STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055755	A. Building B. Wing	11/19/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise:The care plan for one of two sampled residents (Resident 1) after the resident had his urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) removed and reinserted (to put something back in).This deficient practice had the potential to place the resident at risk for urinary retention (inability to fully empty your bladder when urinating), infection (harmful germs such as bacteria, viruses, or fungi, enter your body, multiply, and cause harm), hospitalization and sepsis (a life-threatening blood infection).2. And update the comprehensive care plan for one of three sampled residents (Resident 2) who had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD- lung disease causing restricted airflow and breathing problems) who returned from the hospital on [DATE] following an episode of respiratory failure (a condition caused by inadequate supply of oxygen and/or the inability to remove carbon dioxide from the lungs). This deficient practice resulted in Resident 2 being discharged back to the facility on [DATE] with no revisions to reflect associated monitoring requirements or interventions to address the resident's changed respiratory status. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 10/21/2025 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) with acute(sudden onset) exacerbation(when a medical condition gets worse), chronic respiratory failure with hypoxia (a serious condition that happens when your lungs cannot get enough oxygen into your blood), atherosclerosis of coronary artery bypass graft(when the detour artery used in bypass surgery itself develops plaque buildup over time, causing it to narrow) without angina pectoris(chest pain or discomfort when part of your heart muscle does not get oxygen-rich blood), unspecified atrial fibrillation(an irregular and often rapid heart rhythm in the upper chambers of the heart), unspecified severe protein-calorie malnutrition(when the body is severely deprived of the essential building blocks[protein] and fuel[calories] it needs to function), essential hypertension(high blood pressure), dementia (a progressive state of decline in mental abilities) and benign prostatic hyperplasia(a non-cancerous enlargement of the prostate gland that happens as men get older) without lower urinary tract(the body's drainage system for getting rid of waste and extra water as urine) symptoms. During a review of Resident 1's History and Physical dated 10/22/2025, the H&P indicated Resident 1 had the capacity (ability) to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS – a resident assessment tool) dated 10/24/2025, the MDS indicated Resident 1 had moderate cognitive (ability to think, understand, learn, and remember) impairment(reduced). The MDS indicated Resident 1 was dependent (helper does all the effort) with toileting hygiene (practices and habits that maintain cleanliness and prevent the spread of germs), showering/bathing, and lower body dressing. The MDS indicated Resident 1 needed (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	substantial/maximal assistance (helper does more than half the effort) on staff to roll from left to right, sitting to lying in bed, and from lying position to sitting position on the side of the bed. During a concurrent interview and record review on 11/19/2025 at 11:18 AM, with Licensed Vocational Nurse (LVN) 3, Resident 1's Care Plan Report initiated on 10/22/2025 titled The resident is on enhanced barrier precautions (EBP) [set of extra infection control rules for healthcare workers such as wearing a gown and gloves for every single patient] related to foley catheter and Resident 1's Order Summary Report dated 11/19/2025, indicated Resident 1 had an order to discontinue urinary catheter on 10/27/2025 and an order on 11/4/2025 for an indwelling (device left inside the body) urinary catheter for urinary retention was reviewed. LVN 3 confirmed that Resident 1's care plan had not been updated or revised since 10/22/2025, to have indicated Resident 1's urinary catheter had been discontinued and reinserted on a later date. LVN 3 stated care plans addressed Resident 1's needs. LVN 3 stated care plans were a guide to direct Resident 1's care and there could have been miscommunication amongst staff who cared for Resident 1's if the care plan had not been updated. LVN 3 stated any licensed nurse could have updated Resident 1's care plan. LVN 3 stated if the care plan was not updated for Resident 1's urinary catheter, there would not have been guidance on urinary catheter care such as monitoring for output(amount of urine), color, sediment(tiny bits of solid material, like fine sand, flakes or tiny particles that you can see settled in the catheter tube or bag), and any change in Resident 1 would have had such as a complication of infection or distention(enlargement or swelling). During an interview with Registered Nurse (RN) 2 on 11/19/2025 at 11:48 PM , RN2 stated a care plan that was not updated for a urinary catheter (in general) would not have had interventions on how to have taken care of the urinary catheter such as have had to drained(empty out) the urine bag, what to have watched for such as signs(what other can see) and symptoms(things you feel) of infection, output, or sediment. RN3 stated a care plan would have provided a treatment guide and interventions in place to have taken for anything that would have been out of the normal range for the resident. During an interview with the Director of Nursing (DON), on 11/19/2025 at 2:22 PM the DON stated care plans were a guideline on how to care for residents and were to be updated to have provided communication among care providers for better resident care. The DON stated, care plans were updated quarterly (four times a year), prn (as needed), and when there was a change of condition (any noticeable decline in a person's health, behavior, or ability to function). The DON stated all licensed nurse could have updated the care plan. The DON stated that if a urinary catheter was taken out and the care plan was not updated with new documented interventions, there would be no guidance to look for retention of urine in the care plan, and the use of a bladder scanner(a handheld device that uses sound waves to non-invasively[not requiring the instrument to enter the body] measure how much urine is in a person's bladder). The DON stated when a resident had a urinary catheter that was reinserted the care plan would have had to have interventions such as monitoring for sediment, blood in the urine, complaints of pain and signs and symptoms of infections. The DON stated if a resident had an infection, it could have led to sepsis and hospitalization. During a review of the facility's policy and procedure (P&P) titled, Care Plan Comprehensive, dated 12/16/2024, the P&P indicated Each resident ' s comprehensive care plan is designed to incorporate identified problem areas. Incorporate risk and contributing factors associated with identified problems. Build on the resident's individualized needs. Reflect currently recognized professional standards of practice for problem areas and conditions. The P&P indicated Assessments of residents (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are ongoing and care plans are reviewed and revised as information about the resident and the resident's condition change. 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was initially admitted to the facility on [DATE] with diagnosis of COPD, then readmitted on [DATE] with diagnosis of acute respiratory failure with hypoxia (low levels of oxygen in your body tissues). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had intact cognitive (ability to think, remember and reason) the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS indicated Resident 2 was independent (Resident completes the activity by themself with no assistance from a helper) for eating, oral hygiene, upper body dressing, personal hygiene, rolling left and right, sit to lying, and lying to sitting on side of bed. The MDS indicated Resident 2 required supervision (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for toileting, lower body dressing, putting on taking off footwear, sit to stand, toilet and shower transfer. During a review of Resident 2's Care Plan, dated 5/30/2025, the Care Plan indicated administer oxygen as prescribed for COPD. No revisions to the Care Plan for diagnosis of COPD were found after Resident 2 had returned from the hospital on [DATE]. During an interview with RNS 2, on 11/19/2025 at 12:34 PM the RNS 2 stated the Care Plan had not been updated after Resident 2's return from the hospital. The RNS stated failure to revise the Care Plan placed Resident 2 at risk for unmet needs and inadequate management of respiratory status. During an interview with the DON, on 11/19/2025 at 2:14 PM the DON stated it was important to update and revise Care Plans as needed, following a change in condition, and quarterly in order to guide nurses to provide the care residents need and failure to do so places residents at risk for unmet needs and miscommunication among licensed nurses. During a review of the facility's P&P titled Care Plan Comprehensive, dated 12/16/2024, the P&P indicated the facility is responsible for evaluation and updating of care plans when there has been a significant change in the resident's condition, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly.

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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** Based on observation, interview, and record review, the facility failed to ensure licensed nurses disposed of used tube feeding formula and tubing, discarded remaining formula, and tubing per facility policy for one of three resident (Resident 3).This failure placed Resident 3 at risk for contamination of enteral formula, bacterial growth, aspiration (The accidental breathing in of food or fluid into the lungs, potentially causing pneumonia or other lung problems), gastrointestinal infection, sepsis (systemic infection), and compromised nutritional status.During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnosis of dysphagia (Difficulty or discomfort in swallowing), and gastrostomy (G-tube- tube inserted through the belly that brings nutrition directly to the stomach), COPD, and respiratory failure.During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 8/20/2025, indicated Resident 3 had severely impaired cognitive (ability to think, remember and reason) skills for daily decision making. The MDS indicated Resident 3 was dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) on staff for oral hygiene, toileting, showering, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and rolling left and right. The MDS indicated Resident 3 had a feeding tube (a way of delivering nutrition directly to your stomach or small intestine) to deliver nutrition. During a concurrent observation and interview on 11/19/2025 at 1:18 PM with the Director of Nursing (DON) in Resident 3's room, the DON verified that Resident 3's tube feeding was connected to an empty formula bottle and a bag with water. No labels were present on the tubing, formula bottle, nor the bag of water to indicate when these were first used. The DON stated the tubing should be dated and initiated by the staff who hung the formula and tubing with a date of when these were administered and should be disposed of once they are turned off. The DON stated failure to discard the tubing and formula and failing to label the feeding supplies placed Resident 3 at risk for inaccurate monitoring of nutritional intake, aspiration, and increased risk of infection. During an interview with Licensed Vocational Nurse (LVN) 1, on 11/19/2025 at 1:43 PM the LVN1 stated she turned off Resident 3's feeding in the morning but failed to dispose of the feeding tubing, empty bottle of formula, and acknowledged she should have discarded the tubing and formula according to facility policy. During a review of the facility's policy and procedures (P&P) titled Enteral Feedings Safety Precautions, dated 12/16/2024, the P&P indicated, to ensure the safe administration of enteral nutrition, prevent errors in administration by labeling enteral nutrition with date and time formula was prepared, and on the formula label document initials, date and time the formula was hung, and initial that the label was checked against the order.