

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Sherman Oaks Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 3) received care consistent with professional standards of practice to prevent pressure ulcers (PU, a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) by failing to ensure staff used one sheet and one chux (an absorbent under pads or bed pads used to protect surfaces from incontinence or spills) or disposable brief between Resident 3 and the Low Air Loss Mattress (LALM - a mattress composed of inflatable air cushions used to relieve pressure on body parts). This deficient practice placed Resident 3 at risk for the development of pressure ulcers. Findings: During a review of Resident 3's undated admission Record, the admission Record indicated the facility admitted the resident on 10/31/2025 with diagnoses including age-related osteoporosis (a disease that makes bones thin, weak, and brittle, increasing the risk of fractures [broken bones]), unspecified dementia (a decline in brain function including memory, language, reasoning, and behavior severe enough to interfere with daily life but the specific type had not been identified), and essential hypertension (high blood pressure that is not due to another medical condition). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 1/5/2026, the MDS indicated Resident 3's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were moderately impaired. During a review of Resident 3's Care Plan on pressure ulcers, last revised on 1/6/2026, the Care Plan indicated the resident had the potential for PU development. The Care Plan Interventions indicated the use of pressure relieving devices as needed. During a review of Resident 3's Physician Orders, dated 3/17/2026, the Physician Orders indicated an order for low air loss mattress for skin care management. During a concurrent observation and interview on 4/1/2026 at 11:43 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated LALM was an intervention for residents with PU or were at risk for developing PU. LVN 1 stated Resident 3's LALM was observed with one fitted sheet, two layers of cloth chux, and a disposable brief. LVN 1 stated a LALM required one layer of flat sheet and one layer of chux or disposable brief. LVN 1 stated more than two layers of linen between Resident 3 and the LALM will prevent air circulation, create pressure, and trap moisture that may cause Resident 3 to develop PU. During an interview on 4/1/2026 at 12:15 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she (CNA 1) changed Resident 3's disposable brief and placed two pieces of chux between Resident 3 and the LALM before she (CNA 1) went on a lunch break. During an interview on 4/1/2026 at 1:10 p.m. with the Director of Nursing (DON), the DON stated a LALM were provided for residents with PU and for residents at risk for developing PU. The DON stated a LALM required the use of one linen and one chux or disposable brief. The DON stated multiple layers of linen prevented the air from circulating and had the potential to cause friction and result in PU. The DON the acknowledged and stated the facility failed to ensure there were only two layers of linen between the LALM and Resident 3. During a review of the facility's policy and procedure (PnP) titled, Support Surface Guidelines, last reviewed on 9/27/2025, the PnP indicated redistributing support surfaces are to promote comfort for all bed or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. The PnP indicated to monitor for other pressure ulcer risk factors and provide interventions as indicated.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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