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	11/26/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interviews and record reviews, the facility failed to report to the Medical Doctor (MD) when there was a change in condition (COC) for one of the three sampled residents (Resident 1) who was refusing to eat more than 50% of her meals. This deficient practice resulted in Resident 1 being severely dehydrated and possible deterioration of her (Resident 1) sacral (a triangular bone in the lower back) pressure ulcer (PU- localized damage to the skin and/or underlying tissue usually over a bony prominence). As a result, Resident 1 was transferred to General Acute Care Hospital (GACH) where she was treated with intravenous (IV - tube inserted into a vein) fluids, antibiotics and was treated for acute kidney injury (AKI - a sudden decline in kidney function)A review of Resident 1's admission record indicated the facility admitted the resident on 11/18/2015, with diagnosis that included rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), anemia (a condition where the body does not have enough healthy red blood cells), and hypertension (HTN-high blood pressure). During a review of Resident 1's history and physical (H&P) dated 12/12/2024 indicated, Resident 1 was able to make needs known but could not make medical decisions. The same H&P indicated Resident 1's family member (FM) was the DPOA (durable power of attorney - legal authority to make Resident 1's decisions). The same P&P indicated the visit diagnoses as, Dementia without behavioral disturbance. A review of Resident 1's Minimum Data Set (MDS- standardized data collection tool) dated 8/8/2025, indicated the resident had severe cognitive impairments (a condition that involves a significant loss of abilities like memory, decision-making, and problem-solving, to the point where an individual often cannot live independently). The MDS indicated Resident 1 mostly partial/moderate assistance for activities of daily living (ADLs) such as toileting hygiene, Shower/bathe, upper and lower body dressing, and putting on/taking off footwear. During a review of nutritional assessment notes dated 10/13/2025 at 8:42 am, the notes indicated a goal of gradual weight loss to healthy BMI (basal metabolic index- a measurement of your body fat based on your height and weight). The same notes indicated a recent weight change with an average oral intake of approximately 58% for 18 meals. The notes indicated risk factors which included pressure injuries: stage 2 to the sacrococcyx [a collective term for sacrum which is a large, triangular bone and the coccyx which is the small tailbone at the very end of the spine. They are two distinct but connected bones at the base of the vertebral column]. During a review of Resident 1's interdisciplinary team care conference [a formal meeting where healthcare professionals from various fields meet to collaboratively plan, coordinate, and evaluate a patient's care] dated 10/27/2025 at 5:22 pm, indicated, Resident 1 had skin alterations. The attendees of the conference were the Director of Nursing (DON) and the Treatment Nurse (TN). During a review of Resident 1's oral intake of meals indicated Resident 1 consumed less than 50% of her meals on the following dates:10/28/2025 14:30 0% Eaten (lunch) 10/29/2025 13:52 25% Eaten (lunch) 22:50 0% Eaten (dinner) 10/30/202520:17 Refused (dinner) 11/1/2025Breakfast, lunch, and dinner (not documented). 11/2/2025Breakfast - Not documentedLunch - not documented21:46 25% Eaten (dinner). 11/3/2025 18:22 Refused (dinner). 11/4/202508:17 25% Eaten (breakfast) 12:41 25% Eaten (lunch) 18:26 Refused (dinner). 11/5/2025Breakfast - not documentedLunch - not (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented20:33 Refused (dinner).The above indicated Resident 1 missed or consumed less that 50% of her meals for a total of 17/32 meals. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents) progress note dated 10/29/2025 at 12 am, indicated, During weekly wound rounds c [with] wound consultant noted increased in size measurement of pressure injury on sacra-coccyx site. 0 [no] s/s [signs and symptoms] of infection, 0 c/o pain or discomfort. Poor PO [by mouth] intake c meals. Charge nurse and supervisor made aware]. The same SBAR indicated, Sacra-coccyx pressure injury- St3 [stage 3. PU stages are stage 1- reddened, unbroken skin, stage 2- Partial-thickness loss of skin, stage 3 - Full-thickness loss of skin. Dead and black tissue may be visible, and stage 4 - Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone] (re-opened)= 3.6cm [centimeters- length] x 2.9cm [width] x 0.2cm [depth], s/p [status post] debridement of devitalized tissue [the medical removal of dead, damaged, or infected tissue from a wound to promote the healing potential of the remaining healthy tissue]; 70% granulation [new, pink, and bumpy connective tissue that forms on a healing wound's surface], 30% slough [dead, stringy tissue that is often yellowish or grayish and can be soft or sticky and may be a sign of infection]; moderate serosanguinous exudate [a thin, pink or reddish wound drainage that is a mix of clear, watery serous fluid and small amounts of blood]; fragile; decline in condition. During a review of Resident 1's physician's orders dated 11/5/2025 indicated, Registered Dietician consult During a review of Resident 1's SBAR progress note dated 11/6/2025 at 2:42 pm, indicated, Noted existing pressure injury on sacra-coccyx area to increase in size of measurements, and now c100 % slough. During a review of Resident 1's physician orders dated 11/7/2025 indicated to transfer to ER [Emergency Room) due to failure to thrive ams (altered mental status] anfd [and] sacral wound. During a review of Resident 1's GACH Emergency Department (ED) admission dated 11/7/2025 indicated the following visit diagnoses: Dehydration (primary)[occurs when the body doesn't have enough water to function properly because it has lost more fluid than it has consumed]. Acute renal failure (the sudden and rapid loss of the kidneys' ability to filter waste from the blood, balance fluids, and regulate electrolytes). Sepsis with acute renal failure without septic shock (a body-wide infection (sepsis) triggers a sudden failure of the kidneys to filter waste from the blood). Severe sepsis (an infection that leads to organ dysfunction or tissue hypoperfusion. This is a more advanced stage of sepsis where the infection has caused at least one of the body's organs to malfunction, which can be indicated by signs like low urine output, elevated lactate levels, or changes in mental status).The same ED admission note included the following hospital problems:respiratory failure (HCC) AKI (acute kidney injury) Bacteremia (the presence of bacteria in the bloodstream). Encephalopathy (a disorder that affects the brain's function or structure, causing confusion, memory loss, personality changes, and trouble thinking). Hypernatremia (abnormally high concentration of sodium levels in the blood often caused by dehydration). Lactic acidosis (abnormal buildup in the bloodstream (lactic acidosis) that occurs due to specific types of malnutrition). Metabolic acidosis (a condition where too much acid builds up in the body's fluids which may result from a lack of food and nutrients). Uremia (the buildup of toxins, like urea, in the blood when the kidneys can't filter them out properly, leading to a serious toxic condition).During a review of the ED to hospital admission notes dated 11/7/2025 indicated a weight of 95 pounds (lbs.). The same notes indicated, Per EMS (emergency medical services), pt [patient - Resident 1] has not eaten since last night, and has not taken medications. EMT [emergency medical technician] states O2 sat [oxygen saturation -oxygen in the blood] 80's [normal levels between 92-100%] in field, pt placed on NC [nasal cannula - a tube placed in the nostrils] 6L [liters per minute]. The same notes indicated laboratory (lab) report results which indicated the following: Sodium - 158 mmol/L (millimoles per liter, is a unit of concentration that measures the amount of a substance dissolved in a liter of liquid) [Ref Range: 132 - 146]. Chloride - 117 mmol/L [Ref Range: 98 - 107]. Urea nitrogen: 128.0 mg/dL [Ref Range: 9.8 - 20.1] Creatinine: 4.40 mg/dL [Ref Range: 0.57 - 1.11] Lactate: 4.1 mmol/L [Ref Range: 0.5 - 2.2] WBC (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	16.03 During a review of the GACH H&P spine consult (a medical specialist who focuses on diagnosing and treating conditions affecting the bones, joints, and soft tissues of the spine) dated 11/8/2025 indicated the hospital placed the consultation due to concern for intraspinal gas in setting of sacral decubitus ulcer (PU). The consultation notes indicated CT (computed tomography - a medical imaging method that uses X-rays to take multiple cross-sectional slices of the body, which a computer then combines to create a detailed 3D picture) pelvis (the bowl-shaped bone structure at the base of the spine that connects the torso to the legs) confirmed sacral decubitus ulcer with subcutaneous (fatty layer tissue under the skin), intramuscular (inside the muscles), and intraspinal (situated within or going into the spine, especially the spinal canal)gas. Erosive (damaged, destroyed, or worn away) changes of the sacrum suggestive of osteomyelitis (an infection and inflammation of the bone, mostly caused by bacteria). During a review of the GACH inpatient consultation notes dated 11/10/2025 indicated under assessment, 1. Proteus mirabilis bacteremia [a serious bloodstream infection caused by the Proteus mirabilis bacterium, which has entered the bloodstream and is causing systemic illness]- possibly from superinfected sacral ulcer versus other. Other sources considered include urinary (however, urinalysis has no pyuria making it less likely) and respiratory (though clinically has no evidence of a pneumonia)2. Sacral decubitus ulcer with osteomyelitis and subcutaneous and intramuscular gas-Evaluated by surgery without concerns of necrotizing soft tissue infection-Reasonable to treat for a short course for superimposed SSTI [skin soft tissue infection]. Would NOT treat for osteomyelitis given largely absence of benefit in treating osteomyelitis complicating sacral ulcers when overlying defect (ulcer) is not corrected. During an interview with Certified Nursing Assistant (CNA) 1 on 11/25/2025 at 10:30 am, CNA 1 stated that she was familiar with Resident 1. CNA 1 stated that Resident one had an open wound to her bottom. CNA 1 stated that Resident 1 Was confused sometimes more than other days. CNA 1 stated that Resident 1 would sometimes fight and refuse to get Her incontinence briefs changed and remained soiled. CNA 1 stated that on average she got Resident 1 changed at least twice per shift. CAN 1 stated that Resident 1 did not want food and would only drink coffee and eat about 25% of her meals. CNA 1 stated that she reported to the charged nurse. During an interview with registered nurse (RN) 1 on 11/25/2025 at 11:40 am, RN 1 stated that She had noted that there were orders when she came in during her shift on 11 7 2025 ordered on 11/6/2025 for inserting an IV and administering fluids due to poor oral intake which had not been carried out the previous night. RN1 stated that the previous RN had endorsed to her that resident one had refused to have an IV inserted. RN 1 stated that she had attempted to insert the IV that was also unsuccessful, so she reported to the nurse practitioner who had come in to see Resident 1. The NP ordered for Residence 1 to be transferred to acute for poor oral intake. RN 1 Stated that when a resident refuses a procedure, the doctor must be informed about the refusal. RN1 stated that the physician should have been notified on 11/6/2025 when Resident 1 refused to have the IV inserted as that is not following physician's orders. RN 1 stated that the importance of notifying the physician is to ensure that the resident's condition does not get worse and get orders for what to do next. During an interview with FM 1 and FM 2 on 11/25/2025 at 3:06 pm, FM 1 stated that Resident 1 was in her usual state of health where she would helped up out of bed and sit in her wheelchair and socialize with other residents in the dining room, FM 1 stated that Resident gradually stopped and stayed in bed and was noted to have increased confusion. FM 2 stated that the facility had not reached out to any family members for a meeting to discuss Resident 1's care or progress in over a year. FM 1 stated that the facility did not inform them that Resident 1 had pressure ulcers nor that she was refusing care. FM 1 stated that Resident was confused and unable to make decisions. FM 2 stated that the facility called her on 11/6/2025 for the first time to inform her that Resident 1 was refusing to eat and refusing to have an IV inserted to administer IV fluids to support her while she was refusing to eat. FM 1 stated that the facility called her on 11/7/2025 to inform her that Resident 1 was sent to GACH for poor oral intake. When FM 1 and FM 2 arrived at GACH, they were both shocked at Resident 1's condition as she appeared to be very skinny and had a wound to her (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sacrum which was very scary to look at it had reached the bone and were told that Resident 1 had infection from the wound which had gone to her blood. During an interview with the DON on 11/26/2025 at 2:36 PM, the DON stated that when a resident consumes less than 50% of their meals the physician must be notified after two to three meals. The DON Confirmed that Resident 1 consumed less than 50% of her meals on 10/28/2025 and progressively decreased several times after that but that the physician had not been notified about this COC. The DON Stated that it is important to notify the physician about decreased oral intakes for the resident's well-being and for improving PU outcomes. The DON Confirmed that reduced intake could result in dehydration. During a review of a policy and procedure (P&P) titled, Change in Condition: Notification of, reviewed 12/16/2024 indicated, To ensure residents, family, legal representatives, and physicians are informed 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, andnotify, 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 form of treatment); or A decision to transfer or discharge the Resident from the Center. When making notification of above, the Facility must ensure that all pertinent information is available and provided upon request to the physician and/ or NP. During a review of a P&P titled, Physician Orders, reviewed on 12/16/2024 indicated, This will ensure that all physician orders are complete and accurate. The same P&P indicated, Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other health care disciplines will be transcribed onto the appropriate communication system for that discipline. During a review of a P&P titled, Resident Hydration and Prevention of Dehydration, reviewed 3/4/2025, indicated, This facility will strive to provide adequate hydration and to prevent and treat dehydration. The same P&P indicated under Policy interpretation and implementation the following:- Nurses will assess for signs and symptoms of dehydration during daily care.- Laboratory tests may be ordered to assess hydration if intake and symptoms indicate possible significant dehydration.

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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. Based on observation, interview and record review, the facility failed to conduct an Interdisciplinary Team (IDT- brings together knowledge from different health care disciplines to help people receive the care they need) which included resident and or responsible party (RP) for one of the three sampled residents (Resident 1). This deficient resulted in a failure to address Resident 1's non-compliance for care such as eating, personal care, and ordered procedure (laboratory draws and supportive treatments). Refer to F580, F658, F686A review of Resident 1's admission record indicated the facility admitted the resident on 11/18/2015, with diagnosis that included rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), anemia (a condition where the body does not have enough healthy red blood cells), and hypertension (HTN-high blood pressure). The admission record indicated family member (FM) 1 as the healthcare proxy (a trusted person you legally appoint to make medical decisions for you if you become unable to communicate or decide for yourself, ensuring your healthcare wishes are followed even in an emergency or serious illness) and healthcare representative. During a review of Resident 1's history and physical (H&P) dated 12/12/2024 indicated, Resident 1 was able to make needs known but could not make medical decisions. The same H&P indicated Resident 1's family member (FM) was the DPOA (durable power of attorney - legal authority to make Resident 1's decisions). The same P&P indicated the visit diagnoses as, Dementia without behavioral disturbance. A review of Resident 1's Minimum Data Set (MDS- standardized data collection tool) dated 8/8/2025, indicated the resident had severe cognitive impairments (a condition that involves a significant loss of abilities like memory, decision-making, and problem-solving, to the point where an individual often cannot live independently). The MDS indicated Resident 1 mostly partial/moderate assistance for activities of daily living (ADLs) such as toileting hygiene, Shower/bathe, upper and lower body dressing, and putting on/taking off footwear. During a review of Resident 1's interdisciplinary team care conference [a formal meeting where healthcare professionals from various fields meet to collaboratively plan, coordinate, and evaluate a patient's care] dated 10/27/2025 at 5:22 pm, indicated, Resident 1 had skin alterations. The attendees of the conference were the Director of Nursing (DON) and the Treatment Nurse (TN). During a review of Resident 1's physician's orders dated 11/5/2025 indicated the following:- CBC [complete blood count - a common blood test that measures the main components of your blood: red blood cells, white blood cells, and platelets] WITH DIFF [differential] and BASIC METABOLIC [basic metabolic panel - a blood test that measures glucose (sugar), electrolytes, and kidney function]. One time only.- CULTURE, URINE [C&S - a lab test that checks for bacteria or other germs in a urine sample to diagnose a urinary tract infection UTI]. One time only.- URINALYSIS [UA - a simple medical test of a urine sample that checks its appearance, chemical makeup, and microscopic components to help diagnose and monitor conditions like kidney disease, diabetes, and UTI].- May insert peripheral IV for IV hydration. During a review of Resident 1's physician's orders dated 11/6/2025 at 7:02 pm indicated, Dextrose-NaCl Solution 5-0.45 % [Dextrose-Sodium Chloride- an intravenous (IV) fluid that combines 5% dextrose (dextrose monohydrate) and 0.45% sodium chloride in water for injection for patients who cannot take fluids orally, to treat dehydration and provide minimal calories] Use 1000 ml [milliliters] intravenously one time only for hydration support for 1 Day D5 1/2 NS@ 75 cc/hr [cubic centimeters per hour-measure of volume rate] X 1 Liter. During an interview with Certified Nursing Assistant (CNA) 1 on 11/25/2025 at 10:30 am, CNA 1 stated that she was familiar with Resident 1. CNA 1 stated that Resident one had an open wound to her bottom. CNA 1 stated that Resident 1 Was confused sometimes more than other days. CNA 1 stated that Resident 1 would sometimes fight and refuse to get Her incontinence briefs changed and remained soiled. CNA 1 stated that on average she got Resident 1 changed at least twice per shift. CAN 1 stated that Resident 1 did not want food and would only drink coffee and eat about 25% of her meals. CNA 1 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that she reported to the charged nurse. During an interview with the Registered Nurse (RN) 1 on 11/25/2025 at 11:40 am, RN 1 stated that the outgoing RN had endorsed to her (RN1) that Resident 1 had orders to insert an IV and fluid administration for decreased oral intake but that the orders had not been carried out because Resident 1 had refused. RN 1 confirmed that the orders for labs had also not been carried out and that there was no documented evidence that the physician or Resident 1's healthcare proxy (a trusted person you legally appoint to make medical decisions for you if you become unable to communicate or decide for yourself, ensuring your healthcare wishes are followed even in an emergency or serious illness) had been informed about the refusal. During an interview with the DON on 11/26/2025 at 2:36 PM, the DON stated that when a resident consumes less than 50% of their meals the physician must be notified after two to three meals. The DON Confirmed that Resident 1 consumed less than 50% of her meals on 10/28/2025 and progressively decreased several times after that but that the physician had not been notified about this COC. The DON confirmed that the orders for inserting IV, administering IV fluids, collecting labs for CBC, BMP, UA, C&S had not been carried out and that there was no documented evidence that the physician or the healthcare proxy was notified. The DON confirmed that Resident 1's healthcare proxy and Resident 1 were not invited to any of the IDTs reviewed over the last year. During a review of the facility's policy and procedures (P&P) titled, Change in Condition: Notification of, reviewed 12/16/2024, the P&P indicated, To ensure residents, family, legal representatives, and physicians are informed 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, andnotify, 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 form of treatment); or A decision to transfer or discharge the Resident from the Center. When making notification of above, the Facility must ensure that all pertinent information is available and provided upon request to the physician and/ or NP. During a review of the facility's P&P titled, CARE PLANNING - INTERDISCIPLINARY TEAM, reviewed on 12/16/2024, indicated, Our facility's Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. The same P&P indicated the care plan is based on the resident's comprehensive assessments developed by the interdisciplinary team with included the following:1. The resident's Attending Physician. 2. A registered nurse with responsibility for the resident. 3. The Dietary Manager/Dietitian. 4. The Social Services Worker responsible for the resident. 5. The Activity Director/Coordinator. 6. Specialized Rehabilitative Service Therapists, as applicable. 7. To the extent practicable, the participation of the resident and the resident's representative(s). 8. The Charge Nurse responsible for resident care.Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, the facility failed to meet professional standards of quality by failing to carry out the physician's order for one of the three sampled residents (Resident 1) who had orders to check laboratory (lab) for blood and urine as well as intravenous (IV) fluids for poor oral intake. This failure resulted in the physician having limited information to determine the extent of Resident 1's health status and potentially worsening of Resident 1's hydration status leading to altered mental status (AMS). As a result, Resident 1 was transferred to General Acute Care Hospital (GACH) for failure to thrive (FTT- a complex syndrome characterized by a state of decline that includes weight loss, decreased appetite, poor nutrition, and inactivity), AMS, and sacral wound. Refer to F580A review of Resident 1's admission record indicated the facility admitted the resident on 11/18/2015, with diagnosis that included rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), anemia (a condition where the body does not have enough healthy red blood cells), and hypertension (HTN-high blood pressure). During a review of Resident 1's history and physical (H&P) dated 12/12/2024 indicated, Resident 1 was able to make needs known but could not make medical decisions. The same H&P indicated Resident 1's family member (FM) was the DPOA (durable power of attorney - legal authority to make Resident 1's decisions). The same P&P indicated the visit diagnoses as, Dementia without behavioral disturbance. A review of Resident 1's Minimum Data Set (MDS- standardized data collection tool) dated 8/8/2025, indicated the resident had severe cognitive impairments (a condition that involves a significant loss of abilities like memory, decision-making, and problem-solving, to the point where an individual often cannot live independently). The MDS indicated Resident 1 mostly partial/moderate assistance for activities of daily living (ADLs) such as toileting hygiene, Shower/bathe, upper and lower body dressing, and putting on/taking off footwear. During a review of Resident 1's physician's orders dated 11/5/2025 indicated the following:- CBC [complete blood count - a common blood test that measures the main components of your blood: red blood cells, white blood cells, and platelets] WITH DIFF [differential] and BASIC METABOLIC [basic metabolic panel - a blood test that measures glucose (sugar), electrolytes, and kidney function]. One time only.- CULTURE, URINE [C&S - a lab test that checks for bacteria or other germs in a urine sample to diagnose a urinary tract infection UTI]. One time only.- URINALYSIS [UA - a simple medical test of a urine sample that checks its appearance, chemical makeup, and microscopic components to help diagnose and monitor conditions like kidney disease, diabetes, and UTI].- May insert peripheral IV for IV hydration. During a review of Resident 1's physician's orders dated 11/5/2025 indicated, transfer to ER [Emergency Room] DUE TO FAILURE TO THRIVE AMS ANFD [sic] SACRAL WOUND. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents) progress note dated 11/5/2025 at 12 pm, indicated, decreased appetite/fluid intake with recommendations for registered dietician (RD) and blood tests by the physician. During a review of the nursing progress notes dated 11/5/2025 at 12:01 pm, indicated, Food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts) Weight loss. The same notes indicated recommendations for RD consultation along with labs for CBC, BMP, UA, C&S.During a review of Resident 1's physician's orders dated 11/6/2025 at 7:02 pm indicated, Dextrose-NaCl Solution 5-0.45 % [Dextrose-Sodium Chloride- an intravenous (IV) fluid that combines 5% dextrose (dextrose monohydrate) and 0.45% sodium chloride in water for injection for patients who cannot take fluids orally, to treat dehydration and provide minimal calories] Use 1000 ml [milliliters] intravenously one time only for hydration support for 1 Day D5 1/2 NS@ 75 cc/hr [cubic centimeters per hour-measure of volume rate] X 1 Liter. During a review of the patient care report dated 11/7/2025 by the Emergency Medical Technicians (EMT) for the ambulance services that transported Resident 1 to GACH, the report indicated the chief complaint was FTT. The same report indicated upon arrival, the nursing staff had (continued on next page)

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	055755	A. Building B. Wing	11/26/2025

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not checked a full set of vital signs (key indicators of a person's basic body function, including temperature, pulse [HR], respiration rate, oxygen saturation [O2 sat), and blood pressure [BP]) and had only checked Resident 1's BP and HR. during the EMTs assessment, Resident 1 was noted to had an O2 sat of 91% (normal between 92-100%) on room air and was placed on 6 liters of oxygen via nasal cannula (tubing placed to bilateral nares). During an interview with the Registered Nurse (RN) 1 on 11/25/2025 at 11:40 am, RN 1 stated that the outgoing RN had endorsed to her (RN1) that Resident 1 had orders to insert an IV and fluid administration for decreased oral intake but that the orders had not been carried out because Resident 1 had refused. RN 1 confirmed that the orders for labs had also not been carried out and that there was no documented evidence that the physician or Resident 1's healthcare proxy (a trusted person you legally appoint to make medical decisions for you if you become unable to communicate or decide for yourself, ensuring your healthcare wishes are followed even in an emergency or serious illness) had been informed about the refusal. RN 1 stated that the physician should have been informed at first refusal on 11/6/2025 so that further orders could be given to prevent Resident 1's condition from worsening. RN 1 stated that not following orders could be considered negligent. During an interview with the DON on 11/26/2025 at 2:36 PM, the DON Confirmed that reduced intake could result in dehydration and malnutrition. The DON stated that IV fluids should have been administered to prevent Resident 1 from getting dehydrated. The DON confirmed that the orders for inserting IV, administering IV fluids, collecting labs for CBC, BMP, UA, C&S had not been carried out and that there was no documented evidence that the physician or the healthcare proxy was notified. The DON stated that the physician must be immediately notified to ensure that they know what steps to take next. During a review of the facility's policy and procedure (P&P) titled, Change in Condition: Notification of, reviewed 12/16/2024 indicated, To ensure residents, family, legal representatives, and physicians are informed 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, andnotify, 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 form of treatment); or A decision to transfer or discharge the Resident from the Center. When making notification of above, the Facility must ensure that all pertinent information is available and provided upon request to the physician and/ or NP. During a review of the facility's P&P titled, Physician Orders, reviewed on 12/16/2024 indicated, This will ensure that all physician orders are complete and accurate. The same P&P indicated, Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other health care disciplines will be transcribed onto the appropriate communication system for that discipline. During a review of a P&P titled, Resident Hydration and Prevention of Dehydration, reviewed 3/4/2025, indicated, This facility will strive to provide adequate hydration and to prevent and treat dehydration. The same P&P indicated under Policy interpretation and implementation the following:- Nurses will assess for signs and symptoms of dehydration during daily care.- Laboratory tests may be ordered to assess hydration if intake and symptoms indicate possible significant dehydration.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent the deterioration of pressure injuries and provided care and services consistent with professional standards of practice for one out of three sampled residents (Resident 1) by failing to:1. Change Resident 1's incontinence briefs when she was soiled.2. Follow the physician's order for intravenous (IV) fluids administration3. Implement the physician's order for registered dietician (RD) due to poor oral intake and weight loss.4. Report Resident 1's decreased oral intake upon identification on 10/29/2025 to the physician as well as Resident 1's healthcare proxy (a trusted person you legally appoint to make medical decisions for you if you become unable to communicate or decide for yourself, ensuring your healthcare wishes are followed even in an emergency or serious illness) FM 1. This deficient practice potentially caused Resident 1's sacrococcyx pressure ulcer (a type of pressure sore (bedsore) that forms on the tailbone or lower back due to prolonged pressure on the skin, which restricts blood flow) to rapidly deteriorate. As a result, Resident 1 was transferred to General Acute Care Hospital (GACH) where she was diagnosed with severe sepsis (an infection that leads to organ dysfunction or tissue hypoperfusion. This is a more advanced stage of sepsis where the infection has caused at least one of the body's organs to malfunction, which can be indicated by signs like low urine output, elevated lactate levels, or changes in mental status), bacteremia (the presence of bacteria in the bloodstream), osteomyelitis (an infection and inflammation of the bone, mostly caused by bacteria), and intramuscular (inside the muscles), and intraspinal (situated within or going into the spine, especially the spinal canal) and expired on 11/15/2025 Refer to F580 and F658A review of Resident 1's admission record indicated the facility admitted the resident on 11/18/2015, with diagnosis that included rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), anemia (a condition where the body does not have enough healthy red blood cells), and hypertension (HTN-high blood pressure). During a review of Resident 1's history and physical (H&P) dated 12/12/2024 indicated, Resident 1 was able to make needs known but could not make medical decisions. The same H&P indicated Resident 1's family member (FM) was the DPOA (durable power of attorney - legal authority to make Resident 1's decisions). The same P&P indicated the visit diagnoses as, Dementia without behavioral disturbance. A review of Resident 1's Minimum Data Set (MDS- standardized data collection tool) dated 8/8/2025, indicated the resident had severe cognitive impairments (a condition that involves a significant loss of abilities like memory, decision-making, and problem-solving, to the point where an individual often cannot live independently). The MDS indicated Resident 1 mostly partial/moderate assistance for activities of daily living (ADLs) such as toileting hygiene, Shower/bathe, upper and lower body dressing, and putting on/taking off footwear. During a review of Resident 1's oral intake of meals indicated Resident 1 consumed less than 50% of her meals on the following dates:10/28/2025 14:30 0% Eaten (lunch) 10/29/2025 13:52 25% Eaten (lunch) 22:50 0% Eaten (dinner) 10/30/202520:17 Refused (dinner) 11/1/2025Breakfast, lunch, and dinner (not documented). 11/2/2025Breakfast - Not documentedLunch - not documented21:46 25% Eaten (dinner). 11/3/2025 18:22 Refused (dinner). 11/4/202508:17 25% Eaten (breakfast) 12:41 25% Eaten (lunch) 18:26 Refused (dinner). 11/5/2025Breakfast - not documentedLunch - not documented20:33 Refused (dinner).The above indicated Resident 1 missed or consumed less that 50% of her meals for a total of 17/32 meals. During a review of the skin assessment dated [DATE] indicated, Sacro-coccyx MASD (Moisture-Associated Skin Damage an umbrella term for inflammation or erosion of the skin caused by prolonged exposure to a source of moisture, such as urine, stool, perspiration, or wound fluid)) c [with] denuded [the skin's top layer (epidermis) has been removed, exposing the raw, red, sensitive layer underneath (dermis), often looking shiny and weepy, caused by moisture, friction, or chemicals, making it painful and prone to infection, like a raw patch of skin] skin= 3cm [centimeters- length] x 1cm [width] x 0.1 [depth] cm. During a review of Resident 1's Situation, Background, Assessment, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Recommendation (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents) progress note dated 10/29/2025 at 12 am, indicated, During weekly wound rounds c [with] wound consultant noted increased in size measurement of pressure injury on sacra-coccyx site. 0 [no] s/s [signs and symptoms] of infection, 0 c/o pain or discomfort. Poor PO [by mouth] intake c meals. Charge nurse and supervisor made aware]. The same SBAR indicated, Sacra-coccyx pressure injury- St3 [stage 3. PU stages are stage 1- reddened, unbroken skin, stage 2- Partial-thickness loss of skin, stage 3 - Full-thickness loss of skin. Dead and black tissue may be visible, and stage 4 - Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone] (re-opened)= 3.6cm [centimeters- length] x 2.9cm [width] x 0.2cm [depth], s/p [status post] debridement of devitalized tissue [the medical removal of dead, damaged, or infected tissue from a wound to promote the healing potential of the remaining healthy tissue]; 70% granulation [new, pink, and bumpy connective tissue that forms on a healing wound's surface], 30% slough [dead, stringy tissue that is often yellowish or grayish and can be soft or sticky and may be a sign of infection]; moderate serosanguinous exudate [a thin, pink or reddish wound drainage that is a mix of clear, watery serous fluid and small amounts of blood]; fragile; decline in condition. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers when there is a change of condition among the residents) progress note dated 11/5/2025 at 12 pm, indicated, decreased appetite/fluid intake with recommendations for registered dietician (RD) and blood tests by the physician. During a review of Resident 1's physician's orders dated 11/5/2025 indicated, Registered Dietician consult During a review of Resident 1's physician's orders dated 11/6/2025 at 7:02 pm indicated, Dextrose-NaCl Solution 5-0.45 % [Dextrose-Sodium Chloride- an intravenous (IV) fluid that combines 5% dextrose (dextrose monohydrate) and 0.45% sodium chloride in water for injection for patients who cannot take fluids orally, to treat dehydration and provide minimal calories] Use 1000 ml [milliliters] intravenously one time only for hydration support for 1 Day D5 1/2 NS@ 75 cc/hr [cubic centimeters per hour-measure of volume rate] X 1 Liter. During a review of Resident 1's SBAR progress note dated 11/6/2025 at 2:42 pm, indicated, Noted existing pressure injury on sacra-coccyx area to increase in size of measurements, and now c100 % slough. During a review of Resident 1's physician's orders dated 11/7/2025 indicated, transfer to ER [Emergency Room] DUE TO FAILURE TO THRIVE AMS ANFD [sic] SACRAL WOUND. During a review of Resident 1's GACH Emergency Department (ED) admission dated 11/7/2025 indicated the following visit diagnoses: Dehydration (primary)[occurs when the body doesn't have enough water to function properly because it has lost more fluid than it has consumed]. Acute renal failure (the sudden and rapid loss of the kidneys' ability to filter waste from the blood, balance fluids, and regulate electrolytes). Sepsis with acute renal failure without septic shock (a body-wide infection (sepsis) triggers a sudden failure of the kidneys to filter waste from the blood). Severe sepsis (an infection that leads to organ dysfunction or tissue hypoperfusion. This is a more advanced stage of sepsis where the infection has caused at least one of the body's organs to malfunction, which can be indicated by signs like low urine output, elevated lactate levels, or changes in mental status).The same ED admission note included the following hospital problems:respiratory failure (HCC) AKI (acute kidney injury) Bacteremia (the presence of bacteria in the bloodstream). Encephalopathy (a disorder that affects the brain's function or structure, causing confusion, memory loss, personality changes, and trouble thinking). Hypernatremia (abnormally high concentration of sodium levels in the blood often caused by dehydration). Lactic acidosis (abnormal buildup in the bloodstream (lactic acidosis) that occurs due to specific types of malnutrition). Metabolic acidosis (a condition where too much acid builds up in the body's fluids which may result from a lack of food and nutrients). Uremia (the buildup of toxins, like urea, in the blood when the kidneys can't filter them out properly, leading to a serious toxic condition).During a review of the ED to hospital admission notes dated 11/7/2025 indicated a weight of 95 pounds (lbs.). The same notes indicated, Per EMS (emergency medical services), pt [patient - Resident 1] has not eaten since last night, and has not taken medications. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EMT [emergency medical technician] states O2 sat [oxygen saturation -oxygen in the blood] 80's [normal levels between 92-100%] in field, pt placed on NC [nasal cannula - a tube placed in the nostrils] 6L [liters per minute]. The same notes indicated laboratory (lab) report results which indicated the following: Sodium - 158 mmol/L (millimoles per liter, is a unit of concentration that measures the amount of a substance dissolved in a liter of liquid) [Ref Range: 132 - 146]. Chloride - 117 mmol/L [Ref Range: 98 - 107]. Urea nitrogen: 128.0 mg/dL [Ref Range: 9.8 - 20.1] Creatinine: 4.40 mg/dL [Ref Range: 0.57 - 1.11] Lactate: 4.1 mmol/L [Ref Range: 0.5 - 2.2] WBC 16.03 During a review of the GACH H&P spine consult (a medical specialist who focuses on diagnosing and treating conditions affecting the bones, joints, and soft tissues of the spine) dated 11/8/2025 indicated the hospital placed the consultation due to concern for intraspinal gas in setting of sacral decubitus ulcer (PU). The consultation notes indicated CT (computed tomography - a medical imaging method that uses X-rays to take multiple cross-sectional slices of the body, which a computer then combines to create a detailed 3D picture) pelvis (the bowl-shaped bone structure at the base of the spine that connects the torso to the legs) confirmed sacral decubitus ulcer with subcutaneous (fatty layer tissue under the skin), intramuscular (inside the muscles), and intraspinal (situated within or going into the spine, especially the spinal canal)gas. Erosive (damaged, destroyed, or worn away) changes of the sacrum suggestive of osteomyelitis (an infection and inflammation of the bone, mostly caused by bacteria). During a review of the GACH inpatient consultation notes dated 11/10/2025 indicated under assessment, 1. Proteus mirabilis bacteremia [a serious bloodstream infection caused by the Proteus mirabilis bacterium, which has entered the bloodstream and is causing systemic illness]- possibly from superinfected sacral ulcer versus other. Other sources considered include urinary (however, urinalysis has no pyuria making it less likely) and respiratory (though clinically has no evidence of a pneumonia)2. Sacral decubitus ulcer with osteomyelitis and subcutaneous and intramuscular gas-Evaluated by surgery without concerns of necrotizing soft tissue infection-Reasonable to treat for a short course for superimposed SSTI [skin soft tissue infection]. Would NOT treat for osteomyelitis given largely absence of benefit in treating osteomyelitis complicating sacral ulcers when overlying defect (ulcer) is not corrected. During an interview with the treatment nurse (TN) 1 on 11/25/2025 at 9:59 am, TN 1 stated that Resident 1 was no -complaint with her care especially getting changed when she was soiled. TN 1 stated that on a few occasions Resident 1 was found to be completely soaked in urine from the night before. TN 1 stated that the wound was observed to seem worse when found in that stated (not changed and cleaned). During an interview with Certified Nursing Assistant (CNA) 1 on 11/25/2025 at 10:30 am, CNA 1 stated that she was familiar with Resident 1. CNA 1 stated that Resident one had an open wound to her bottom. CNA 1 stated that Resident 1 Was confused sometimes more than other days. CNA 1 stated that Resident 1 would sometimes fight and refuse to get Her incontinence briefs changed and remained soiled. CNA 1 stated that on average she got Resident 1 changed at least twice per shift. CAN 1 stated that Resident 1 did not want food and would only drink coffee and eat about 25% of her meals. CNA 1 stated that she reported to the charged nurse. During an interview with registered nurse (RN) 1 on 11/25/2025 at 11:40 am, RN 1 stated that She had noted that there were orders when she came in during her shift on 11 7 2025 ordered on 11/6/2025 for inserting an IV and administering fluids due to poor oral intake which had not been carried out the previous night. RN1 stated that the previous RN had endorsed to her that resident one had refused to have an IV inserted. RN 1 stated that she had attempted to insert the IV that was also unsuccessful, so she reported to the nurse practitioner who had come in to see Resident 1. The NP ordered for Residence 1 to be transferred to acute for poor oral intake. RN 1 Stated that when a resident refuses a procedure, the doctor must be informed about the refusal. RN1 stated that the physician should have been notified on 11/6/2025 when Resident 1 refused to have the IV inserted as that is not following physician's orders. RN 1 stated that the importance of notifying the physician is to ensure that the resident's condition does not get worse and get orders for what to do next. During an interview with FM 1 and FM 2 on 11/25/2025 at 3:06 pm, FM 1 stated that (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1 was in her usual state of health where she would helped up out of bed and sit in her wheelchair and socialize with other residents in the dining room, FM 1 stated that Resident gradually stopped and stayed in bed and was noted to have increased confusion. FM 2 stated that the facility had not reached out to any family members for a meeting to discuss Resident 1's care or progress in over a year. FM 1 stated that the facility did not inform them that Resident 1 had pressure ulcers nor that she was refusing care. FM 1 stated that Resident was confused and unable to make decisions. FM 2 stated that the facility called her on 11/6/2025 for the first time to inform her that Resident 1 was refusing to eat and refusing to have an IV inserted to administer IV fluids to support her while she was refusing to eat. FM 1 stated that the facility called her on 11/7/2025 to inform her that Resident 1 was sent to GACH for poor oral intake. When FM 1 and FM 2 arrived at GACH, they were both shocked at Resident 1's condition as she appeared to be very skinny and had a wound to her sacrum which was very scary to look at it had reached the bone and were told that Resident 1 had infection from the wound which had gone to her blood. During an interview with TN 2 on 11/26/2025 at 9 am, TN 2 stated that during a skin sweep with the wound care specialist (a medical professional like a physician or nurse with extra training to heal hard-to-heal or complex wounds, such as diabetic ulcers, bedsores, or surgical wounds that won't close, using advanced techniques to speed up healing and prevent complications, working as part of a team) stated that on 9/18/2025 during a skin sweep (comprehensive, head-to-toe examination of a patient's entire skin to) of the facility, Resident 1 was found to have MASD. TN 2 stated that Resident 1 was not eating well, had lost weight which could have contributed to her (Resident 1) PU reopening on 10/21/2025. TN 2 confirmed that he had found Resident 1 soiled from the night before and reported it to administration and was changed right away. During an interview with the DON on 11/26/2025 at 2:36 PM, the DON stated that when a resident consumes less than 50% of their meals the physician must be notified after two to three meals. The DON Confirmed that Resident 1 consumed less than 50% of her meals on 10/28/2025 and progressively decreased several times after that but that the physician had not been notified about this COC. The DON Stated that it is important to notify the physician about decreased oral intakes for the resident's well-being and for improving PU outcomes. The DON Confirmed that reduced intake could result in dehydration. The DON Confirmed that reduced intake could result in dehydration and malnutrition. The DON stated that IV fluids should have been administered to prevent Resident 1 from getting dehydrated. The DON confirmed that the orders for inserting IV, administering IV fluids, collecting labs for CBC, BMP, UA, C&S had not been carried out and that there was no documented evidence that the physician or the healthcare proxy was notified. The DON stated that the physician must be immediately notified to ensure that they know what steps to take next. During a review of a policy and procedure (P&P) titled, Change in Condition: Notification of, reviewed 12/16/2024 indicated, To ensure residents, family, legal representatives, and physicians are informed 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, andnotify, 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 form of treatment); or A decision to transfer or discharge the Resident from the Center. When making notification of above, the Facility must ensure that all pertinent information is available and provided upon request to the physician and/ or NP. During a review of a P&P titled, Physician Orders, reviewed on 12/16/2024 indicated, This will ensure that all physician orders are complete and accurate. The same P&P indicated, Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other health care disciplines will be transcribed onto the appropriate (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	communication system for that discipline. During a review of a P&P titled, Resident Hydration and Prevention of Dehydration, reviewed 3/4/2025, indicated, This facility will strive to provide adequate hydration and to prevent and treat dehydration. The same P&P indicated under Policy interpretation and implementation the following:- Nurses will assess for signs and symptoms of dehydration during daily care.- Laboratory tests may be ordered to assess hydration if intake and symptoms indicate possible significant dehydration. During a review of the P&P titled, Skin Integrity Management, reviewed 12/16/2024, indicated, To provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and Promote healing of all wounds. The same P&P indicated, Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated. Implement pressure ulcer prevention for identified risk factors Determine the need for support surface for bed and chair. Determine the need for offloading devices. Turning and repositioning based on resident care needs For surgical wounds (e.g., flaps, grafts, donors, incisions, etc.), follow specific orders from the surgeon. Implement Special Wound Care treatments/techniques, as indicated and ordered Notify patient, resident representative of plan of care Notify Dietitian and/or rehabilitation services as indicated. During a review of the P&P titled, CARE PLANNING - INTERDISCIPLINARY TEAM, reviewed on 12/16/2024, indicated, Our facility's Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. The same P&P indicated the care plan is based on the resident's comprehensive assessments developed by the interdisciplinary team with included the following:1. The resident's Attending Physician. 2. A registered nurse with responsibility for the resident. 3. The Dietary Manager/Dietitian. 4. The Social Services Worker responsible for the resident. 5. The Activity Director/Coordinator. 6. Specialized Rehabilitative Service Therapists, as applicable. 7. To the extent practicable, the participation of the resident and the resident's representative(s). 8. The Charge Nurse responsible for resident care.Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family.