

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055755	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Sharon Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a Comprehensive Care Plan (a personalized document that outlines a resident's needs, goals, and the specific services required to achieve them, ensuring consistent and holistic care) for one of four sampled residents (Resident 3), to address Resident 3's left ear hearing loss. This failure resulted in the absence of individualized interventions and assessments to manage Resident 3's reported loss of hearing to his left ear. 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 epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures, which are sudden surges of abnormal electrical activity in the brain, causing temporary disruptions in behavior, movement, or awareness), femur fracture (a break in the thigh bone) and end stage renal disease (ESRD- Condition in which the kidneys cease functioning on a permanent basis leading to the need for regular course of long-term dialysis or kidney transplant to maintain life). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 10/25/2025, the MDS indicated Resident 3 had cognitive skills for daily decision making. The MDS indicated Resident 3 was independent (Resident completes the activity by themselves with no assistance from a helper) for eating, personal hygiene, oral hygiene, required maximal assistance (Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for toileting, showering, lower body dressing, putting on taking off footwear, and partial assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for upper body dressing, roll left and right, sit to lying, and lying to sitting on side of bed. The MDS indicated Resident 3 had the ability to hear adequately. During a review of Resident 3's Ear Nose and Throat (ENT) consult, dated 12/25/2025, the ENT consult indicated Resident 3 was examined for history of hearing loss for three years, as a courtesy visit. The ENT consult included treatment to remove wax from the ear canal, and patient education, as well as a follow up in six months or more. During a review of Resident 3's medical record, no Care Plan interventions were found that addressed Resident 3's history of hearing loss to include problem statement, goals, monitoring parameters, comfort measures, or physician notification requirements. During a concurrent observation and interview on 1/7/2026 at 1 PM with Resident 3, in Resident 3's room, Resident 3 was sitting up in bed and expressed concern with his hearing loss to his left ear. Resident 3 stated he had received treatment once at the facility but wanted to know if other interventions would be offered to him since he still experienced hearing loss to his left ear which had started before admission to the facility. During a concurrent interview and record review interview on 1/8/2026 at 11:08 AM with the Minimum Data Set (MDS) nurse, the MDS nurse stated she had searched the medical record for Resident 3's hearing loss but no care plan, orders, or any guidance was found to treat Resident 3's hearing loss diagnosis. MDS nurse stated Resident 3 should have a Care</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055755
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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan for each diagnosis and problem currently affecting him to meet his care needs. During an interview on 1/8/2026 at 11:18 PM with the Director of Nursing (DON), the DON stated a Comprehensive Care Plan should have been initiated for Resident 3's hearing loss to include interventions to guide nurses to determine if hearing loss worsens, communicate effectively with Resident 3, and notify provider if problem worsens. The DON stated failure to have interventions in place placed Resident 3 at risk for unmet needs and worsening hearing condition. During a review of the facility's policy and procedure titled Care Plan Comprehensive, dated 8/25/2021, indicated the facility's interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident's identified problem areas, incorporate risk and contributing factors associate with identified problems, build on resident's needs, strengths, preferences, identify professional services required, and aid in preventing or reducing declines in resident's functional level. The resident's comprehensive care plan is developed within seven days of the completion of the comprehensive assessment (MDS) and updated when there has been a significant change in resident's condition, when readmitted to the facility, and at least quarterly.</p>