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	10/22/2024

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36395 Based on interview and record review the facility failed to ensure residents are correctly identified for two of five sampled residents (Resident 1 and Resident 2). On 10/16/24, Resident 1 was for transfer to another skilled nursing facility (SNF) and Resident 2 had an appointment with the ophthalmologist (medical doctor with specialized training in medical and surgical eye care). The transportation company came and picked up Resident 2 and drove Resident 2 to the SNF instead of the ophthalmologist. This deficient practice resulted in Resident 2 stated that he felt mad and upset when the facility took him to the SNF resulting in Resident 2 missing his appointment with the eye specialist on 10/16/24. Findings: 1.During a review of the Admission Record indicated the facility admitted Resident 1 on 10/15/24 with diagnoses including metabolic encephalopathy (alteration in consciousness caused by brain dysfunction) and generalized muscle weakness. During a review of the Minimum Data Set (MDS - a federally mandated resident assessment tool) indicated Resident 1 had severe cognitive impairment. Resident 1 needed substantial assistance (helper does more than half of the effort) with eating, oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing. During a review of the Case Management Progress Note dated 10/16/24 at 10:37 a.m., indicated Resident 1 was for transfer to another SNF on 10/16/24. The Notes indicated the transportation pick up time was at 10 a. m. 2. During a review of the Admission Record indicated the facility admitted Resident 2 on 3/6/23 and readmitted on [DATE] with diagnoses including legally blind (level of visual impairment that limits the activities performed by individuals without assistance) and difficulty in walking. During a review of the MDS dated [DATE], indicated Resident 1 had moderately impaired cognitive impairment. The same MDS indicated Resident 1 needed moderate assistance (helper does less than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, set up with oral hygiene, upper body dressing, personal hygiene and was independent with eating. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Physician Order dated 9/17/24 at 8:40 a.m., indicated Resident 2 had confirmed appointment with the ophthalmologist on 10/16/24 at 12:30 p.m. During a review of Resident 2's Progress Notes dated 10/16/24 at 11:35 a.m., indicated Resident 2 left for his appointment at 11:30 a.m., with private transport, accompanied by certified nursing assistant (CNA). During a review of the Progress Note with late entry dated 10/16/24 at 12:09 pm indicated Resident 2 was sent to a wrong location with the CNA. The Notes indicated Resident 2 missed his appointment with the eye specialist and was re-scheduled for 10/24/24. During an interview on 10/21/24 at 9:24 a.m., Resident 2 stated on 10/16/24 he had an appointment with the eye specialist for his cataract. Resident 2 stated the transportation driver took him to the wrong place. Resident 2 stated he missed the appointment and had to reschedule. Resident 2 stated he was mad and upset that this happened. During a telephone interview on 10/21/24 at 11:29 a.m., licensed vocational nurse (LVN 1) stated on 10/16/24 the driver came to the facility and the driver stated that he will pick up a resident, using the resident's first name. LVN 1 stated she asked the driver if the driver was to pick up Resident 2, using Resident 2's last name. The driver stated yes. LVN 2 stated Resident 2 and the CNA left with the driver. LVN 1 stated after 30 minutes, the CNA who was with Resident 2 called the facility and informed the facility that they were taken to the SNF instead of the appointment with the eye specialist. LVN 1 stated Resident 1 was supposed to go to the SNF and not Resident 2. During an interview on 10/21/24 at 1:43 p.m., the registered nurse supervisor (RNS 1) stated Resident 1 and Resident 2 had the same first name. RNS 1 stated the driver drove Resident 2 to SNF instead of Resident 1. During the exit conference on 10/22/24 at 12:40 p.m., with the director of nursing (DON) and the administrator (ADM), the ADM stated the issue was with the transportation company. ADM stated Resident 2 was carrying an envelope with Resident 2's name written on the envelope. ADM further stated Resident 2 was accompanied by the CNA, but the driver drove Resident 2 to the wrong place. DON stated Resident 2 missed his appointment and had to be rescheduled. During a review of the facility policy and procedure (P&P) titled Resident Identification System reviewed on 1/18/24 indicated a resident identification system is used to help facility personnel provide medical and nursing care. The same Policy indicate the facility had adopted a photo and/or wristband identification system to help assure that medication and treatments are administered to the right resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 36395 Based on interview and record review the facility failed to provide care to the resident who had a fall in accordance with professional standards of practice for one of four sampled residents (Resident 1). For Resident 1 who had a fall on 10/16/24 during the night shift (11 p.m. to 6 p.m.), the facility failed to: 1.Assess Resident 1 immediately after the fall. 2.Notify Resident 1's physician and responsible party of the fall. These deficient practices resulted in Resident 1 not given immediate care after the fall. Findings: During a review of the Admission Record indicated the facility admitted Resident 1 on 10/15/24 with diagnoses including metabolic encephalopathy (alteration in consciousness caused by brain dysfunction) and generalized muscle weakness. During a review of the Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/16/24, indicated Resident 1 had severe cognitive impairment. Resident 1 needed substantial assistance (helper does more than half of the effort) with eating, oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing. During a review of the Progress Note dated 10/16/24 at 12:33 p.m., indicated licensed vocational nurse (LVN 1) was made aware that Resident 1 was observed on the floor early this morning on a sitting position. Resident 1 had no pain and no edema (swelling in parts of the body). The notes indicated Resident 1 denied hitting his head. The Notes indicated the nurse practitioner (NP, registered nurse with advanced clinical education and training) was notified and gave order to start neurological check (series of test that assess that includes mental status, reflexes, and movement) and to continue to monitor Resident 1. During a telephone interview on 10/21/24 at 1:38 p.m., LVN 1 stated on 10/16/24, Resident 1 had a fall during the night shift. LVN 1 stated she was made aware of the fall at about noon on 10/16/24. LVN 1 stated there was no documentation that Resident 1 fell during the night shift. LVN 1 further stated, Resident 1's physician was not notified right after the fall. LVN 1 stated when she was made aware, LVN 1 notified Resident 1's NP. LVN 1 stated the NP gave order to do the neuro check and to continue to monitor Resident 1. During an interview on 10/22/24 at 10:23 a.m. the admission coordinator (AC) stated Resident 1's caregiver informed him that Resident 1 had a fall the on 10/16/24 during the night shift. The AC stated he informed the director of nursing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/24 at 12:18 p.m., the director of nursing (DON) stated Resident 1 fell during the night shift on 10/16/24 and there was no documentation of the fall. DON stated when Resident 1 fell the physician should be notified immediately to obtain orders or what the physician wants to do. During a review of the facility's Policy and Procedure (P&P) titled Fall Management, reviewed on 1/18/24, the P&P indicated residents who are experiencing a fall will receive appropriate care and investigation of the cause. The same Policy indicated if a resident falls: 1.Observe/check for injury 2.Perform neurological evaluation for all unwitnessed falls and witnessed falls with injury to the head or face. 3.Document accident/incident in the clinical record 4.Update the care plan to reflect new interventions. 5.Notify physician and responsible party 6.Interdisciplinary to review post fall. During a review of the facility's P&P titled Change in Condition: Notification, reviewed on 1/18/24, indicated the facility must immediately inform the resident, consult with the resident's physician and/or nurse practitioner and notify, consistent with his/her authority, residents' representative that included where there is an accident involving the resident.