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	12/08/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of five sampled residents (Resident 1 and Resident 2) were free from significant medication errors by failing to ensure the physician orders were followed. The facility failed to ensure Resident 1 and 2's calcium carbonate oral tablet (a medication, taken by mouth, used for calcium supplement, relieve heartburn, indigestion, and upset stomachs) 600 milligrams (mg - unit of measurement) was administered on multiple dates. This deficient practice had the potential to cause Resident 1 and Resident 2's discomfort. Findings: During a review of Resident 1's admission Record (undated), the admission Record indicated the facility admitted Resident 1 on 1/14/2013 with diagnoses including chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar [glucose]), and muscle weakness. During a review of Resident 1's Physician Orders, dated 12/14/2023, the Physician Orders indicated calcium carbonate oral tablet 600 mg, once a day for osteoporosis (bone loss). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 10/28/2025, the MDS indicated Resident 1's cognition (refers to conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was intact. During a review of the facility-provided Medical Supply Order Request, dated 11/24/2025 to 12/8/2025, the Medical Supply Order Request indicated the calcium carbonate 600 mg was requested on 12/5/2025, a Friday. The comment section of the Medical Supply Order Request indicated will order first thing Monday. During an interview on 12/8/2025 at 10:15 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the calcium carbonate oral tablet 600 mg was not available in medication cart 2. LVN 1 stated Resident 1 did not receive the ordered calcium carbonate oral tablet 600 mg for one week. LVN 1 stated Resident 1's Attending Physician (MD) 1 was notified and had ordered to hold the calcium carbonate oral tablet 600 mg until the medication was available. During an interview on 12/8/2025 at 1:29 p.m. and concurrent record review of Resident 1's Physician Orders and Medication Administration Record (MAR), dated 12/1/2025 to 12/31/2025, reviewed with Registered Nurse (RN) 1, RN 1 stated the licensed nurses did not administer Resident 1's scheduled 7 a.m. dose of calcium carbonate oral tablet 600 mg on 12/2/2025, 12/4/2025, and 12/8/2025. RN 1 stated Resident 1's Progress Notes, dated 12/2/2025, 12/4/2025, and 12/8/2025, indicated the calcium carbonate oral tablet 600 mg was not available in the medication cart. RN 1 stated there was no documented evidence that MD 1 was notified and that the calcium carbonate oral tablet 600 mg was placed on hold. RN 1 stated the facility failed to ensure Resident 1's medication was given 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. The PnP indicated the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. During a review of Resident 2's admission Record (undated), the admission Record indicated the facility admitted Resident 2 on 12/9/2019 with diagnoses including acute kidney failure (also known as acute kidney injury, condition in which the kidneys suddenly cannot filter waste from the blood), type 2 diabetes mellitus, and gastro-esophageal reflux disease (a condition in which the stomach contents leak backward from the stomach into the esophagus [food pipe]). During a review of Resident 2's Physician Orders, dated 11/26/2024, the Physician Orders indicated calcium carbonate oral tablet 600 mg, two times a day for supplementation. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was intact. During a review of the facility-provided Medical Supply Order Request, dated 11/24/2025 to 12/8/2025, the Medical Supply Order Request indicated the calcium carbonate 600 mg was requested on 12/5/2025, a Friday. The comment section of the Medical Supply Order Request indicated will order first thing Monday. During an interview on 12/8/2025 at 10:15 a.m. with LVN 1, LVN 1 stated the calcium carbonate oral tablet 600 mg was not available in medication cart 2. LVN 1 stated Resident 2 did not receive the ordered calcium carbonate oral tablet 600 mg for one week. LVN 1 stated MD 1 was notified and had ordered to hold the calcium carbonate oral tablet 600 mg until the medication was available. During an interview on 12/8/2025 at 1:29 p.m. and concurrent record review of