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	03/05/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview and record review, the facility failed to develop and implement a comprehensive care plan that meet the care/services based on the resident ' s individual assessed needs for one of five sampled resident (Resident 1) by failing to ensure a baseline care plan was initiated and implemented for Resident 1 ' s pain management and left lower leg fracture with splint. This deficient practice had the potential to result negative impact on Resident 1 ' s health and safety, as well as the quality of care and services received. Findings: A review of Resident 1's Admission Record indicated that Resident 1 was admitted to the facility on [DATE] with diagnosis including fracture (broken bone) of left fibula (long, thin bone located in the lower leg) and osteoporosis (a condition in which bones become weak and brittle). A review of Resident 1's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool) dated 2/16/2025, MDS indicated Resident 1 has an intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring moderate to maximal assistance from staff for activities of daily living (ADLs- toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and sit to stand). A review of Resident 1 ' s Medical Record (MR), from 2/9/2025 to 3/4/2025, MR indicated no care plan was initiated and implemented for Resident 1 ' s pain management and left lower leg fracture with splint. During a concurrent interview and record review with the Director of Nursing (DON) on 3/5/2025 at 12:03 p.m. , DON verified missing care plans for Resident 1 ' s pain management and left lower leg fracture with splint. DON stated that baseline care plan should be initiated within 48 hours upon admission to be able to provide an individualized plan of care to the residents. A review of the facility ' s policy and procedures (P&P), titled, Care Plan-Baseline, reviewed on 12/16/2024, P&P indicated that the baseline care plan is developed within 48 hours of a resident ' s admission. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s P&P, titled, Pain Management, reviewed on 12/16/2024, P&P indicated that an individualized, interdisciplinary plan of care will be developed and include: Addressing/treating underlying causes of pain to the extent possible. Non-pharmacological and pharmacological approaches Using specific strategies for preventing or minimizing different levels of sources of pain or pain related symptoms. A review of facility ' s P&P, titled, Skin Integrity Management, reviewed on 12/16/2024, P&P indicated to develop comprehensive, interdisciplinary plan of care including prevention and wound treatments as indicated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on observation, interview, and record review, the facility failed to ensure assessment and monitoring of the left lower leg splint to one of one sampled resident (Resident 1). This deficient practice has the potential for Resident 1 to develop complications such as skin breakdown and possibly compartment syndrome (excessive pressure builds up inside an enclosed muscle space in the body which slows the flow of blood, oxygen and nutrients to and from the affected tissue). Findings: A review of Resident 1's Admission Record indicated that Resident 1 was admitted to the facility on [DATE] with diagnosis including fracture (broken bone) of left fibula (long, thin bone located in the lower leg) and osteoporosis (a condition in which bones become weak and brittle). A review of Resident 1's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool) dated 2/16/2025, MDS indicated Resident 1 has an intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring moderate to maximal assistance from staff for activities of daily living (ADLs- toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and sit to stand). MDS also indicated Resident 1 was at risk for developing pressure ulcers/injuries (injury to skin and underlying tissue resulting from prolonged pressure on the skin). A review of Resident 1 ' s Medical Record (MR), from 2/9/2025 to 3/5/2025, MR indicated no documentation of assessment and monitoring of Resident 1 ' s left lower leg splint. During an observation on 3/5/2025 at 10:36 a.m., Resident 1 was observed with left lower leg splint. During a concurrent interview and record review with the Director of Nursing (DON) on 3/5/2025 at 12:03 p.m. , DON verified missing documentation on assessment and monitoring Resident 1 ' s left lower leg splint. DON stated that they are supposed to assess and monitor the site every shift with a physician order to make sure no complications A review of the facility ' s policy and procedure (P&P), titled, Skin Integrity Management, reviewed on 12/16/2024, P&P indicated that facility will provide safe and effective care to prevent occurrence of pressure ulcers, manage treatment and promote healing of all wounds. P&P indicated to perform skin inspection on admission/re-admission, weekly for the first month, quarterly and with significant change in condition. P&P also indicated to perform daily monitoring of wounds or dressing for presence of complications or declines and document.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview, and record review, the facility failed to ensure sufficient nursing staff was available to provide nursing and related services to meet the resident ' s needs safely and in a manner that promotes each resident ' s rights, physical, mental, and psychosocial well-being for three of five sampled residents (Residents 1, 4 and 5) by failing to: 1. Ensure prompt assistance with basic care for Resident 1. 2. Ensure scheduled showers were provided to Residents 4 and 5. These deficient practices resulted in Residents 1 waiting for more than three hours for basic care, while Resident 4 and 5 not receiving the scheduled shower which has the potential to affect the quality of life for Residents 1, 4 and 5. Findings: 1. A review of Resident 1's Admission Record indicated that Resident 1 was admitted to the facility on [DATE] with diagnosis including fracture (broken bone) of left fibula (long, thin bone located in the lower leg) and osteoporosis (a condition in which bones become weak and brittle). A review of Resident 1's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool) dated 2/16/2025, MDS indicated Resident 1 has an intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and requiring moderate to maximal assistance from staff for activities of daily living (ADLs- toileting hygiene, shower/bathing self, upper and lower body dressing, repositioning from sit to lying and sit to stand). MDS also indicated Resident 1 has frequent episodes of incontinence (having no or insufficient voluntary control over urination or defecation) with urine. During an interview with Resident 1 on 3/5/2025 at 10:36 a.m., Resident 1 stated that she (Resident 1) had to wait more than three hours to get assistance for incontinence care. During an interview with the Certified Nursing Assistant 1 (CNA1) on 3/5/2025 at 11:32 a.m., CNA1 stated that Resident 1 needed to wait longer before she (CNA1) was able to assist her (Resident 1). During an interview with the Director of Nursing (DON) on 3/5/2025 at 12:03 p.m., DON stated that they have to assist the resident as soon as possible and that waiting for three hours to get the care was too long and unacceptable. A review of facility ' s policy and procedure (P&P), titled, Activities of Daily Living, Supporting, reviewed on 12/16/2024, P&P indicated that Residents will be provided with care, treatment and services as appropriate to maintain or improve the ability to carry out ADLs. P&P also indicated that Residents who are unable to carry out ADLs independently will received the services necessary to maintain good nutrition, grooming and personal hygiene. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a. A review of Resident 4's Admission Record indicated that Resident 4 was admitted to the facility on [DATE] with diagnosis including Parkinson ' s Disease (a disorder in the brain that affects movement, often including tremors), epilepsy (a disorder in which a nerve cell activity in the brain is disturbed causing seizure [a sudden, uncontrolled electrical disturbance in the brain]) and dementia (loss of cognitive functioning-thinking, remembering, and reasoning). A review of Resident 4's MDS dated [DATE], MDS indicated Resident 4 has severely impaired cognition for daily decision-making and requiring maximal assistance from staff for ADLs. A review of Resident 4 ' s ADLs flowsheet, dated 3/5/2025, ADLs flowsheet indicated no documentation that Resident 4 was bathed or showered. A review of facility ' s shower schedule, dated 3/5/2025, shower schedule indicated Resident 4 was scheduled to shower every Wednesday. During an interview with CNA1 on 3/5/2025 at 11:32 a.m., CNA1 stated that she (CNA1) was not able to shower Resident 4 due to not having enough time and that she (CNA1) got busy with four residents needing to be showered. 2b. A review of Resident 5's Admission Record indicated that Resident 5 was admitted to the facility on [DATE] with diagnosis including atrial fibrillation (AF-an irregular rapid heart rate that commonly causes poor blood flow), generalized weakness and abnormalities with gait (ambulation) and mobility. A review of Resident 5's MDS dated [DATE], MDS indicated Resident 5 has moderately impaired cognition for daily decision-making and requiring moderate assistance from staff for ADLs. A review of Resident 5 ' s ADLs flowsheet, dated 3/5/2025, ADLs flowsheet indicated no documentation that Resident 5 was bathed or showered. A review of facility ' s shower schedule, dated 3/5/2025, shower schedule indicated Resident 5 was scheduled to shower every Wednesday. During an interview with Certified Nursing Assistant 2 (CNA2) on 3/5/2025 at 11:42 a.m., CNA2 stated that she (CNA2) was not able to shower Resident 5 due to having too many residents assigned to her (CNA2) to shower. During an interview with the DON on 3/5/2025 at 12:03 p.m., DON stated that residents should be showered twice a week and as needed unless resident refused. A review of the facility ' s policy and procedure (P&P), titled, Activities of Daily Living, Supporting, reviewed on 12/16/2024, P&P indicated that Residents will be provided with care, treatment and services as appropriate to maintain or improve the ability to carry out ADLs. P&P also indicated that Residents who are unable to carry out ADLs independently will received the services necessary to maintain good nutrition, grooming and personal hygiene. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility ' s P&P, titled, Bath, Shower/Tub reviewed on 12/16/2024, P&P indicated that facility promote cleanliness, provide comfort to the resident and to observe the condition of the resident ' s skin. A review of facility ' s Job Description (JD), titled, Certified Nursing Assistant, reviewed on 12/16/2024, JD indicated that CNAs will assist residents in accordance to their needs ranging from minimal assistance to total dependent care on ADLs.