STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055711	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1321 Franklin Street Santa Monica, CA 90404	

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent the deterioration of pressure injuries (localized damage to skin and underlying soft tissue, usually over bony prominences [heels, hips, tailbone], caused by prolonged pressure, friction, or [NAME]) and provided care and services consistent with professional standards of practice for one out of three sampled residents (Resident 1) who had multiple pressure ulcers/injuries by failing to:1. Set the low air loss (LAL - a medical bed system with air-filled cells that let out tiny amounts of air through microscopic holes to keep the user's skin cool, dry, and moisture-free. It acts like a floating surface that reduces pressure on the body, actively prevents bedsores, and helps heal existing skin ulcers. They are generally adjusted to match the patient's weight) mattress to appropriate and recommended settings.2. Create individualized Care Plans (CP, is a customized, written document detailing specific health, social, and functional needs, goals, and actions for a person in medical, residential, or school setting) for Pressure injuries.These deficient practices resulted in on worsening of the existing PU as well as the development of facility acquired PUs.Cross Reference: F726. A review of Resident 1's admission record indicated the facility initially admitted the resident on 5/13/2025 and was readmitted on [DATE], with diagnosis that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), encephalopathy (any disease, damage, or malfunction that affects the brain's structure or function, resulting in an altered mental state), and cognitive communication deficit (difficulty communicating because of impaired thinking skills like attention, memory, problem-solving, and organization, often following brain injury, stroke, or conditions like dementia). The same admission record indicated additional diagnoses of pressure ulcers, stage 4 (stage 1 -intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness; stage 2 -partial-thickness loss of skin, presenting as a shallow open sore or wound; stage 3 - full-thickness loss of skin. Dead and black tissue may be visible; Stage 4 - full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the sacral region (the triangular area at the base of the spine, overlying the sacrum, a bone formed by five fused vertebrae connecting the spine to the pelvis and lower body), left and right hips on 10/1/2025. A review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 10/1/2025, indicated the resident had mild cognitive impairment (noticeable memory or thinking problems that are worse than normal aging but don't significantly interfere with daily life, unlike dementia). The same MDS indicated Resident 1 was mostly dependent on staff for activities of daily living (ADLs) such as toileting hygiene, Shower/bathe, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 1 had three stage 4 Pus and was at risk of developing more (PUs).During a review of Resident's 1 physician orders dated 9/11/2025, indicated, May provide pressure relieving mattress.During a review of Resident's 1 physician orders dated 9/11/2025, indicated, turn and reposition q [every] 2hrs [hours], (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	patient may refuse, document if patient refuses.During a review of a care plan (CP) initiated 9/12/2025 with a focus, Impaired skin integrity as manifested by resident with stage 4 pressure injury to right buttocks extending to thigh right posterior thigh, indicated interventions which included:Monitor skin daily for any changes and report to MD [Medical Doctor) if T x [treatment] ineffectiveTreatment as ordered and monitor for effectivenessDuring a review of a care plan (CP) initiated 9/12/2025 with a focus, Impaired skin integrity as manifested by resident with stage 2 pressure injury on sacrum extending to right buttocks-reclassified to stage 4 by wound MD 10/13/2025, indicated interventions which included:Labs [laboratory] as neededObserve and report signs of infectionTreatment as ordered and monitor for effectivenessTum and reposition every 2 hours and as neededDuring a review of a document titled, Skin Observation Tool, dated 9/12/2025, included the following: Left trochanter (hip) abrasion 4 [centimeters-unit of measure/cm] length and 1 [cm] width. Right buttock shearing injury 20 [cm] length and 8 [cm] width. Sacrum pressure 3 length and 2 width.The same documented indicated, skin and body check done with above findings. stage 2 pressure injury to the sacrum extending to the right buttocks, shearing injury to right buttocks extending to thigh.During a review of Resident's 1 physician orders dated 12/23/2025, indicated, pressure injury to sacrum: cleanse with NS [a sterile, 0.9% solution of salt {sodium chloride} in water, designed to match the natural salt concentration in human blood widely used to treat dehydration, clean wounds etc.], pat dry, apply Santyl [a prescription topical medication used to debride chronic skin ulcers and severe burns by breaking down dead tissue to promote healing], pack gently with gauze and cover with foam dressing].During a review of Resident's 1 physician orders dated 12/23/2025, indicated, right buttocks pressure injury stage 4: cleanse with NS, pat dry, apply Santyl, pack gently with gauze and cover with foam dressing].During a review of a document titled, Task: Monitor - Turn and reposition, where the Certified Nursing Assistants were required to document when Resident 1 was repositioned every two hours. There was no documented evidence indicating Resident 1 was repositioned during the following times slots:1/1/20264 pm, 6 pm, 8 pm1/2/202612 am, 8 am, 10 am, 4 pm, 8 pm1/3/20268 am, 10, 12 pm, 2 pm, 10 pm1/4/20262 am, 8 am, 10 am, 12 pm, 4 pm, 8 pm, 10 pm1/5/202612 am, 2 am, 6 am, 8 am,1/6/20258 am, 10 am, 12 pm, 4 pm, 6 pm, 10 pm.1/7/202612 am, 2 am, 8 am, 10 am, 4 pm, 10 pm.1/8/20264 pm, 6 pm, 8 pm, 10 pm.1/9/20268 am, 10 am, 2 pm.1/10/202612 am, 2 am, 4 pm, 8 pm, 10 pm.1/12/202612 am, 2 am, 6 am, 8 am, 10 am, 12 pm, 4 pm, 6 pm, 10 pm.1/13/202612 am, 2 am, 8 am, 10 am, 12 pm, 2 pm, 4 pm, 6 pm, 8 pm, 10 pm.1/14/202612 am, 2 am, 4 am, 8 am, 10 am, 12 pm, 4 pm, 6 pm, 8 pm.1/16/20264 am, 8 am, 10 am, 12 pm, 2 pm.1/17/20262 am, 6 am, 8 am, 10 am, 12 pm, 2 pm, 4 pm, 6 pm, 10 pm.1/18/202612 pm, 2 pm.1/19/20262 am, 8 am, 10 am, 12 pm.1/20/20262 am, 4 am, 8 am, 10 am, 12 pm, 4 pm, 6 pm, 10 pm.1/21/20262 am, 4 pm, 6 am, 8 am, 10 am, 12 pm, 4 pm, 6 pm, 10 pm.1/22/20268 am, 10 am, 12 pm, 4 pm, 8 pm.1/23/20264pm, 8 pm.1/24/20268 am, 10 am, 12 pm, 2 pm, 4 pm, 10 pm.1/25/20266 am, 6 pm.1/26/202612 am, 2 am, 4 am, 6 am, 8 am, 10 am.1/27/20262 am, 4 am, 6 am, 4 pm, 10 pm.1/28/202612 am, 2 am, 8 am, 10 am. During a concurrent observation of Resident 1 and an interview with Certified Nurse Assistant (CNA) 1, on 1/21/2026 at 1/21/2026 at 12:30 pm, Resident 1 was noted to have an adhesive dressing to the right upper arm as well as the left leg around the shin area. CNA 1 stated that Resident 1 did not speak. CNA 1 stated that Resident 1 had PU to his buttocks, right upper arm and recently (approximately 2 weeks) to the left lower leg. CNA stated that she did her best to reposition Resident 1 but that there were instances when Resident 1 was found in the same position that he had been placed 4 hours prior. CNA 1 denied assisting with dressing change that morning and stated that the Treatment Nurse (TN) 2 completed the wound care treatments daily during Resident 1's care when she was assigned with him.During a concurrent interview and record review of Resident 1's chart with TN 1 on (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1/21/2026 at 1:50 pm, TN 1 stated that Resident 1 was currently being treated for four pressure ulcers:Sacrum- stage 4 pressure injury measuring 6.2 cm (length) X 6 cm (width) X 3 cm (depth).Left posterior trochanter -Stage 4 pressure injury measuring 15.3 X 10.5 X 3Right buttocks- Stage 4 pressure injury Measurements 8.3 X 6 X 3Right shoulder- DTPI (Deep Tissue Pressure Injury - a serious form of damage to skin and underlying soft tissue caused by prolonged pressure or shear, often appearing as a persistent, non-blanchable purple or maroon area, or a blood-filled blister) measuring 4.6 cm X 5 cm. TN 1 was unable to state was under the dressing to the right upper arm or to the right shin and stated that Resident 1 had healed PUs in the areas. TN 1 stated that before/during wound care treatments, he also assessed Resident 1's skin from head to toe. On 8/23/2026 at 7:49 am, TN 1 was asked to let this writer know when he was going to complete Resident 1's wound care treatments so that this writer could observed. TN 1 verbalized understanding.During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers) progress note dated 1/23/2026 at 8:07 am, indicated, Pressure injury to left shin and right shoulder. The same SBAR indicated, development of pressure injury due to pillow placement. The SBAR indicated, noted on am rounds with redness on shin concern for unstageable pressure injury. right shoulder noted with concern for dti [Deep Tissue Pressure Injury (DTPI or DTI) is a severe form of pressure ulcer occurring over bony prominences, resulting from intense, prolonged pressure that damages underlying soft tissue while the surface skin remains intact or forms a blood-filled blister]/uti.During an interview with Family Member (FM) 1 on 1/23/2026 at 8:30 am, FM 1 stated that they only became aware of the PUs to the left shin a few days prior when Resident 1 was being repositioned during a visit. FM 1 stated that the facility had not informed FM 1 about the new PU.During a concurrent observation of Resident 1's wound care treatment and interview with TN 1 1/23/2026 at 9:22 am, the room had a pungent, foul odor. The ulcer to the right upper arm and covered in black-brownish jelly appearing eschar (a thick, black or brown scab of dead tissue that forms on the skin after a severe burn, injury, or infection) tissue and measured about 4 cm x 4 cm with no drainage. The ulcer to the left shin was elongated, almond shaped measuring approximately 7 cm x 3 cm. the wound bed was covered in hard yellow-greyish hard slough (type of necrotic [dead] tissue found in a wound bed that has transitioned from a soft/moist state to a firm, dry, or leathery texture after prolonged poor circulation which begins in inflammation) which was lifting around the edges and surrounded by a red halo. The was no drainage.During an interview with Licensed Vocational Nurse (LVN) 2 on 1/23/2026 at 11 am, LVN 2 stated that the LAL mattress setting are based on a patient's weight and must be set to as close to their weight as possible. LVN 2 stated that if the mattress is way below the weight of a resident, it becomes too soft and could lead to more pressure injuries. If set too high, it becomes too firm preventing offloading and may lead to more or worsening of pressure ulcers.During a concurrent observation of Resident 1's LAL mattress settings with the Director of Nursing (DON) on 1/23/2026 at 11:04 am, the DON confirmed that the mattress was set to over the maximum of 400 pounds. The DON stated that the LAL mattress is comfort and weight based. The DON stated that all mattress are usually set at 400 to make sure that tubes are inflated. And should not be set lower than 152 pounds (lbs.) which was a weight that was taped to the LAL mattress setting control but was unable to state why. A review of Resident 1's weight log indicated Resident 1 weighed 139 lbs.During an interview with TN 1 on 1/23/2026 11:10 am, TN stated that it would defeat the purpose of a LAL mattress is not set based on weight and could be either too hard or too soft causing it to be untherapeutic. During a follow up interview and record review of Resident 1's CPs and SBARs with TN 1 on 1/23/2026 at 12:25 pm, TN 1 stated that a head-to-toe skin assessment which included a Braden scale and CPs are developed upon (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	admission. TN 1 stated that all resident must have CP for issues such as wounds, treatments which must be updated when it is reclassified to a higher or lower level or when there is a new SBAR. TN 1stated that CPs must be individualized to a resident and factors such as staging must be included. TN 1 stated treatments are not specified and simply indicate, treatment as ordered. TN 1 stated that If there is a new order, then the order will only be reflected in the TAR (Treatment Administration Record) because it would be redundant to include it in the CP. TN 1 stated that an SBAR must be done immediately change happens to ensure that the physician, resident representatives, other staff are aware about the change, and that everything carried out was documented. The TN 1 admitted that the interventions for care plans dated 9/12//2026.During a follow up interview and record review of Resident 1's CPs and SBARs with TN 1 on 1/23/2026 at 12:25 pm, TN 1 stated that a head-to-toe skin assessment which included a Braden scale and CPs are developed upon admission. TN 1 stated that all resident must have CP for issues such as wounds, treatments which must be updated when it is reclassified to a higher or lower level or when there is a new SBAR. TN 1stated that CPs must be individualized to a resident and factors such as staging must be included. TN 1 stated treatments are not specified and simply indicate, treatment as ordered. TN 1 stated that If there is a new order, then the order will only be reflected in the TAR (Treatment Administration Record) because it would be redundant to include it in the CP. TN 1 stated that an SBAR must be done immediately change happens to ensure that the physician, resident representatives, other staff are aware about the change, and that everything carried out was documented. The TN 1 admitted that the interventions for care plans dated 9/12//2026 for the PU to the sacrum extending to the buttocks, TN 1 stated that it was redundant to indicate the type of treatment that was order for Resident 1 stating, it is redundant to place the actual order on the care plan. TN 1 stated that listing the treatment as ordered was enough for him. TN 1 confirmed that he indicated the same verbiage (treatment as ordered) for the residents that had various treatments ordered. TN 1 stated that the treatments for Resident 1 were for the stage 4 pressure ulcers to the left trochanter, sacrum, right buttocks, and the right shoulder DTI which was initiated on 1/14/2026. TN 1 admitted that there were no SBAR completed for the right shoulder DTI when it was discovered on 1/14/2026. TN 1 stated that the left shin DTI had just been discovered that morning at 8 am and could have developed a few hours ago due to using a regular head soft pillow. TN 1 confirmed that a head to toe assessment could have helped identify the pressure ulcer to the left shin earlier which could have prompted an completion of the SBAR, physician notification as well as Resident 1's representatives. TN 1 stated that he had not performed Resident 1's wound care on 1/21/2026 which was why he did not know about the pressure ulcer to the left shin and that it was completed by LVN 3. TN 1 confirmed that lack of treatment to the left shin could have resulted in wound deteriorate, infection, sepsis, organ failure and/or death. During an interview with LVN 3 on 1/23/2026 at 1:05 pm, LVN 3 confirmed that she had been covering as treatment nurse on 1/21/2026. LVN 3 stated that she had not completed Resident 1's treatment because she (LVN 3) was assigned to station 1 (Resident 1 was on station 2) which was covered by TN 1.During an interview with the Wound Care Specialist (WCS) on 1/23/2026 at 1:15 pm, the WCS stated that a LAL mattress helped in preventing as well as the development of PUs and that it was weight based. The WCS stated the settings must be set as close to the residents' weight as possible and that setting it to 400 lbs. for a resident who weight 139 lbs. would be like placing them on a table which could result in worsening of current wounds or the development of new PUs.During an interview with TN 1 on 1/27/26 1:34 pm, TN 1 stated that he had just remembered that he was the one who had completed the wound care treatments on 1/21/2026. TN 1 was unable to describe the PU to Resident 1's shin and repeatedly stated, it looked like a DTI, but (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	still unable to describe what a DTI looked like.During an interview with the Medical Director of the facility, (MD) on 1/27/26 at 6:05 pm, the MD stated that the facility staff must notify a physician of a change in condition as soon as possible and urgently for new PUs. The MD stated that a care plan must include clear goals that are individualized to the resident. The MD stated that placing a resident on a hardened surface such as a table for a prolonged period could worsen and possibly cause more PUs.During a review of the facility's policy and procedure (P&P) titled, CARE PLANNING (IDT) POLICY, reviewed 2025, indicated, All residents will have a comprehensive care plan to meet their individual needs that is prepared by the Interdisciplinary Team (IDT) within 7 days after the completion of the comprehensive assessment and periodically reviewed and revised after subsequent assessments. During a review of the facility's P&P titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, reviewed 1/2026, the P&P indicated under assessment and recognition, the nurse shall describe and document/report the following:a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudate or necrotic tissue;b. Pain assessment.c. Resident's mobility status.d. Current treatments, including support surfaces; ande. All active diagnoses.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Licensed nurses had specific competencies and skill sets necessary to adequately, assess, describe, and report the development of a new Pressure Ulcer (PUs- localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), for one of the three sampled residents (Resident 1) who had a new PU to the left shin to the physician. This failure resulted in Resident 1's delay in getting treatment for the left shin unstageable (deep wound where the true depth and severity cannot be seen because it is covered by dead tissue (slough) or thick, hardened, black/brown scabs known as eschar) pressure injury which could have resulted in further deterioration of the PU, infection, sepsis, organ failure, and or death. Cross reference to F686A review of Resident 1's admission record indicated the facility initially admitted the resident on 5/13/2025 and was readmitted on [DATE], with diagnosis that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), encephalopathy (any disease, damage, or malfunction that affects the brain's structure or function, resulting in an altered mental state), and cognitive communication deficit (difficulty communicating because of impaired thinking skills like attention, memory, problem-solving, and organization, often following brain injury, stroke, or conditions like dementia). The same admission record indicated additional diagnoses of pressure ulcers, stage 4 (stage 1 -intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness; stage 2 -partial-thickness loss of skin, presenting as a shallow open sore or wound; stage 3 -full-thickness loss of skin. Dead and black tissue may be visible; Stage 4 - full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the sacral region (the triangular area at the base of the spine, overlying the sacrum, a bone formed by five fused vertebrae connecting the spine to the pelvis and lower body), left and right hips on 10/1/2025.left and right hips on 10/1/2025. During a review of a CP dated 9/12/2025 with a focus, Impaired skin integrity as manifested by resident with stage 4 pressure injury to - right buttocks extending to thigh - right posterior, included the following interventions, Treatment as ordered. During a review of Resident's 1 physician orders dated 9/11/2025, indicated, May provide pressure relieving mattress. During a review of Resident's 1 physician orders dated 9/11/2025, indicated, turn and reposition q [every] 2hrs [hours], patient may refuse, document if patient refuses. During a review of a care plan (CP) initiated 9/12/2025 with a focus, Impaired skin integrity as manifested by resident with stage 4 pressure injury to right buttocks extending to thigh right posterior thigh, indicated interventions which included:Monitor skin daily for any changes and report to physician if T x [treatment] ineffectiveTreatment as ordered and monitor for effectiveness During a review of a care plan (CP) initiated 9/12/2025 with a focus, Impaired skin integrity as manifested by resident with stage 2 pressure injury on sacrum extending to right buttocks-reclassified to stage 4 by wound physician 10/13/2025, indicated interventions which included:Labs [laboratory] as neededObserve and report signs of infectionTreatment as ordered and monitor for effectivenessTum and reposition every 2 hours and as needed During a review of a document titled, Skin Observation Tool, dated 9/12/2025, included the following: Left trochanter (hip) abrasion 4 [centimeters-unit of measure/cm] length and 1 [cm] width. Right buttock shearing injury 20 [cm] length and 8 [cm] width. Sacrum pressure 3 length and 2 width.The same documented indicated, skin and body check done with above findings. stage 2 pressure injury to the sacrum extending to the right buttocks, shearing injury to right buttocks extending to thigh. A review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 10/1/2025, (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the resident had mild cognitive impairment (noticeable memory or thinking problems that are worse than normal aging but don't significantly interfere with daily life, unlike dementia). The same MDS indicated Resident 1 was mostly dependent on staff for activities of daily living (ADLs) such as toileting hygiene, Shower/bathe, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 1 had three stage 4 Pus and was at risk of developing more (PUs). During a review of Resident's 1 physician orders dated 12/23/2025, indicated, pressure injury to sacrum: cleanse with NS [a sterile, 0.9% solution of salt {sodium chloride} in water, designed to match the natural salt concentration in human blood widely used to treat dehydration, clean wounds etc.], pat dry, apply Santyl [a prescription topical medication used to debride chronic skin ulcers and severe burns by breaking down dead tissue to promote healing], pack gently with gauze and cover with foam dressing]. During a review of Resident's 1 physician orders dated 12/23/2025, indicated, right buttocks pressure injury stage 4: cleanse with NS, pat dry, apply Santyl, pack gently with gauze and cover with foam dressing]. During a review of a document titled, Task: Monitor - Turn and reposition, where the Certified Nursing Assistants were required to document when Resident 1 was repositioned every two hours. There was no documented evidence indicating Resident 1 was repositioned during the following times slots:1/1/20264 pm, 6 pm, 8 pm1/2/202612 am, 8 am, 10 am, 4 pm, 8 pm1/3/20268 am, 10, 12 pm, 2 pm, 10 pm1/4/20262 am, 8 am, 10 am, 12 pm, 4 pm, 8 pm, 10 pm1/5/202612 am, 2 am, 6 am, 8 am,1/6/20258 am, 10 am, 12 pm, 4 pm, 6 pm, 10 pm.1/7/202612 am, 2 am, 8 am, 10 am, 4 pm, 10 pm.1/8/20264 pm, 6 pm, 8 pm, 10 pm.1/9/20268 am, 10 am, 2 pm.1/10/202612 am, 2 am, 4 pm, 8 pm, 10 pm.1/12/202612 am, 2 am, 6 am, 8 am, 10 am, 12 pm, 4 pm, 6 pm, 10 pm.1/13/202612 am, 2 am, 8 am, 10 am, 12 pm, 2 pm, 4 pm, 6 pm, 8 pm, 10 pm.1/14/202612 am, 2 am, 4 am, 8 am, 10 am, 12 pm, 4 pm, 6 pm, 8 pm.1/16/20264 am, 8 am, 10 am, 12 pm, 2 pm.1/17/20262 am, 6 am, 8 am, 10 am, 12 pm, 2 pm, 4 pm, 6 pm, 10 pm.1/18/202612 pm, 2 pm.1/19/20262 am, 8 am, 10 am, 12 pm.1/20/20262 am, 4 am, 8 am, 10 am, 12 pm, 4 pm, 6 pm, 10 pm.1/21/20262 am, 4 pm, 6 am, 8 am, 10 am, 12 pm, 4 pm, 6 pm, 10 pm.1/22/20268 am, 10 am, 12 pm, 4 pm, 8 pm.1/23/20264pm, 8 pm.1/24/20268 am, 10 am, 12 pm, 2 pm, 4 pm, 10 pm.1/25/20266 am, 6 pm.1/26/202612 am, 2 am, 4 am, 6 am, 8 am, 10 am.1/27/20262 am, 4 am, 6 am, 4 pm, 10 pm.1/28/202612 am, 2 am, 8 am, 10 am. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR, a communication tool used by healthcare workers) progress note dated 1/23/2026 at 8:07 am, indicated, Pressure injury to left shin and right shoulder. The same SBAR indicated, development of pressure injury due to pillow placement. The SBAR indicated, noted on am rounds with redness on shin concern for unstageable pressure injury. right shoulder noted with concern for dti/uti [unable to determine - a type of serious skin injury where the wound is covered by dead tissue - slough/eschar, making it impossible for a healthcare provider to see the base of the wound to determine how deep it actually is]. During a concurrent observation of Resident 1 and interview with CNA 1 on 1/21/2026 at 1/21/2026 at 12:30 pm, Resident 1 was noted to have an adhesive dressing to the right upper arm as well as the left leg around the shin area. CNA 1 stated that Resident 1 did not speak. CNA 1 stated that Resident 1 had PU to his buttocks, right upper arm and recently (approximately 2 weeks) to the left lower leg. CNA stated that she did her best to reposition Resident 1 but that there were instances when Resident 1 was found in the same position that he had been placed 4 hours prior. CNA 1 denied assisting with dressing change that morning and stated that the Treatment Nurse (TN) 2 completed the wound care treatments daily during Resident 1's care when she was assigned with him. During a concurrent interview and record review of Resident 1's chart with TN 1 on 1/21/2026 at 1:50 pm, TN 1 stated that Resident 1 was currently being treated for four pressure ulcers:Sacrum- stage 4 pressure injury measuring 6.2 cm (length) X 6 cm (width) X 3 cm (depth).Left posterior trochanter -Stage 4 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055711	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Health Care Center	1321 Franklin Street Santa Monica, CA 90404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure injury measuring 15.3 X 10.5 X 3Right buttocks- Stage 4 pressure injury Measurements 8.3 X 6 X 3Right shoulder- DTPI (Deep Tissue Pressure Injury - a serious form of damage to skin and underlying soft tissue caused by prolonged pressure or shear, often appearing as a persistent, non-blanchable purple or maroon area, or a blood-filled blister) measuring 4.6 cm X 5 cm.TN 1 was unable to state was under the dressing to the right upper arm or to the right shin and stated that Resident 1 had healed PUs in the areas. TN 1 stated that before/during wound care treatments, he also assessed Resident 1's skin from head to toe. On 8/23/2026 at 7:49 am, TN 1 was asked to let this writer know when he was going to complete Resident 1's wound care treatments so that this writer could observed. TN 1 verbalized understanding. During an interview with Family Member (FM) 1 on 1/23/2026 at 8:30 am, FM 1 stated that they only became aware of the PUs to the left shin a few days prior when Resident 1 was being repositioned during a visit. FM 1 stated that the facility had not informed FM 1 about the new PU. During a concurrent observation of Resident 1's wound care treatment and interview with TN 1 1/23/2026 at 9:22 am, the room had a pungent, foul odor. The ulcer to the right upper arm and covered in black-brownish jelly appearing eschar (a thick, black or brown scab of dead tissue that forms on the skin after a severe burn, injury, or infection) tissue and measured about 4 cm x 4 cm with no drainage. The ulcer to the left shin was elongated, almond shaped measuring approximately 7 cm x 3 cm. the wound bed was covered in hard yellow-greyish hard slough (type of necrotic [dead] tissue found in a wound bed that has transitioned from a soft/moist state to a firm, dry, or leathery texture after prolonged poor circulation which begins in inflammation) which was lifting around the edges and surrounded by a red halo. The was no drainage. During an interview with Licensed Vocational Nurse (LVN) 2 on 1/23/2026 at 11 am, LVN 2 stated that the LAL mattress setting are based on a patient's weight and must be set to as close to their weight as possible. LVN 2 stated that if the mattress is way below the weight of a resident, it becomes too soft and could lead to more pressure injuries. If set too high, it becomes too firm preventing offloading and may lead to more or worsening of pressure ulcers. During a concurrent observation of Resident 1's LAL mattress settings with the Director of Nursing (DON) on 1/23/2026 at 11:04 am, the DON confirmed that the mattress was set to over the maximum of 400 pounds. The DON stated that the LAL mattress is comfort and weight based. The DON stated that all mattress are usually set at 400 to make sure that tubes are inflated. And should not be set lower than 152 pounds (lbs.) which was a weight that was taped to the LAL mattress setting control but was unable to state why. A review of Resident 1's weight log indicated Resident 1 weighed 139 lbs. During an interview with TN 1 on 1/23/2026 11:10 am, TN stated that it would defeat the purpose of a LAL mattress is not set based on weight and could be either too hard or too soft causing it to be untherapeutic. During a follow up interview and record review of Resident 1's CPs and SBARs with TN 1 on 1/23/2026 at 12:25 pm, TN 1 stated that a head-to-toe skin assessment which included a Braden scale and CPs are developed upon admission. TN 1 stated that all resident must have CP for issues such as wounds, treatments which must be updated when it is reclassified to a higher or lower level or when there is a new SBAR. TN 1stated that CPs must be individualized to a resident and factors such as staging must be included. TN 1 stated treatments are not specified and simply indicate, treatment as ordered. TN 1 stated that If there is a new order, then the order will only be reflected in the TAR (Treatment Administration Record) because it would be redundant to include it in the CP. TN 1 stated that an SBAR must be done immediately change happens to ensure that the physician, resident representatives, other staff are aware about the change, and that everything carried out was documented. The TN 1 admitted that the interventions for care plans dated 9/12//2026 for the PU to the sacrum extending to the buttocks, TN 1 stated that it was redundant to indicate the type of (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Brentwood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1321 Franklin Street Santa Monica, CA 90404	

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment that was order for Resident 1 stating, it is redundant to place the actual order on the care plan.TN 1 stated that listing the treatment as ordered was enough for him. TN 1 confirmed that he indicated the same verbiage (treatment as ordered) for the residents that had various treatments ordered. TN 1 stated that the treatments for Resident 1 were for the stage 4 pressure ulcers to the left trochanter, sacrum, right buttocks, and the right shoulder DTI which was initiated on 1/14/2026. TN 1 admitted that there were no SBAR completed for the right shoulder DTI when it was discovered on 1/14/2026. TN 1 stated that the left shin DTI had just been discovered that morning at 8 am and could have developed a few hours ago due to using a regular head soft pillow. TN 1 confirmed that a head to toe assessment could have helped identify the pressure ulcer to the left shin earlier which could have prompted an completion of the SBAR, physician notification as well as Resident 1's representatives. TN 1 stated that he had not performed Resident 1's wound care on 1/21/2026 which was why he did not know about the pressure ulcer to the left shin and that it was completed by LVN 3. TN 1 confirmed that lack of treatment to the left shin could have resulted in wound deteriorate, infection, sepsis, organ failure and/or death.During an interview with LVN 3 on 1/23/2026 at 1:05 pm, LVN 3 confirmed that she had been covering as treatment nurse on 1/21/2026. LVN 3 stated that she had not completed Resident 1's treatment because she (LVN 3) was assigned to station 1 (Resident 1 was on station 2) which was covered by TN 1. During an interview with the Wound Care Specialist (WCS) on 1/23/2o26 at 1:15 pm, the WCS stated that a LAL mattress helped in preventing as well as the development of PUs and that it was weight based. The WCS stated the settings must be set as close to the residents' weight as possible and that setting it to 400 lbs. for a resident who weight 139 lbs. would be like placing them on a table which could result in worsening of current wounds or the development of new PUs. During an interview with TN 1 on 1/27/26 1:34 pm, TN 1 stated that he had just remembered that he was the one who had completed the wound care treatments on 1/21/2026. TN 1 was unable to describe the PU to Resident 1's shin and repeatedly stated, it looked like a DTI, but still unable to describe what a DTI looked like. During an interview with the Medical Director of the facility, (MD) on 1/27/26 at 6:05 pm, the MD stated that the facility staff must notify a physician of a change in condition as soon as possible and urgently for new PUs. The MD stated that a care plan must include clear goals that are individualized to the resident. The MD stated that placing a resident on a hardened surface such as a table for a prolonged period could worsen and possibly cause more PUs.During a review of the facility's policy and procedures (P&P) titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, reviewed 1/2026, indicated under assessment and recognition, the nurse shall describe and document/report the following:a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudate or necrotic tissue;b. Pain assessment.c. Resident's mobility status.d. Current treatments, including support surfaces; ande. All active diagnoses.