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	03/12/2025

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on interview and record review, the facility failed to ensure staff properly assessed and document for one of three sampled residents (Resident 1) on Preadmission Screening and Resident Review, (PASARR- a federally required screening to help identify individuals with possible serious mental illnesses requiring a specialized follow up evaluation). The deficient practice resulted in Resident 1 not receiving a PASRR II (assessment that determines if resident's mental condition could be met in the nursing facility or if the individual requires specialized services) and subsequent follow up. Findings: During a review of the admission record for Resident 3 indicated Resident 3 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including metabolic encephalopathy (a brain dysfunction caused by underlying conditions affecting the body's metabolism, leading to impaired brain function and potentially symptoms like confusion, memory loss, or coma), schizophrenia (a mental illness that is characterized by disturbances in thought), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 12/18/2024, indicated Resident 1 had moderate cognitive impairment (a stage of cognitive decline that affects short-term memory and the ability to complete complex tasks). The same MDS indicated Resident 1 had feelings of feeling down, depressed, hopeless, and feeling bad about herself/she was a failure/let herself or family down seven to 11 days. Resident 1 ' s MDS indicated, Resident 1 required between supervision or touching assistance and partial/moderate assistance for all Activities of Daily Living such as: (ADLs- routine tasks/activities such as eating, oral hygiene, toileting hygiene, personal hygiene, lower/upper body dressing, putting on/taking off footwear). During a review of Resident 1 ' s care plan titled Focus: Resident 1 exhibits verbal behaviors aeb (as evidenced by) yelling at staff and becoming physical with staff members related to: Cognitive loss/Dementia, Psychiatric Disorder(s): Schizophrenia, mood disorder dated 12/10/2024, indicated approaches for staff to evaluate the nature and circumstances (i.e., triggers) of the [verbal behavior] with resident/patient and/or resident representative. Remove resident/patient from environment, if needed. Gently guide the resident from the environment while speaking in a calm, reassuring voice. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s care plan titled Resident/patient exhibits or is at risk for distressed/fluctuating mood symptoms related to episodes of paranoia dated 12/17/2024, Provide an environment that is conducive to the residents/patients ability to get adequate sleep and maintain resident's/patient's preferred sleep/wake schedule. Allow time for expression of feelings; provide empathy, encouragement, and reassurance. During a review of Resident 1 ' s PASARR level I dated 12/10/2024, the PASRR level I indicated, the screening was no completed. Section III-Mental Illness of the PASARR question 10 Suspected Mental Illness. After observing the Individual or reviewing their records, do you believe the Individual may be experiencing serious depression or anxiety, unusual or abnormal thoughts, extreme difficulty coping, or significantly unusual behaviors or does the individual actively engage in community mental health services? Was not answered. During a review of Resident 1 ' s Situation Background Assessment and Recommendation (SBAR: a form that is a documentation of a complete assessment in response to a change in condition) form dated 1/14/2025 at 11:13 pm, indicated Resident 1 had a change in condition (COC, a sudden clinically important decline from a patient's baseline in physical, cognitive, behavioral, or functional abilities) behavioral symptoms identified as verbal aggression. The SBAR indicated, Patient (Resident 1) became increasingly agitated because she wanted her medication scheduled to be changed from 2100 to 19:30 (9pm to 7:30 pm) Patient (Resident 1) stated, I will pull your hair if you don't give me the medication. During a review of Resident 1 ' s SBAR dated 3/3/2025 at 6:30 pm indicated, Resident 1 had alleged that her (Resident 1) roommate said inappropriate comments. The SBAR indicated, Patient (Resident 1) get agitated often or behavioral changes happens frequently, she create situation to be getting extra attention. During an interview with the Minimal Data Set Nurse (MDSN) on 3/7/25 at 12:01 pm, the MDSN stated that every admission packet of a resident being admitted from General Acute Care Hospital (GACH) must include a PASRR level I and II level II if a resident is determined to have serious mental illness. The MDSN stated that the facility reviews and ensures that the PASRR is accurate. The facility initiates another PASRR assessment if it is inaccurate during the first clinical team (Director of Nursing [DON], Social Services, MDSN, Medical Records Director) meeting held within the first 24 hours of the resident ' s admission. MDSN confirmed that Resident 1 should have had a PASRR level II completed due to her schizophrenia diagnosis. A PASRR level II triggers additional support from the Department of Mental Health (DMH). During a concurrent interview and record review of Resident 1 ' s PASRR level I with the DON on 3/11/25 at 12:20 pm, the DON admitted that the evaluation was inaccurate because question number 10 was not answered which may have prompted that PASRR level II be completed. The DON admitted that the facility should have reviewed and worked to rectify the inaccuracy of PASRR level I. The DON admitted that support from the DMH personnel may have assisted with finding the right plan of care to prevent escalation of behaviors. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, BEHAVIOR MANAGEMENT, revised 12/16/2024, the P&P indicated, Resident exhibiting behavioral symptoms will be individually evaluated to determine the behavior. The interdisciplinary team identifies underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental causes that contribute to changes in the Resident's behavior. The same P&P indicated, staff must ensure that a resident Whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty does not display a pattern of decreased social intervention and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on interview and record review, the facility failed to notify a physician after a significant change (COC- a sudden clinically important decline from a patient's baseline in physical, cognitive, behavioral, or functional abilities) in the mental or physical condition of a resident who has mental illness for one of the three sampled residents (Resident 1). This deficient practice resulted in Resident 1 ' s increased behavioral, psychiatric, and mood-related symptoms requiring General Acuate Care Hospital (GACH) admission on 3/6/2025. Cross reference F645and F656. Findings: During a review of the admission record for Resident 3 indicated Resident 3 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including metabolic encephalopathy (a brain dysfunction caused by underlying conditions affecting the body's metabolism, leading to impaired brain function and potentially symptoms like confusion, memory loss, or coma), schizophrenia (a mental illness that is characterized by disturbances in thought), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 12/18/2024, indicated Resident 1 had moderate cognitive impairment (a stage of cognitive decline that affects short-term memory and the ability to complete complex tasks). The same MDS indicated Resident 1 had feelings of feeling down, depressed, hopeless, and feeling bad about herself/she was a failure/let herself or family down seven to 11 days. Resident 1 ' s MDS indicated, Resident 1 required between supervision or touching assistance and partial/moderate assistance for all Activities of Daily Living such as: (ADLs- routine tasks/activities such as eating, oral hygiene, toileting hygiene, personal hygiene, lower/upper body dressing, putting on/taking off footwear). During a review of Resident 1 ' s Situation Background Assessment and Recommendation (SBAR: a form that is a documentation of a complete assessment in response to a change in condition) form dated 1/14/2025 at 11:13 pm, indicated Resident 1 had a change in condition (COC, a sudden clinically important decline from a patient's baseline in physical, cognitive, behavioral, or functional abilities) behavioral symptoms identified as verbal aggression. The SBAR indicated, Patient (Resident 1) became increasingly agitated because she wanted her medication scheduled to be changed from 2100 to 19:30 (9pm to 7:30 pm) Patient (Resident 1) stated, I will pull your hair if you don't give me the medication. The same SBAR indicated that the physician was not yet informed about the COC. During a review of Resident 1 ' s SBAR dated 3/3/2025 at 6:30 pm indicated, Resident 1 had alleged that her (Resident 1) roommate said inappropriate comments. The SBAR indicated, Patient (Resident 1) get agitated often or behavioral changes happens frequently, she create situation to be getting extra attention. The SBAR did not include any recommendations from the physician (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s SBAR dated 3/6/2025 at 9:25 am, indicated, Resident 1 was evaluated for Altered Mental Status (AMS). The same SBAR indicated that Resident 1 had personality changes and AMS. Resident 1 was sent to Emergency Department (ED) for further evaluation. During a review of nursing notes dated 3/6/2025 at 9:26 am indicated, Pt attempted to choke herself with hair bonnet. Assisted by license nurses, 3 CNA's, activities and maintenance director. Removed bonnet and attempted to redirect the pt (Resident 1) . Fire department responded for 5150 (a temporary, involuntary psychiatric hold in California, where a person is taken into custody for up to 72 hours for evaluation and treatment if they are deemed a danger to themselves or others, or are gravely disabled due to a mental illness) followed by LAPD (Pos Angeles Police Department) officers Pt (Resident 1) transferred via 911 (the emergency telephone number in the United States and Canada used to contact police, fire, or ambulance services for immediate help) to GACH. During a concurrent interview and record review of Resident 1 ' s SBAR for 1/14/2025 with Licensed Vocational Nurse (LVN) 2 on 3/10/2025 at 9:27 am, LVN 2 admitted that there was no documented evidence that the physician was notified about the change. She stated that the physician must be informed about all changes in condition. During a concurrent interview and record review of Resident 1 ' s SBAR dated 1/14/2025 with the Director of Nursing (DON) on 3/11/2025 at 12:20 pm confirmed that there was no documented evidence that the physician was called and informed. The DON stated that notifying the physician is important because they (physician) will give new orders or instructions on how to handle the behaviors presented. During a review of the facility's policy and procedure (P&P) titled, Change in Condition: Notification of, revised 12/16/2024, the P&P indicated, To ensure residents, family, legal representatives, and physicians are infom1ed of changes in the resident's condition. The same P&P indicated, A Facility must immediately inform the resident, consult with the Resident's physician and/or NP (Nurse Practitioner), and notify, consistent with his/her authority, Resident Representative where there is: An accident involving the Resident. A significant change in the Resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications). A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new fom1 of treatment); or A decision to transfer or discharge the Resident from the Center.

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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** 45524 Based on observations and record reviews, the facility failed to monitor one of the three sampled residents (Resident 1) by failing to: 1. Update Resident 1 ' s care plan for at risk for physical behavior towards others, after a Change of Condition (COC) on 1/14/2025 and 2/24/2025. 2. create an individualized and specific interventions for quetiapine fumarate (Seroquel- an antipsychotic medication that treats several kinds of mental health conditions including schizophrenia and bipolar disorder) and schizophrenia. This failure resulted in the escalation of behaviors requiring Resident 1 to be admitted to General Acute Care Hospital (GACH) on 3/6/2025. Findings: Cross reference F645. During a review of the admission record for Resident 3 indicated Resident 3 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including metabolic encephalopathy (a brain dysfunction caused by underlying conditions affecting the body's metabolism, leading to impaired brain function and potentially symptoms like confusion, memory loss, or coma), schizophrenia (a mental illness that is characterized by disturbances in thought), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 12/18/2024, indicated Resident 1 had moderate cognitive impairment (a stage of cognitive decline that affects short-term memory and the ability to complete complex tasks). The same MDS indicated Resident 1 had feelings of feeling down, depressed, hopeless, and feeling bad about herself/she was a failure/let herself or family down seven to 11 days. Resident 1 ' s MDS indicated, Resident 1 required between supervision or touching assistance and partial/moderate assistance for all Activities of Daily Living such as: (ADLs- routine tasks/activities such as eating, oral hygiene, toileting hygiene, personal hygiene, lower/upper body dressing, putting on/taking off footwear). During a review of Resident 1 ' s care plan titled Focus: Resident 1 exhibits verbal behaviors aeb (as evidenced by) yelling at staff and becoming physical with staff members related to: Cognitive loss/Dementia, Psychiatric Disorder(s): Schizophrenia, mood disorder dated 12/10/2024, indicated approaches for staff to evaluate the nature and circumstances (i.e., triggers) of the [verbal behavior] with resident/patient and/or resident representative. Remove resident/patient from environment, if needed. Gently guide the resident from the environment while speaking in a calm, reassuring voice. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s care plan titled Resident/patient exhibits or is at risk for distressed/fluctuating mood symptoms related to episodes of paranoia dated 12/17/2024, Provide an environment that is conducive to the residents/patients ability to get adequate sleep and maintain resident's/patient's preferred sleep/wake schedule. Allow time for expression of feelings; provide empathy, encouragement, and reassurance During a review of Resident 1 ' s Situation Background Assessment and Recommendation (SBAR: a form that is a documentation of a complete assessment in response to a change in condition) form dated 1/14/2025 at 11:13 pm, indicated Resident 1 had a change in condition (COC, a sudden clinically important decline from a patient's baseline in physical, cognitive, behavioral, or functional abilities) behavioral symptoms identified as verbal aggression. The SBAR indicated, Patient (Resident 1) became increasingly agitated because she wanted her medication scheduled to be changed from 2100 to 19:30 (9pm to 7:30 pm) Patient (Resident 1) stated, I will pull your hair if you don't give me the medication. During a review of Resident 1 ' s physician ' s order dated 1/24/2025 indicated, Seroquel oral tablet. Give 250mg by mouth at bedtime for schizophrenia m/b (manifested by) anger outburst. During a review of Resident 1 ' s physician ' s order dated 2/28/2025 indicated, Seroquel 50 mg oral tablet. Give 1 tablet by mouth every 6 hours as needed for agitation and give 1 tablet by mouth one time a day for schizophrenia aeb (as evidence by) agitation related to schizophrenia. During a review of Resident 1 ' s SBAR dated 3/3/2025 at 6:30 pm indicated, Resident 1 had alleged that her (Resident 1) roommate said inappropriate comments. The SBAR indicated, Patient (Resident 1) get agitated often or behavioral changes happens frequently, she create situation to be getting extra attention. During an interview with the Minimal Data Set Nurse (MDSN) on 3/7/2025 at 12:01 pm, MDSN stated that a care plan is a tool to address pt (resident) needs to provide the right care during a resident ' s stay. MDSN stated that all residents must have care plans about their diagnoses, medications, and treatments such as skin care treatments. MDSN stated that care plans must be initiated and updated if there is a change in conditions. Interventions for medications must be specific to each medication such as the exact side effects to observe and when to report. During a concurrent interview and record review of Resident 1 ' s chart with Licensed Vocational Nurse (LVN) 2 on 3/10/2025 at 9:27 am, LVN 2 stated that a care plan must be initiated when there is a COC or updated when one had already been developed because that is how nursing staff know what the needs of a resident are and ensure safety and quality of life. LVN 2 confirmed that the care plan for Seroquel did not list the specific interventions nursing staff should have been monitoring. LVN 2 admitted that the behavior monitoring care plan was not updated when Resident 1 had a change in condition on 1/14/2025 and 2/24/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 1 ' s chart with the Director of Nursing (DON) on 3/11/2025 at 12:20 pm admitted that a care plan should have been developed/updated when she had behavioral changes on 1/14/25 to show what the plan is for the resident. The potential could be that staff may miss something that could help with the Resident 1 ' s behavior. The DON confirmed admitted that the behavior care plan should have included the types of behavior Resident 1 was presenting. The DON admitted stated that for the Seroquel, the interventions must include the specifics that the facility were monitory as listed in the behavior monitoring. During a review of the policy and procedure (P&P) titled, CARE PLAN COMPREHENSIVE, revised 12/16/2024, the P&P indicated, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident' s medical, physical, mental and psychosocial needs shall be developed for each resident. The same P&P indicated the following procedures which included: Each resident ' s comprehensive care plan is designed to: - Incorporate identified problem areas. - Build on the resident's individualized needs, strengths, preferences. Assessments of residents are ongoing and care plans arc reviewed and revised as information about the resident and the resident's condition change.