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	05/07/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the physician's order for bumetanide oral tablet (medication prescribed to treat excess fluid retention and swelling [edema]) was carried out timely for one of four sampled residents (Resident 1) per facility's policy and procedures (P&P) titled, Physician's Order.This deficient practice has the potential to result in Resident 1 in unintended complications related to the management of congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including acute on chronic diastolic CHF, acute and chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) with hypoxia (a dangerous condition where your body's tissues and organs do not receive enough oxygen to function properly) and insomnia (trouble falling asleep or staying asleep). During a review of the Minimum Data Set (MDS - resident assessment tool) dated 8/18/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Medication List from General Acute Care Hospital 1 (GACH 1) indicated, continue bumetanide 0.5 mg - take 1 tablet by mouth in the morning and 1 tablet before bedtime.During a review of Resident 1's Baseline Care Plan (BCP), dated 8/12/2025, the BCP indicated interventions that included, to administer medications, treatments, and other services in accordance with physician orders.During a review of Resident 1's Order Summary Report (OSR), the OSR indicated the bumetanide oral tablet 0.5 mg - give 1 tablet by mouth every 12 hours, dated 8/12/2025.During a review of Resident 1's Medication Administration Record (MAR), the MAR indicated:On 8/12/2025, 9 p.m., - Bumetanide oral tablet 0.5 mg - not givenOn 8/13/2025, 9 a.m., - bumetanide oral tablet 0.5 mg - not givenOn 8/13/2025, 9 p.m., - bumetanide oral tablet 0.5 mg - not givenOn 8/14/2025, 9 a.m. - bumetanide oral tablet 0.5 mg - not givenOn 8/15/2025, 9 p.m. - bumetanide oral tablet 0.5 mg - not given During a review of Resident 1's Progress Notes (PN - Nurse's notes) dated 8/13/2026, the PN indicated that, Per Nurse Practitioner (NP), ok to continue bumetanide (bumex - brand name) since she (Resident 1) got it at the hospital and tolerated well.During a concurrent interview and record review with Director of Nursing (DON) on 5/6/2026 at 3:24 p.m., DON stated, upon admission, the admitting nurse should verify the medications to be continued/started with the referral facility. DON reviewed Resident 1's Medication List from GACH 1 and stated, Resident 1 should be on bumetanide oral tablet upon admission as ordered by the physician, dated 8/12/2025. DON stated, Resident 1's MAR indicated, Resident 1 did not receive bumetanide medication until 8/14/2025. DON stated, if resident did not receive the medications as ordered, they need to notify the physician and document it on resident's medical record. DON stated, staff should also call the pharmacy to deliver medications and/or follow-up if medications were not available.During a review of the facility's P&P titled, Physician Orders, reviewed on 12/2025, the P&P indicated, Purpose: This will ensure that all (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician orders are complete and accurate. The Licensed urse receiving the order will be responsible for documenting and implementing the order. Medication/treatment orders will be transcribed onto the appropriate resident administration record. Supplies/medications required to carry out the physician order will be ordered.During a review of the facility's P&P titled, Medication Utilization and Prescribing - Clinical Protocol, reviewed on 12/2025, the P&P indicated that, When a medication is prescribed for any reason, the physician and staff will identify the indications, considering the resident's age, medical and psychiatric conditions, risks, health status, and existing medication regimen.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary respiratory care services for one of three sampled residents (Resident 1), by failing to:Follow physician's order for bilevel positive airway pressure machine (BiPAP - a device that helps people breathe easier, especially when they have breathing difficulties like sleep apnea [a sleep disorder where breathing repeatedly stops and starts during sleep]) per facility's protocol.Ensure a complete physician's order was in place for BiPAP therapy per facility's policy and procedures (P&P) titled, CPAP (continuous positive airway pressure-a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in), CPAP -Auto, BiPAP, Auto-PAP (Automatic Positive Airway Pressure) machine is a breathing device used to treat sleep apnea), & BIPAP St (Spontaneous - follows natural breathing).These deficient practices had the potential to cause complications associated with respiratory treatment.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including acute on chronic diastolic congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), acute and chronic respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) with hypoxia (a dangerous condition where your body's tissues and organs do not receive enough oxygen to function properly) and insomnia (trouble falling asleep or staying asleep). During a review of the Minimum Data Set (MDS - resident assessment tool) dated 8/18/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required maximal assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's history and physical (H&P), dated 7/27/2025, the H&P indicated, (Resident 1) to continue BiPap at bedtime. the H&P indicated, Acute Respiratory Orders or Rehab BiPAP mode: BiPap; IPAP (inspiratory pressure - the highest level of pressure applied to the lungs during inhalation): 15; EPAP (expiratory positive airway pressure - breathing support only applies positive pressure when you are exhaling): 5; FiO2 (a comparison between the oxygen level in the blood and the oxygen concentration that is breathed) (% - unit of measure): 21 at bedtime every six hours.During a review of Resident 1's Nursing Documentation Evaluation (NDE), dated 8/12/2026, the NDE indicated the form for respiratory needs (such as Bipap, Cpap (continuous positive airway pressure-a breathing machine designed to increase air pressure, keeping the airway open when the person breathes in), Ventilator (a medical device to help support or replace breathing), Oxygen, etc) was blank. The NDE also indicated an additional comment that stated, (Resident 1) new admit from General Acute Care Hospital 1 (GACH) 1. on Bipap at nighttime.During a review of Resident 1's Order Summary Report (OSR), dated 8/13/2025, The OSR indicated, physician ordered, BiPAP: fill with sterile water at bedtime for sleep apnea.During a review of Resident 1's Treatment Administration Record (TAR), the TAR order for BiPap indicated a start date of 8/14/2025. The BiPAP order did not indicate a specific order for BiPAP mode and settings.During a review of Resident 1's Care Plan (CP) date initiated 8/14/2025, the CP indicated (Resident 1) exhibits or is at risk for respiratory complications related to asthma (respiratory condition marked by spasms in the bronchi of the lungs, causing difficulty in breathing), acute and chronic respiratory failure with hypoxia using BiPap at nighttime.During an interview with Respiratory Therapist 1 (RT 1) on 5/6/2026 at 2:48 p.m., RT 1 stated, upon admission, if there is an order for BiPap treatment, they need to set up the machine and start the BiPAP treatment at bedtime. RT 1 stated, if the BiPAP was not started upon admission per physician's order, they need to notify the physician. RT 1 stated, registered nurses and RTs are responsible for setting up and managing the BiPAP therapy. RT 1 further stated, the RNs and RTs are the responsible staff to manage and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document respiratory services that residents received. During a concurrent interview and record review with Director of Nursing (DON) on 5/6/2026 at 3:4 p.m., DON stated, if there is a physician's order for BiPAP therapy upon admission, they have to ensure that the machine was available prior to admission and set up the machine as ordered. DON reviewed Resident 1's medical record and TAR on BiPAP treatment, and stated and confirmed, the BiPAP order was incomplete and was started two days after admission. DON stated, there should be documentation and notification to the physician why the BiPap order was not started upon admission with complete documentation.During a review of the facility's policy and procedures (P&P) titled, CPAP, CPAP -Auto, BIPAP, AUTO-PAP, & BIPAP St, effective date 4/7/2026, the P&P indicated that, Verify physician's order. The Order should state the CPAP pressure. The BiPap/BiPap ST order should include the inspiratory and expiratory pressures, and a respiratory rate, if needed.During a review of the facility's P&P titled, Respiratory Treatments, effective date 4/7/2026, the P&P indicated that, The respiratory services aim to improve the quality of life, reduce complications, and manage respiratory health through comprehensive, evidence-based care, education, and support for residents and their families. The Registered Nurse (RN) or Respiratory Therapist (RT) will document the respiratory treatment administration in the resident's eMAR module. The RN or RT will document daily the summary of resident's response to treatment(s) and respiratory assessment on the Respiratory Daily Treatment Note form in the resident's electronic health record for each treatment provided. The Daily assessments should be completed during evaluation of the resident's response to treatments and overall respiratory status. During a review of the facility's P&P titled, Physician Orders, reviewed date 12/18/2025, the P&P indicated that, Purpose: This will ensure that all physician orders are complete and accurate. Physician orders will include the following: Name of the prescriber, the name of the resident, the date and time the order was received; and the signature of the Licensed Nurse receiving and documenting the order, if by telephone. Treatment orders will include the following: A description of the treatment, including the treatment site, if applicable. The frequency of treatment and duration of order; and the condition/diagnosis for which the treatment is ordered.