STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056159	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherman Village Hcc	12750 Riverside Drive North Hollywood, CA 91607

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the medical records of one of three sampled residents (Resident 1) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to ensure Resident 1's Change of Condition (COC -major decline or improvement in a resident's status that will not resolve without intervention) form contained documentation of Resident 1's oxygen administration and vital signs (measurements that indicate a resident's basic psychological functions such as temperature, heart rate, blood pressure, respiratory rate, and oxygen saturation) monitoring. This deficient practice had the potential to result in inaccurate medical interventions for Resident 1. Findings: During a review of Resident 1's admission Record, the admission Record indicated that the facility originally admitted Resident 1 on 7/11/2025, and readmitted on [DATE], with diagnoses including anemia (a condition where the body does not have enough healthy red blood cells), chronic kidney disease (a condition in which they kidneys gradually lose their ability to filter waste products from the blood, leading to damage and impaired function over time), and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 8/21/2025, the MDS indicated Resident 1's moderately impaired (poor decisions, supervision required) cognitive (relating to the mental process of knowing, learning, and understanding) skills for daily decision making. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) from facility staff with oral hygiene and upper body dressing. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) with toileting hygiene, showers, lower body dressing. During a review of Resident 1's Care Plan, initiated on 10/11/2025, the Care Plan indicated Resident 1 had a change of condition manifested by tachycardia (a condition where the hears beats abnormally fast, exceeding 100 beats per minute at rest) and hypertension (HTN-high blood pressure [force exerted by blood on the walls of the blood vessels]). During a review of Resident 1's COC form, dated 10/11/2025, the COC form indicated on 10/11/2025, at approximately 9:30 a.m., Resident 1's heart rate (the number of times the heart beats per minute) reached 130 beats per minute, oxygen saturation (O2 sat-measurement of how much oxygen blood is carrying as a percentage of the maximum it could carry) was 96 percent at room air and Resident 1 denied having difficulty breathing. The COC form indicated on 10/11/2025, at approximately 1 p.m., Resident 1 was experiencing oxygen desaturation (a decrease in the blood oxygen level), tachycardia, and Resident 1's blood pressure was varying. The COC form indicated on 10/11/2025, at approximately 1:20 p.m. paramedics arrived at the facility while Resident 1 was experiencing hypoxia (a condition where there is an inadequate supply of oxygen to the body's organs). The COC form indicated on 10/11/2025, at approximately 1:40 p.m., Resident 1 was transferred to general acute care hospital (GACH) per physician's order. During an interview on 10/11/2025 at 10:40 p.m. with Registered Nurse (RN) 1, RN 1 stated on 10/11/2025, at approximately 1 p.m., Resident 1's oxygen saturation went down to approximately 85 percent (%-unit of measurement) and Resident 1 was placed on oxygen via nonrebreather mask (a medical device that delivers high concentration of oxygen to a resident) and later via nasal cannula (a device that gives additional oxygen through the nose). RN 1 was unable to indicate the time and the amount of oxygen administered to Resident 1. RN 1 stated that after the oxygen administration (unable to indicate time), Resident 1's O2 level increased to approximately 91%. RN 1 stated he (RN 1) documented Resident 1's change in condition and treatment provided on the COC form dated 10/11/2025. During an interview on 10/16/2025 at 11:45 a.m. with the Director of Nursing (DON), the DON stated the Resident 1's COC form, dated 10/11/2025, did not have accurate, complete, and concise documentation of Resident 1' s vital signs. The DON stated the COC form did not have documentation of Resident 1's O2 changes and oxygen administration. The DON stated the facility staff failed to document accurate monitoring of Resident 1's vital signs and oxygen administration on Resident 1's COC form dated 10/11/2025. The DON stated the changes in residents' condition should be accurately documented during COCs, to reflect care and treatment that was provided to the residents. The DON stated the documentation of Resident 1's COC from was incomplete and had the potential to result in inaccurate description of Resident 1's condition. During a record review of the facility-provided policy and procedure titled, Charting and Documentation, last reviewed on 4/24/2024, the policy and procedure indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition