STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056250	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherman Oaks Health & Rehab	14401 Huston St. Sherman Oaks, CA 91423

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 43878 Based on observation, interview, and record review, facility failed to maintain privacy of confidential information when staff left electronic health record (EHR- a digital version of a patient's paper chart) opened and unattended for one of four sampled residents (Resident 4). This deficient practice violated Resident 4's right to privacy and confidentiality of medical records. Findings: During a review of Resident 4's Admission Record, the Admission Record indicated the facility admitted Resident 4 on 1/5/2024 with diagnoses including essential (primary) hypertension (HTN-high blood pressure), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and history of falling. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 4 had the ability to understand and be understood. The MDS indicated Resident 1 was dependent (helper does all the effort) with toileting, showering, lower body dressing, and putting on and taking off footwear, and required substantial assistance (helper does more than half the effort) assistance with upper body dressing, and personal hygiene. During a concurrent observation and interview on 4/21/2025 at 4:41 p.m., in Nurses' Station 2 with the Director of Nursing (DON), the DON observed Resident 4's EHR was open and unattended. The DON stated there was no staff in sight attending to Resident 4's EHR. The DON stated when staff are not in front of the computers EHRs should be locked because it is a risk for Health Insurance Portability and Accountability Act (HIPPA- establishes federal standards protecting sensitive health information from disclosure without patient's consent) violation. The DON stated there is a potential for someone to access Resident 4's information who may not have the authorization. During a review of the facility's Policy and Procedure (P&P) titled, Computer Terminals/Workstations, last reviewed on 9/27/2024, the P&P indicated computer terminals and workstation will be positioned/shielded to ensure that protected health information (PHI) and facility information is protected from public view or unauthorized access. 1. In sofar as practical/feasible, computer terminals/workstations will be positioned or shielded so that screens are not visible to the public or to unauthorized staff. (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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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. A user may not leave his/her workstation or terminal unattended unless the terminal screen is cleared, and the user is logged off. Ensure user must log off at the end of his/her work shift.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878 Based on interview and record review, the facility failed to ensure an assistive device was used to prevent accidents for one of four sampled residents (Resident 1) when Resident 1, a resident who was dependent (helper does all the effort) on facility staff for surface-to-surface transfers, was transferred without the use of a mechanical lift (also known as a Hoyer lift, a mechanical device used to lift and/or transfer a person). This deficient practice resulted in Resident 1's transfer to the General Acute Care Hospital (GACH), on 3/31/2025, at 1 p.m., where Resident 1 was diagnosed with a left knee fracture (a break or crack in a bone) of the anterior tibial tuberosity (a bony bump located on the front of your shinbone [tibia], just below the kneecap). Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted the resident on 6/14/2023 and readmitted the resident on 4/4/2025 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting right dominant side, cerebral infarction (a stroke, specifically the kind caused by a blockage of blood flow to the brain, leading to brain tissue death), and end stage renal disease (ESRD - irreversible kidney failure). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 1 usually understood and was usually understood. The MDS indicated Resident 1 used a wheelchair for mobility and was dependent on facility staff for oral care, toileting, showering, upper and lower body dressing, putting on and taking off footwear, and personal hygiene and required substantial assistance (helper does more than half the effort) with eating. The MDS indicated Resident 1's prior device used included a manual wheelchair and mechanical lift. During a review of Resident 1's Fall Risk Assessment, dated 3/21/2025, the Fall Risk Assessment indicated Resident 1 had a fall risk score of 20 (a score of 18 or more is high risk for fall), with no history of falls or history of fall more than 12 months. During a review of a facility provided record with no title, dated 3/27/2025, the record indicated Resident 1 was a two-person assist using a Hoyer lift. During a review of Resident 1's Physician's Orders, dated 3/30/2025, the Physician's Orders indicated venous doppler ultrasound (a procedure that uses sound waves to visualize and assess blood flow in the veins, especially to check for blood clots or other problems) of left lower extremity related to pain and swelling one (1) time only for 1 day. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Change in Condition (COC)/Interact Assessment Form (SBAR - Situation-Background-Assessment-Recommendation, a structured communication tool used in healthcare to improve information sharing and resident safety, especially during critical situations), dated 3/30/2025, the assessment form indicated at 11:30 a.m., Resident 1 complained to Licensed Vocational Nurse (LVN) 2 of pain when she moved the leg. The assessment form indicated LVN 2 assessed Resident 1 and noted swelling on Resident 1's left leg. The assessment form indicated Resident 1 informed LVN 2 the swelling is new. The assessment form indicated at 11:45 a.m., Medical Doctor (MD) 1was notified and ordered a venous doppler ultrasound. The assessment form indicated on the 3/31/2025 7 a.m. to 3 p.m. shift recap, Resident 1 complained of pain to LVN 2 and upon assessment, the resident's left leg was very swollen, warm to touch, and significant bruising noted around the left knee surrounding the area. The assessment form indicated at the time, Resident 1 was in a lot of pain upon touching affected area, pain medication administered, ice pack applied to assist with swelling. The assessment form indicated MD 1 was notified and ordered to transfer Resident 1 to GACH 1 for x-ray (a type of radiation that allows doctors to take pictures of the inside of your body, specifically your bones and organs). The assessment form indicated Resident 1 rested in bed with eyes closed, however, when awake, claimed she was in pain. During a review of Resident 1's Discharge Summary Report, dated 3/31/2025 at 2 p.m., the Discharge Summary Report indicated Resident 1 was discharged on [DATE] at 1 p.m. to the GACH due to Resident 1's complaint of pain, swelling and bruising noted to the left leg. During a review of Resident 1's GACH record, dated 3/31/2025, the GACH records indicated Resident 1 was in the emergency room and the x-ray of left knee showed Patella Alta (a condition where the kneecap is positioned abnormally high in relation to the thigh bone and the trochlear groove [a groove in the thigh bone where the kneecap sits]) noted secondary to avulsion fracture (occurs when a ligament or tendon pulls a piece of bone away from the rest of the bone) at the anterior tibial tuberosity involving the patellar tendon (a strong band of tissue, or tendon, that connects the kneecap to the top of the shinbone). Severe swelling through out the left knee. Moderate suprapatellar effusion (another name for knee effusion, which happens when fluid builds up in the tissues surrounding the joint). The GACH records indicated Resident 1 reported moderate left lower extremity pain and limited range of motion at this time, and swelling was noted. During an interview on 4/21/2025 at 11:15 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 3/30/2025 Resident 1 complained of leg pain. CNA 1 stated Resident 1 stated she was transferred by a male staff without a Hoyer lift. CNA 1 stated Resident 1 is a two-person Hoyer lift transfer. CNA 1 stated when he looked at Resident 1's leg it was pushed in around the knee area, was warm, no bruising at that moment, and the leg did not look right compared to her other leg. CNA 1 stated he reported to LVN 2 who then reported to Registered Nurse (RN) 1. CNA 1 stated Resident 1 transferred to the hospital and believed Resident 1 had a fracture. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/21/2025 at 1:40 p.m. with LVN 2, LVN 2 stated she worked on 3/30/2025 with Resident 1. LVN 2 stated on 3/30/2025 in the morning prior to lunch time Resident 1 was complaining of left knee pain. LVN 2 stated Resident 1's left knee pain was a new pain, and noted the left knee was swollen, no redness, tender to touch which she (LVN 2) reported to RN 1. LVN 2 stated she administered pain medication to Resident 1 while RN 1 called MD 1 who ordered for an ultrasound. LVN 2 stated she worked the following day (3/31/2025) and Resident 1's swelling was worse; hence, Resident 1 was sent out to the GACH. LVN 2 stated she did ask Resident 1 what had caused the new pain and Resident 1 said she (Resident 1) was transferred to her wheelchair by one staff and without the use of the Hoyer lift. LVN 2 stated Resident 1 being transferred without a Hoyer lift is not the proper way to transfer Resident 1 because Resident 1 is a two-person transfer with the use of a Hoyer lift. LVN 2 stated Resident 1 ended up having a fracture. LVN 2 stated the improper transfer was what caused Resident 1's fracture. During an interview on 4/21/2025 at 3:56 p.m. with RN 1, RN 1 stated Resident 1 required a two-person assist and the use of a Hoyer Lift for transfers. RN 1 stated on 3/30/2025 LVN 2 called RN 1 prior to lunch and told RN 1 that Resident 1 was complaining of left leg pain. RN 1 stated assessed Resident 1's left leg which was swollen and painful. RN 1 stated the left knee pain was something new for Resident 1. During an interview on 4/21/2025 at 4:54 p.m. with the Administrator (Adm), the Adm stated he was made aware of Resident 1's new pain when he came into work on 3/31/2025. The Adm stated he did not speak to Resident 1, but the nurse spoke to Resident 1 and Resident 1 stated the pain was caused during the transfer by CNA 2. The Adm stated Resident 1 did have a fracture and it was concluded that it was during the transfer that the fracture occurred. During a review of the facility's P&P titled, Lifting Machine, Using a Mechanical, last reviewed on 9/27/2024, the P&P indicated at least two (2) nurses or qualified trained staff are needed to safely move a resident with a mechanical lift. During a review of the facility's P&P titled, Safety and Supervision of Residents, last reviewed on 9/27/2024, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43878 Based on observation, interview, and record review, the facility failed to ensure medication carts were locked when staff were out of view for two of two medication carts (Medication Cart 1 and Medication Cart 2). This deficient practice had the potential for residents and/or unauthorized personnel to have access to the medications in the medication carts. Findings: During a concurrent observation and interview, on 4/21/2025, at 4:41 p.m., in Nurses' Station 2, with the Director of Nursing (DON), Medication Cart 1 and Medication Cart 2 were open. The DON stated both Medication Cart 1 and Medication Cart 2 were open and all medication carts should be locked when staff are out of sight. The DON stated medication carts should be locked because this is for the safety of the residents. The DON stated if carts are left unlocked,someone can get into the medication carts and get the medication. During a review of the facility's Policy and Procedures (P&P) titled, Security of Medication Carts, last reviewed on 9/27/2024, the P&P indicated medication carts must be securely locked at all times when out of the nurse's view.Based on observation, interview, and record review, the facility failed to ensure medication carts were locked when staff were out of view for two of two medication carts (Medication Cart 1 and Medication Cart 2). This deficient practice had the potential for residents and/or unauthorized personnel to have access to the medications in the medication carts. Findings: During a concurrent observation and interview on 4/21/2025 at 4:41 p.m. in Nurses' Station 2 with the Director of Nursing (DON), the DON observed Medication Cart 1 and Medication Cart 2 were open. The DON stated both Medication Cart 1 and Medication Cart 2 are open and all medication carts should be locked when staff are out of sight. The DON stated medication carts should be locked because this is for the safety of the residents. The DON stated if carts are left unlocked someone can get into the medication carts and get the medications. During a review of the facility's Policy and Procedures (P&P) titled, Security of Medication Carts, last reviewed on 9/27/2024, the P&P indicated medication carts must be securely locked at all times when out of the nurse's view.