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	05/21/2026

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 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 interview and record review, the facility failed to revise the care plan regarding leave of absence without notice (LAWN, leaving the facility unsupervised) for one of three sampled residents (Resident 1) by failing to: -Ensure to address Resident 1's LAWN on 5/17/2026. This failure had the potential to for Resident 1 to leave unsupervised again.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 4/22/2026 with diagnoses that included but not limited to unspecified dementia (loss of memory and other mental abilities severe enough to interfere with daily life) and hypotension (low blood pressure). During a review of Resident 1's Minimum Data Set (MDS, resident assessment tool) dated 4/20/2026, the MDS indicated Resident 1 sometimes made himself understood and sometimes understood others. The MDS indicated Resident 1 had severely impaired cognition (significant decline in a resident's mental abilities that profoundly impacts their daily life and independence). The MDS indicated Resident 1 self-propelled (maneuver) a manual wheelchair for mobility. During a review of Resident 1's Care Plan Report dated 5/11/2026, the Care Plan Report indicated Resident 1 was at risk for LAWN dated 5/11/2026. The Care Plan Report indicated there were no updated interventions for Wander Guard Elopement Device (a bracelet that sounds when near a door and alerts staff when a confused resident tries to leave unsupervised) ordered for Resident 1 on 5/17/2026 and monitor Resident 1's whereabouts on 5/20/2026. During a review of Resident 1's History and Physical dated 5/13/2026, the History and Physical indicated Resident 1 did not have the capacity to make decisions. During a review of Resident 1's Leave of Absence Without Notice (LAWN) Evaluation Form, dated 5/17/2026, the LAWN Evaluation Form indicated IDT (interdisciplinary team) determined that Resident 1 was at risk for LAWN. The evaluation form indicated reviewing and update the plan of care to address Resident 1's specific interventions and application of Wander Guard. During a review of Resident 1's Order Summary Report dated 5/20/2026, the Order Summary Report indicated Resident 1 had orders on 5/17/2026 to have Wander Guard elopement device due to poor safety awareness, on 5/20/2026 to monitor Wander Guard device for placement and function every shift and on 5/20/2026 to monitor Resident 1's whereabouts at least every hour. During an interview on 5/20/2026 at 2:50 PM, with Licensed Vocational Nurse1 (LVN 1), LVN 1 stated a care plan was a person-centered care specific to the needs of residents (in general) and updated with change of condition. LVN 1 stated Wander Guard was ordered on 5/17/2026 for Resident 1. LVN 1 stated care plan of Resident 1 on LAWN should have been updated with Wander Guard Device intervention. During a concurrent interview and record review on 5/21/2026 at 2:58 PM, with the Director of Nursing (DON), Resident 1's Order Summary Report dated 5/20/2026 and the Care Plan Report dated 5/11/2026 were reviewed. The DON stated the Care Plan Report indicated Resident1 was at risk for Leave of Absence without notice (LAWN) . The DON stated that a care plan served as a guide to address resident-centered needs and should have been updated with any change in condition. The DON stated that the care plan specifically on LAWN was not revised to include Wander Guard intervention ordered on 5/17/2026, and Monitor whereabouts interventions ordered on 5/20/2026. The DON stated it was important to update the LAWN care plan dated 5/11/2026 with interventions to prevent resident 1 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from a repeat LAWN. During a concurrent interview and record review on 5/22/2026, at 3:54 PM, with the DON, the facility's policy and procedure (P&P) titled Leave of Absence Without Notice (LAWN), last review date on 1/16/2026 was reviewed. The DON stated the policy indicated to update plan of care when a resident is at risk for LAWN. During a review of the facility's recent P&P titled Care Plan Comprehensive: last reviewed on 12/18/2025, the P&P indicated: The Comprehensive care plan includes a. The services that are to be furnished to attain or maintain the residents' highest practicable physical, mental and psychological being. During a review of the facility's recent P&P titled Leave of Absence without Notice (LAWN) last reviewed on 1/16/2026, the P&P indicated: Procedural guidelines: 1.Residents will be evaluated by interdisciplinary team members (IDT) for possible leave of absence without notice /authorization upon admission, quarterly and when there is a significant change of condition. 3.A resident deemed at risk for Leave of Absence without Notice by IDT a re to consider the following measures but not limited to: Initiate/update plan of care 4. Procedural Post Leave of Absence without notice. Documentation in the medical record will include findings from nursing and social services, physician/family notification, and care plan discussions as applicable. During a review of the facility's recent P&P titled Wandering and Elopements last reviewed on 12/18/2026, the P&P indicated: Policy Statement The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Policy Interpretation and Implementation 1.If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) who was confused and had a diagnosis of dementia (a progressive state of decline in mental abilities) did not elope (the act of leaving a facility unsupervised and without prior authorization) the facility on 5/17/2026 at approximately after 10:45AM by failing to: - Ensure the Interdisciplinary Team (IDT, group of diverse health care professionals from different fields) assessed Resident 1 as at risk for elopement (leaving the facility unsupervised). This failure resulted for Resident 1 to leave the facility on 5/17/2026 unsupervised and placed Resident 1 at risk for harm, injury, and/or death.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility originally admitted the resident on 9/26/2025 and readmitted the resident on 11/13/2025 with diagnoses that included but not limited to unspecified dementia, hypotension (low blood pressure), and hyperlipidemia (a condition having too many lipids (fats), in the blood). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 4/20/2026, the MDS indicated Resident 1 sometimes made himself understood and sometimes understood others. The MDS indicated Resident 1 had severely impaired cognition (significant decline in a resident's mental abilities that profoundly impacts their daily life and independence). The MDS indicated Resident 1 self-propelled (steer) a manual wheelchair for mobility. During a review of Resident 1's Nursing Document Evaluation Form dated 5/11/2026, the Nursing Document Evaluation Form indicated Resident 1 was at risk for Leave of Absence Without Notice (LAWN) and Resident 1 had a history of exhibiting exit -seeking behavior while at home or from the facility without informing staff. The Nursing Document Evaluation Form did not indicate IDT considerations. During a review of Resident 1's Care Plan Report dated 5/11/2026, the Care Plan Report indicated Resident 1 was at risk for Leave of Absence without notice (LAWN). The Care Plan Report indicated to monitor the resident's location with visual checks during routine care and as needed. During a review of Resident 1's History and Physical dated 5/13/2026, the History and Physical indicated Resident 1 did not have the capacity to make decisions. During a review of Resident 1's SBAR Communication Form dated 5/17/2026, the SBAR indicated the staff (unidentified) last saw Resident 1 on 5/17/2026 at 10:45 AM. The SBAR indicated that a receptionist (unidentified) received a call from a rehab staff (unidentified) that they found Resident 1 down the street from the facility. The SBAR indicated the staff (unidentified) brought Resident 1 back to the facility at 11:24 AM. During a review of Resident 1's Interdisciplinary Care Conference document dated 5/19/2026, the Interdisciplinary Care Conference indicated the IDT determined the likely root cause to be unsupervised exit through the facility's front door. The Interdisciplinary Care Conference document indicated Resident 1 was known to walk throughout the facility as part of daily routine. During an interview on 5/20/2026 at 9:54 AM with Receptionist 1, Receptionist 1 stated her job duties included answering telephone calls and monitoring individuals entering and exiting the facility through the front entrance. Receptionist 1 stated nursing staff (in general) were aware when residents (in general) would try to leave the facility. During an interview on 5/20/2026 at 12:57 PM, with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated Resident 1 had a diagnosis of dementia and required frequent reminders and reorientation to place due to confusion and forgetfulness regarding his surroundings. CNA 1 stated Resident 1 was able to get out of bed independently and would ambulate (walk) throughout the facility without assistance or supervision at times. CNA 1 stated she (CNA1) assisted Resident 1 in a wheelchair to the activity room entrance on 5/17/2026 (unidentified time). During an interview on 5/20/2026 at 2:24 PM, with Activities Assistant1 (AA 1), AA 1 stated Resident 1 self-propelled his wheelchair into the activity room on 5/17/2026 at approximately 10 AM. AA 1 stated Resident 1 remained in the activity room for about 30 minutes. AA 1 stated Resident 1 had dementia and liked to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wander throughout the facility, and frequently would go out to the patio area. AA 1 stated Resident 1's elopement could have been prevented if Resident 1 had been properly supervised. AA 1 stated that without supervision, Resident 1 was at risk of injury becoming involved in an accident due to his wandering behaviors and cognitive impairment. During an interview on 5/20/2026 at 2:50 PM, with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 1 had a diagnosis of dementia and demonstrated significant cognitive impairment. LVN 1 stated residents with dementia (in general) may not fully understand their care needs or safety risks. LVN 1 stated based on her assessment, Resident 1 exhibited more severe dementia related behaviors compared to other residents in the facility. LVN 1 stated Resident 1 was observed ambulating in the hallway near the receptionist area and Resident 1 had a wandering behavior. LVN 1 stated Resident 1 could benefit from increased supervision to monitor wandering and maintaining resident safety. LVN 1 stated the Wander Guard device (a bracelet that sounds when near a door and alerts staff when a confused resident tries to leave unsupervised) could have been placed prior to 5/17/2026 if Resident 1's wandering behavior had been assessed as being at risk for exiting through the facility entrance. During an interview on 5/20/2026 at 3:54 PM, with Receptionist 2, Receptionist 2 stated he was aware of the Elopement Binder (book of resident's information at risk for elopement) located at the front desk. Receptionist 2 stated the elopement binder had no information of residents at risk for elopement prior to 5/17/2026. During a concurrent interview and record review on 5/21/2026 at 9:05 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Leave of Absence Without Notice (LAWN) was reviewed. The DON stated the LAWN assessment replaced the facility's elopement risk evaluation approximately three months prior to 5/11/2026. The DON stated the LAWN assessment was used to identify residents at risk for leaving the facility without notice. The DON stated the P&P indicated that when a resident was identified as being at risk for elopement, the resident's physician was notified to obtain an order for a wonder guard device. The DON stated the facility failed to implement a Wander Guard intervention for Resident 1. During a concurrent interview and record review on 5/21/2026 at 9:10 AM, Resident 1's Nursing Documentation Evaluation dated 5/11/2026 was reviewed with the DON. The DON stated that the Nursing Documentation Evaluation of Resident 1 indicated Resident 1 was assessed as high risk for history of exit seeking behavior. During a concurrent interview and record review on 5/21/2026 at 9:15 AM, with the DON the facility's P&P titled Elopement of Resident dated 5/11/2026 was reviewed. The DON stated the P&P required that a photograph be obtained, an elopement identification form be completed, and the resident's information be placed in the elopement risk binder for residents identified as being at risk for elopement. The DON stated the elopement risk binder should be readily accessible to staff. The DON stated Resident 1 was assessed as being at risk for LAWN. The DON stated Resident 1's photograph and identification information were not included in the elopement risk binder on 5/11/2026 in accordance with the facilities P&P. During an interview on 5/21/2026 at 2:28 PM, with the Activities Director (AD), the AD stated Elopement risk refers to residents with wandering behaviors who required interventions to prevent them from leaving the facility and to ensure their safety. The AD stated Resident 1 had a diagnosis of dementia and exhibited wandering behaviors. The AD stated president wants LAWN on 5/17/2020 six could have been prevented with appropriate supervision. The ad stated resident one was not under direct supervision at the time of Resident 1's elopement incident on 5/17/2026. The AD stated Resident 1 should have been included in the facilities elopement risk binder to alert staff of the residents wandering and elopement risk. The AD stated that additional supervision and elopement prevention intervention should have been implemented for Resident 1. During a review of the facility's recent P&P titled Leave of Absence Without Notice last reviewed on 1/16/2026, the P&P indicated: The interdisciplinary team members (IDT) are recommended to evaluate if a resident is deemed at risk of leaving the facility without notice and identify resident-specific measures in a least restrictive environment. Procedural guidelines 1.Residents will be evaluated by the interdisciplinary team members (IDT) for possible leave of absence without notice/authorization upon admission, quarterly (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and when there is a significant change in condition. 2.The IDT is recommended to use the Leave of Absence without Notice flow chart as a guide to consider resident specific factors to determine if resident is at risk for elopement. 3.A resident deemed at risk for Leave of Absence without Notice by IDT are to consider the following measures but not limited to: Initiate/Update plan of care Consider application of a wander guard in collaboration with the physician and responsible party In the absence of a wander guard system the IDT to collaborate and identify measures necessary to avoid leaving the facility without notice /authorization. During a review of the facility's recent P&P titled Elopement Resident last reviewed on 12/18/2025, the P&P indicated: I.PURPOSE To provide a process for managing residents at risk for elopement. II. POLICY Residents will be evaluated for elopement risk upon admission, re-admission, quarterly and with a change in condition as part of the clinical assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. Elopement occurs when a patient leaves the premises without authorization (i.e., an order for discharge or leave of absence (LOA) and/or any necessary supervision to do so. State definitions for elopement vary; follow state definition if different. III. PROCEDURE Assessment/Evaluation: Identify patient's elopement risk by reviewing the following upon admission, re- admission, quarterly, or with a significant change in conditions as defined by [NAME] Manual criteria utilizing the nursing assessment, social services assessment, and other disciplinary assessments. For residents identified as at risk, an interdisciplinary elopement prevention person? centered care plan will be developed with patient participation and patient representative when applicable. Obtain current photograph of patient. Complete the Elopement Risk Identification form for all residents at risk of elopement and place in a binder that is easily accessible to staff.