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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056159 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/22/2026 |
| NAME OF PROVIDER OR SUPPLIER Sherman Village Hcc | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for one of three sampled residents (Residents 1) by failing to hold Eliquis (a blood thinner-medication used to prevent and treat blood clots [gel-like clumps of blood that forms inside the body when blood vessels [a tube through which the blood circulates in the body] are injured or damaged] by slowing down the body's clotting process and increase the risk for bleeding) as ordered by the physician. This failure had the potential for Resident 1 to experience hemorrhage (rapid, excessive loss of blood from damaged blood), negatively affecting Resident 1's well-being. Findings:a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted originally admitted Resident 1 on 1/26/2016 and readmitted on [DATE] with diagnoses including age related osteoporosis (bone disease that causes bones to become weak, brittle, and fragile, significantly increasing the risk of fractures) with current pathological fracture of right humerus (a break in the upper arm bone caused by an underlying disease that has weakened the bone), epilepsy (a chronic brain disorder characterized by sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares and loss of consciousness), and type two diabetes mellitus (DM II-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 9/24/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 3/9/2026, the MDS indicated Resident 1's had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 1 was dependent (helper does all the effort) on facility staff for personal hygiene, toileting hygiene, showers, upper and lower body dressing. During a review of Resident 1's Change of Condition (COC -major decline or improvement in a resident's status that will not resolve without intervention) form, dated 4/12/2026, the COC form indicated that on 4/12/2026, at 9:50 p.m., Resident 1 was observed with bluish discoloration on the inner upper right arm. During a review of Resident 1's Order Summary Report, the report indicated the following physician's order:-11/7/2025: Eliquis Oral tablet 2.5 milligram (mg-unit of measurement). Give one tablet via gastrostomy tube (G-tube-a medical device inserted through the abdomen into the stomach to deliver food, liquids, and medication directly, bypassing the mouth) every 12 hours for deep venous thrombosis (DVT- a condition where a blood clot forms in a deep vein, typically in the legs or thigh, causing swelling, pain, warmth, and redness) prophylaxis. -4/13/2026: Hold on blood thinners for three days. During a concurrent interview and record review on 4/22/2026 at 11:06 a.m. with Registered Nurse (RN) 1, 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 April 2026 was reviewed. The MAR indicated, on 4/13/2026, at 9a.m. and 9 p.m. administration time, Resident 1 received 1 tablet of 2.5mg Eliquis. RN 1 stated the failure to hold Eliquis 2.5 mg as ordered by the physician was a medication error and had the potential to cause (continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Resident 1 to experience bleeding. During an interview on 4/22/2026 at 11:52 a.m. with the Director of Nursing (DON), the DON stated the physician had ordered to hold Eliquis after Resident 1's discoloration on right upper arm was noted until the cause of the discoloration was identified. The DON stated failure to follow the physician's order and hold Eliquis had the potential for Resident 1 to experience bleeding and adverse effects (harmful, unintended, and undesired reactions resulting from medications). During a review of facility provided policy and procedure (P&P) titled, Administering Medications, last reviewed on 3/26/2026, 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. 5. Medication administration times are determined by resident need and benefit, not staff convenience.</p> | | |