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	05/06/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48142 Based on observation, interview, and record review, the facility failed to promote care for residents in a manner and an environment to maintain or enhance each resident ' s dignity in full recognition of his or her individuality when 151 of 158 sampled residents received their meals in a plastic container and utensils. This failure had the potential to result in psychosocial distress, a lack of self esteem and frustration for 151 residents. Cross Reference F804 Findings: During a review of Resident 5 ' s Admission Record, the Admission Record indicated the facility initially admitted Resident 5 on 6/1/2022 and readmitted on [DATE] with diagnoses that included hypertension (high blood pressure - when the force of your blood pushing against the walls of your blood vessels is too high). During a review of Resident 5 ' s Minimum Data Sheet (MDS - a resident assessment tool) dated 1/13/2025, the MDS indicated Resident 5 understood others and made self-understood. During a review of the Physician's Orders dated 2/19/2025, the Physician's Orders indicated to provide regular diet, regular texture, standard thin liquid consistency, small portion, and one snack upon request. During an interview on 5/1/2025 at 11:06 a.m., Resident 5 stated the food was semi cold when it arrived, not appetizing to eat, especially when eating in a plastic container and stated the coffee was cold. Resident 5 stated it was very frustrating to open the plastic container. She notified the facility staff and asked the dietary supervisor to address the issue, but the dietary supervisor did not address it. Resident 5 stated she did not want to eat in the facility. During a review of Resident 9 ' s Admission Record, the Admission Record indicated the facility initially admitted the resident on 12/24/2024 with diagnoses including type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 9 ' s Order Listing Report dated 2/19/2025, the Order Listing Report indicated to provide consistent carbohydrate diet, regular texture, standard thin liquid consistency, and no added salt. During a review of Resident 9 ' s MDS dated [DATE], the MDS indicated Resident 9 understood others and made self-understood. During an observation on 5/1/2025 at 12:20 p.m., with Kitchen Aid (KA) 1 and the Dietary Supervisor (DS), KA 1 checked the temperature of the test tray food and results were as follows: Milk Shake 60.9 degrees Fahrenheit (F, a scale of temperature) Orange Juice 44.7 F Milk 41.9 F White [NAME] 131.2 F Chicken Stir Fry with Vegetables 117.3 F Dinner Roll/Bread 86.7 F. During a concurrent interview, KA 1 and DS tried the Chicken Stir Fry with Vegetables, rice and dinner roll. KA 1 stated the food was barely warm. The DS stated it was because the plastic container could not retain the heat of the food. The DS stated the residents would not like to eat the food because it was cold. After review of the document titled, Service Line Checklist (the temperature of the food prior to serving the residents) with the DS, the DS stated for the Chicken Stir Fry with Vegetable, the temperature indicated 174 F (over 50 degree difference from the observation temperature) and the white rice was 176 F (over 40 degree difference). During an interview on 5/1/2025 at 1:20 p.m., the Director of Nursing (DON) stated the facility used a disposable food container and utensils since the elevator was not working. The DON stated that the staff formed lines on the stairs to pass on trays. The DON stated eating in a disposable plastic container did not affect the residents and it was like ordering food from the outside. The DON further stated the plastic food container can retain heat for it to reach the residents and did not receive any complaints from the residents. During an interview on 5/5/2025 at 11:19 a.m., the DS stated at this time the facility continued using disposable food containers. It was important to make sure that the food temperature was right for the residents. The DS stated the residents would not like the food, they would not eat it and complained about it. The DS further stated eating from a disposable food container was not presentable and the facility only used it during emergency situations. The DS stated, We don ' t use disposable at home and this is the resident ' s home. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/6/2025 at 1:14 p.m., Resident 9 stated food was horrible, cold and it should not be cold. Resident 9 stated he was sick of the plastic food container, and it had continued for a while. Resident 9 stated, We always invited the dietary supervisor to the meetings to raise this concern, but he never shows up. Resident 9 also stated the Administrator never asked about the food here. During a review of the current facility policy and procedure titled, Resident Rights Under Federal Law, last reviewed date 4/2025, the policy and procedure indicated to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her self-esteem and self-worth. The policy indicated to provide a safe, clean, comfortable, and homelike environment.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 48142 Based on observation, interview, and record review, the facility failed to follow the meal ticket and ensure residents receive their dietary preferences for one of three sampled residents (Resident 7). Resident 7's meal tray was observed in his room with onions but Resident 7 did not like onions. This deficient practice had the potential to result in decreased food and nutrient intake which may result in unintended (not planned) weight loss for the resident. Findings: During a review of Resident 7 ' s Admission Record, the Admission Record indicated the facility admitted Resident 7 on 2/14/2025 with diagnoses including hypertension (high blood pressure - when the force of your blood pushing against the walls of your blood vessels is too high). During a review of Resident 7 ' s Minimum Data Set (MDS - a resident assessment tool), dated 3/12/2025, the MDS indicated Resident 7's cognition (the process of knowing, understanding, and thinking) was intact with thought process and required clean up assistance from staff during eating. During a review of Resident 7 ' s Physician's Order Listing Report, dated 3/17/2025, indicated a renal diet (special eating plan designed to help people with kidney disease manage their health), regular texture, thin consistency, no onions, and two apple snacks. During a concurrent observation and interview on 5/5/2025 at 12:45 p.m. with the Infection Preventionist Nurse (IPN), inside Resident 7 ' s room, the resident meal tray had salisbury steak with brown gravy and slices of onions. During a concurrent review of Resident 7's meal ticket, it indicated no onion. The IPN stated Resident 7 should not receive onion because Resident 7 did not like it and most likely the resident would not eat his food. During a concurrent interview and record review on 5/5/2025 at 1:05 p.m. with the Director of Nursing (DON), the physician's order was reviewed and indicated no onion. The DON stated it was important not to serve onion to Resident 7 because it would affect their nutrition status and If we don ' t honor it the resident could lose weight and won ' t eat it. During a review of the current facility-provided policy and procedure titled, Person Centered Choice, reviewed 4/2025, the policy and procedure indicated Patients/Residents were offered a choice of nourishing, palatable, well balanced food and beverage options that meet their daily nutritional needs, taking into consideration the preferences of each resident.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48142 Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved temperature, flavor and appearance. The residents' food was served in plastic food containers and staff distributed this food via the stairs as the elevator was in disrepair. This deficient practice placed 151 of 158 facility residents on regular, therapeutic diets (a meal plan that controls the intake of certain food and nutrients) and puree diets (food with soft pudding like consistency) at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Cross Reference F557 Findings: During a review of Resident 5 ' s Admission Record, the Admission Record indicated the facility initially admitted Resident 5 on 6/1/2022 and readmitted on [DATE] with diagnoses including hypertension (high blood pressure - when the force of your blood pushing against the walls of your blood vessels is too high). During a review of Resident 5 ' s Minimum Data Sheet (MDS - a resident assessment tool) dated 1/13/2025, the MDS indicated Resident 5 ' s understood others and made self-understood. During an interview on 5/1/2025 at 11:06 a.m.,Resident 5 stated the food was semi cold when it arrived, not appetizing to eat, especially when eating in a plastic container, and that the coffee was cold. Resident 5 stated it was very frustrating to open the plastic container. During a review of Resident 9 ' s Admission Record, the Admission Record indicated the facility initially admitted Resident 9 on 12/24/2024 with diagnoses including type two diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension. During a review of Resident 9 ' s MDS dated [DATE], the MDS indicated Resident 9 understood others and made self-understood. During a concurrent interview and record review on 5/1/2025 at 11:17 a.m. with Maintenance Director (MD) 1, a screen shot on his phone record titled Elevator Support Services Inc. was reviewed indicating the following: Invoice Date Amount Payment Release Date 11/1/2024 $214.00 1/10/2025 11/1/2024 $508.00 1/10/2025 12/1/2024 $220.24 4/4/2025 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/1/2025 $220.24 4/4/2025 2/1/2025 $220.24 4/4/2025. MD 1 stated there was a delay in repairing the elevator due to back and forth from the elevator company indicating that the facility owed them money. MD 1 stated the facility was paying them but the elevator company asked the facility to pay for March, April and May payments before they would come out. During a concurrent review of the receipts, the facility released the payment for 12/1/2024, 1/1/2025 and 2/1/2025 not until 4/4/2025. MD 1 continued to respond that the facility was paying their bill and would send this receipt as proof. During an observation and concurrent interview on 5/1/2025 at 12:20 p.m., with Kitchen Aid (KA)1 and the Dietary Supervisor (DS), KA 1 and DS tried the Chicken Stir Fry with Vegetables, rice and dinner roll. KA 1 stated the food was barely warm. The DS stated that because the facility used the plastic containers they could not retain the heat of the food. The DS stated the residents would not like to eat the food because it was cold. During an interview on 5/1/2025 at 1:20 p.m., the Director of Nursing (DON) stated the facility used a disposable food container and utensils since the elevator was not working. The DON stated that the staff formed lines on the stairs to pass the trays to the residents. The DON stated, Eating in a disposable plastic container doesn ' t affect the residents and it was like ordering food from the outside. The DON further stated that the plastic food container can retain heat for it to reach the residents and did not receive any complaints from the residents. During an interview on 5/5/2025 at 11:19 a.m., the DS stated at this time the facility was still using disposable food containers. It was important to make sure that the food temperature was right for the residents. The DS further stated eating in disposable food container was not presentable and the facility only used it during emergency situations. The DS stated, We don ' t use disposable at home and this is resident ' s home. During an interview on 5/6/2025 at 11:27 a.m., the Administrator stated that there was a delay in repairing the elevator because of a back-and-forth problem with the facility elevator company. The Administrator further stated that she gives her personal credit card and pays them and still the complany did not come to fix the elevator. During a concurrent review record titled Elevator Support Services Inc. with the Administrator, the payments indicated the following: Invoice Date Amount Payment Release Date 11/1/2024 $214.00 1/10/2025 11/1/2024 $508.00 1/10/2025 12/1/2024 $220.24 4/4/2025 1/1/2025 $220.24 4/4/2025 2/1/2025 $220.24 4/4/2025 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator stated she paid the elevator company twice, tried to pull out the receipts from her personal phone and was unable to locate it. During an interview on 5/6/2025 at 1:14 p.m., Resident 9 stated the food was horrible, it was cold. Resident 9 stated he was sick of the plastic food container, as it had been a while. During a record review of the email from the Administrator on 5/12/2025 at 10:31 a.m., the Administrator provided a screenshot of the invoice number, with gross amount and schedule date. Invoice Date Amount Schedule Date 12/1/2024 $220.24 12/31/2024 1/1/2025 $220.24 1/31/2025 2/1/2025 $220.24 3/3/2025 During a review of the current facility-provided undated policy and procedure titled, Food Preparation dated 4/2025, the policy and procedure indicated, All foods are prepared in accordance with the FDA Food Code.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48142 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to: -Maintain infection control by storing Certified Nursing Assistant (CNA) 1 personal cup inside the clean linen cart and drinking in the hallways. -Implement Enhanced Barrier Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted gown and glove use during high contact resident care activities) when CNA 7 was observed not wearing a gown after showering one of 10 sampled residents (Resident 10). -Maintain infection control when CNA 2 retrieved clean linen from Resident 2's bed and returned it to a clean linen cart parked outside the resident's room. -Ensure staff wear Personal Protective Equipment (PPE) inside a contact isolation room (Resident 1). -Ensure the nasal cannula and humider was dated. These deficient practices had the potential to spread infections and illnesses among residents and staff. Findings: During a concurrent observation and interview on 5/1/2025 at 9:25 a.m., CNA 1 was observed in the hallway drinking water. CNA 1 stated that he was drinking from his personal cup and stored it in a clean linen cart because the break room was downstairs and he was busy. CNA 1 stated he was not supposed to store his personal cup in the clean linen cart due to contamination. After observation and interview from CNA 1, CNA 1 observed to continue to store his personal cup in dirty linen cart. During a review of Resident 10 ' s Admission Record, the Admission Record indicated the facility admitted Resident 10 on 10/29/2024 with diagnoses including hypertension (high blood pressure - when the force of your blood pushing against the walls of your blood vessels is too high). A review of the Physician ' s Orders, dated 12/30/2024, indicated Resident 10 required enhanced standard/barrier precautions (EBP) due to wound care every shift. During a review of Resident 10 ' s Minimum Data Set (MDS - a resident assessment tool), dated 1/28/2025, the MDS indicated Resident 10 had moderately impaired thought process and required substantial assistance from staff to complete activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/1/2025 at 9:27 a.m., with CNA 7, inside Resident 10's room, CNA 7 was not wearing a gown when dressing Resident 10 and stripping the bed sheets. CNA 7 stated, after showering Resident 10, she was not wearing a gown and should wear a gown because Resident 10 was on EBP due to Resident 10's wound to protect myself and other residents. During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility initially admitted Resident 2 on 10/2/2023 and readmitted on [DATE] with diagnoses including acute respiratory failure with hypoxia (lungs are suddenly failing to get enough oxygen into your bloodstream). During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 was intact with thought process and required partial assistance from staff to complete activities of daily living. During an observation on 5/1/2025 at 9:36 a.m., CNA 2 was in the hallway returning a plastic bag containing linen to the inside of the clean linen cart. During a concurrent interview, CNA 2 stated she was returning the linens and it was okay for her to put it back in the clean linen cart because it was inside a clean plastic bag which was placed on top of Resident 2's bed. CNA 2 further stated that she would ask the Infection Preventionist (IP) nurse for the answer. During an interview on 5/1/2025 at 9:55 a.m., CNA 2 stated the IP indicated, I should not return any linens from residents ' room to the clean linen cart due to cross contamination. d. During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility initially admitted Resident 1 on 2/1/2023 and re admitted on [DATE] with diagnoses including hypertension. During a review of Resident 1 ' s MDS, dated [DATE], the MDS indicated Resident 1 was intact with thought process and required substantial assistance from staff to complete activities of daily living. A review of the Physician ' s Orders, dated 4/28/2025, indicated Resident 1 required contact isolation precaution every shift. During an observation on 5/1/2025 at 10:12 a.m., CNA 4 was in the hallway wearing gloves. During a concurrent interview, CNA 4 stated, I will remove my gloves and wash my hands now. CNA 4 was then observed entering Resident 1 ' s room and washed her hands inside the bathroom. CNA 4 then went outside of Resident 1's room. During a review of Resident 4 ' s Admission Record, the Admission Record indicated the facility admitted Resident 4 on 4/23/2025 with diagnoses of hypertension. During a review of Resident 4 ' s History and Physical Examination (H&P), dated 4/25/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/1/2025 at 10:57 a.m. with Registered Nurse (RN) 3, inside Resident 4 ' s room, the nasal cannula was on the floor undated, and the humidifier was undated. RN 3 stated the nasal cannula and humidifier must be dated to know when was the last time it was changed due to infection control and if the nasal cannula was not being changed this could cause respiratory infection for Resident 4. During an interview on 5/5/2025 at 11:36 a.m., the IP stated staff should not store their personal cup in the clean linen cart nor drink in the hallway due to infection control. The IP stated staff should not wear gloves in the hallway and must remove them inside the room and wash their hands after. Staff should not enter a contact isolation room without wearing proper protective equipment. Staff should wear a gown when taking care of a resident with wounds to avoid any bacteria pathogen entering the body. The IP stated staff must not return any linen in the clean linen carts from residents ' rooms due to cross contamination. The nasal cannula should not touch the floor and must be dated. Humidifiers must be dated to to know when the last time was changed because bacteria could build up if it was not changed weekly and possible not to deliver proper oxygen for the residents. During an interview on 5/5/2025 at 11:49 a.m., the Director of Nursing (DON) stated staff should not wear gloves in the hallway due to infection control, staff should not have their personal belongings in the clean linen cart nor drink in the hallway, because it was supposed to be clean and there was a potential for cross contamination. The DON further stated staff should wear proper protective equipment according to residents ' isolation to protect clothes from potential splashes and staff would not be protected. The DON stated we must indicate the date for nasal cannula and humidifier to know when the last time was changed. During a review of the facility policy and procedure titled, Oxygen: Nasal Cannula, dated 4/2025, the policy and procedure indicated the nasal cannula must be labelled with date of initial set up. If humidifier was used, label with date. During a review of the facility policy and procedure titled, Personal Protective Equipment, last reviewed date 4/2025, the policy and procedure indicated, PPE will be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach the employee ' s work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time when the protective equipment will be used. During a review of the facility policy and procedure titled, Linen Handling, last reviewed date 4/2025, the policy and procedure indicated, All linen will be handled, stored, transported, and processed to contain and minimize exposure to waste products. To ensure proper handling, storage, processing, and transport of linen in a safe and sanitary method to prevent the spread of infection. Nothing shall be kept on top of the linen carts. Only rolls of bags used for linen transport may be kept on the carts. Limit linen in the patient ' s room for immediate use only (do not store up linen in the patient ' s room to prevent in advert contamination). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy and procedure titled, Infection Prevention and Control Program last reviewed date 4/2025, the policy and procedure indicated, Implementation of Control Measures and Precautions includes basics such as hand hygiene, standard and transmission-based precautions, cleaning/disinfecting equipment and measures to protect persons from communicable disease of infections. Prevention of Infection includes staff and patient education focusing on risk of infection and practices to decrease risk. Policies, procedures, and infection prevention and control practices are followed by staff.