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	05/28/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record reviews, the facility did not accurately document the administration of insulin for one of three sampled residents (Resident 1) This deficient practice had the potential to compromise Resident 1's safety by causing confusion among staff who administrate medications and potentially result in a medication error that could harm Resident 1.During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE] to the facility with diagnoses including but not limited to heart failure, hyperlipidemia (elevated cholesterols levels), Type 2 diabetes mellitus (DM-elevated blood sugar levels).During a review of Resident1's Minimum Data Set (MDS- a resident assessment tool), dated 4/9/2026, the MDS indicated Resident 1 had a brief interview for mental status(BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 14 (score of 13-14 cognitively intact).During a review of Resident 1's History and Physical (H&P - document detailing a resident's current and past medical history), dated 1/7/2026, the H&P indicated Resident 1 is not having memory loss and has capacity to make medical decisions.During a review of Resident 1's Care Plan Report (CP), dated 1/17/2025, it was noted that the resident has a diagnosis of diabetes and is prescribed Novolog insulin (type of insulin to control blood sugar). The care plan indicated that Resident 1 is to remain free of signs and symptoms of both hypoglycemia and hyperglycemia (low/high blood sugar), with the intervention identified as, administering medication as ordered.During a review of resident 1's Order Summary Report (OSR), dated 5/28/2026, the OSR stated: NovoLog Injection Solution 100 UNIT/ML (Insulin Aspart) Inject as per sliding scale: if 0 - 150 = 0 (if blood glucose is less than 70, call MD) give a glass of juice; 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 399 = 12 and (if glucose is greater than 400, call MD immediately for further instruction), subcutaneously before meals for sliding scale insulin coverage for diabetes Rotate injection site. Order date/start date is 1/23/2026During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 5/2026, the MAR indicated on May 24th at 6:30a.m. and May 26th at 11:30 a.m. the medication Novolog was not documented as given or refused by the resident.During an interview on 5/28/2026, at 10:04a.m. with Resident1, Resident 1 stated that their medications were not given on time and were sometimes missed when a particular staff member was not working. Resident 1 stated that insulin is not administered on time and that blood glucose finger sticks are completed after meals instead of before meals. Resident 1 further stated that their 9:00 a.m. medications were given one to two hours late.During an interview on 5/28/2026 at 11:10 a.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated that Resident 1 is knowledgeable about their daily medications and promptly voices any concerns if something is missing. LVN 1 stated they ensure medications and care tasks are completed correctly because Resident 1 is particular about their care and aware of their medication regimen. LVN 1 further stated that Resident 1 has complained on several occasions that other nursing staff did not give medications on time, could not locate medications, or failed to administer medications all together.During an interview on 5/28/2026 at 1:17 p.m. with the director of nursing (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DON), the DON stated that the insulin administration process requires blood sugar to be checked before meals. If insulin is needed, it is to be administered with food or shortly after to prevent a drop in blood sugar. The DON stated that if a resident refuses the blood sugar check or the insulin administration, the refusal must be documented on the Medication Administration Record (MAR) and in the progress notes. The DON further stated that any medication not given must always be documented as a refusal on the MAR. The DON acknowledged that the MAR for Resident 1 does not indicate whether insulin was administered on May 24 and May 26, noting that the entries were left blank. The DON stated that leaving MAR entries blank can cause confusion among staff and potentially result in a medication error that could harm Resident 1.During a review of the facility's policy and procedure (P&P) titled, Insulin Administration, not dated, the P&P indicated that insulin documentation includes the residents' blood glucose, the dose and concentration and the injection site and if the resident tolerated medication. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated if a drug is withheld, refused, or given at a time other than the scheduled, document refusal.