STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056056	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brier Oak on Sunset	5154 Sunset Blvd Los Angeles, CA 90027

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 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. 42311 Based on interview and record review, the facility failed to ensure a licensed staff administered medication for one of three sampled residents (Resident 1). This deficient practice had the potential to result in a medication error. Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 1/14/2013 with diagnoses that included right ankle and right foot acute hematogenous (originating in the blood or spread through the bloodstream) osteomyelitis (inflammation of bone or bone marrow, usually due to infection), unspecified (unconfirmed) peripheral vascular disease (PVD-a slow progressive narrowing of the blood flow to the arms and legs), and generalized muscle weakness. During a record review of Resident 1's History and Physical Examination (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 5/9/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a record review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/12/2024, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 needed moderate assistance from staff for toileting and shower. The MDS indicated Resident 1 was frequently incontinent (unable to control) for bowel and bladder functions. During a record review of Resident 1's Physician Order, dated 2/12/2025, the Physician Order indicated nystatin (medication used to treat fungal or yeast infection in the skin) external powder 100,000 unit per gram topical (pertaining to a particular surface area), apply to abdominal pundus (excess skin and fat hangs from the abdomen) topically everyday shift and as needed for fungal rash (a skin infection caused by fungi. It can appear as red, itchy, scaly, or discolored patches of skin). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/2025 at 10:04 a.m., with Certified Nursing Assistant 1 (CNA1), CNA 1 stated she (CNA 1) was instructed by Licensed Vocational Nurse 1 (LVN1) to administer the nystatin powder to Resident 1's lower abdomen since she (CNA1) provides incontinent care. CNA 1 stated she (CNA 1) had administered the nystatin powder to Resident 1. CNA 1 stated nystatin powder is a medication that should have not been administered by a CNA. CNA 1 stated she was not trained and licensed to administer medication. CNA 1 stated she (CNA 1) should have not followed LVN 1's instruction. CNA 1 stated she (CNA 1) does not know the effect or side effect (undesirable effect) of the medication. During an interview on 3/6/2025 at 10:09 a.m. with the Assistant Director of Nursing (ADON), the ADON stated nystatin powder is a medication that should only by administered by licensed nurse (a nurse who has completed an approved nursing program, passed a state licensing exam, and is licensed to provide patient care). The ADON stated CNAs cannot administer medication. The ADON stated CNA does not know the medication information. During an interview on 3/6/2025 at 10:20 a.m., with the Director of Staff Development (DSD), the DSD stated medication administration is not in the CNAs scope of practice (refers to the activities that a licensed health professional is allowed to perform). The DSD stated resident can receive wrong medication if CNA administers medication. The DSD stated CNA should have reported if they were instructed to administer medication. The DSD stated CNA are not competent (to have the skills, knowledge, and experience to do something well or to meet a standard) and trained for medication administration. During an interview on 3/6/2025 at 10:41 a.m. with the Director of Nursing (DON), the DON stated CNAs are not competent for medication administration. The DON stated medication administration is not in the CNAs scope of practice. The DON stated CNAs will not be able to monitor and assess resident after each medication administration. During a record review CNA 1's Job Description (a document that outlines the tasks, duties, and responsibilities of a position), dated 9/22/2023, the Job Description did not indicate that a CNA can administer medication. During a record review of facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, dated 8/8/2024 and last reviewed on 2/27/2025, the P&P indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. Licensed nurses and nursing assistants are trained and must demonstrate competency in identifying, documenting and reporting resident changes of condition consistent with their scope of practice and responsibilities. During a record review of facility's P&P titled, Medication Administration-General Guidelines, dated 10/2017 and last reviewed on 2/27/2025, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Medications are administered only by licensed nursing, medical, pharmacy personnel authorized by state laws and regulations to administer medication.

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NAME OF PROVIDER OR SUPPLIER Brier Oak on Sunset		STREET ADDRESS, CITY, STATE, ZIP CODE 5154 Sunset Blvd Los Angeles, CA 90027	

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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 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. 42311 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of three sampled residents (Resident 1) by failing to ensure a licensed staff administer medication for one of three sampled residents (Resident 1). This deficient practice had the potential to result in a medication error. Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 1/14/2013 with diagnoses that included right ankle and right foot acute hematogenous (originating in the blood or spread through the bloodstream) osteomyelitis (inflammation of bone or bone marrow, usually due to infection), unspecified (unconfirmed) peripheral vascular disease (PVD-a slow progressive narrowing of the blood flow to the arms and legs), and generalized muscle weakness. During a record review of Resident 1's History and Physical Examination (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 5/9/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a record review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/12/2024, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 needed moderate assistance from staff for toileting and shower. The MDS indicated Resident 1 was frequently incontinent (unable to control) for bowel and bladder functions. During a record review of Resident 1's Physician Order, dated 2/12/2025, the Physician Order indicated nystatin (medication used to treat fungal or yeast infection in the skin) external powder 100,000 unit per gram topical (pertaining to a particular surface area), apply to abdominal pundus (excess skin and fat hangs from the abdomen) topically everyday shift and as needed for fungal rash (a skin infection caused by fungi. It can appear as red, itchy, scaly, or discolored patches of skin). During an interview on 3/6/2025 at 10:04 a.m., with Certified Nursing Assistant 1 (CNA1), CNA 1 stated she (CNA 1) was instructed by Licensed Vocational Nurse 1 (LVN1) to administer the nystatin powder to Resident 1's lower abdomen since she (CNA1) provides incontinent care. CNA 1 stated she (CNA 1) had administered the nystatin powder to Resident 1. CNA 1 stated nystatin powder is a medication that should have not been administered by a CNA. CNA 1 stated she was not trained and licensed to administer medication. CNA 1 stated she (CNA 1) should have not followed LVN 1's instruction. CNA 1 stated she (CNA 1) does not know the effect or side effect (undesirable effect) of the medication. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/2025 at 10:09 a.m. with the Assistant Director of Nursing (ADON), the ADON stated nystatin powder is a medication that should be administered by a licensed nurse (a nurse who has completed an approved nursing program, passed a state licensing exam, and is licensed to provide patient care). The ADON stated CNAs should not administer a medication. The ADON stated CNA does not know the medication information. During an interview on 3/6/2025 at 10:20 a.m., with the Director of Staff Development (DSD), the DSD stated medication administration is not in the CNA's scope of practice (refers to the activities that a licensed health professional is allowed to perform). The DSD stated resident can receive wrong medication if CNA administers medication. The DSD stated CNA should have reported if they were instructed to administer medication. The DSD stated CNA are not competent (to have the skills, knowledge, and experience to do something well or to meet a standard) and trained for medication administration. During an interview on 3/6/2025 at 10:41 a.m. with the Director of Nursing (DON), the DON stated CNAs are not competent for medication administration and should not administer medication. The DON stated medication administration is not in CNAs scope of practice. The DON stated CNAs will not be able to monitor medication effect and assess resident after each medication administration. During a record review CNA 1's Job Description (a document that outlines the tasks, duties, and responsibilities of a position), dated 9/22/2023, the Job Description did not indicate that CNA can administer medication. During a record review of facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, dated 8/8/2024 and last reviewed on 2/27/2025, the P&P indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. Licensed nurses and nursing assistants are trained and must demonstrate competency in identifying, documenting and reporting resident changes of condition consistent with their scope of practice and responsibilities. During a record review of facility's P&P titled, Medication Administration-General Guidelines, dated 10/2017 and last reviewed on 2/27/2025, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Medications are administered only by licensed nursing, medical, pharmacy personnel authorized by state laws and regulations to administer medication.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 42311 Based on interview and record review, the facility failed to maintain accurate and complete medical record for one of three sampled residents (Resident 1). This deficient practices had the potential to cause confusion in the care and the medical records containing inaccurate documentation. Findings: During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 1/14/2013 with diagnoses that included right ankle and right foot acute hematogenous (originating in the blood or spread through the bloodstream) osteomyelitis (inflammation of bone or bone marrow, usually due to infection), unspecified (unconfirmed) peripheral vascular disease (PVD-a slow progressive narrowing of the blood flow to the arms and legs), and generalized muscle weakness. During a record review of Resident 1's History and Physical Examination (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 5/9/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a record review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/12/2024, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 needed moderate assistance from staff for toileting and shower. The MDS indicated Resident 1 was frequently incontinent (unable to control) for bowel and bladder functions. During a record review of Resident 1's Situation Background Assessment Recommendation (SBAR-technique that provides a framework for communication between members of the health care team about a resident ' s condition) Communication Form, dated 2/15/2025, the SBAR indicated Resident 1 complained of difficulty in urinating on 2/15/2025 at 2:25 p.m. and the physician was notified on 2/15/2025 at 12 a.m. During a record review of Resident 1's Physician Order, dated 2/15/2025 timed at 3:05 p.m., the Physician Order indicated an order for urinalysis (urine test) and urine culture (a test that detects and identifies bacteria or other microorganisms in a urine sample). During a concurrent interview and record review on 3/6/2025 at 10:09 a.m. with the Assistant Director of Nursing (ADON), Resident 1's SBAR dated 2/15/2025 and Physician Order dated 2/15/2025 were reviewed. The ADON stated the SBAR was opened and started on 2/15/2025 at 2:43 p.m. and the Physician Order was timed at 3:05 p.m. The ADON stated the documentation of physician notification was still accurate even if the SBAR indicated physician was notified on 2/15/2025 at 12 a.m. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/2025 at 10:41 a.m., with the Director of Nursing (DON), the DON stated the documentation for physician notification was not accurate. The DON stated if staff did not manually enter the time, they made the notification to the physician and the responsible party, the computer system automatically documentation 12 a.m. The DON stated staff forgot to document in SBAR, the time physician was notified, and staff should manually enter the time they notify the physician for accurate documentation. During a record review of facility's policy and procedure (P&P) titled, Nursing Documentation, dated 5/1/2023 and last reviewed on 2/27/2025, the P&P indicated, Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's/patient's (hereinafter patient) condition, situation, and complexity. Documentation of nursing care is recorded in the medical record and is reflective of the care provided by nursing staff. Nurses will not: 1. Document services that were not performed, 2 Document services before they are performed. Timely entry of documentation must occur as soon as possible after the provision, of care and in conformance with time frames for completion as outlined by other policies and procedures.