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	05/06/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update a resident's care plan for one of three sampled residents (Resident 1) to reflect Resident 1's current wound treatment orders for sacrococcyx (the large triangular bone at the base of the spine and the tailbone) pressure ulcer (damage to the skin and underlying soft tissue caused by prolonged pressure).This deficient practice had the potential for Resident 1's need not being met.Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 9/13/2021 and was readmitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 10/25/2025, the MDS indicated Resident 1 had severe cognitive impairment (significant trouble with thinking, memory, concentration, and decision-making). The MDS indicated Resident 1 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's care plan titled, Actual pressure sore. Resident is noted with sacrococcyx extending right and left buttocks, dated 10/16/2025, the care plan goal indicated to minimize risk of complications and decline and will show signs and symptoms of improvement through appropriate interventions through the next assessment. The care plan intervention indicated to Administer treatment as ordered.During a concurrent interview and record review on 5/6/2026 at 12:46 p.m. with Treatment Nurse (TXN) 1, Resident 1's care plan titled, Actual pressure sore. Resident is noted with sacrococcyx extending right and left buttocks, was reviewed. TXN 1 stated that Resident 1's wound care plan was not resident-centered because it failed to include the treatment Resident 1 was receiving for Sacrococcyx pressure ulcer. TXT 1 further stated that care plan should include the current treatment orders so nursing staff would know how to properly care for Resident 1.During a concurrent interview and record review on 5/6/2026 at 4:02 p.m. with the Director of Nursing (DON), the DON stated that nursing staff should have updated Resident 1's wound care plan to reflect Resident 1's current wound order. The DON stated that without an updated care plan, the nurses will not have a guide on how to provide appropriate care for Resident 1.During a review of facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person-Centered, revised on 3/2022, the P&P indicated, Assessments of resident are ongoing, and care plans are revised as information about the residents and the resident condition changes. Care plan interventions are derived from thorough analysis of the information gathered as part of the comprehensive assessment.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **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) received proper care in accordance with professional standards of practice, by: 1. Failing to accurately complete comprehensive assessment for Resident 1 after readmission from the General Acute Care Hospital (GACH) on 10/15/2025.2. Failing to implement treatment consistent with physician orders by not holding hydralazine (a medication to treat high blood pressure) oral tablet when systolic blood pressure was less than 110 millimeters of mercury (mmHg - standard unit of measurement for pressure) on 9/6/2025 and 9/7/2025 during morning shift.These deficient practices had the potential to result in harm to Resident 1 and increased Resident 1's risk for adverse outcome related to blood pressure management.Cross reference F755. Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 9/13/2021 and was readmitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 10/25/2025, the MDS indicated Resident 1 had severe cognitive impairment (significant trouble with thinking, memory, concentration, and decision-making). The MDS indicated Resident 1 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent interview and record review on 5/6/2026 at 12:46 p.m. with Treatment Nurse (TXN) 1, Resident 1's clinical admission assessment dated [DATE] and skin reassessment dated [DATE] were reviewed. TXN 1 stated that nursing staff completed the clinical admission assessment inaccurately because the assessment did not indicate Resident 1's skin issues upon admission to the facility. TXN 1 further stated that Resident 1 was admitted to the facility with a pressure injury to sacrum extending to right and left buttocks. TXN 1 stated staff (registered nurses) left many questions unanswered and incomplete, resulting in an inaccurate clinical assessment. TXN 1 stated that staff must complete clinical assessment accurately to ensure Resident 1's needs are properly identified and addressed.During a concurrent interview and record review on 5/6/2026 at 2:41 p.m. with Registered Nurse (RN) 1, RN 1 stated that the registered nurses in the facility are responsible for completing the initial clinical assessments for all new admissions. RN 1 stated that Resident 1's Clinical assessment dated [DATE] was incomplete and not accurate because no skin issues were identified and when the treatment nurse reassessed Resident 1 the next day, they identified multiple skin problems. RN 1 stated that if the clinical assessment was not done accurately it looks like Resident 1 skin issues were developed at the facility. During a review of Resident 1's Order Summary Report, dated 8/10/2025, the Order Summary Report indicated Hydralazine HCl oral tablet 50 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) to be given one tablet by mouth three times a day for hypertension (HTN-high blood pressure) and hold if systolic blood pressure (SBP-top number in blood pressure reading) less than 110 mmHg.During a review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medication given to a resident), dated 9/2025, the MAR indicated that on 9/6/2025 and 9/7/2025, during the morning shift, hydralazine was given when systolic blood pressure was less than 110 mmHg. During a concurrent interview and record review on 5/6/2026 at 2:41 p.m. with RN 1, Resident 1's MAR dated 9/2025 was reviewed. RN 1 stated that the MAR indicated that on 9/6/2025 at 1 p.m. Resident 1's blood pressure was 95/63 mmHg, on 9/7/2025 at 9 a.m. Resident 1's blood pressure was 86/60 mmHg, and on 9/7/2025 at 1 p.m. Resident 1's blood pressure was 86/60 mmHg. RN 1 stated that nursing staff did not follow doctors' order because the systolic blood pressure was less than 110 and giving the dose of hydralazine will lower Resident 1's blood pressure even more. RN 1 further stated that it is important to follow doctors' orders to prevent any side effects and cause harm to Resident 1. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/6/2026 at 4:02 p.m. with the Director of Nursing (DON), the DON stated that nursing staff failed to follow the physicians order and administered hydralazine to Resident 1 when the medication should have been held. The DON stated that the nurses must follow physicians orders to prevent harm to the residents. The DON stated that Registered Nurses (RN) are responsible for completing clinical assessment upon admission. The DON further stated that RNs should perform thorough clinical assessment to ensure the assessment accurately reflects each residents current needs. During a review of facility's policy and procedure (P&P) titled, Comprehensive Assessments, revised on 3/2022, the P&P indicated, Comprehensive assessment are conducted and coordinated by a registered nurse with appropriate participation of other health professionals on the interdisciplinary team. Comprehensive assessments are conducted to assist in developing person-center care plans.During a review of facility's P&P titled, Administering Medication, revised on 4/2021, the P&P indicated, Medications are administered in accordance with prescriber orders, including any required time frames.

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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 review, the facility failed to hold the hydralazine (a medication to treat high blood pressure) oral tablet when systolic blood pressure was less than 110 millimeters of mercury (mmHg - standard unit of measurement for pressure) on 9/6/2025 and 9/7/2025 during morning shift in accordance with the physician order for one of three sampled residents (Resident 1).This deficiency practice had the potential to result in increased risk for adverse outcome related to blood pressure management to Resident 1. Cross reference F684. Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 9/13/2021 and was readmitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool), dated 10/25/2025, the MDS indicated Resident 1 had severe cognitive impairment (significant trouble with thinking, memory, concentration, and decision-making). The MDS indicated Resident 1 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Order Summary Report, dated 8/10/2025, the Order Summary Report indicated Hydralazine HCl oral tablet 50 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) to be given one tablet by mouth three times a day for hypertension (HTN-high blood pressure) hold if systolic blood pressure (SBP-top number in blood pressure reading) less than 110 mmHg.During a review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medication given to a resident), dated 9/2025, the MAR indicated that on 9/6/2025 and 9/7/2025, during the morning shift, hydralazine was given when systolic blood pressure was less than 110 mmHg. During a concurrent interview and record review on 5/6/2026 at 2:41 p.m. with RN 1, Resident 1's MAR dated 9/2025 was reviewed. RN 1 stated that the MAR indicated that on 9/6/2025 at 1 p.m. Resident 1's blood pressure was 95/63 mmHg, on 9/7/2025 at 9 a.m. Resident 1's blood pressure was 86/60 mmHg, and on 9/7/2025 at 1 p.m. Resident 1's blood pressure was 86/60 mmHg. RN 1 stated that nursing staff did not follow the doctors' order because the systolic blood pressure was less than 110 mmHg and giving the dose of hydralazine will lower Resident 1's blood pressure even more. RN 1 further stated that it is important to follow doctors' orders to prevent any side effects and cause harm to Resident 1. During a concurrent interview and record review on 5/6/2026 at 4:02 p.m. with the Director of Nursing (DON), the DON stated that nursing staff failed to follow the physicians order and administered hydralazine to Resident 1 when the medication should have been held. The DON stated that the nurses must follow physician's orders to prevent harm to the residents.During a review of facility's Policy and procedures (P&P) titled Administering Medication, revised on 4/201, the P&P indicated, Medications are administered in accordance with prescriber orders, including any required time frames.