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	04/30/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) to meet the needs of five of 18 sampled residents (Resident 2, Resident 9, Resident 11, Resident 40, and Resident 88) by failing to ensure to: 1.Implement Resident 2's care plan for at risk for skin breakdown. 2.Develop a care plan for Resident 9's language communication preference. 3.Implement Resident 11's care plan for Activities of Daily Living (ADLs, the basic self-care tasks such as bathing, dressing, eating, and mobility that individuals perform daily to maintain independence and hygiene) self-care performance deficit (when a resident cannot independently perform daily activities due to physical or mental health limitations). 4.Develop a care plan for Resident 40's flu (a respiratory virus) vaccine (medications used to prevent diseases usually given by injection or by mouth) refusal. -Develop a care plan for Resident 40's arteriovenous (AV) fistula/shunt (a surgically created connection linking an artery [a type of blood vessel that carries oxygen-rich blood the entire body] directly to a vein [a type of blood vessel that collected oxygen-poor blood and returns it to the heart] to facilitate blood flow for HD) in the right upper arm. 5. Develop a care plan for Resident 88's refusal of the pneumonia (PNA-an infection/inflammation in the lungs) vaccines. These failures had the potential for Resident 2, Resident 9, Resident 11, Resident 40, and Resident 88 to receive inadequate care causing resident injury and harm.Findings: 1.During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted Resident 2 on 7/16/2025 and re-admitted the resident on 9/17/2025 with diagnoses including gastrostomy (GT- a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration), malnutrition (lack of sufficient nutrients in the body), and generalized muscle weakness (weakening, shrinking, and loss of muscle). During a review of Resident 2's History and Physical (H&P) dated 9/3/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 3/20/2026, the MDS indicated Resident 2 had impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and maximal assistance (helper does more than half the effort) to dependent (helper does all the effort) from staff for ADLs. The MDS indicated Resident 2 was at risk of developing pressure ulcers/injuries (PI, injuries to the skin and underlying tissue resulting from prolonged pressure on the skin) with treatment for pressure reducing devices for bed. During a review of Resident 2's Braden Scale (pressure ulcer risk predictor tool) for predicting pressure ulcer risk (BSPPUR) dated 4/14/2026, the BSPPUR indicated Resident 2 was at risk for (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure ulcer development. During a review of Resident 2's Care Plan Report revised on 4/14/2026, Care Plan Report indicated Resident 2 was at risk for skin breakdown, related to advanced age (greater than 75 years), decreased activity, frail fragile skin, impaired cognition and limited mobility with intervention to provide lower extremity protectors-prevalon boots (type of heel protector to help reduce the risk of bedsores by keeping the heel floated, relieving pressure) and off load/float heels while in bed. During a concurrent observation and interview on 4/27/2026 at 9:38 AM, with Certified Nursing Assistant 9 (CNA 9) and Resident 2, inside Resident 2's room, Resident 2 was observed in bed with both heels touching the bed mattress, and without the prevalon boots. CNA 9 stated that both heels were supposed to be elevated, not touching the bed mattress. CNA 9 also stated Resident 2 was supposed to have prevalon boots. During a concurrent observation and interview on 4/28/2026 at 10:20 AM with Licensed Vocational Nurse 3 (LVN 3), inside Resident 2's room, Resident 2 was observed in bed with both heels touching the bed mattress and without prevalon boots. LVN 3 stated that since Resident 2 was on a low air loss mattress (LAL-a mattress designed to prevent and treat pressure wounds), Resident 2 did not need any offloading/floating of the heels and as well as the prevalon heels. During an interview on 4/30/2026 at 11:51 AM, with the Director of Nursing (DON), the DON stated that Resident 2 was at risk for skin breakdown and nursing staff should be following the care plan specifically for Resident 2. The DON stated and validated that Resident 2's bilateral heels should still be offloaded when in a LAL mattress and Resident 2 should be provided with prevalon boots per care plan. The DON also stated importance of implementing care plans to be able to provide proper care to Resident 2. 2. During a review of Resident 9's admission Record, the admission Record indicated the facility admitted Resident 9 on 3/21/2026 with diagnoses including atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls), metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood) and dementia (a chronic or persistent disorder of mental processes caused by brain disease). During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 had impaired cognition for daily decision-making and maximal assistance from staff for ADLs. During a review of Resident 9's H&P dated 4/27/2025, the H&P indicated Resident 9 did not have the capacity to understand and make decisions. During an interview with Resident 9 and Activities Assistant (AS) on 4/27/2026 at 11:02 AM during initial tour, Resident 9 was speaking a different language, unable to speak English when asked if she (Resident 9) could communicate in English. The AS stated that Resident 9 mainly spoke a different language and facility staff used communication board to communicate with her (Resident 9). During a concurrent interview and record review on 4/30/2026 at 11:31 AM with the DON, Resident 9's Care Plan Report was reviewed. The Care Plan Report indicated Resident 9 did not have a care plan in regards with Resident 9's communication needs related to language barrier. The DON stated that Resident 9 was at risk for impaired verbal communication related to language barrier since (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 9 spoke mainly spoke a different language, and facility communicated via communication board written in Resident 9's language. The DON stated it was important to have an individualized and comprehensive care plan for Resident 9's communication needs. 3. During a review of Resident 11's admission Record, the admission Record indicated the facility admitted the resident on 8/17/2024 with diagnoses that included type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), End Stage Renal Disease (ESRD, irreversible kidney damage), and dependence on renal (kidney) dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 11's MDS dated [DATE], the MDS indicated Resident 11 was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 11 normally used a wheelchair. The MDS indicated Resident 11 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort) with sit to stand mobility, chair/bed-to-chair transfer, toilet transfer, and tube/shower transfer. During a review of Resident 11's Nursing Documentation Evaluation dated 2/22/2026 at 6:57 PM, the Nursing Documentation Evaluation indicated Resident 11 had fall risk factors (any attribute, characteristic, or exposure that increases the likelihood of developing a disease, injury, or negative outcome) that included impaired balance (a condition in which an individual feels unsteady), predisposed disease or injury (a pre-existing medication condition, physical, or genetic trait that increases an individual's susceptibility to develop a different disease or injury), and required assistance for toileting. During a review of Resident 11's Care Plan Report dated 4/19/2026, the Care Plan Report indicated Resident 11 had an ADLs self-care performance deficit related to impaired mobility (a condition that limits a person's ability to move freely or perform activities), generalized weakness (reduced muscle strength throughout the entire body), polyneuropathy (a condition in which multiple peripheral nerves in the body become damaged and causing numbness, tingling, and pain), and the use of the wheelchair. The Care Plan Report indicated the goal for Resident11 was to maintain Resident 11's current level of mobility. The Care Plan Report indicated Resident 11 required total assistance with transfers, two staff participation, the use of the Hoyer lift machine, and a yellow color medium size sling (a supportive fabric device used with resident lifts to safely transfer residents between beds, chairs, and the floor). During a review of Resident 11's SBAR (Situation, Background, Assessment, Recommendation – a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form dated 4/20/2026, the SBAR Communication Form indicated Resident 11 had a fall. The SBAR Communication Form indicated that while the CNA (unidentified) was getting Resident 11 up to go to dialysis Resident 11 slipped from the bed to the floor and landed on her (Resident 11) knees. The SBAR Communication Form indicated Resident 11 was observed lying on the floor by the charge nurse (unidentified) when the charge nurse was informed that Resident 11 had a fall. The SBAR Communication Form indicated Resident 11 had right and left knee pain that (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1 rated a level five (rated on a scale of 1-10 with 10 being the worst). The SBAR Communication Form indicated Resident 11 did not show any obvious signs of injury. The SBAR Communication Form indicated Resident 11 stated her (Resident 11) knees hurt from the fall. The SBAR Communication Form indicated Resident 11 was safely put back on the wheelchair assisted by three people using a bed sheet. The SBAR Communication Form indicated Resident 11 was given Tylenol (acetaminophen, a medication used to reduce pain). The SBAR Communication Form indicated Resident 11 was taken to the lobby to wait for transportation to dialysis. The SBAR Communication Form indicated Resident 11 left the facility in stable condition. The SBAR Communication Form indicated Resident 11's Nurse Practitioner (NP, unidentified) was notified on 4/20/2026 at 7:30 AM of Resident 11's fall. The SBAR Communication form indicated Resident 11's NP ordered to monitor Resident 11 and to inform the NP if an x-ray (an imaging test that uses electromagnetic radiation to create pictures of bones and tissues) was needed when Resident 11 returned from dialysis. During a review of Resident 11's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 4/20/2026 to transfer Resident 11 to General Acute Care Hospital (GACH 1's) emergency room (ER) for further evaluation related to knee pain. During a review of Resident 11's GACH 1 bilateral (both) knee x-ray report dated 4/20/2026 at 5:41 PM, the bilateral knee x-ray report indicated Resident 11 had a mildly displaced comminuted extra-articular fracture of the right distal femoral meta diaphysis (an injury where the right lower thigh bone is broken into multiple pieces). The bilateral knee x-ray report indicated Resident 11 had a displaced comminuted peri implant fracture involving the distal left femur (an injury where the lower thigh bone is broken into multiple pieces near an existing orthopedic implant). During a review of Resident 11's Hospitalist History and Physical from GACH 1 dated 4/21/2026, the Hospitalist History and Physical indicated Resident 11 presented to GACH 1 on 4/20/2026 for a fall. The Hospitalist History and Physical indicated Resident 11 had a mechanical fall (a fall caused by an external, physical force. such as tripping, slipping, or stumbling rather than an internal medical issue like fainting or dizziness) while trying to get back into the wheelchair and landed on her (Resident 11) knees. The Hospitalist History and Physical indicated Resident 11 had severe pain, was unable to bear weight, and was found to have bilateral distal femur fractures. During a review of Resident 1's Orthopedic Arthroplasty (a physician who focuses on replacing, repairing, or reconstructing damaged joints) Progress Note from GACH 1 dated 4/22/2026 at 6:08 AM, the Orthopedic Arthroplasty Progress Note indicated Resident 11 sustained bilateral distal femur fractures after an accident at the resident's care facility. The Orthopedic Arthroplasty Progress Note indicated Resident 11 was informed that it was best to address treatment for Resident 11's legs one leg at a time given Resident 11's comorbidities (the presence of more than one disease or disorder) and the risks of anesthesia (is the use of medications to block pain during medical procedures or surgery) and surgery. The Orthopedic Arthroplasty Progress Note indicated the intended plan was for Resident 11 to have an Open Reduction and Internal Fixation (ORIF, a surgical procedure to repair severe bone fractures) of the right femur first. The Orthopedic Arthroplasty Progress Note indicated surgery was planned for Resident 11's right femur on 4/23/2026. During a telephone interview on 4/28/2026 at 10:29 AM with Resident 11, Resident 11 stated she (Resident 11) was at the GACH (unidentified). Resident 11 stated that on 4/20/2026 at almost 7 AM, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA 7 was assisting her (Resident 11) to get to the wheelchair so the resident could go to dialysis. Resident 11 stated CNA 7 stood behind the wheelchair and grabbed the resident by her (Resident 11) sweatpants and waist. Resident 11 stated she (Resident 11) fell to the floor and landed on both knees. Resident 11 stated CNA 7 and her roommate (unidentified) were the only people in the room when she (Resident 11) fell. Resident 11 stated only CNA 7 was helping her Resident 11 during the resident's transfer. Resident 11 stated Registered Nurse 3 (RN 3) came to the room after Resident 11 had fallen. Resident 11 stated CNA 7 and RN 3 helped her (Resident 11) back to the wheelchair after the fall. Resident 11 stated she (Resident 11) was having a lot of pain. Resident 11 stated her pain level was 20, out of 10. Resident 11 stated she (Resident 11) was then taken to dialysis. Resident 11 stated she (Resident 11) was not doing good at the dialysis facility because she (Resident 11) was in a lot of pain. Resident 11 stated she (Resident 11) asked to go to the GACH (unidentified) when she (Resident 11) was at the dialysis facility. Resident 11 stated both of her (Resident 11) legs were broken. Resident 11 stated she (Resident 11) had surgery on her right leg on 4/23/2026 and was scheduled to have another surgery on her left leg on 4/30/2026. Resident 11 stated I'm so frustrated, and I am in a lot of pain. During a telephone interview on 4/29/2026 at 8:45 AM with CNA 7, CNA 7 stated that on 4/20/2026 at 6:50 AM she (CNA 7) was transferring Resident 11 from the bed to the wheelchair to get Resident 11was ready to go to dialysis. CNA 7 stated there were no other staff present in Resident 11's room at the time the CNA was assisting Resident 11 to the wheelchair. CNA 7 stated she (CNA7) was trying to get the wheelchair into position by Resident 11's bed, when Resident 11 started scooting to the edge of the bed trying to get to the wheelchair. CNA 7 stated Resident 11 started to slide to the floor. CNA 7 stated she (CNA 7) tried to grab Resident 11 under the resident's arms, but Resident 11 landed on her (Resident 11) knees. CNA 7 stated she (CNA 7) assisted Resident 11 to lay on her (Resident 11) back and called RN 3 to Resident 11's room. CNA 7 stated that Resident 11 said her (Resident 11) knees were hurting, but CNA 7 could not remember the resident's pain level. During an interview on 4/29/2026 at 9:29 AM with the Director of Nursing (DON), the DON stated RN 3 was on vacation. On 4/29/2026 at 9:29 AM an attempt to contact RN 3 by telephone was made, but RN 3 could not be reached for an interview. During a telephone interview on 4/29/2026 at 10:36 AM with Dialysis Registered Nurse 1 (DRN 1), DRN 1 stated she (DRN 1) worked at Dialysis Facility 1 (DF 1). DRN 1 stated Resident 11 received dialysis at DF 1. DRN1 stated she (DRN 1) was one of the nurses who assisted Resident 11 on 4/20/2026. DRN 1 stated Resident 11 informed DRN 1 that she (Resident 11) had fallen when she (Resident 11) was being assisted by a staff member (unidentified) at the facility during a transfer. DRN 1 stated Resident 11 informed DRN 1 that the person (unidentified) who was transferring the resident at the SNF was holding the resident from behind, when Resident 11 slipped and fell on her (Resident 11) knees. DRN 1 stated Resident 11 had a pain level of 10 out of 10 while at DF 1. DRN 1 stated that after dialysis Resident 11 stated she (Resident 11) would not be able to get back into the wheelchair, because it was too painful for Resident 11. DRN 1 stated Resident 11 wanted to go to the ER. During an interview on 4/29/2026 at 10:42 AM with Dialysis LVN 1 (DLVN 1), DLVN 1 stated that on 4/20/2026 (unidentified time), he (DLVN 1) called DRN 1 to assess Resident 11 at DF 1. DLVN 1 stated that Resident 11 had informed him (DLVN 1) that she (Resident 11) had slid and landed on both (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her (Resident 11) knees when a staff (unidentified) assisted Resident 11 during a transfer at the SNF. DLVN 1 stated Resident 11 had a 10 out of 10 pain level to both of her (Resident 11) knees. DLVN 1 stated that when Resident 11 finished dialysis, Resident 11 requested a gurney (stretcher) transportation to the GACH (unidentified). DLVN 1 stated Resident 11 could not bend her (Resident 11) knees because it was too painful. DLVN 1 stated the DF1 called 911 (emergency services phone number) and Resident 11 was transferred to the GACH (unidentified). On 4/29/2026 at 1:43 PM a second attempt to contact RN 3 by telephone was made. RN 3 could not be reached for interview. During a concurrent interview and record review on 4/29/2026 at 3:33 PM with the DON, Resident 11's Care Plan Report dated 4/19/2026 was reviewed. The DON stated a care plan was a guide that had interventions for the nurses (in general) and the staff (in general) to follow the care plan to provide good care for the residents (in general). The DON stated the care plan was resident centered and based on resident needs. The DON stated Resident 11 had a care plan for an ADL self-care performance deficit related to impaired mobility, generalized weakness, polyneuropathy, and use of the wheelchair. The DON stated Resident 11's ADL self-care performance deficit care plan had an intervention for transfers. The DON stated Resident 11's ADL self-care performance deficit care plan indicated Resident 11 required total assistance with transfers, two staff participation, use of the Hoyer lift machine, and a medium yellow color sling size. The DON stated staff (in general) were expected to follow Resident 11's care plan when transferring the resident. The DON stated that if Resident 11's care plan indicated the resident required total assistance with transfers, two staff participation and use of the Hoyer lift machine it was the expectation that the resident be transferred with two staff members. The DON stated Resident 11's care plan was not followed. The DON stated Resident 11 was being transferred to the wheelchair from the bed by one staff member, CNA 7, on the morning of 4/20/2026. The DON stated it was important that Resident 11's care plan be followed for safety and prevention of injury. The DON stated Resident 11's fall on 4/20/2026 could have been prevented if two staff members transferred Resident 11 from the bed to the wheelchair on 4/20/2026. During an interview on 4/30/2026 at 11:31 AM with Restorative Nursing Assistant 2 (RNA 2), RNA 2 stated she (RNA 2) was familiar with Resident 11. RNA 2 stated she (RNA 2) was often called to help transfer the resident to and from the wheelchair to the bed, especially after dialysis. RNA 2 stated she (RNA2) had just assisted Resident 11 with a transfer the week before. RNA 2 stated Resident 11 required a gait belt (a strap with a metal or plastic buckle, used by caregivers to safely assist individuals with mobility issues during walking or transfers) and assistance from two staff members with transfers. During a concurrent interview and record review on 4/30/2026 at 12:33 PM with the Director of Staff Development (DSD), Resident 11's Care Plan Report dated 4/19/2026 was reviewed. The DSD stated Resident 11's Care Plan Report indicated Resident 11 needed two-person assistance with a Hoyer lift for transfers. The DSD stated that based on Resident 11's care plan, the CNAs (in general) were expected to have two-persons with a Hoyer lift when assisting Resident 11 with transfers. The DSD stated Resident 11's care plan needed to be followed. The DSD stated the care plan was a guide that indicated what the staff (in general) needed to do for Resident 11. The DSD stated interventions on the care plan were to be followed for the safety of the residents (in general). The DSD stated injury to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a resident (in general) could happen if interventions on the care plan were not followed. The DSD stated if Resident 11's care plan was followed and two staff were present and used a Hoyer lift during Resident 11's transfer, the resident's fall on 4/20/2026 could have been prevented. 4. During a review of Resident 40's admission Record, the admission Record indicated the facility originally admitted Resident 40 on 7/12/2023 and was readmitted on [DATE] with diagnoses including end stage renal disease (ESRD-a medical condition in which a person's kidney [organ in the body that filters waste and excess fluid from the blood] stop functioning on a permanent basis), and dependence on hemodialysis (HD-a life-sustaining treatment for kidney failure that acts as an artificial kidney, filtering waste, toxins and excess water from the person's body using a machine). During a review of Resident 40's H&P dated 2/19/2026, the H&P indicated Resident 40 had a capacity to understand and make decisions. During a review of Resident 40's MDS dated [DATE], the MDS indicated Resident 40 had intact cognition for daily decision-making and with varying needs on assistance from being independent to maximal assistance from staff for ADLs. During a review of Resident 40's vaccine consent form dated 8/18/2025, the vaccine consent form indicated Resident 40 declined flu vaccine. During a concurrent interview and record review on 4/30/2026 at 1:30 PM, with the Infection Preventionist Nurse (IPN), Resident 40's Care Plan Report was reviewed. Resident 40's Care Plan Report indicated missing refusal of flu vaccine care plan. The IPN stated that Resident 40 refused flu vaccine and was supposed to have to have a care plan for refusal of the flu vaccine. During an interview on 4/30/2026 at 2:02 PM with the DON, the DON stated it was important to develop a care plan when a resident (in general) refused medication, treatment and/or any care services provided by the facility. The DON stated that when a resident refused vaccines, the facility was supposed to develop a care plan for refusal since Resident 40 would be at risk for infection. -During a review of Resident 40's MDS dated [DATE], the MDS indicated the resident received dialysis (a medical treatment that acts as an artificial kidney, filtering waste products, toxins, and excess water from the blood when a person's kidneys can no longer perform these tasks properly). During a review of Resident 40's Order Summary Report dated 11/3/2025, the Order Summary Report indicated dialysis on Tuesday, Thursday, and Saturday using right chest Permacath (a flexible, soft tube placed into a large vein to use for short term dialysis) access site. During a review of Resident 40's Order Summary Report dated 1/26/2026, the Order Summary Report indicated HD access site monitoring location on the left arm shunt. During a review of Resident 40's Order Summary Report dated 1/26/2026, the Order Summary Report indicated to remove the dressing from Resident 40's left arm shunt post-dialysis treatment. During a review of Resident 40's Order Summary Report dated 1/30/2025, the Order Summary Report indicated Resident 40 had an external HD Permacath on the right chest. During a review of Resident 40's Order Summary Report dated 2/16/2026, the Order Summary Report (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated not to perform blood pressure (BP, the force of blood pushing against the artery walls as the heart pumps it around the body) measurements, venipunctures (blood draws), or intravenous (IV, fluids given directly into the blood stream) therapy on the access arm (unidentified arm). During a review of Resident 40's Care Plan Report dated 2/16/2026, the Care Plan Report indicated HD access site monitoring of the left arm shunt. The Care Plan Report indicated Do not perform BP measurements, venipunctures, or IV therapy on the access arm. The Care Plan Report indicated dialysis on Tuesday, Thursday, and Saturday using left chest Permacath access site. During a review of Resident 40's Body Check dated 2/19/2026, the report indicated Right medial of upper arm surgical incision with dermabond [a skin adhesive that holds wound edges together following surgical incisions]. During a review of Resident 40's Access Details undated, the report indicated Resident 40's left upper arm AV fistula was permanently unusable on 9/26/2024. The report did not indicate a removal date for the left upper arm AV fistula. The report indicated a chest Permacath actively in use starting 9/26/2024. The report indicated the previous chest Permcath was removed on 10/9/2023. The report indicated an AV fistula was placed in Resident 40's right upper arm on 2/11/2026. During a concurrent observation and interview on 4/27/2026 at 11:37 AM with Resident 40 in Resident 40's room, Resident 40 had a Permacath on the right upper chest. Resident 40 stated the left upper arm AV fistula was removed and he (Resident 40) currently would get dialysis through the temporary Permcath. Resident 40 stated the right upper arm fistula was placed a couple months ago, but it could not be used until May 2026. During a concurrent interview and record review on 4/29/2026 at 9:20 AM with Licensed Vocational Nurse 2 (LVN 2), Resident 40's Special Instructions, undated was reviewed. The instructions indicated, No BP on left arm. LVN 2 stated new orders should have been obtained to ensure staff do not take BP on the right upper arm with the AV fistula. During an interview on 4/29/2026 at 9:29 AM with Registered Nurse (RN) 1, RN 1 stated Resident 40's AV shunt site should have been updated in the chart but was not. RN 1 stated it is important for care plan interventions to be accurate because staff might take BP on the right arm which has the AV fistula. RN 1 stated pressure from the BP cuff can damage the AV fistula, cause clotting and make the HD access unusable. During an interview on 4/29/2026 at 2:39 PM with the Minimum Data Set Coordinator (MDSC), the MDSC stated the dialysis order, AV fistula location, and BP restrictions should have been clarified with the doctor. The MDSC stated orders and care plans must be updated for accuracy of care. The MDSC stated taking BP on the access site can damage the AV fistula. The MDSC stated Resident 88 could not get HD if there was no usable access site, so the toxins would build up in the body, and the resident would end up hospitalized . During a concurrent interview and record review on 4/30/2026 at 10:20 AM with the DON, the facility's policy and procedure (P&P) titled, Dialysis Care, dated August 2021 was reviewed. The P&P indicated The Interdisciplinary Team (IDT) will ensure that the resident's care plan includes documentation of the resident's renal condition and necessary precautions (e.g., shunt site, weights, dietary and fluid restrictions, no BP on affected side, lab draws, IV, injection on arm with shunt, observe for signs and symptoms of infection, etc.). The DON stated the P&P was not followed (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because Resident 40's orders and care plan were not updated to reflect the resident's current condition. The DON stated it was important to update care plans so staff (would know what care activities residents need. 5. During a review of Resident 88's admission record, the admission record indicated the facility originally admitted Resident 88 on 6/30/2022 and was readmitted on [DATE] with diagnoses including epilepsy (a disorder in which a nerve cell activity in the brain is disturbed causing seizure [a sudden, uncontrolled electrical disturbance in the brain]), cerebral infarction (also called stroke, a result of inadequate blood flow to the brain) and gastrostom

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control practices for three of five sampled residents (Resident 17, 19 and 28) by failing to: 1. Ensure Resident 17, who was re-admitted to the facility with a Peripherally Inserted Central Catheter (PICC-a long, thin flexible tube inserted through a vein in the upper arm, extending to the supervisor vena cava [a large valve in the heart] near the heart) and surgical wound, was placed in enhanced barrier precautions (EBP-infection control strategy for nursing home, requiring gowns and gloves to be used during high-contact care for residents with or at high risk for multidrug-resistant organisms [MDRO: bacteria, often called superbugs, that have evolved to resist the antibiotics designed to kill them]). 2. Ensure Certified Nursing Assistant 10 (CNA 10) wore proper personal protective equipment (PPE-wearable gear-like gloves, mask, goggles, gowns-designed to protect person from injuries, illness or hazardous materials) during Resident 19's incontinence (loss of bowel and or bladder control) care, who was on EBP. 3. Ensure Certified Nursing Assistant 6 (CNA 6) wore proper PPE while feeding Resident 28, who was also on EBP. These deficient practices had the potential to result in the spread of MDRO and/or infection to Resident 17, 19 and 28, as well as to the other residents that were at risk of infection. Findings: 1. During a review of Resident 17's admission Record, the admission Record indicated the facility originally admitted Resident 17 on 3/22/2026 and was re-admitted on [DATE] with diagnoses including left femur fracture (a break, crack or crush injury of the thigh bone), presence of left artificial hip joint (a man-made, mechanical joint used to replace a diseased or damaged hip) and infection following a surgical procedure. During review of Resident 17's Minimum Data Set (MDS - a standardized assessment tool), dated 3/27/2026, the MDS indicated Resident 17 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and varying assistance from setup to maximal (helper does more than half the effort) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 17's History and Physical (H&P) dated 4/28/2026, the H&P indicated Resident 17 had the capacity to make medical decisions. During an observation of Resident 17's room on 4/27/2026 at 10:39 AM, no EBP signage and/or PPE cart were observed in front of Resident 17's room. During a follow up observation of Resident 17's room on 4/28/2026 at 8:25 AM, no EBP signage and/or PPE cart were observed in front of Resident 17's room. During an interview with the Infection Preventionist Nurse (IPN) on 4/29/2026 at 3:04 PM, the IPN stated that Resident 17 should have been in EBP due to Resident 17's surgical wound. The IPN stated that she (IPN) had not had time to check on the resident information and criteria since Resident 17 was recently re-admitted on [DATE]. The IPN stated she (IPN) was the only person that evaluated if a resident needs to be placed in EBP. During an interview on 4/30/2026 at 11:51 AM, with the Director of Nursing (DON), the DON stated that Resident 17 should have been in EBP as soon as the resident was re-admitted due to high risk of infection. The DON stated Resident 17 was admitted with surgical wounds and a PICC line, which (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should have prompted the nurses to put Resident 17 in EBP upon admission. During a review of the facility's policy and procedure (P&P), titled, Infection Prevention and Control Program, reviewed on 12/18/2025, the P&P indicated that the facility established and maintained an infection prevention and control program (IPCP) to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. During a review of facility's P&P, titled, Enhanced Standard/Barrier Precautions: Infection Control, reviewed on 12/18/2025, the P&P indicated that facility implemented the EBP for the prevention of transmission of MDRO via prompt recognition of need, initiation and implementation of EBP. 2. During a review of Resident 19's admission Record, the admission Record indicated the facility originally admitted Resident 19 on 12/19/2025 and re-admitted the resident on 3/11/2026 with diagnoses including but not limited to unspecified protein caloric malnutrition (condition caused by a lack of enough calories and protein in the diet), muscle weakness, and essential hypertension (blood pushes too hard against artery walls without a known, specific medical cause). During a review of Resident 19's MDS dated [DATE], the MDS indicated Resident 19 rarely made himself understood and rarely understood others. The MDS indicated Resident 19's cognition (mental abilities that profoundly impact their daily life and independence) was severely impaired and the resident required maximum assistance with toileting, transferring and mobility. During a review of Resident 19's Order Summary Report dated 4/30/2026, the Order Summary Report indicated Resident 19 had EBP orders related to Resident 19's gastrostomy tube (a surgical procedure to insert a tube through the abdomen and into the stomach used for feeding, usually via a feeding tube). During an observation on 4/27/2026 at 10:05 A.M. outside of Resident 19's room, there was a green dot sticker next to Resident 19's name plate that was observed. EBP signage was observed by the door indicating those that entered the room were to wear a gown, a mask and gloves. During an observation on 4/272026 at 10:15 A.M in Resident 19's room, CNA 10 was observed performing an incontinent brief change wearing gloves and a mask but with no gown on. During an interview on 4 /272026 at 10:31 A.M., CNA 10 stated Resident 19 was in EBP, and he (CNA 10) had just performed an incontinent brief change. CNA10 stated Resident 19 was in EBP related to Resident 19 's gastrostomy tube. CNA 10 stated he (CNA 10) should have worn the gown when he performed incontinent brief change to Resident 19. CNA stated that PPE was necessary to prevent infection and cross contamination from body fluids and bacteria. CNA 10 stated he (CNA 10) got distracted and did not wear a gown. CNA 10 stated it was a failure to not failure to follow infection protocol. During an interview on 4 /29/2026 at 11:55 A.M., Licensed Vocational Nurse LVN 3 stated there were signs outside the resident rooms and a green dot next to resident's name let staff know when to wear PPE. LVN 3 stated if a resident was on EBP, the CNA had to wear PPE when performing incontinent brief changes. LVN 3 stated if CNA 10 did not wear a gown when performing an incontinent brief change it was not a safe infection control practice. LVN 3 stated CNA 10 not wearing a gown during incontinent care was a failure in infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4 /30/2026 at 11:55 A.M, the IPN stated her role was to educate and train staff and residents focused on Infection Control. The IPN stated EBP required the use of PPE. The IPN stated the EBP was indicated for residents with catheters, tubes feedings, dialysis catheter and wounds. The IPN stated Resident 19 was on EBP related to having a G-Tube. The IPN stated CNA 10 should have worn a gown when performing an incontinent brief change. The IPN stated the EBP signs were posted and a green dot next to resident's name meant EBP. A review of the facility's policy and procedure titled, Enhanced Standard /Barrier Precaution, dated 12/18/2025, the P&P indicated: POLICY It is the policy of this facility to implement enhanced barrier precaution for the prevention of transmission of multidrug-resistant organisms Policy Explanation 3.Implementation of enhanced Barrier Precaution: PPE is necessary for High Contact care activities. High Contact Care Activities included. f. Changing briefs or assisting with toileting g. Device care or use: feeding tubes. 3. During a review of Resident 28's admission Record, the admission Record indicated the facility admitted the resident on 9/11/2019, with diagnoses that included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dysphagia (difficulty swallowing) and hypothyroidism (a condition where the thyroid gland does not make enough hormones). During a review of Resident 28's MDS dated [DATE], the MDS indicated the resident required moderate assistance (helper lifts, holds, or supports trunks or limbs, but provides less than half the effort) from facility staff with eating. During a review of Resident 28's Order Summary Report, dated 4/21/26, the report indicated Resident 28 was on Enhanced Barrier Precautions (EBP, the use of gown and gloves during high-contact resident care activities to reduce multidrug resistant organism [MDRO] transmission) related to an open wound on the sacral coccyx (tailbone). During a review of Resident 28's care plan report with an intervention titled At risk for infection – general, revised on 4/28/26, the care plan indicated, Enhanced barrier precautions related to sacral coccyx open wound. During an observation on 4/27/26 at 11:37 a.m. in Resident 28's room, an EBP sign was observed posted at the doorway entrance and a green dot sticker was placed on Resident 28's name plate. A cart filled with personal protective equipment (PPE, clothing and equipment that is worn or used to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide protection against hazardous substances and/or environments) was observed near Resident 28's room entrance. During a concurrent observation in Resident 28's room and interview on 4/27/26 at 12:50 p.m. with Certified Nursing Assistant (CNA) 6, CNA 6 was observed feeding Resident 28 with only gloves on. CNA 6 stated the green dot sticker on the resident's name plate meant the resident was on some type of precaution (an infection control intervention to prevent the spread of infections among residents, staff, and visitors) which required staff to wear PPE while providing care. During an interview on 4/29/26 at 11:05 a.m. with Registered Nurse (RN), RN 1 stated staff had to wear PPE when helping residents with activities of daily living such as changing diapers, feeding, and showering. RN 1 stated it was important to wear PPE to avoid the spread of infection, avoid possible contamination, and for the safety of residents and nurses. During a concurrent interview and record review on 4/29/26 at 11:19 a.m. with the Infection Preventionist Nurse (IPN), the local health department document titled, Enhanced Barrier Precautions, dated September 2021 was reviewed by the IPN. The IPN stated it was important to follow EBP to prevent infection and cross contamination. During a concurrent interview and record review on 4/30/26 at 10:13 a.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Enhanced Standard/Barrier Precautions, revised on February 2025 was reviewed by the DON. The DON stated the P&P was not followed. The DON stated facility staff were expected to wear a gown and gloves for EBP. During a review of the local health department document titled, Enhanced Barrier Precautions, dated September 2021, the document indicated that facility staff was to wear gloves and a gown for high-contact resident care activities such as dressing, grooming, bathing, changing bed linens, and feeding. During a review of the facility's P&P titled Enhanced Standard/Barrier Precautions, revised by the facility on February 2025, the P&P indicated PPE for enhanced barrier precautions is only necessary when performing high-contact care activities.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to implement and maintain an effective infection prevention and control program for one of eight residents (Resident 76) sampled for immunizations, by failing to: 1. Ensure Resident 76 was assessed for and offered the influenza (Flu-common viral infection that can be deadly, especially in high-risk groups) vaccine, including documentation of administration and/or refusal, in accordance with facility policy and procedures (P&P) titled Influenza Vaccine reviewed by the facility on 12/18/2025 and current standards of practice. 2.Ensure Resident 76 was assessed for and offered the pneumococcal (Pneumonia [PNA]-infection that inflames air sacs in one or both lungs which may fill with fluid) vaccine, including documentation of administration and/or refusal, in accordance with facility policy and procedures (P&P) titled Pneumococcal Vaccine reviewed by the facility on 12/18/2025 and current standards of practice. These deficient practices placed Resident 76 at a higher risk of acquiring and transmitting vaccine-preventable respiratory infections, including influenza and pneumonia, to other residents, visitors and staff within the facility.Findings: During a review of Resident 76's admission Record, the admission Record indicated the facility admitted Resident 76 on 11/8/2025 with diagnoses including left radius fracture (a break, crack or crush injury of the forearm bone), heart failure (chronic condition where the heart muscle becomes too weak or stiff to pump blood efficiently) and pleural effusion (water on the lungs, excess buildup of fluid between the thin membranes lining the lungs and chest cavity). During a review of Resident 76's vaccine consent form, dated 11/10/2026, the vaccine consent form indicated Resident 76 consented to receive both flu and PNA vaccines. During a review of Resident 76's vaccine consent form, dated 11/13/2026, vaccine consent form indicated Resident 76 consented to receive both flu and PNA vaccines. During a review of Resident 76's Order Summary Report (OSR), dated 12/4/2025, the OSR indicated Resident 76 had a physician order for Fluzone (type of flu vaccine) 0.7 milliliter (ml) intramuscular (IM-injection administration of medication deep into the muscle) as needed for vaccination yearly. During a review of Resident 76's OSR, dated 12/4/2025, the OSR indicated Resident 76 had a physician order for Pneumococcal 13 (type of PNA vaccine) vaccine 0.5 ml IM as needed for vaccination. During a review of Resident 76's History and Physical (H&P- a record of a physician's comprehensive medical assessment and plan), dated 12/10/2025, the H&P indicated Resident 76 was alert and oriented to name, place, time and situation. During review of Resident 76's Minimum Data Set (MDS - a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 76 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and varied with assistance needs from staff from being independent to supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance) for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a concurrent interview and record review on 4/30/2026 at 1:30 PM with the Infection Preventionist Nurse (IPN), Resident 76's immunization record was reviewed via CAIR (California Immunization Registry: secure web-based system that stores immunization records for children and adults in California) as of 4/30/2026. Resident 76's immunization record indicated last flu vaccine was received on 11/4/2024 with recommendation for a flu vaccine. Resident 76's immunization record also indicated PNA vaccine was received on 7/18/2014 with recommendation for the second dose of PNA vaccine. IPN stated the facility was able to get flu and PNA vaccines from the pharmacy with no issues. IPN stated Resident 76 refused on 1/13/2026 when re-offered for flu and PNA vaccines. During an interview on 4/30/2026 at 11:51 AM, with the Director of Nursing (DON), the DON stated that Resident 76 should have received flu and PNA vaccines as soon as consent was received by Resident 76. The DON also stated that Resident 76 was at risk for flu and PNA infections. During a review of the facility's P&P titled, Influenza Vaccine, reviewed by the facility on 12/18/2025, the P&P indicated the facility was to offer flu vaccines to the residents annually between October 1st to (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	March 31st. During a review of facility's P&P, titled, Pneumococcal Vaccine, reviewed by the facility on 12/18/2025, the P&P indicated that all residents were to be offered pneumococcal vaccines to aid in preventing PNA infections.