coccyx pressure ulcer and the right lateral heel vascular wound. These deficient practices caused an increased risk for Resident 1's skin integrity to worsen and prevent healing. Findings: A review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 4/15/2024, indicated the resident was at risk of developing pressure ulcers. A review of Resident 1's Admission Record indicated the facility readmitted the resident on 4/19/2024 with diagnoses including altered mental status, hemiplegia (severe or complete loss of strength or paralysis on one side of the body), hemiparesis (mild or partial weakness or loss of strength on one side of the body), muscle wasting and atrophy (the decrease in size or wasting away of a tissue, organ, or body part), and gastrostomy (G-Tube, a tube inserted through the abdomen that delivers nutrition directly to the stomach). A review of Resident 1's Wound Care Specialist Progress Note dated 4/23/2024, indicated Resident 1 had unstageable pressure induced tissue damage (also known as an unstageable pressure injury or pressure ulcer, a type of pressure sore that occurs when tissue is compressed for a long time resulting in tissue death. Unstageable pressure injuries are when the stage of the injury is not clear) on their sacral coccyx (tailbone area) extending to the left buttock. The progress note indicated Resident 1 also had a right lateral (side) heel vascular wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Care Plan initiated on 4/25/2024, indicated Resident 1 had unstageable pressure induced tissue damage on the sacral coccyx extending to the left buttock. The care plan indicated a goal for Resident 1's wound to heal as evidenced by a decrease in size, absence of erythema (skin redness caused by increase blood flow) and drainage, and/or the presence of granulation (the appearance of red, bumpy tissue in the wound bed as the wound heals). The care plan indicated an intervention of sacral coccyx extending to left buttock unstageable pressure induced tissue damage. There were no other listed interventions on the care plan. A review of Resident 1's Care Plan initiated on 4/25/2024, indicated the resident had a right lateral heel vascular wound with the goal to heal as evidenced by a decrease in size, absence of erythema and drainage, and/or the presence of granulation. The care plan indicated an intervention to paint the right heel vascular wound with betadine (a topical antiseptic that helps prevent infections in minor cuts, scrapes, burns, and other wounds) and cover with foam dressing every day shift for wound care management for 30 days until finished. There were no other listed interventions listed on the care plan. A review of Resident 1's Braden scale dated 5/18/2024, indicated the resident was at severe risk of developing a pressure ulcer with a score of 8. The Braden scale indicated Resident 1 had completely limited sensory perception (unresponsive to painful stimuli due to diminished level of consciousness or sedation), was constantly moist, was bedfast (confined to bed), was completely immobile, and had a problem with friction and shear (required moderate to maximum assistance in moving). According to a review of Resident 1's Wound Specialist Progress Note dated 6/18/2024, the wound specialist changed the classification of the resident's sacral coccyx wound that extended to the left buttock to a Stage IV pressure ulcer and noted the condition of the sacral coccyx wound was stable. The note further indicated Resident 1 had the right lateral heel vascular wound. A review of Resident 1's Care Plan dated 4/25/2024, for the unstageable pressure induced tissue damage on the sacral coccyx extending to the left buttock, indicated the care plan was not revised when the Wound Specialist changed the classification of resident's sacral coccyx wound to a Stage IV. A review of Resident 1's Skin Check Documentation dated 9/3/2024, indicated the resident had a Stage IV pressure injury to the sacro coccyx and a right lateral heel PVD wound. The documentation further indicated Resident 1 had a new PVD wound to the right lateral lower leg. A review of Resident 1's Wound Specialist Progress note dated 9/3/2024, indicated the resident had an improved Stage IV pressure wound to their sacral coccyx extending to the left buttock. The progress note indicated Resident 1 had a right lateral heel vascular wound that was in stable condition and was unavoidable due to the resident's vascular condition. A review of Resident 1's Care Plans indicated there was no care plan developed for the new PVD wound to the resident's right lateral lower leg. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/25/2024 at 1:07 PM, Resident 1's Care Plans initiated 4/25/2024 were reviewed with Treatment Nurse (TN) 1. TN 1 stated Resident 1 was being seen by the wound specialist every week and was receiving treatment for the wounds daily. TN 1 stated the care plan for the resident's sacro coccyx pressure ulcer indicated the pressure ulcer was unstageable. TN 1 stated the care plan should have been revised when the wound specialist re-classified the sacro coccyx pressure ulcer as a Stage IV. TN 1 stated both the care plans for the sacro coccyx wound and the right lateral heel vascular wound were both lacking interventions. TN 1 stated the care plans should have included more interventions such as the use of a low air loss mattress (LALM, mattresses that are designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown), wound care, notifying the physician if there were any changes to the wounds, monitoring for signs and symptoms of infection, and repositioning the resident every 2 hours. During a concurrent interview and record review on 9/26/2024 at 3:44 PM, Resident 1's care plans were reviewed with the Director of Nursing (DON). The DON stated there was no care plan developed for the PVD wound to Resident 1's right lateral leg. The DON stated Resident 1's care plan was not revised to reflect the sacro coccyx pressure ulcer being reclassified from an unstageable to a Stage IV pressure ulcer. The DON stated the care plans for the sacro coccyx pressure ulcer and right lateral heel wound also needed more substance. The DON stated the care plans should list more than one intervention, should be revised when there was a change in the resident's condition, as needed, and every three months. Additionally, the DON stated care plans were important to help prevent pressure ulcers, they inform the staff of the type of care the resident needs, and helped to improve the resident's skin health. The DON stated there was a potential for the staff to not be aware of the care Resident 1 needed which could potentially lead to the worsening of the resident's wounds because the care plans did not reflect the resident's current wound status. A review of the facility's policy and procedure titled, Person-Centered Care Plan, revised 10/24/2022, indicated A comprehensive person-centered care plan must be developed for each patient and must describe the following: Services that are to be furnished; any services that would otherwise be required but are not provided due to the patient's exercise of rights, including the right to refuse treatment .in consultation with the patient and the resident representatives (s): Goals for admission and desired outcomes .The care plan must be customized to each individual patient's preferences and needs .Care plans will be: . Revised 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. A review of the facility's policy and procedure titled, Skin Integrity and Wound Management, revised 5/1/2024, indicated A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influence skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed Complete risk evaluation on admission/readmission, weekly for the first month, quarterly, and with significant change in condition .Identify patient's skin integrity status and need for prevention or treatment interventions through review of all appropriate assessment information .Review care plan and revise as indicated.