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	10/10/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan (a written or electronic record containing all the information the resident needs to effectively manage their own health) for one out of three sampled residents (Resident 1) by failing to ensure Resident 1's care plan was updated and revised after Resident 1 refused a blood draw for complete blood count (CBC- a routine blood test that gives doctors a snapshot of your overall health by measuring the types and quantities of cells circulating in your bloodstream) test. This deficient practice had the potential to result in lack of delivery of care and services to Resident 1. Findings:During a review of Resident 1's admission Record, undated, the admission Record indicated the facility admitted Resident 1 on 7/22/2025 with diagnoses of metabolic encephalopathy (a condition in which the brain does not function properly due to an imbalance in body chemistry), altered mental status (a state of confusion, change in consciousness or unusual behavior), type 2 diabetes mellitus (DM - a chronic condition characterized by high blood sugar levels that occur when the body does not produce enough insulin [a hormone that turns food into energy and manages your blood sugar level] or does not use insulin effectively), and essential hypertension (abnormally high blood pressure with no identifiable underlying medical cause). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/29/2025, the MDS indicated Resident 1 was moderately impaired in thought process (demonstrating noticeable breakdown in thinking that causes significant difficulty with daily tasks, communication, and decision-making). The MDS indicated that Resident 1 required substantial or maximal assistance (a person requires more than half of the effort from a helper to complete a task) from staff with activities of daily living (ADLs - basic tasks of personal care that a resident needs help with to function day-to-day) for toileting hygiene, showering or bathing, upper body dressing, and lower body dressing.During a review of Resident 1's CIC Evaluation form, dated 9/26/2025, timed at 4:47 a.m., the CIC Evaluation indicated that Resident 1 had a first episode of bright red blood in stool, described as moderate amount (exact amount not specified). The CIC Evaluation form indicated that Resident 1 left voicemail and text messages to MD 1 and NP 1 on 9/26/2025 at 6 a.m., reporting the episode. On 9/26/2025 at 7:30 a.m., no response from MD 1 and NP 1 have been received, and the CIC was endorsed to the next RN Supervisor (RN 2) for follow-up. During a review of Resident 1's Active Orders as of 9/27/2025, the Active Orders indicated the following: - To obtain occult blood test (a screening test to detect small amounts of hidden blood in a stool sample that are not visible to the naked eye and used to screen for medical conditions that may cause bleeding) one time only for evaluation of blood in stool for one day with an order date of 9/26/2025 (creation time not indicated).- To obtain occult blood test STAT (immediately) for blood in stool with an order date of 9/26/2025 (created on 9/26/2025 at 2:04 p.m.). - To obtain CBC STAT one time only for three days with an order date of 9/27/2025 (created on 9/27/2025 at 5:51 a.m.). During a review of Resident 1's Test Request Form, dated 9/26/2025, the Test Request Form indicated that the date to be drawn was 9/26/2025 for CBC STAT and Occult Blood STAT for Resident 1 and that Resident 1 refused the CBC STAT. During a concurrent interview and record review on 10/1/2025 at 3:21 p.m. with RN 3, Resident 1's Progress Notes (from 9/26/2025 to 9/27/2025) and Laboratory Request Form dated 9/26/2025 and 9/27/2025 were reviewed. RN 3 stated that she (RN 3) could not provide any documented evidence that Resident 1 refused the STAT blood draw. RN 3 stated that no CBC STAT order was entered on 9/26/2025. However, a copy of the laboratory request form indicated that Resident 1 refused the laboratory test, and a CBC was ordered on 9/27/2025 but was not drawn. RN 3 was unable to provide documentation of any communication between herself (RN 3) and MD 1. During a concurrent interview and record review on 10/3/2025 at 6:40 a.m., with RN 1, Resident 1's COC dated 9/26/2025 (first episode of blood in the stool) was reviewed. The COC indicated that Resident 1 had signs and symptoms of blood in the stool in a moderate amount. RN 1 stated that LVN 1 notified him (RN 1) that Resident 1 had an episode of bright red blood in the stool, approximately 10 cc in volume. RN 1 stated that on 9/26/2025 at around 6 a.m. he (RN 1) notified MD 1 and NP 1 by calling them (MD 1 and NP 1) using the facility phone and also sending text messages from his (RN 1) personal phone.During an interview on 10/3/2025 at 10:09 a.m., with RN 2, RN 2 stated that RN 1 informed her (RN 2) between 7:45 a.m. to 8 a.m. that NP 1 had ordered a CBC STAT and Occult Blood Test STAT for Resident 1. RN 2 stated that she (RN 2) entered the orders into the facility's computer system; however, only a routine (non-STAT) occult blood test was entered. RN 2 stated that she (RN 2) also called the laboratory to inform them that the order was STAT. RN 2 stated that Resident 1 had a second episode of blood in the stool at

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on interview and record review, the facility failed to ensure that one of three sampled residents (Resident 1), who had moderately impaired cognition (a noticeable decline in thinking, memory, and judgment that is more significant than normal aging but does not prevent the resident from performing most daily tasks), bed-bound (unable to leave the bed due to illness or weakness), dependent on staff for activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily), and was receiving Porcine Heparin injection (a powerful anticoagulant [blood thinner] medication used to prevent and treat blood clots that increases the risk of bleeding), was provided the necessary care and services in accordance with professional standards of practice when on 9/26/2025 at 4:47 a.m., Resident 1 had a change in condition (CIC - a major decline in a resident's status) when Resident 1 had bright red blood of moderate amount in the stool. The facility failed to: 1. Ensure Registered Nurse 1 (RN 1) conducted a comprehensive assessment of Resident 1's respiratory (relating to breathing or the organs of respiration), cardiovascular (relating to the heart and blood vessels), neurological (relating to the brain, spinal cord, and nerves), genitourinary (GU - relating to the genital and urinary organs), and behavioral (relating to or involving observable behavior) status following Resident 1's CIC on 9/26/2025 at 4:47 a.m. RN 1 also failed to assess and document the presence or absence of bowel sounds (the noises made when food, fluids, and gases move through the intestines). 2. Ensure RN 1 followed the facility's policy and procedure (P&P) titled, Change of Condition (COC - when there is a sudden change in a resident's condition): Notification of, indicating, . must immediately . consult with the patient's physician . where there is: . a significant change in the patient's physical . status; A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or A decision to transfer or discharge the patient from the Center. a. RN 1 stated it was his (RN 1) judgment not to immediately notify the physician after Resident 1's CIC on 9/26/2025 at 4:47 a.m. RN 1 stated he (RN 1) had been instructed by Medical Director 2 (MD 2) not to call during the night for non-emergent (medical condition that is not immediately dangerous or serious and does not require immediate action to prevent harmful results) and stable (medical condition that is not worsening or under control) residents. b. RN 1 stated that if he (RN 1) calls the physician in the middle of the night the physician would get mad, and that 4:47 a.m. was too early to call. RN 1 stated that it was his personal decision to wait until 6 a.m. to notify the physician because 6 a.m. was the acceptable time. c. RN 1 left a voicemail message for Resident 1's physician (Medical Doctor 1 [MD 1]) and sent a text message to Nurse Practitioner 1 (NP 1) on 9/26/2025 at 6 a.m. (1 hour and 13 mins after Resident 1's CIC). d. RN 1 stated he (RN 1) did not follow up with MD 1 and NP 1 to confirm receipt of the voicemail or text message on 9/26/2025 at 6 a.m. e. RN 1 stated that on 9/26/2025 at 8 a.m., he (RN 1) received a text message from NP 1 with an order to obtain STAT (immediately) occult blood test (a screening test to detect small amounts of hidden blood in a stool sample that are not visible to the naked eye and used to screen for medical conditions that may cause bleeding) and a STAT complete blood count (CBC - a laboratory {lab} test [a procedure that analyzes a sample of your blood to provide information about your health] that measures various components of the blood that can help diagnose and monitor conditions such as bleeding). RN 1 then called Registered Nurse 2 (RN 2) to relay the orders (approximately 3 hours and 13 minutes after Resident 1's CIC). 3. Ensure that the STAT occult blood test and STAT CBC ordered on 9/26/2025 at 8 a.m. for Resident 1 were accurately entered and carried out. On 9/26/2025 at 10 a.m., RN 2 entered an order for a routine (not STAT) occult blood test (one time), resulting in a two (2) hour delay from receipt of the STAT order and a three (3) hour and 13 minutes delay from the time of Resident 1's CIC. RN 2 did not enter the STAT CBC order for Resident 1. 4. Ensure there was a clearly documented process for communicating Resident 1's multiple episodes of blood in the stool to MD 1 or NP 1 following Resident 1's initial CIC (first episode of red blood in the stool) on 9/26/2025 at 4:47 a.m. a. RN 2 stated she (RN 2) informed NP 1 by phone on 9/26/2025 (unable to recall specific time) that Resident 1 had a second episode of presence of approximately 30 cubic centimeters (cc - a unit of volume) of blood in the stool on 9/26/2025 at 9:50 a.m. During a telephone interview on 10/8/2025 at 9:11 a.m., with NP 1, NP 1 stated she (NP 1) did not receive any phone call regarding the second episode of blood in the stool on 9/26/2025 at 9:50 a.m. and did not receive any other information that Resident 1 had subsequent episodes of blood in the stool. NP 1 stated that had she (NP 1) known that Resident 1 had a second episode of presence of blood in the stool, she would have ordered to hold heparin administration and transferred Resident 1 to the General

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from significant medication errors by failing to ensure the physician orders were followed. The facility failed to ensure Resident 1's metoprolol oral tablet (a medication, taken by mouth, used to treat high blood pressure) 25 milligrams (mg - unit of measurement) was not administered for systolic blood pressure (SBP - the pressure in the arteries when the heart beats) of less than 110 or heart rate (HR) of less than 60 beats per minute (bpm) on multiple dates.This deficient practice placed Resident 1 at risk for inadequate blood pressure management which can cause hypotension (low blood pressure) and irregular heartbeat. Findings: During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted Resident 1 on 7/22/2025 with diagnoses including metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and essential hypertension (an abnormally high blood pressure that was not a result of a medical condition). During a review of Resident 1's Physician Orders, dated 7/22/2025, the Physician Orders indicated metoprolol oral tablet 25 mg, to give 0.5 tablet two times a day for hypertension. The Physician Orders indicated to hold metoprolol medication for SBP of less than 110 or HR of less than 60 bpm. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/29/2025, the MDS indicated Resident 1's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was moderately impaired. During a review of Resident 1's Physician Orders, dated 9/24/2025, the Physician Orders indicated metoprolol oral tablet 25 mg, to give 0.5 tablet two times a day with food for hypertension. The Physician Orders indicated to hold metoprolol medication for SBP of less than 110 or HR of less than 60 bpm. During an interview on 10/6/2025 at 8:45 a.m. and a concurrent record review of Resident 1's Medication Administration Record (MAR), dated 9/1/2025 to 9/30/2025, reviewed with Licensed Vocational Nurse (LVN) 5, LVN stated Resident 1's metoprolol had parameters to hold for SBP of less than 110 or HR of less than 60 bpm. Resident 1's metoprolol was given outside the parameters on the following dates:a. 9/1/2025 at 9 p.m. for HR of 59 bpm. b. 9/4/2025 at 9 p.m. for SBP of 98.c. 9/10/2025 at 9 p.m. for SBP of 108.d. 9/15/2025 at 9 p.m. for SBP of 96.e. 9/16/2025 at 9 p.m. for SBP of 107.f. 9/18/2025 at 9 p.m. for SBP of 102.g. 9/20/2025 at 9 p.m. for SBP of 108.h. 9/23/2025 at 9 p.m. for SBP of 108.i. 9/24/2025 at 9 p.m. for SBP of 108.LVN 5 stated Resident 1's blood pressure had the potential to drop low and cause the resident to experience serious conditions that may lead to death. During an interview on 10/8/2025 at 4 p.m. with the Director of Nursing (DON), the DON stated medications should be administered within the physician order's parameters. The DON stated Resident 1's metoprolol was administered while the resident's SBP or HR were below the ordered medication parameters. The DON stated Resident 1's blood pressure had the potential to drop and cause less tissue perfusion to other organs. The DON stated the facility failed to ensure Resident 1's medication was administered as ordered by the physician. During a review of the facility-provided policy and procedure (PnP) titled, Medication Administration-General Guidelines, last reviewed on 7/31/2025, the PnP indicated Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The PnP indicated Medications are administered in accordance with written orders of the attending physician.