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	11/26/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44252 Based on interview and record review, the facility failed to follow their abuse policy and procedures for two of 10 sampled residents (Residents 1 and 7). This deficient practice resulted in the resident-to-resident abuse incident was not reported to state licensing/certification office, police, and ombudsman, the incident was not investigated, and the residents were not separated (rooms changed) in a timely manner. Findings: During a review of Resident 1's Admission Record, dated 11/21/24, indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breath), pneumonia (infection in the lungs), neoplasm of the prostate (tumor of the male gland in the rectum), muscle weakness, and abnormalities of gait and mobility. During a review of Resident 1's Minimum Data Set (MDS - resident assessment tool), dated 4/10/24, indicated, Resident 1 had mild cognitive issues (ability to think, understand and make daily decisions - considered to have intact cognition showing no significant signs of impairment). The same MDS indicated Resident 1 required set up assistance from staff while eating, and partial/moderate assistance from staff for toileting, bathing, dressing and personal hygiene. [NAME] a review of Resident 1 ' s Case Management Progress Note dated 11/1/24 indicated, 'LATE ENTRY, responded to pt ' s (patient ' s) room after hearing shouting in hallway. Arrived to the pt ' s room to find pt and roommate arguing and shouting. Separated pts and roommate attempted to strike pt in bed from bedside. Removed the pt outside of room and placed in patio. Pt requesting to remain in room and have roommate change as pt feels he should remain in the room as he was admitted first. Presented with empty rooms available. Pt declined for room change. Endorsed to RN (Registered Nurse) supervisor and CN (Charge Nurse) . During a review of Resident 1 ' s Progress Note dated 11/12/24 at 9:00 am indicated Resident 1 requested room change due poor roommate compatibility and misunderstanding. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Progress Note assessment dated [DATE] 4:08 pm indicated resident is expected to transfer rooms because of roommate compatibility patient ' s responsible party was notified, roommate notified. During a review of Resident 7's Admission Record, dated 11/21/24, indicated, Resident 7 (Resident 1 ' s roommate) was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain disfunction due to chemical imbalance in the blood), dysphagia (difficulty swallowing), hemiplegia (paralysis on one side of the body and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke), Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 7's MDS, dated [DATE], indicated, Resident 7 had moderate cognitive issues (ability to think, understand and make daily decisions - may need help with activities of daily living and specific tasks), and had behaviors of inattention that would fluctuate (come and go). The same MDS indicated Resident 7 required substantial/maximal assistance from staff for eating, oral and personal hygiene, and was dependent on staff for toileting, bathing, dressing and bed mobility. During a review of Resident 7 ' s Case Management Progress Note dated 11/1/24 indicated, LATE ENTRY, responded to pt ' s (patient ' s) room after hearing argument. Attempted to redirect pt from arguing and attempting to strike roommate. Pt requesting to room change. Offered open rooms. Pt agreeable to room change. Endorsed and communicated to RN supervisor and CN. During a review of Resident 7 census indicated resident was never moved to a different room, and Resident 1 was moved to a different room on 11/12/24 (11 days after the original incident). During a review of the Resident 1 and Resident 7 ' s medical records indicated no contact to the ombudsman, police or resident representatives post incident, nor an investigation of the incident. During a telephone interview on 11/20/24 at 5:11 pm with Case Manger (CM), the CM stated she has training on abuse and reporting procedures. The CM further stated she (CM) responded to and argument between Resident 1 and Resident 7 on 11/1/24 toward the end of her shift and separated them by taking Resident 1 to the patio. CM offered room changes to both and they both refused the change in room. CM stated Resident 1 was agreeable to stay since Resident 7 did not want to move either. CM statedshe endorsed the situation to the RN supervisor and CN, and also notified all leadership via group chat. During an interview on 11/20/24 at 5:30 pm, with the facility Administrator (ADM), the incident between Resident 1 and Resident 7 was discussed. The ADM stated since it was just an argument and there was no injury she didn ' t think it should be reported. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedures titled Abuse Prohibition Policy and Procedure, dated 2/23/21, indicated, HealthCare Centers prohibit abuse . for all residents. This includes, but is not limited to, freedom from corporal punishment . employees are designated as mandated reporters and are obligated to immediately report any suspicion of a crime against a resident. Reporting a suspicion of a crime only to an immediate supervisor does not meet the obligation to report . The Center will implement an abuse prohibition program through the following . prevention of occurrences . Investigation of incidents and allegations . Reporting of incidents, investigations, and Center response to the results of their investigations. Abuse is defined as the willful . intimidation, injury or mental anguish . It includes verbal abuse . Willful . the individual must have acted deliberately . Verbal Abuse is any use of oral, written or gestured language. 6. Staff will identify events . This also includes the patient-to-patient abuse. 6.1 Anyone who witnesses and incident of suspected abuse . is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately. 6.1.1 The notified supervisor will report the suspected abuse immediately to the Center Executive Director (CED) or designee and other officials in accordance with state law . 6.1.3 All reports of suspected abuse must also be reported to the patient ' s family and attending physician . 6.2 If the suspected abuse is resident-to-resident, the resident who has in any way threated or attacked will be removed from the setting or situation and an investigation will be completed. 7. Upon receiving the information concerning a report of suspected or alleged abuse . 7.1 Report allegations involving abuse (physical, verbal, sexual, mental) not later than two (2) hours after the allegation is made . 7. 4 Notify local law enforcement, Ombudsman, Licensing District Office, Licensing Boards, Registries and other agencies as required. Based on interview and record review, the facility failed to follow their abuse policy and procedures for two of 10 sampled residents (Residents 1 and 7). This deficient practice resulted in the resident-to-resident abuse incident was not reported to state licensing/certification office, police, and ombudsman, the incident was not investigated, and the residents were not separated (rooms changed) in a timely manner. Findings: During a review of Resident 1's Admission Record, dated 11/21/24, indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, a group of lung diseases that block airflow and make it difficult to breath), pneumonia (infection in the lungs), neoplasm of the prostate (tumor of the male gland in the rectum), muscle weakness, and abnormalities of gait and mobility. During a review of Resident 1's Minimum Data Set (MDS - resident assessment tool), dated 4/10/24, indicated, Resident 1 had mild cognitive issues (ability to think, understand and make daily decisions - considered to have intact cognition showing no significant signs of impairment). The same MDS indicated Resident 1 required set up assistance from staff while eating, and partial/moderate assistance from staff for toileting, bathing, dressing and personal hygiene. (continued on next page)

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