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	05/20/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42311 Based on interview and record review, the facility failed to report allegation of visitor-to-resident verbal abuse (the act of harassing, labeling, insulting, scolding, rebuking, or excessive yelling towards an individual) within two hours to the State Survey Agency (the agency that inspects long-term care facilities for the purposes of survey and certification), the ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and to local law enforcement (LLE - police) as per its policies on abuse for one of three sampled residents (Resident 1). This failure resulted in a delay in the investigation and had the potential to place Resident 1 at risk for abuse. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 4/16/2025, with diagnoses including syncope (fainting or a brief loss of consciousness due to temporary reduced blood flow to the brain, often caused by a drop in blood pressure), collapse (a broader term referring to a sudden falling or weakening due to various factors, not necessarily involving a loss of consciousness), generalized muscle weakness and unspecified (unconfirmed) epilepsy (seizures that can cause them to stare into space, shake uncontrollably, or fall down). During a review of Resident 1's History and Physical (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 4/18/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/22/2025, the MDS indicated resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. During a review of Resident 1's Interdisciplinary Team (IDT - a coordinated group of experts from several different fields who work together) Narrative, dated 5/19/2025, the IDT Narrative indicated on 5/18/2025, Resident 1 claimed Resident 2's Visitor 1 used inappropriate language towards Resident 1. The IDT indicated Social Service spoke to Visitor 1 and informed Visitor 1 that inappropriate language directed towards residents was unacceptable and can negatively affect the community environment. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/2025 at 9:08 a.m. with Resident 1, Resident 1 stated on Sunday, 5/18/2025, at around 8:30 p.m., Visitor 1 used inappropriate language towards Resident 1. Resident 1 stated she (Resident 1) reported the incident to Social Service Assistant (SSA) 1 on the morning of 5/19/2025. During an interview on 5/20/2025 at 9:24 a.m. with SSA 1, SSA 1 stated yesterday 5/19/2025, Resident 1 went to SSA 1's office and reported that on Sunday, 5/18/2025, night, Visitor 1 called Resident 1 inappropriate names because Resident 1's television was loud. SSA 1 stated she (SSA 1) notified the Administrator (ADM) on 5/19/2025, and the ADM advised her (SSA 1) to call Visitor 1. SSA 1 stated using inappropriate language is a form of verbal abuse. SSA 1 stated verbal abuse are unwanted comments against a person. SSA 1 stated verbal abuse was the reason why she (SSA 1) reported to the ADM. SSA 1 stated any allegation of abuse should also be reported to the police, the ombudsman, and State Survey Agency. During an interview on 5/20/2025 at 9:58 a.m. with SSA 1, SSA 1 stated Resident 1 reported the allegation of verbal abuse on 5/19/2025, between 11 a.m. to 11:15 a.m. During an interview on 5/20/2025 at 10 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 5/19/2025, between 9 a.m. to 10 a.m., Resident 1 reported that Visitor 1 called Resident 1 an inappropriate name and Visitor 1 intentionally messed up her (Resident 1) television to annoy her (Resident 1). LVN 1 stated it was a verbal abuse, and she (LVN 1) reported to Registered Nurse (RN) 1 and RN 1 advised her (LVN 1) to report to Social Services. During an interview on 5/20/2025 at 10:09 a.m. with RN 1, RN 1 stated LVN 1 reported allegation of verbal abuse on 5/19/2025, at around 10 a.m. RN 1 stated she (RN 1) notified LVN 1 to report to Social Service right away. RN 1 stated allegation of abuse should be reported right away to the State Survey Agency, the ombudsman, and the police so investigation could be done for resident safety. During a concurrent interview and record review on 5/20/2025, at 10:17 a.m., with the ADM, the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, dated 3/2023 and last reviewed on 9/27/2024, was reviewed and the P&P indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) are thoroughly investigated by facility management. Findings of all investigations are documented and reported. Reporting Allegations to the Administrator and Authorities: 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. The resident's representative; d. Law enforcement officials; e. The resident's attending physician; and f. The facility medical director. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 4. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone. Investigating Allegations: 1. All allegations are thoroughly investigated. The administrator initiates investigations. The ADM stated he (ADM) did not receive any report of allegation of abuse involving Resident 1. The ADM stated calling Resident 1 with inappropriate names is verbal abuse and should be reported to State Survey Agency, ombudsman, and police. The ADM stated staff should have informed him (ADM) of the verbal allegation of abuse on 5/19/2025. The ADM stated if he (ADM) was informed he (ADM) would have initiated the report to the State Survey Agency and ombudsman, reported the incident to the police,and start the investigation. The ADM stated their P&P indicated to report allegation of abuse within two hours. During an interview on 5/20/2025 at 10:26 a.m. with SSA 1 and the ADM, SSA 1 stated she (SSA 1) informed the ADM about the verbal abuse allegation between Visitor 1 and Resident 1 while informing the ADM about a noise complaint from Visitor 1. The ADM stated he (ADM) did not hear the part about the verbal abuse allegation and was only aware of the noise complaint from Visitor 1. SSA 1 stated there was miscommunication between her (SSA 1) and the ADM. The ADM stated when informed, he (ADM) would have initiated the Report of Suspected Dependent Adult/Elder Abuse form, separated Resident 1 and Visitor 1, report to LLE, the ombudsman, and the State Survey Agency, and start an investigation. During a review of facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021 and last reviewed on 9/27/2024, the P&P indicated, 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements.