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	12/11/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of three sampled residents (Resident 1) by failing to implement interventions to address Resident 1's preference of not attending group activities.This deficient practice had potential for a delay in the delivery of necessary care and services to Resident 1. Findings:During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 4/3/2024, with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (nerve damage that is caused by diabetes), acquired absence of right leg below the knee and left shoulder pain.During a review of Resident 1's Order Summary Report, dated 4/4/2024, the Order Summary Report indicated Resident 1 may participate in planned activities if not contraindicated with resident's plan of care.During a review of Resident 1's Care Plan, dated 5/28/2024 about not attending group activities, the Care Plan indicated the following interventions: a. to encourage self-directed (making your own decisions and organizing your own work) activities. b. conduct rounds (visits) to monitor activity needs and offer appropriate interventions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 10/12/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required set up assistance from staff for toileting, lower body dressing and transfers.During a review of Resident 1's Interdisciplinary Team (IDT-a coordinated group of experts from several different fields who work together), dated 10/12/2025, the IDT indicated Resident 1's preferred activity was to attend group activities, independent activities, and room visits.During an interview on 12/4/2025, at 9:30 a.m. with Resident 1, Resident 1 stated activity room visits were not done. Resident 1 stated activity had not asked him (Resident 1) what he (Resident 1) needed for in-room activity. Resident 1 stated he (Resident 1) likes to create a ball made from rubber elastic band.During an interview, and record review on 12/4/2025, at 10:17 a.m., with Activity Staff (AS), AS stated Resident 1 only attends group activities when his (Resident 1) room is being deep cleaned. AS stated, he (Resident 1) last attended a group activity on 12/2/2025. AS stated the activity staff does not visit him (Resident 1) unless he (Resident 1) asks for the activity staff. AS stated they (AS) do not do room visits unless he (Resident 1) asks. AS stated, Resident 1 had no group activity and in room visits from 11/1/2025 to 12/1/2025.During an interview on 12/4/2025, at 10:30 a.m., with the Director of Nursing (DON), the DON stated Resident 1's care plan on refusal of group activity was not followed. The DON stated Activity Staff should encourage self-directed activities and conduct rounds to monitor activity needs and offer appropriate interventions as indicated in Resident 1's care plan. The DON stated providing daily activity helps Resident 1 to get away from the routine of the facility and helps Resident 1 boost his (Resident 1) self-esteem. The DON stated if activity was not provided daily, it could lower the self-esteem (confidence in one's own worth or abilities; self-respect) of Resident 1.During an interview o0n 12/5/2025 at 8:59 a.m. with the DON, the DON stated Resident 1's care plan outlines the care and intervention individualized for him (Resident 1). The DON stated staff should follow the interventions in Resident 1's Care Plan to prevent Resident 1's emotional decline (a sudden decrease in mood, energy, or emotional state). During a review of facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Plan, dated 3/2022, and last reviewed on 10/23/2025, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial (the interrelation of social factors and individual thought and behavior) and functional needs is developed and implemented for each resident 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes. b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment, . c. includes the resident's stated goals upon admission and desired outcomes. d. builds on the residents' strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. (continued on next page)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to provide an ongoing activity program that is resident-centered for one of three sampled residents (Resident 1).This deficient practice had the potential to affect Resident 1's sense of self-worth (the internal sense of being good enough and worthy of love and belonging from others) and psychosocial (the interaction between an individual's mental and emotional state [psychological] and their social environment) well-being.Findings:During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 4/3/2024, with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (nerve damage that is caused by diabetes), acquired absence of right leg below the knee and left shoulder pain.During a review of Resident 1's Order Summary Report, dated 4/4/2024, the Order Summary Report indicated may participate in planned activities if not contraindicated with resident's plan of care.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 10/12/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required set up assistance from staff for toileting, lower body dressing and transfers.During a review of Resident 1's Interdisciplinary Team (IDT-a coordinated group of experts from several different fields who work together), dated 10/12/2025, the IDT indicated Resident 1's preferred activity was to attend group activities, independent activities and room visits.During an interview on 12/4/2025, at 9:30 a.m. with Resident 1, Resident 1 stated activity was not provided to him (Resident 1). Resident 1 stated activity room visits were not done. Resident 1 stated activity had not asked him (Resident 1) what he (Resident 1) needed for in-room activity. Resident 1 stated he (Resident 1) likes to create a ball made from rubber elastic band.During an interview, and record review on 12/4/2025, at 10:17 a.m., with Activity Staff (AS), AS stated Resident 1 only attends group activities when his (Resident 1) room is being deep cleaned. AS stated he (Resident 1) last attended a group activity on 12/2/2025. AS stated the activity staff does not visit him (Resident 1) unless he (Resident 1) asks for the activity staff. AS stated they (AS) do not do room visits unless he (Resident 1) asks. AS stated Resident 1 had no group activity and in room visits from 11/1/2025 to 12/1/2025.During an interview on 12/4/2025, at 10:30 a.m., with the Director of Nursing (DON), the DON stated activity should be provided daily to Resident 1. The DON stated there should be a documentation when Resident 1 refuses activity or Resident 1 only wants activity when he (Resident 1) requests it. The DON stated providing daily activity helps Resident 1 to get away from the routine of the facility and helps Resident 1 boost his (Resident 1) self-esteem. The DON stated if activity was not provided daily, it could lower the self-esteem (confidence in one's own worth or abilities; self-respect) of Resident 1.During a review of facility's policy and procedure (P&P) titled, Activity Program, undated and last reviewed on 10/23/2025, the P&P indicated, This chapter provides information on the facility's policies and procedures related to the activity program. All activity program has the following benefits: .- Encourages motivation for activities of daily living and the resumption of as normal functioning as is reasonably possible.- Provides alternatives to compensate for loss of mental and physical capacities.- Gives psychological support and understanding in helping the resident accept his/her illness and/ or limitations.- Creates in the resident the will to make his/her life more meaningful by using his/her physical and mental capacities to their fullest extent; and- Maintains the resident's sense of usefulness, self-respect, and self-satisfaction.B. Resident Activity Program1. Assessment for Activity Program.d. The activity coordinator uses the assessment form to write progress notes and maintain records of the resident's progress and response.e. The activity coordinator determines to the best of his/her ability the residents' interests, capacities, motivations, and realistic objectives and includes information regarding rehabilitative potential during this initial assessment. This information Is changed whenever new information is received and is used to modify the activity plan, with participation from the resident.2. Activity Plan as Part of Resident Care Plans.c. The activity coordinator consults with the nursing staff to develop a suitable activity plan for the resident.f. The plan is utilized by the nursing staff and nurse assistant to encourage and help the resident to participate in appropriate activities.

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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	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of three sampled residents (Resident 2) by failing to follow Resident 2's physician order to hold (temporarily stopping certain medications as instructed by a healthcare provider) amlodipine (medication used to treat high blood pressure) for systolic blood pressure (sbp- the top number in a blood pressure reading, indicating the pressure in your arteries when your heart beats) below 110 millimeters of mercury (mmHg-a standard unit of pressure).This deficient practice had the potential to result in medication error and could cause hypotension (low blood pressure) to Resident 2.Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 3/12/2025, with diagnoses that included unspecified (unconfirmed) organism sepsis (a life-threatening blood infection), unspecified organism lobar pneumonia (infection and inflammation that may affect one part [lobe] of the lung), and essential hypertension (high blood pressure that is not due to another medical condition).During a review of Resident 2's Physician Order, dated 5/5/2025, the Physician Order indicated amlodipine besylate oral tablet five milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), give one tablet via gastrostomy (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube two times a day for hypertension (HTN- high blood pressure), hold for sbp less than 110 mmHg.During a review of Resident 2's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 5/6/2025, 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 9/19/2025, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 2 was dependent on staff for all activities of daily living (ADL-activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 2's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 11/2025, the MAR indicated amlodipine was administered to Resident 2 at 9 a.m. on 11/1/2025, with a blood pressure of 105/76 mmHg.During a concurrent interview, and record review on 12/5/2025, at 8:30 a.m., with the Assistant Director of Nursing (ADON), Resident 2's Physician Order, dated 5/5/2025, and MAR, dated 11/2025, were reviewed. The ADON stated Registered Nurse 1 (RN 1) should have held the amlodipine on 11/1/2025. The ADON stated nurses should obtain the blood pressure and follow the physician order to not administer the amlodipine for blood pressure below 110 mmHg. The ADON stated Resident 2's blood pressure can drop by taking medication to lower the blood pressure when Resident 2's blood pressure was already low.During an interview on 12/5/2025, at 8:40 a.m., with the Director of Nursing (DON), the DON stated RN 1 should verify the physician order before amlodipine administration. The DON stated Resident 2's blood pressure can drop because amlodipine was administered.During a review of facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, and last reviewed on 10/23/2025, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required time frame.11. The following information is checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs (measurements of the body's most basic functions), if necessary.

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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	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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	Based on interview and record review, the facility failed to maintain accurate and complete medical record for one of three sampled residents (Resident 2) by failing to document medications that were held (temporarily stopping certain medications as instructed by a healthcare provider) following a physician order.This deficient practice had the potential to result in medication errors, cause confusion in care and the medical records containing inaccurate documentation for Resident 2.Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 3/12/2025, with diagnoses that included unspecified (unconfirmed) organism sepsis (a life-threatening blood infection), unspecified organism lobar pneumonia (infection and inflammation that may affect one part [lobe] of the lung), and essential hypertension (high blood pressure that is not due to another medical condition).During a review of Resident 2's Physician Order, dated 5/5/2025, the Physician Order indicated the following:1. Amlodipine Besylate (medication used to treat elevated blood pressure) oral tablet five milligrams (mg-metric unit of measurement, used for medication dosage and/or amount), give one tablet via gastrostomy (G tube-a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube two times a day for hypertension (HTN-high blood pressure), hold for systolic blood pressure (sbp- the top number in a blood pressure reading, indicating the pressure in your arteries when your heart beats) less than 110 millimeter of mercury (mmHg-a standard unit of pressure).2. Sacubitril-valsartan (medication used to treat congestive heart failure [CHF-heart was too weak to pump enough blood]) oral tablet 24 mg - 26 mg, give one tablet via G tube two times a day for CHF, hold for sbp less than 110 mmHg.During a review of Resident 2's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 5/6/2025, 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 9/19/2025, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 2 was dependent on staff for all activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 2's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 11/2025, the MAR indicated Licensed Vocational Nurse 2 (LVN 2) administered amlodipine to Resident 2 on 11/25/2025, at 9 a.m. with a blood pressure of 109/65 mmHg.During a review of Resident 2's MAR, dated 11/2025, the MAR indicated (LVN 2) administered Sacubitril-valsartan to Resident 2 at 9 a.m. on the following dates:1. On 11/6/2025, with a blood pressure of 105/56 mmHg2. On 11/ 25/2025, with a blood pressure of 109/65 mmHgDuring a concurrent interview, and record review on 12/5/2025, at 8:30 a.m., with the Assistant Director of Nursing (ADON), Resident 2's Physician Order, dated 5/5/2025, and MAR, dated 11/2025, were reviewed. The ADON stated LVN 2 should have held the amlodipine on 11/25/2025, and the Sacubitril-valsartan on 11/6/2025, and 11/25/2025. The ADON stated nurses should obtain the blood pressure and follow the physician order to not administer the amlodipine and the Sacubitril-valsartan for blood pressure below 110 mmHg. The ADON stated Resident 2's blood pressure can drop by taking medication to lower the blood pressure when Resident 2's blood pressure was already low.During an interview on 12/5/2025, at 8:40 a.m., with LVN 2, LVN 2 stated she (LVN 2) did not administer the amlodipine on 11/25/2025, and she (LVN 2) did not administer the Sacubitril-valsartan on 11/6/2025, and 11/25/2025. LVN 2 stated she (LVN 2) must have documented administration in the electronic health record, but she (LVN 2) knows she (LVN 2) did not administer the medications because Resident 2's blood pressure was low.During an interview on 12/5/2025 at 8:59 a.m., with the Director of Nursing (DON), the DON stated LVN 2 should document accurately especially for medication administration. The DON stated LVN 2 documented the blood pressure but did not document if she (LVN 2) had held the medication. The DON stated LVN 2 should have documented the right code which is number five for holding medication in MAR to prevent confusion and inaccurate medical record.During a review of facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/2017 and last reviewed on 10/23/2025, the P&P 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, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.2. The following information is to be documented in

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to implement its infection control measures for one of three sampled residents (Resident 2) who was on enhanced barrier precaution (EBP-wearing a protective gown and gloves whenever you are doing close-contact care with a patient who might be carrying these germs) by failing to ensure Licensed Vocational Nurse 1 (LVN 1) wore protective gown while providing gastrostomy (G tube-a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube care.This deficient practice had the potential for cross contamination (unintentional transfer of bacteria or germs or other contaminants from one surface to another) of infection among staff and residents.Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 3/12/2025, with diagnoses that included unspecified (unconfirmed) organism sepsis (a life-threatening blood infection), unspecified organism lobar pneumonia (infection and inflammation that may affect one part [lobe] of the lung, and gastrostomy. During a review of Resident 2's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 5/6/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.During a review of Resident 2's Physician Order, dated 5/6/2025, the Physician Order indicated Enhanced Barrier Precaution due to presence of wound and tube feeding. [NAME] (to put on) personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) gown when providing direct patient care. During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 9/19/2025, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 2 was dependent on staff for all activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 2 had a feeding tube.During a concurrent observation, and interview on 12/4/2025, at 9:46 a.m., with LVN 1, in Resident 2's room. Observed an EBP signage posted by Resident 2's door that indicated Resident 2 was on EBP. Observed LVN 1 went inside Resident 2's room wearing gloves but without a gown and stood by Resident 2's right side. Observed LVN 1 opened Resident 2's blanket and LVN 1 attempted to disconnect Resident 2's G tube from the feeding formula tubing. LVN1 stated she (LVN 1) wanted to loosen the G tube first before donning the gown. LVN 1 stated she (LVN 1) should have worn the gown before providing G ube care.During an interview on 12/4/2025, at 10:30 a.m., with the Director of Nursing (DON), the DON stated Resident 2 was on EBP because of the G tube. The DON stated LVN 1 should have worn a gown before touching the G tube to prevent the transmission of infection.During an interview on 12/4/2025, at 10:43 a.m., with the Infection Preventionist (IP), the IP stated Resident 2 was on EBP and LVN 1 should wear PPE like gloves and gown, when providing G tube care. The IP stated Resident 2 had an opening (G tube) in the abdomen therefore Resident 2 was at risk for infection as staff can introduce it because PPE was not worn.During a review of facility's policy and procedure (P&P), titled, Enhanced Barrier Precautions dated 2001, and last reviewed on 10/23/2025, the P&P indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDRO-is a germ that is resistant to many antibiotics) to residents. 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents.2. EBPs employ targeted gown and glove use during high contact (activities that have been demonstrated result in the transfer of MDROs to hands or clothing of healthcare personnel, even if blood and body fluid exposure is not anticipated) resident care activities when contact precautions do not otherwise apply.a. Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room).b. Personal protective equipment (PPE) is changed before caring for another resident.c. Face protection may be used if there is also a risk of splash or spray.3. Examples of high-contact resident care activities requiring the use of gowns and gloves for EBPs include:a. dressing;b. bathing/showering;c. transferring;d. providing hygiene;e. changing linens;f. changing briefs or assisting with toileting;g. device care or use (central line [provides access to a person's blood supply, which allows the patient to receive medications, fluids or additional blood, and allows practitioners to measure or draw blood], urinary catheter [a hollow tube inserted into the bladder to drain or collect urine], feeding tube, tracheostomy [a procedure to help air and oxygen reach the lungs by creating an opening into the windpipe from outside