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	06/17/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, the facility failed to follow professional standards of practice for one of three sampled residents (Resident 1) by failing to: 1. Ensure licensed nurses communicated with the transport services the correct dialysis (process of removing waste products and excess fluid from the body when the kidneys stop working properly) center for Resident 1. 2. Ensure licensed nurses communicated Resident 1 ' s late transport to the dialysis center. 3. Ensure that Resident 1's decreased dialysis treatment time was communicated among licensed nurses. 3. Ensure the Attending Physician (MD) was notified of Resident 1 ' s decreased dialysis treatment duration. This deficient practice resulted to Resident 1 being transported to the wrong dialysis center. On 6/2/2025 Resident 1 was brought to the wrong dialysis center. This resulted to a decrease in Resident 1's dialysis treatment duration from three hours to two hours that could potentially place Resident 1 at risk for fluid overload (there was too much fluid or blood in the body) which could negatively impact the resident's health and safety. Findings: During a review of Resident 1 ' s admission Record, the admission Record indicated the facility admitted Resident 1 on 7/1/2024 with diagnoses that included type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool), dated 3/18/2025, the MDS indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. During a review of Resident 1 ' s Physician Orders, dated 4/23/2025, the Physician Order indicated dialysis schedule for Monday, Wednesday, and Friday at 5 a.m. with transportation pick up time at 4:30 a.m. and return to the facility time at 9 a.m. (continued on next page)

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

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 4/30/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1 ' s Progress Notes, dated 6/2/2025, the Progress Notes indicated Resident 1 was transported to dialysis in stable condition by Registered Nurse (RN) 2 around 6 a.m. via wheelchair. During an interview on 6/17/2025 at 3:18 p.m. with Resident 1, Resident 1 stated two weeks ago, he was sent to a wrong dialysis center and had to be brought back to the facility. Resident 1 stated the dialysis treatment was started late. Resident 1 stated he had two hours of dialysis instead of three hours. During an interview on 6/17/2025 at 3:50 p.m. with RN 1, RN 1 stated RN 2 did not notify her that Resident 1 was transported to a wrong dialysis center on 6/2/2025. RN 1 stated if she knew Resident 1 had a shortened dialysis treatment, she would notify the MD and monitor the resident. During an interview on 6/17/2025 at 3:55 p.m. with the Assistant Director of Nursing (ADON), the ADON stated she was not notified that Resident 1 was late for the dialysis treatment. The ADON stated she was not notified that Resident 1 had a 2-hour dialysis treatment instead of 3 hours. The DON stated Resident 1 ' s excess waste would not be removed that could cause the resident ' s fluid overload. The ADON stated the facility failed to ensure Resident 1 was transported to the right dialysis center to receive the full dialysis treatment. The ADON stated the facility failed to ensure licensed nurses communicated Resident 1 ' s delayed dialysis treatment to the next shift to ensure the MD was notified. During a review of the facility ' s policy and procedure (PnP) titled, Identification of Patient, last reviewed on 1/31/2025, the PnP indicated the purpose to identify a method of patient identification. The PnP indicated 6. Staff will use at least two patient identifiers to verify patient identity . while being evaluated or prior to undergoing procedures or treatments. During a review of the facility ' s PnP titled, Dialysis: Hemodialysis (HD) – Communication and Documentation, last reviewed on 1/31/2025, the PnP indicated the purpose to ensure ongoing communication and collaboration with the certified dialysis facility regarding hemodialysis (HD) patient care and services.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services for one of three sampled residents (Resident 6) by failing to ensure the resident ' s medications were not left unattended at bedside. This deficient practice had the potential to cause medication errors and can possibly lead to unsafe drop in Resident 6's blood sugar and may have other adverse side effects. Findings: A review of Resident 6 ' s admission Record indicated the facility admitted the resident on 1/14/2013 with diagnoses that included type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), and major depressive disorder (mental health condition that causes a persistently low or sad mood and a loss of interest in activities that once brought joy). During a review of Resident 6 ' s Physician Order, dated 8/7/2022, the Physician Order indicated Novolin R solution (an insulin medication used to control blood sugar) inject per sliding scale (a system used to determine how much insulin a person with diabetes should take based on current blood sugar level) subcutaneously before meals and at bedtime. During a review of Resident 6 ' s History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 1/27/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6 ' s Minimum Data Set (MDS- a resident assessment tool), dated 2/6/2025, the MDS indicated Resident 6 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. During a review of Resident 6 ' s Physician Order, dated 3/7/2025, the Physician Order indicated Novolog solution (an insulin medication used to treat type 2 diabetes) inject 18 units subcutaneously two times a day for diabetes mellitus. The Physician Order indicated to give with breakfast and lunch. During a review of Resident 6 ' s Progress Notes, dated 6/15/2025, the Progress Notes indicated Resident 6 ' s insulin syringe was on the resident ' s wheelchair. The Progress Notes indicated the insulin syringe needle poked Certified Nursing Assistant (CNA) 2 ' s finger. During an observation on 6/17/2025 at 12:21 p.m., observed Registered Nurse (RN) 1 inside Resident 6 ' s room with the resident ' s Novolog solution, Novolin R solution, and two insulin syringes in a pink medication tray. RN 1 placed the pink medication tray with the syringes and medications on Resident 6 ' s bed. RN 1 walked out of the room and left the medications unattended on Resident 6 ' s bed. RN 1 returned inside Resident 6 ' s room and administered the medications to Resident 6. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/17/2025 at 1:39 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated on 6/15/2025 at around 12 p.m., she went inside Resident 6 ' s room to administer the resident ' s insulin medications. LVN 3 stated she placed the two syringes with insulin on Resident 6 ' s wheelchair and stepped out of the room. LVN 3 stated medications should not be left unattended. LVN 3 stated medications left unattended had the potential to get lost or cause injury such as accidental needle prick. During an interview on 6/17/2025 at 2:02 p.m. with RN 1, RN 1 stated she went out of Resident 6 ' s room and left the resident ' s insulin medications unattended on the resident ' s bedside. RN 1 stated she should take Resident 6 ' s insulin syringes with medications with her when she left the resident ' s room. RN 1 stated unattended medications had the potential to get lost and cause medication errors. RN 1 stated the facility failed to ensure Resident 6 ' s medications were not left unattended. During an interview on 6/17/2025 at 2:22 p.m. with CNA 2, CNA 2 stated LVN 3 left Resident 6 ' s insulin syringes on the seat of the resident ' s wheelchair. CNA 2 stated LVN 3 stepped out of Resident 6 ' s room and left the resident ' s medication on the wheelchair. Resident 6 ' s unattended syringes with medications poked CNA 2 ' s finger. During an interview on 6/17/2025 at 2:35 p.m. with the Assistant Director of Nursing (ADON), the ADON stated medications and needles should not be left unattended. The ADON stated unattended medication syringes had the potential to cause injuries such as needle pricks that may cause spread of blood-borne pathogens (infectious microorganisms the human blood that can cause diseases). The ADON stated the facility failed to ensure Resident 6 ' s medications were not left unattended. During a review of the facility ' s policy and procedures (PnP) titled, Preparation and General Guidelines, last reviewed on 1/31/2025, the PnP indicated 4. Medications are administered at the time they are prepared . and 5. medications are administered without unnecessary interruptions. During a review of the facility ' s policy and procedures (PnP) titled, Medication Storage in the Facility, last reviewed on 1/31/2025, the PnP indicated all nurses are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage .