

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055755	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER Sharon Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524</p> <p>Based on interviews and record review, the facility failed to ensure:</p> <ol style="list-style-type: none"> 1. Licensed nurses had the skills and knowledge to identify a change in condition for one of the three sampled residents (Resident 1) who had a critically low platelet count (PLT- a laboratory test that measures the number of platelets in the blood. Platelets are small, cell-like fragments that play a crucial role in blood clotting by forming a plug at the site of injury) level of 33,000 (normal PLT is between 150,000 and 400,000 platelets per microliter [uL]). 2. The physician was informed immediately when the critically low PLT count as soon as it was called in by the laboratory staff. <p>This failure resulted in Resident 1 ' s delay in getting transferred to General Acute Care Hospital (GACH) for treatment and placing him at a risk for spontaneous bleeding which could result in death. Resident 1 died seven days later at GACH.</p> <p>Findings:</p> <p>During a review of the admission record for Resident 1 indicated Resident 1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including urinary tract infection (UTI- a bacterial infection in the urinary system), chronic obstructive pulmonary disease (COPD- a progressive lung disease that makes it difficult to breathe caused by damage to the lungs that blocks airflow), and paroxysmal atrial fibrillation (a type of irregular heartbeat that lasts a few hours or days and then goes away on its own).</p> <p>During a review of Resident 1 ' s history and physical (a term used to describe a physician's examination of a patient) for Resident 1 dated [DATE] indicated, Resident 1 was alert, conversant, nontoxic (not harmful or destructive). The H&P indicated Resident 1 had a history of hemorrhagic disorder (a condition that makes it difficult for a person to stop bleeding) due to circulating oral anticoagulants (medications that can cause hemorrhaging as a side effect). The same P&P indicated the PLT count was 95,000 uL on [DATE].</p> <p>(continued on next page)</p>

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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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated [DATE], indicated Resident 1 was cognitively intact (has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of their environment). The same MDS indicated Resident 1 required between supervision or touching assistance and substantial/maximum assistance for his Activities of Daily Living such as: (ADLs- routine tasks/activities such as eating, oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, lower/upper body dressing, putting on/taking off footwear).</p> <p>During a review of Resident 1 ' s nursing progress noted dated [DATE] at 3:19 pm indicated, Resident 1 was transferred to GACH at 3 pm due to low platelets and persisting gross hematuria.</p> <p>During a review of Resident 1 ' s laboratory report dated [DATE] at 12:03 pm indicated a PLT count of 35, 000 uL. The same lab report indicated the results were reported to the facility on [DATE] at 9:32 am.</p> <p>During a review of Resident 1 ' s laboratory results dated [DATE], indicated a PLT count of 33, 000 uL. The same lab report indicated the results were reported to the facility on [DATE] at 1:06 pm.</p> <p>During a review of Resident 1 ' s Situation, Background, Assessment, and Recommendation/Change of Condition (SBAR- a structured communication tool used to share information between people, especially in critical situations/COC- a significant change in a person's physical, financial, or cognitive state that may require intervention) dated [DATE] at 12 pm indicated, Patient was reporting for having nausea and not feeling good also due to low platelets result and persisting Hematuria (blood in urine) NP (Nurse Practitioner) notified and got new order for transferring him (Resident 1) to the Hospital.</p> <p>During a review of Resident 1 ' s physician order dated [DATE] at 12:29 pm, indicated, TRANSFER PATIENT TO ED FOR LOW PLATELETS AND PERSISTING GROSS HEMATURIA VIA ORDINARY TRANSPORT.</p> <p>During an interview with Licensed Vocational Nurse (LVN) 2 [DATE] at 10:15 am, LVN 2 stated when emergency situations arise such as critically low labs results including PLTs, a resident must be sent via emergency services via 911 (a number called for emergencies such as fire, medical, and theft). LVN 2 stated that she would use her critical nursing judgment especially if a resident was symptomatic to notify the MD that non-emergency will not work because the resident is unstable.</p> <p>During an interview with LVN 1 on [DATE] at 12:32 pm, LVN 1 stated when critical lab results are reported, LVN 1 first informs the supervisor, then the ordering physician. LVN 1 stated that she (LVN1) first follows what the supervisor recommends for critical results no matter how emergent the results and stated, The supervisor knows better what to do. LVN 1 stated that even if a resident was in Cardiac Arrest (when the heart stops beating), LVN 1 would wait until the supervisor or Director of Nursing (DON) said so. LVN 1 stated that she (LVN 1) did not specifically remember when a supervisor (unable to recall) notified her that there was a critical lab result of 33, 000 uL for Resident 1. LVN 1 stated that the supervisor then called the physician and called for non-emergency ambulance. LVN 1 admitted that Resident 1 ' s low PLT count could cause internal bleeding. LVN 1 also admitted that Resident 1 ' s consistently bleed through his foley catheter (a medical device used to drain fluids from or deliver medications and other treatments directly into the body). LVN 1 confirmed that bleeding would be categorized as an emergency and that an emergency health issue required emergency services via 911.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the DON on [DATE] at 2 pm, the DON stated that Resident 1 had a critical low PLT count of 35, 000 on [DATE]. The labs were reordered to confirm the result which came back at 33,000 on [DATE]. The DON stated that Resident 1 was not sent to GACH upon confirmation of the critical low PLT count on [DATE] because there was no change of condition. The DON defined a change in condition as a change in a resident ' s baseline. The DON admitted that Resident 1 ' s critical PLT count as a change in condition. The DON stated that the physician must be notified immediately when a critical lab is received and sent to GACH via 911, otherwise the resident will be at risk for bleeding.</p> <p>During an interview with Medical Doctor (MD) 1 on [DATE] at 11:35 am, MD 1 stated the facility had reported the PLT count of 35,000 on [DATE] which was a pretty sizable drop given that Resident 1 ' s level was at 113, 000 while at GACH. MD 1 reordered a second set to confirm the critical level. MD 1 stated that the facility then called to report the confirmation level on [DATE] which was no at 33, 000. MD 1 gave orders to transfer Resident 1 emergently via 911 because there is a risk of bleeding out if the PLT count continued to drop which may result in death. MD 1 was not aware that the facility has received the second set of results on [DATE]. MD1 stated critical results must be reported to the physician immediately.</p> <p>During a review of the facility ' s Policy and Procedure (P&P) titled, Lab and Diagnostic Test Results - Clinical, reviewed [DATE], the P&P indicated,</p> <p>When test results are reported to the facility, a nurse will first review the results.</p> <p>a. If staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow or coordinate the procedure.</p> <p>Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results:</p> <p>a. Whether the physician has requested to be notified as soon as a result is received.</p> <p>b. Whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors).</p> <p>During a review of the facility ' s P&P titled, Competency of Nursing Staff, reviewed [DATE], the P&P indicated, All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law, the same P&P indicated, Demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care.</p>		