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	04/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Care Center	8167 West Third St. Los Angeles, CA 90048

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 45777 Based on observation, interview, and record review, the facility failed to assess and ensure one of three sampled residents (Resident 11) had an order to self-administer a medication. This failure had a potential for Resident 11 to over or under medicate herself which could lead to complications. Findings: During a record review of Resident 11's Admission Record, the Admission Record indicated the facility admitted Resident 11 on 5/12/2023 with diagnosis including type 2 diabetes mellitus (a medical condition characterized by the body's inability to regulate blood sugar levels) hyperglycemia (too much sugar in the blood). During a review of Resident 11's Minimum data Set (MDS, a resident assessment tool), dated 2/10/2025, the MDS indicated Resident 11's cognition (thought process) was intact. The MDS indicated Resident 11 needed set up assistance with toilet hygiene and personal hygiene, partial moderate assistant (helper does less than half the effort) with shower bathe self, upper and lower body dressing. During an observation and interview on 4/12/2025 at 9am, the bedside of Resident 11, Resident 11 had two tubes of prescription medication triamcinolone acetonide ointment 0.1 %. The directions indicated to apply to left axillary (arm pit) and right buttocks rash. Resident 11 stated the CNAs (in general) would apply the medication to her buttocks daily or whenever she (Resident 11) would request the cream to be applied. Resident 11 stated the medication was prescribed from her doctor outside the facility. During an interview on 4/12/2025 at 3:25 p.m., with CNA 4, CNA 4 stated after cleaning Resident 11 she (CNA4) would apply the triamcinolone acetonide ointment to Resident 11's bilateral (both) armpits, buttocks, and in between Resident 11's thighs. CNA 4 stated Resident 11 told her the triamcinolone acetonide ointment was approved and stated she (CNA4) thought it was ok to apply it. CNA4 stated she did not ask the charge nurse (unidentified). CNA 4 stated it was important not to give any medication to a resident because she (CNA4) was not a licensed nurse, and it could cause harm to the resident. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/12/2025 at 3:40p.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated before a resident (in general) could administer their own medications, the licensed nurses (in general) needed to complete an assessment form called Self Administration of Medications and would need to call the doctor and create a care plan. LVN stated there could be a bad outcome because Resident 1 was alert and her baseline could change. LVN 3 stated if a medication was left at the bedside, Resident 11 could ingest the medication or overmedicate herself. During an interview on 4/13/2025 at 10:14 a.m., with the Director of Nursing (DON), the DON stated medication should not be left at the resident's bedside and there needs to be an order. The DON stated this could be dangerous the because the medication cream was left at the bedside the resident was at risk of getting too much of the medication. During a review of the facility's undated Policy and Procedures (P&P) titled, Administering Medications, the P&P indicated only persons licensed or permitted by the state to prepare, administer document the administration of medications may do so.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 46144 Based on observation, interview, and record review the facility failed to provide warm water for one of two sampled residents (Resident 2) to make tea during meals. This failure had the potential for Resident 2's preferences not to be honored and for Resident 2 to feel frustrated. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 3/4/2023 with diagnoses that included muscle weakness (a decrease in muscle strength and the ability to move the body, lack of coordination (a failure in the organization and communication of patient care activities across different healthcare providers and settings), and chronic kidney disease (a progressive, irreversible condition where kidney declines significantly over time). During a review of Resident 2's Food Preference Interview, dated 3/6/2023, the Food Preference Interview indicated Resident 2 preferred to drink tea for breakfast, lunch, and dinner. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 2/17/2025, the MDS indicated Resident 2's cognition (ability to learn, reason, remember, understand, and make decisions) was able to usually understand. The MDS indicated Resident 2 required substantial/maximal assist (helper does more than half the effort; helper lifts or holds trunk or limbs and provide more than half the effort) on staff for showering, dressing, and toileting hygiene. During a review of Resident 2's History and Physical (H&P), dated 3/27/2025, the H&P indicated Resident 2 had the capacity to make needs known but could not make medical decisions. During an interview on 4/11/2025 at 7:51 p.m., with Resident 2, Resident 2 stated, that her preference was to have warm tea three times a day. Resident 2 stated, It was frustrating to have to keep asking for hot water every time; when they (the staff) already know what I prefer tea with my meals. During an observation on 4/13/2025 at 7:30 a.m., in Resident 2's room, there was no tea bag on Resident 2's breakfast tray and no hot water. During an interview on 4/13/2025 at 8:15 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated there was no tea bag on Resident 2's breakfast tray. CNA 1 stated she did not bring the hot water to the resident because there was no tea bag on the breakfast tray. CNA 1 stated she was aware Resident 2 preferred to have tea regularly but since she did not see the tea bag, she (CNA1) did not provide the hot water. CNA 1 stated it was important to offer the tea bag and hot water to the resident even if it was does not on the meal tray. CNA 1 stated Resident 2 loved tea. CNA 1 stated if she did not get her (Resident 2) tea with her meals; it could not make her feel well. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 4/13/2025 at 9:59 a.m., with the Dietary Manager, Resident 2's Food Preference Interview, dated 3/6/2023, was reviewed. The Dietary Manager stated the Food Preference Interview indicated Resident 2 preferred to drink tea for breakfast, lunch, and dinner. The Dietary Manager stated Resident 2 liked to drink tea and the food preference sheet indicated she (Resident 2) wanted the tea three times a day. The Dietary Manager stated the hot water was to be provided to Resident 2 by the CNAs (in general) when the trays arrived. The Dietary Manager stated it was important for the facility to provide Resident 2 with the tea daily to maintain a homelike environment and the resident dignity. The Dietary Manager stated if the facility did not provide Resident 2 with services, she (Resident 2) could become depressed (characterized by persistent low mood and a loss of interest in activities) and would make the resident unhappy. During a review facility's policy and procedure (P&P) titled, Resident Food Preferences, dated 7/2017, the P&P indicated the Dietary Manager would complete a dietary profile for residents to reflect current food preferences and nutritional needs upon admission, readmission, quarterly, annually or as needed. The P&P indicated the facility would provide residents with meals consistent with their preferences, as indicated on their tray card.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46144 Based on observation, interview, and record review the facility failed to ensure one of two sampled residents (Resident 2) had a homelike environment (creating a setting that feels more like a personal resident than a hospital-like institution) due to chip paint on the wall. This failure had the potential for Resident 2 not to have a comfortable homelike environment. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 3/4/2023 with diagnoses that included muscle weakness (a decrease in muscle strength and the ability to move the body, lack of coordination (a failure in the organization and communication of patient care activities across different healthcare providers and settings), and chronic kidney disease (a progressive, irreversible condition where kidney declines significantly over time). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 2/17/2025, the MDS indicated Resident 2's cognition (ability to learn, reason, remember, understand, and make decisions) was usually able to understand. The MDS indicated Resident 2 required substantial/maximal assist (helper does more than half the effort; helper lifts or holds trunk or limbs and provide more than half the effort) on staff for showering, dressing, and toileting hygiene. During a review of Resident 2's History and Physical (H&P), dated 3/27/2025, the H&P indicated Resident 2 had the capacity to make needs known but could not make medical decisions. During a concurrent observation and interview on 4/11/2025 at 7:51 p.m., with Resident 2, in Resident 2's room, the wall in Resident 2's room had scattered chip paint. Resident 2 stated the chip paint on the wall made her feel upset. During a concurrent observation and interview on 4/11/2025 at 8:11 p.m., with Licensed Vocational Nurse 1 (LVN1), in Resident 2's room, Resident 2's room had scattered chip paint on the wall. LVN 1 stated the chip paint should be addressed right away. LVN 1 stated it was unacceptable to have the wall looking that way. LVN 1 stated it could make Resident 2 feel like she (Resident 2) was not living in a home like environment. During an interview on 4/13/2025 at 9:02 a.m., with the Maintenance Director, the Maintenance Director stated the chip paint on the wall was reported to him on the night of 4/11/2025. The Maintenance Director stated, I don't think the chip paint on the wall just happened on a Friday night while the resident is sleeping. The Maintenance Director stated, I make rounds every week. The Maintenance Director stated it was important to keep the rooms ready and organized for the residents (in general) to feel like they were at home. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of policy and procedure (P&P) titled, Maintenance Service, dated 12/2009, the P&P indicated the maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. The P&P indicated maintaining the building in good repair and establishing priorities in providing repair service. During a review of facility's policy and procedure (P&P) titled, dated 2/2021, the P&P indicated residents were provided with a safe, clean, comfortable and homelike environment. The P&P indicated the facility staff and management maximized, the extent possible, the characteristics of the facility that reflected a personalized, homelike setting including clean, sanitary, and orderly environment.

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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** 46144 Based on observation, interview, and record review the facility failed to ensure one of six sampled residents (Resident 37) had a comprehensive care plan (a detail individualized document that outlines a patient's goals, needs, and the interventions needed to achieve them across various care settings) when the facility identified Resident 37 had a hard time hearing. This failure had the potential not to meet Resident 37's needs. Findings: During a review of Resident 37's Admission Record, the Admission Record indicated the facility admitted Resident 37 to the facility on [DATE] with diagnoses of anxiety disorder (a mental health condition characterized by excessive and persistent worry and fear), major depressive disorder (a mental health condition characterized by a persistently low mood, loss of interest, or pleasure in activities), and atherosclerotic heart disease (a buildup of fats on the artery walls). During a review of Resident 37's History and Physical (H&P), dated 9/6/2024, the H&P indicated Resident 37 did not have the capacity to understand and make decisions. During a review of Resident 37's Minimum Data Set (MDS, a resident assessment tool), dated 2/5/2025 the MDS indicated Resident 37's cognition (ability to learn, reason, remember, understand, and make decisions) usually understood others. The MDS indicated Resident 37 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) on staff for showering, toileting hygiene, and dressing. During an observation on 4/11/2025 at 8:20 p.m., in Resident 37's room, Resident 37 had a hard time hearing when conversing about the facility. During a concurrent observation and record review on 4/12/2025, at 5:12 p.m., with Social Services Director (SSD), the SSD stated Resident 37 had trouble hearing some of the conversation when speaking to the resident. The SSD stated a care plan should have been developed to ensure the staff was aware of the resident communication needs. During a concurrent interview and record review on 4/12/2025 at 5:25 p.m., with Registered Nurse 3 (RN 3), RN 3 stated there was no care plan developed when Resident 37 became hard of hearing. RN 3 stated the visitor had trouble communicating with Resident 37 and had asked to get her some hearing aids (a device worn in or behind the ear designed to amplify sound for individuals who have difficulty hearing). RN 3 stated a care plan should have been developed to try different interventions such as a communication board, an amplified hearing device (an electronic device that boosts an audio signal), and speaking slowly. RN 3 stated it was important to develop a care plan so the resident (Resident 37) could hear the staff and visitors and communicate her needs. (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 facility's procedure and policy (P&P) titled, Care Plan Comprehensive, dated 8/2021, the P&P indicated an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, physical, mental, and psychosocial needs shall be developed for each resident. The P&P indicated for the facility to identify the professional services that are responsible for each element of care. The P&P indicated to aid in preventing or reducing declines in the resident's functional status and/or functional levels. The P&P indicated to reflect currently recognized professional standards of practice for problem areas and conditions.

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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** 48903 Based on observation, interviews and record reviews, the facility failed to provide necessary treatment and services to minimize the risk of development of pressure injuries (PIs, areas of damaged skin caused by staying in one position for too long) for three of four sampled residents (Resident 28, Resident 35, and Resident 71) by failing to: -Ensure to provide a properly functioning low air loss mattress (LALM, pressure relieving mattress that is filled with air) for Resident 28. -Ensure to set Resident 35 and Resident 71's LALM at the correct weight setting in accordance with the attending physician's (MD) order. These failures had the potential for Resident 28, Resident 35, and Resident 71 to develop PIs and skin wounds to worsen. Findings: a. During a review of Resident 28's Admission Record, the Admission Record indicated the facility admitted Resident 28 on 12/24/2018 with diagnoses of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), and contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) to both legs. During a review of Resident 28's Minimum Data Set (MDS, a resident assessment tool), dated 1/26/2025, the MDS indicated Resident 28 did not have intact cognition and required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, showering, upper/lower body dressing, personal hygiene and putting on/taking off footwear; required set up or clean up assistance (helper sets up or cleans up) for eating and oral hygiene. During a review of Resident 28's Order Summary Report (OSR) dated 4/12/2025, the OSR indicated Resident 28 was ordered a LALM to be set at 65 lbs., to 110 lbs., for wound prevention. During a review of Resident 28's Care Plan titled, At risk for further skin breakdown related to impaired mobility with history of pressure ulcers, dated 8/13/2022, the care plan indicated the nursing interventions included to use the LALM as ordered and to check the LALM settings. During a review of Resident 28's Care Plan titled, Resident at risk for skin breakdown related to actual skin breakdown, indicated the LALM would be set at 65-110 lbs., with interventions including to monitor the LALM for proper functioning and setting every shift. During an observation on 4/11/2025, at 7:22 PM, Resident 28's LALM was observed with tape and making a loud hissing noise. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 4/11/2025, at 7:27 PM with Licensed Vocational Nurse 4 (LVN 4), Resident 28's LALM was observed. LVN 4 stated, The LALM of this resident is leaking air and there's tape all around the machine. If the machine is not working properly, it is not relieving the pressure from the resident's back and they can develop pressure injuries. b. During a review of Resident 71's Admission Record, the Admission Record indicated the facility admitted Resident 71 on 2/27/2025 with diagnoses that included ulcer of the left lower leg and an open wound of the left lower leg. During a review of Resident 71's MDS, dated [DATE], the MDS indicated Resident 71 had intact cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and required substantial/maximal assistance (helper does more than half the effort) for toileting hygiene, showering, lower body dressing and putting on/taking off footwear; required partial/moderate assistance (helper does less than half the effort) for upper body dressing; and required supervision (helper provides verbal cues or touching assistance) for eating and oral hygiene. During a review of Resident 71's OSR dated 3/26/2025, the OSR indicated Resident 71 was ordered a LALM to be set at 120 pounds (lbs., unit of measurement for weight). During a review of Resident 71's Clinical Physician Orders, the Clinical Physician Orders indicated Resident 71 weighed 103.5 lbs. on 4/2/2025. During a review of Resident 71's Care Plan titled, Resident actual skin breakdown due to vascular disease, dated 4/12/2025, the care plan indicated for Resident 71's bed to be set at 80-120 lbs. with interventions including to monitor the LALM for proper functioning and setting every shift. During an observation on 4/11/2025 at 8:06 PM, Resident 71's LALM was observed to be set at 355 lbs. During a concurrent record review and interview on 4/11/2025, at 8:07 PM with Registered Nurse 4 (RN 4), Resident 71's weight record was reviewed. RN 4 stated, On 4/2/2025 she weighed 103.5 lbs. The LALM should not be set at 355 lbs. because it's adding more pressure to her back and she can develop a pressure ulcer. During an interview on 4/13/2025 at 9:04 AM, the Director of Nursing (DON) stated that a LALM set at a higher setting than the resident's weight would add pressure to the resident's wounds, prevent proper healing, and worsen their skin condition. The DON stated that a leaking LALM must be replaced to properly prevent the deterioration of skin ulcers. 46144 c. During a review of Resident 35's Admission Record, the Admission Record indicated, Resident 35 was readmitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD] -a chronic lung disease causing difficulty in breathing), gastrotomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and dysphagia (difficulty swallowing). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 35's History and Physical (H&P), dated 6/23/2023, the H&P indicated Resident 35 had fluctuating capacity to understand and make decisions. During a review of Resident 35's MDS dated [DATE], the MDS indicated Resident 35's cognition (ability to learn, reason, remember, understand, and make decisions) was rarely able to understand. The MDS indicated Resident 35 was dependent (helper does all of the effort. Resident did none of the effort to complete the activity) for showering, dressing, and toileting hygiene. The MDS indicated Resident 35 was to have a pressure reducing device for bed. A review of the Physician's Orders / Order Summary Report, dated 9/20/2023, indicated Resident 35 was to have a LAL mattress with a Level 2, for wound prevention. During a concurrent interview and record review on 4/13/2025 at 2:19 p.m. with Director of Nursing (DON), Resident 35's Order Summary Report was reviewed. The DON stated Level 2 meant the LAL settings would be set for residents that weighed 120 lbs. The DON stated Resident 35 current weight was 82.3 lbs., and it was important to clarify the physician's orders so the staff could lessen the risk for skin breakdown. A review of the facility's policy and procedure titled, Skin Integrity Management, dated 12/16/2024 indicated the purpose was to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds. Staff continuously monitored and observed residents for changes and implements revisions to the plan of care as needed. Implement pressure ulcer prevention for identified risk factors.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on observation, interview, and record review the facility failed to provide a safe environment for two of two sampled residents (Resident 48 and Resident 11) by failing to ensure not to place an electrical extension cord in the residents' walk area. This failure had the potential for Resident 48 and Resident 11 to fall and sustain an injury. Findings: a. During a review of Resident 48's Admission Record, the Admission Record indicated the facility admitted Resident 48 on 4/1/2024 with diagnoses including acute kidney failure (rapid loss of the kidneys' ability to remove waste), chest pain, and muscle weakness. During a review of Resident 48's Minimum Data Set (MDS, a resident assessment tool) dated 2/28/2025, the MDS indicated Resident 48's cognitive skills (ability to think and reason) for daily decision-making was intact. The MDS indicated Resident 48 required set up or clean up assistance (helper provides verbal cues with and assistance) with shower/bathe self, lower body dressing, putting on /taking off footwear and walking ten feet. During a review of Resident 48's Care Plan Report dated 8/26/2024, the Care Plan Report, indicated Resident 48 was at risk for falls related to hoarding (difficulty discarding possessions), ambulatory, intervertebral disc disorders (wear and tear of the disc in the spine) with lumbar region radiculopathy (compression or irritation of nerve roots of the spine), muscle wasting and atrophy (a decrease in size), iron deficiency anemia (low level of healthy red blood cells), generalized anxiety disorder (excessive ongoing worry that is difficult to control), adjustment disorder (excessive reactions to stress that involve negative thoughts) with depressed mood (persistence feelings of sadness), and atherosclerotic heart disease (damage or disease of the heart). The Care Plan indicated the goal was for Resident 48 not to have falls with injury within 90 days. The Care Plan indicated the nursing interventions were to provide verbal cues for safety and sequencing when needed, reposition items as needed to location within visual field, and to provide resident/caregiver education for safe techniques to prevent falls. b. During a review of Resident 11's Admission Record, the Admission Record indicated the facility admitted Resident 11 on 5/12/2023 with diagnoses including type 2 diabetes mellitus (a medical condition characterized by the body's inability to regulate blood sugar levels) hyperglycemia (too much sugar in the blood), and hyperlipidemia unspecified (high level of fat in the blood). During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11's cognition (thought process) was intact. The MDS indicated Resident 11 needed set up assistance with toilet hygiene and personal hygiene, partial moderate assistant (helper does less than half the effort) with shower bathe self, upper and lower body dressing. (continued on next page)

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Sharon Care Center	8167 West Third St. Los Angeles, CA 90048

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/12/2025 at 9 a.m., in resident 48's room, there was an orange extension cord plugged in the bathroom outlet taped on the wall, the cord went down the wall, under the bathroom door on to the floor with tape stretching across the floor plugged into resident 11's bed. Resident 48 told the surveyor to look at the way maintenance set up the extension cord. Resident 48 stated he almost fell when he (Resident 48) went over to help his wife (unspecified date and time). Resident 48 stated it was not safe to have an extension cord on the floor. During an observation and interview on 4/12/2025 at 5:13 p.m., with the Maintenance Director, the Maintenance Director stated the extension cord had been plugged in the bathroom outlet for two weeks. The Maintenance Director stated the tape he (Maintence Director) placed to hold the extension cord in place was coming off. The Maintenance Director stated by placing the extension cord from the bathroom going to the resident's bed was not safe and stated someone could trip, fall, and sustain injuries. During an interview on 4/13/2025 at 10:14 a.m., with the Director of Nursing (DON), the DON stated placing an extension cord from the bathroom to the resident's bed was not safe and it could cause injury. The DON stated the residents could trip over the extension cord. During a review of the facility's undated policy and Procedure (P&P) titled, Electrical Safety for Residents, the P&P indicated the resident would be protected from injury associated with the use of electrical devices, including electrocution, burns and fire. The P&P indicated when extension cords were used, the following precautions must be taken: -Secure extension cords and do not place overhead, under carpets, or where they can cause trips, falls or overheat. -Connect extension cords to only one device -Ensure the type of cord used is appropriate of the size and type of electrical load. -Ensure that cords have proper grounding. -Inspect regularly for fraying, cuts, or breakage

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 46144 Based on observation, interview, and record review the facility failed to provide the necessary care and treatment for one of three sampled residents (Resident 51) who had an indwelling catheter (a medical device inserted into the bladder to drain urine continuously) by failing to notify the physician when there were sediment (the solid matter that settles to the bottom of a liquid, such as urine or blood) in the indwelling catheter's tubing. This failure placed Resident 51 at risk for urinary tract infection (UTI, an infection in any part of the urinary system). Findings: During a review of Resident 51's Admission Record, the Admission Record indicated the facility admitted Resident 51 on 11/25/2024 with diagnoses including osteomyelitis (a bone infection and inflammation caused by bacteria), diabetes mellitus (DM, a medical condition characterized by the body's inability to regulate blood sugar levels), and benign prostatic hyperplasia (a non-cancerous condition when the prostate gland grows larger than normal which can cause urinary problems). During a review of Resident 51's physician order titled, Order Summary Report, dated 2/11/2025, the Order Summary Report indicated to change Resident 51's indwelling catheter for excessive sedimentation. During a review of Resident 51's History and Physical (H&P), dated 3/5/2025, the H&P indicated Resident 51 had the capacity to make needs known but could not make medical decisions. During a review of Resident 51's Minimum Data Set (MDS, a resident assessment tool), dated 3/10/2025 the MDS indicated Resident 51's cognition (ability to learn, reason, remember, understand, and make decisions) usually understood others. The MDS indicated Resident 51 required substantial/maximal assist (helper does more than half the effort; helper lifts or holds trunk or limbs and provide more than half the effort) on staff for showering, toileting hygiene, and putting on footwear. During an observation on 4/11/2025 at 9 p.m., in Resident 51's room there was a large amount of sediment in Resident 51's indwelling catheter. During an observation on 4/12/2025 at 9:01 a.m., in Resident 51's room there was a large amount of sediment in Resident 51's indwelling catheter. During a concurrent observation and interview on 4/12/2025 at 3:07 p.m. with Licensed Vocational Nurse 4 (LVN4) in Resident 52's room. LVN 4 stated Resident 51 had sediment in the indwelling catheter. LVN 4 stated it was important to keep track of the sediment and report to the physician. LVN 4 stated to notify the physician if the sediment was increased or decreased. LVN 4 stated not communicating with the physician placed Resident 51 at risk to miss treatments for the sediment. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/12/2025 at 4:05 p.m. with Registered Nurse 1 (RN 1), Resident 51's physician order titled, Order Summary Report, dated 2/11/2025 was reviewed. RN1 stated the Order Summary Report indicated to change indwelling catheter for excessive sedimentation. RN 1 stated there was sediment in the indwelling catheter. RN 1 stated the nurses (in general) were to notify the physician when there was sediment in the indwelling catheter. RN 1 stated Resident 51's physician was not notified of the sediment. RN 1 stated not notifying the physician placed Resident 51 at risk for a UTI. During a review of facility's policy and procedure (P&P) titled, Change of Condition, dated 8/2021, the P&P indicated to ensure residents, family, legal representatives and physicians are informed of changes in the resident's condition.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46144 Based on observation, interview, and record review the facility failed to ensure to label and date the feeding tube syringe (a specialized syringe used to administer liquid formula or medication directly into a feeding tube) for one of one sampled resident (Resident 35) who had a gastrostomy tube (G-tube, is a tube that is placed directly into the stomach). This failure placed Resident 35 at risk for infection and G-tube complications. Findings: During a review of Resident 35's Admission Record, the Admission Record indicated the facility initially admitted Resident 35 on 12/2/2022 and was readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease(COPD, a chronic lung disease causing difficulty in breathing), gastrotomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and dysphagia (difficulty swallowing). During a review of Resident 35's History and Physical (H&P), dated 6/23/2023, the H&P indicated Resident 35 had fluctuated capacity to understand and make decisions. During a review of Resident 35's Minimum Data Set (MDS, a resident assessment tool), dated 2/21/2025, the MDS indicated Resident 35's cognition (ability to learn, reason, remember, understand, and make decisions) was rarely able to understand. The MDS indicated Resident 35 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) for showering, dressing, and toileting hygiene. The MDS indicated Resident 35's nutritional approaches were feeding tube (a method of delivering nutrition directly to the digestive system through a tube). During an observation on 4/11/2025 at 7:20 p.m., in Resident 35's room, the feeding tube syringe was not dated and was not labeled. During a concurrent interview and record review on 4/12/2025, at 4:36 p.m., with Registered Nurse 1 (RN 1), a picture dated as taken on 4/11/2025 of Resident 35's feeding tube syringe was reviewed. RN 1 stated the feeding tube syringe should be dated and timed. RN 1 stated the feeding tube syringe needed to be changed daily. RN1 stated the nurses (in general) would not be able to know when the last time the feeding tube syringe was changed. RN 1 stated Resident 35 would be at risk for an infection if the feeding tube syringe was not changed daily. During a review of the facility's policy and procedure titled, Enteral Feeding-Close, dated 5/26/2021, the P&P indicated to administered tube feeding and change syringe daily.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on observation, interview, and record review, the facility failed to ensure one of two hemodialysis (HD, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) residents (Resident 125) received dialysis care and services based on professional standards. Resident 125 did not have equipment or supplies, including an emergency kit consisting of clean gauze, tourniquet (a device used to compress a limb to stop bleeding) and tape necessary to manage emergencies such as bleeding at the bedside. The deficient practices had the potential to result in not having the necessary supplies to stop bleeding from an arterial venous fistula shunt (AV shunt, an abnormal connection between an artery and a vein, provides an accessible pathway for blood removal and return during dialysis [a medical procedure that cleans your blood when your kidneys are not working]). Findings: During a review of Resident 125's Admission Record, the Admission Record indicated Resident 125 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD -irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed), peripheral vascular disease, unspecified (a slow and progressive disorder of the blood vessels. During a review of Resident 125's Minimum data Set (MDS, a resident assessment tool) dated 3/30/2025, the MDS indicated Resident 125's cognition (thought process) was intact. The MDS indicated Resident 125 needed set up assistance with eating, partial/moderate assistance (helper does less than half the effort) with toilet hygiene, lower and upper body dressing and shower/bathe self. During a review of Resident 125's Physician's Order Report, active orders as of 4/12/2025, the report indicated to monitor AV shunt site for signs and symptoms of infection, edema (swelling), bleeding and upon return from dialysis. Notify primary care physician and dialysis unit if there were signs and symptoms of infection (invasion and growth of germs in the body), if AV site was bleeding apply pressure for 15 minutes and notify MD /physician extender if bleeding did not stop as needed. During an observation and interview on 4/11/2025 at 8 p.m., in Resident 125's room with the Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated an emergency kit needed to be near Resident 125's bedside. LVN 2 stated Resident 125 had an AV shunt to her left upper arm and after searching for the emergency kit, she stated the resident did not have one. LVN 2 stated it was important to have an emergency kit at the residents bedside in case there was an incident where the AV fistula starts to bleed. She stated this would be an emergency and there would be no delay in care if the emergency kit was present. During an interview on 4/12/2025 at 9:24 a.m., LVN 3 stated an emergency kit was used if the residents AV shunt was dislodged and started to bleed. LVN 3 stated the supplies would be within easy reach for staff to use. LVN 3 stated taking your time in helping the resident could have bad consequences, like hemorrhage, loss of consciousness, or stop breathing. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/13/2025 at 10:14 a.m., the Director of Nursing (DON) stated there should always be an emergency kit at the resident's bedside. It was important for the resident's safety in case of bleeding, staff could prevent. The DON stated if there was no e-kit the resident's blood pressure could become low, 911 must be called and the resident could possibly die. A review of the facility's policy and procedure titled, Dialysis Care dated 12/16/2024, indicated nursing staff would be trained on emergency care for residents with renal diseases and dialysis care (e.g., hypotension, hemorrhage, from dislodging of the catheter, symptoms of sepsis or other needs of the dialysis resident.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 45777 Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistant 4 (CNA4) and CNAs (in general) did not apply triamcinolone acetonide ointment 0.1 % (prescribed medication used to help relieve redness, itching, and swelling) to one of five sampled residents (Resident 11). This failure violated the facility's Administering Medications policy and procedure and had the potential for Resident 11 to use the medication inappropriately. Findings: During a record review of Resident 11's Admission Record, the Admission Record indicated the facility admitted Resident 11 on 5/12/2023 with diagnosis including type 2 diabetes mellitus (a medical condition characterized by the body's inability to regulate blood sugar levels) hyperglycemia (too much sugar in the blood). During a review of Resident 11's Minimum data Set (MDS, a resident assessment tool), dated 2/10/2025, the MDS indicated Resident 11's cognition (thought process) was intact. The MDS indicated Resident 11 needed set up assistance with toilet hygiene and personal hygiene, partial moderate assistant (helper does less than half the effort) with shower bathe self, upper and lower body dressing. During an observation and interview on 4/12/2025 at 9am, the bedside of Resident 11 had two tubes of prescription medication triamcinolone acetonide ointment 0.1 %. The directions indicated to apply to left axillary (arm pit) and right buttocks rash. Resident 11 stated the CNAs (in general) would apply the medication to her buttocks daily or whenever she (Resident 11) would request the cream to be applied. Resident 11 stated the medication was prescribed from her doctor outside the facility. During an interview on 4/12/2025 at 3:25 p.m., with CNA 4, CNA 4 stated after cleaning Resident 11 she (CNA4) would apply the triamcinolone acetonide ointment to Resident 11's bilateral (both) armpits, buttocks, and in between Resident 11's thighs. CNA 4 stated Resident 11 told her the triamcinolone acetonide ointment was approved and stated she (CNA4) thought it was ok to apply it. CNA4 stated she did not ask the charge nurse (unidentified). CNA 4 stated it was important not to give any medication to a resident because she (CNA4) was not a licensed nurse, and it could cause harm to the resident. During an interview on 4/12/2025 at 3:40p.m., with Registered Nurse 3 (RN 3), RN 3 stated triamcinolone acetonide ointment was a prescription medication. RN 3 stated Resident 11 did not have an order for the triamcinolone acetonide ointment and needed a doctor's order. RN3 stated Resident 11 needed to have a self-administration of medication evaluation (a tool used to assess the ability to self-administer medications) and a care plan. RN 3 stated the CNAs (in general) were not licensed nurses and were not allowed to give prescription medication and could harm to the residents. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated Policy and Procedures (P&P) titled, Administering Medications, the P&P indicated only persons licensed or permitted by the state to prepare, administer document the administration of medications may do so.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observation, interview, and record review, the facility failed to properly store two of 20 sampled residents (Resident 62 and Resident 52) medications in accordance with the facility's Storage of Medications policy and procedure (P&P). This failure had the potential to cause Resident 62 and Resident 52 to use the medication improperly which could lead to harm. Findings: a. During a review of Resident 62's Admission Record, the Admission Record indicated the facility admitted Resident 62 on 1/25/2024 with diagnosis of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area). During a review of Resident 62's Minimum Data Set (MDS, a resident assessment tool) dated 1/29/2025, the MDS indicated the resident had intact cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and required partial/moderate assistance (helper does less than half the effort) for toileting hygiene, showering, upper/lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 62 required set up or clean up assistance (helper sets up or cleans up) for eating and oral hygiene. During a review of Resident 62's Order Summary Report (OSR) dated 9/17/2024, the OSR indicated Resident 62 was ordered Preparation H (hemorrhoid [bulging growths in anus] cream). During an observation on 4/11/2025, at 8:03 PM, Preparation H cream was observed in Resident 62's room on Resident 62's bedside table next to food. During a concurrent observation and interview with Registered Nurse 4 (RN 4), Preparation H was observed on Resident 62's bedside table next to food. RN 4 stated, medication should not be left at bedside, because it's not safe, they may eat it, drink it, take in a different route not intended and this may cause harm to the resident. During an interview on 4/13/2024 at 9:11 AM, the Director of Nursing (DON) stated the P&P indicated only persons authorized to prepare and administer medications had access to locked medications. The DON stated, We have to make sure the medication cannot be taken by another resident. It needs to be stored in a secure area with the licensed nurse. It's not appropriate to leave a medication at a resident's bedside. The patient might use it inappropriately or have it stolen by another resident who may use it. 46144 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. During a review of Resident 52's Admission Record, the Admission Record indicated, Resident 52 was initially admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 52's diagnoses included depressive disorder (mental health conditions characterized by persistent low mood and loss of interest or pressure in activities), epilepsy (a neurological disorder characterized by recurrent seizures), and rotator cuff tear (an injury to the muscles and tendons that surround the shoulder joint, causing shoulder pain, weakness, and limited range of motion). During a review of Resident 52's History and Physical (H&P), dated 12/20/2022, the H&P indicated Resident 52 had the capacity to understand and make decisions. During a review of Resident 35's MDS dated [DATE], the MDS indicated Resident 35's cognition (ability to learn, reason, remember, understand, and make decisions) had the ability to understand. The MDS indicated Resident 52 required substantial/maximal assist (helper does more than half the effort; helper lifts or holds trunk or limbs and provide more than half the effort) from staff for showering, dressing, and toileting hygiene. During an observation on 4/11/2025 at 9:28 p.m. in Resident 52's room there were two tablets in a medicine cup on the Resident 52's bedside table. During an interview on 4/12/2025 at 6:33 p.m., the Licensed Vocational Nurse (LVN) stated she had left the medication on the bedside table at 8:35 p.m. and she did this every night. The LVN stated Resident 52 used the medication to help her sleep and it was not okay to leave the medication with the resident. The LVN stated Resident 52 could be hiding the medications and could potentially collect the medication and overdose. During an interview on 4/13/2025 at 11:28 a.m., the Registered Nurse (RN) stated the process was to pour the medication, pass the medication, allow Resident 52 to take the medication, and sign the medication was given. The RN stated the staff was not to leave medications on the bedside table. The RN stated it was best to ensure the resident take the medication before leaving the room, as leaving the medication on the bedside could be dangerous because another resident might take it or have an allergic reaction to Resident 52's medication. The facility's policy and procedure titled, Storage of Medications, dated 12/16/2024 indicated the facility stored all drugs and biologicals in a safe, secure and orderly manner. The drugs used in the facility were stored in locked compartments under proper temperature, light and humidity controls.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety. In the refrigerator, there was no label or date on the sandwiches and the bin of expired butter cups were not discarded. These deficient practices had the potential to cause food-borne illnesses to the residents. -Ensure the low temperature dishwashing machine had the appropriate concentration of sanitizer. Findings: During an observation on [DATE] at 6:36 PM, unlabeled sandwiches were observed in the facility's kitchen refrigerator. During a concurrent observation and interview on [DATE] at 6:41 PM with [NAME] 1, unlabeled sandwiches were observed in the refrigerator. [NAME] 1 stated, There's no date on the sandwiches. If there's no date we don't know how old it is and someone can get sick if they eat an old sandwich. During an observation on [DATE] at 6:58 PM, a bin of expired butter cups were observed in the facility's refrigerator. During a concurrent observation and interview on [DATE] at 6:42 PM with Dishwasher 1, the dishwasher test strip was observed to be white after D1 tested the low temperature dishwashing machine's sanitizer concentration level. D1 stated, the test strip is white but it should be purple to show that the proper concentration of sanitizer is present in the rinse solution. It's important to have the correct concentration of sanitizer so the dishes can be properly sanitized and prevent illness to residents. A review of the facility's policy and procedure (P&P) titled, Food Storage: Cold Foods, dated ,d+[DATE], indicated all food would be labeled and dated. A review of the facility's P&P titled, Warewashing, dated ,d+[DATE], indicated all dishware, service ware and utensils would be cleaned and sanitized after each use. During a concurrent interview and record review on [DATE] at 9:16 AM with the Director of Nursing (DON), the facility's P&P titled, Receiving, dated ,d+[DATE], indicated all food items would be appropriately labeled and dated either through manufacturer packaging or staff notation. The DON stated food must be labeled to ensure it was not expired and to prevent residents from eating old food and getting sick. The DON stated the dishwashing machine must have the appropriate level of sanitizer to disinfect plates and prevent residents from eating from dirty plates which may get residents sick.

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Sharon Care Center	8167 West Third St. Los Angeles, CA 90048

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48903 Based on observation, interview, and record review the facility failed to practice effective infection control for one of two sampled residents (Resident 23) in accordance with the facility's Infection Prevention and Control policy and procedure by failing to keep Resident 23's urinal (a device for males to urinate) away from his food. This failure had the potential for Resident 23 to eat contaminated food and placed Resident 23 at risk for infection. Findings: During a review of Resident 23's Admission Record, the Admission Record indicated the facility admitted Resident 23 on 1/12/2023 with diagnosis of unspecified mental disorder. During a review of Resident 23's History and Physical (H&P) dated 1/13/2023, the HP indicated Resident 23 did not have the capacity to understand and make decisions. During a review of Resident 23's Minimum Data Set (MDS, a resident assessment tool) dated 12/30/2024, the MDS indicated Resident 23 had moderately impaired cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and required partial/moderate assistance (helper does less than half the effort) for toileting hygiene, showering, lower body dressing and putting on/taking off shoes. The MDS indicated Resident 23 required supervision (helper provides verbal cues or touching assistance) for oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 23 required set up or clean up assistance (helper sets up or cleans up) for eating. During an observation on 4/11/2025, at 7:49 PM, in Resident 23's room, a urinal with urine inside was observed on Resident 23's bedside table next to his food and drinks. During a concurrent observation and interview on 4/11/2025, at 7:51 PM with Licensed Vocational Nurse 6 (LVN 6) in Resident 23's room, a urinal with urine inside was observed on Resident 23's bedside table next to his food and drinks. LVN 6 stated, the urinal is next the pt's food. This is not safe for infection control reasons. He might get sick from eating the food exposed to urine. During a concurrent interview and record review on 4/13/2024, at 9:07 AM, with the Director of Nursing (DON), the facility's P&P titled Infection Prevention and Control dated 12/16/2024 was reviewed. The P&P indicated the facility would help maintain a safe and sanitary environment to help prevent and manage the transmission of diseases and infections. The P&P indicated the objectives of the infection prevention and control P&Ps were to monitor, prevent, detect, investigate and control infections in the facility. The DON stated, if the resident's urinal is next to the resident's food it is not a safe and sanitary environment. The resident might get sick if they eat the food exposed to urine because urine is dirty.

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45777 Based on observation, interview, and record review , the facility failed to ensure 14 of 33 residents' rooms (room [ROOM NUMBER], 8, 9, 11, 14, 15, 16, 17, 18, 19, 21, 24, 25) met the space requirements of 80 square feet for each resident in multiple resident bedrooms. This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the impacted residents. Findings: On 4/12/2025 at 9;13 p.m., during a tour of the facility, Rooms 1, 8, 9, 11, 14, 15, 17, 18, 18, 19, 21, 23, 24, 25 were observed not to be occupied with more than four residents. The rooms were observed with enough space for nursing staff to provide care to the residents. The rooms were observed with enough space for nursing staff to provide care to the residents in the rooms. The rooms were observed with privacy curtains for each resident and direct access to the corridors. During a resident council meeting on 4/12/2025 there were no concerns brought up by the residents who attended the meeting, regarding the size of the residents rooms. A review of the facility's Client Accommodation Analysis, dated 4/12/2025 at 5:13 p.m., indicated the following rooms with their corresponding measurements. Room number of Beds Total Square Feet 1 3 228.26 8 3 229.00 9 3 237.00 11 3 233.00 14 3 234.00 15 3 237.00 16 3 230.00 17 3 234.00 18 3 216.00 21 3 225.70 23 3 239.28 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	24 3 236.54 25 3 239.71 The Client Accommodation Analysis indicated the above rooms measured less than the required 80 square footage per resident in multiple resident bedrooms. For a three bed capacity room, the square footage requirements would be at least 240 square feet. During a concurrent observation and interview, on 4/12/2025 at 3:41 p.m., the Maintenance (MD), stated he did not have any residents or staff complain of the rooms being too small. The MD stated the nurses had enough space when using the Hoyer lift (mechanical device allows a person to be lifted and transferred with a minimum of physical effort) and wheelchairs. During an observation and interview on 4/13/2025 at 8:30 a.m., in Resident 1's room, Certified Nurse Assistant 3 (CNA 3) stated she had no problems with the room size when preparing residents to get up in their wheel chairs. CNA 3 stated she could transfer residents in wheelchairs to the bathroom with no problem. During an interview on 4/13/2025 at 10:14 a.m., the Director of Nursing (DON) stated this was an old building, I have never had a nurse complain of the rooms being too small. During a review of a letter from the Administrator dated 6/ 6/2024, indicated the administrator requested for a room waiver for Rooms 1, 8, 9, 11, 14, 15, 16, 17, 18, 19, 21, 23, 24, and 25. The letter indicated each room listed on the attached on the Client Accommodation Analysis had no projections or other obstructions, which may interfere with free movement of wheel chairs and / or sitting devices. The letter indicated there was enough space to provide for each resident's care, dignity, and privacy. The letter indicated the rooms were in accordance with the special needs of the residents and would not have an adverse effect on residents' health and safety or impede the ability of any residents in the rooms to attain his or her highest practical well-being. The letter further indicated all measures would be taken to assure the comfort of each resident, the granting of this variance would not adversely affect the health and safety of the residents, and would be in accordance with any special needs of each resident. The room waiver was recommended to continue and was contingent with federal regulations at accommodation of needs (483.15) Residents Rights (483.10).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 46144 Based on observation, interview, and record review the facility failed to ensure the call light (a device used by a resident to signal his or her need for assistance) for one of 20 sampled resident (Resident 2) functioned properly. This failure had the potential for Resident 2 not to be able to call for assistance. Findings: During a review of Resident 2's Admission Record, the Admission Record indicated the facility admitted Resident 2 on 3/4/2023 with diagnoses that included muscle weakness (a decrease in muscle strength and the ability to move the body, lack of coordination (a failure in the organization and communication of patient care activities across different healthcare providers and settings), and chronic kidney disease (a progressive, irreversible condition where kidney declines significantly over time). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 2/17/2025, the MDS indicated Resident 2's cognition (ability to learn, reason, remember, understand, and make decisions) was able to usually understand. The MDS indicated Resident 2 required substantial/maximal assist (helper does more than half the effort; helper lifts or holds trunk or limbs and provide more than half the effort) on staff for showering, dressing, and toileting hygiene. During a review of Resident 2's History and Physical (H&P), dated 3/27/2025, the H&P indicated Resident 2 had the capacity to make needs known but could not make medical decisions. During an observation on 4/11/2025 at 7:51 p.m., and at 8 p.m., in Resident 2's room, Resident 2 pressed the call light, and the call light did not have a sound and did not have a light appear on the outside of the doorway. During an interview on 4/11/2025 at 8:10 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 2 had the ability to press the call light. LVN1 stated the call light was not working. LVN 1 stated he was not sure how often the call lights were checked by maintenance. LVN 1 stated it was the staff's responsibility to make sure the call lights were fully accessible and working. LVN 1 stated if the call light was not working, the staff would not know if the resident needed help, and the resident would not get help immediately. During an interview on 4/13/2025 at 9:10 a.m., with the Maintenance Supervisor, the Maintenance Supervisor stated he checked the call lights throughout the facility once a week on Fridays from 11 a.m., to 3 p.m. The Maintenance Supervisor stated it was important to make sure the call lights were working so the residents could get help and would get what they (the residents) needed. During a review of policy and procedure (P&P) titled, Maintenance Service, dated 12/2009, the P&P indicated the maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. The P&P indicated functions of maintenance personnel included but were not limited to maintaining the paging system in good working order. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of policy and procedure (P&P) titled, Call System, Resident, dated 9/2022, the P&P indicated residents were provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. The P&P indicated the resident call system remained functional at all times. The P&P indicate the resident call system was routinely maintained and tested by the maintenance department.