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	12/15/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure prompt attempts were made to resolve the grievances for one of three sampled residents (Resident 1) when the facility failed to investigate the concerns reported by Resident 1. This deficient practice had the potential to violate Resident 1's rights. Findings: During a review of Resident 1's admission Record, the admission record indicated the facility admitted Resident 1 on 6/27/2025 with diagnoses including muscle weakness, polyneuropathy (damage to many nerves outside the brain and spine, causing weakness, numbness, tingling, and pain, typically starting in the feet and hands), unspecified fracture (a partial or complete break in a bone) of right lower leg, and unspecified fracture of right hand. During a review of Resident 1's History and Physical (H&P), dated 7/6/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/8/2025, the MDS indicated Resident 1 had clear speech and was able to make self understood. The MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 was independent with personal hygiene and required supervision (helper provides verbal cues and/or touching assistance and assistance may be provided throughout the activity or intermittently) from the facility staff with toileting hygiene, showers, upper and lower body dressing. During an interview on 12/10/2025 at 10:28 a.m. with Resident 1, Resident 1 stated on 6/27/2025, 6/28/2025, and 6/29/2025, she (Resident 1) complained multiple times to the facility staff that at nights, she had seen many cockroaches in the bathroom in Room A (Resident 1's room). Resident 1 stated the facility staff did not address her (Resident 1) concern. During a concurrent interview and record review on 12/11/2025 at 4:20 p.m. with Registered Nurse (RN)1, Resident 1's Change of Condition (COC -major decline or improvement in a resident's status that will not resolve without intervention) form, dated 6/29/2025 was reviewed. The COC indicated Resident had multiple claims that her bathroom was infested with cockroaches. RN 1 stated Resident 1 had informed him (RN 1) on multiple occasions since her admission on [DATE] that she (Resident 1) had seen cockroaches in her room. RN 1 stated he (RN 1) does not know if the facility addressed Resident 1's concern. RN 1 stated upon receipt of Resident 1's concern regarding cockroaches, a grievance form should have been completed. RN 1 stated the Grievance form would allow the social services department to properly address Resident 1's concern to improve Resident 1's quality of care. RN 1 stated the failure to initiate the Grievance process and address Resident 1's concerns had the potential for Resident 1 to feel dissatisfied with the care received in the facility and negatively affect Resident 1's wellbeing. During a concurrent interview and record review on 12/15/2025 at 11:42 a.m. with the Social Services Director (SSD), facility's Grievance Log for 2025 was reviewed. The Grievance Log did not indicate a Grievance form was initiated for Resident 1's concern. The SSD stated once Resident 1 stated that she had seen cockroaches in Room A, the facility should have completed a grievance form, contacted appropriate department, initiated investigation, taken appropriate actions, and informed the resident regarding the progress and resolution. The SSD stated the facility failed to follow the facility's Grievance/Concern policy and procedure. The SSD stated Resident 1's rights were not respected for addressing Resident 1's concerns and issues. During an interview on 12/15/2025 at 2:23 p.m. with the Director of Nursing (DON), the DON stated the facility should have allowed Resident 1 to file a grievance with social services. The DON stated the facility should have investigated Resident 1's concern regarding seeing cockroaches in Room A. The DON stated there was a potential for Resident 1's concerns to go unheard. The DON stated there was a potential for Resident 1 to feel that her concerns are not taken seriously by the facility, affecting Resident 1's comfort in the facility. During a record review of the facility-provided policy and procedure titled, Grievance/Concern, last reviewed on 7/31/2025, the policy and procedure indicated, patients and/or their representatives may voice grievances/concerns and recommendations for changes. Service location leadership will investigate, document, and follow up on all concerns and grievances registered by any patient or patient representative. 3. Upon receipt of the grievance/concern, the Grievance/Concern Form will be initiated by the staff member receiving the concern. Upon receipt of the Grievance/Concern Form, the Administrator or designee will document the grievance/concern on the Grievance Concern Log. 5.1 Immediate action will be taken to prevent further potential violations of any patient right while the alleged violation is being investigated. 6. The department

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its Policy and Procedures (P&P) titled, Discharge Planning Process, for one of three sampled residents (Resident 1) by failing to: 1. Initiate a Care Plan (a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) for Resident 1's discharge plan upon admission. 2. Provie the Discharge Transition Plan to Resident 1 prior to discharge on [DATE]. 3. Provide the Notice of Transfer or Discharge (a mandatory legal document formally informing the resident about the transfer or discharge, stating the reason for discharge or transfer, and their rights to appeal the decision) form to Resident 1 prior to discharge on [DATE]. This deficient practice had the potential to violate Resident 1's rights. Cross Reference with F842.Findings: During a review of Resident 1's admission Record, the admission record indicated the facility admitted Resident 1 on 6/27/2025 with diagnoses including muscle weakness, polyneuropathy (damage to many nerves outside the brain and spine, causing weakness, numbness, tingling, and pain, typically starting in the feet and hands), unspecified fracture (a partial or complete break in a bone) of right lower leg, and unspecified fracture of right hand. During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 7/6/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/8/2025, the MDS indicated Resident 1 had clear speech and was able to make self understood. The MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 was independent with personal hygiene and required supervision (helper provides verbal cues and/or touching assistance and assistance may be provided throughout the activity or intermittently) from the facility staff with toileting hygiene, showers, upper and lower body dressing. During a review of Resident 1's Progress Note, dated 7/31/2025, the Progress Note indicated Resident 1 was discharged home on 7/31/2025, at 11:30 a.m. a. During a concurrent interview and record review on 12/11/2025 at 12:43 p.m. with the Director of Nursing (DON), Resident 1's Care Plan was reviewed. The Care Plan did not indicate a discharge plan was initiated upon Resident 1's admission. The DON stated the facility failed to initiate a discharge care plan for Resident 1. The DON stated the discharge Care Plan was the facility's plan for Resident 1's discharge arrangement and interventions to reach Resident 1's goals prior to discharge. The DON stated the failure to initiate a discharge care plan had the potential for Resident 1's goals not to be identified and met prior to discharge potentially increasing Resident 1's risk of rehospitalization. During a record review of the facility-provided policy and procedure titled, Discharge Planning Process, last reviewed on 7/31/2025, the policy and procedure indicated, The Center must develop and implement an effective discharge planning process that focuses on the patient's/resident's (hereinafter patient) discharge goals, preparation of patients to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable re-admissions. Definition: Discharge Planning is the process that generally begins on admission and involves identifying each patient's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the patient's stay to ensure a successful discharge. Discharge planning will begin upon admission and be completed as part of the Person-Centered Care Plan process. b. During a concurrent interview and record review on 12/11/2025 at 12:43 p.m. with the DON, Resident 1's Discharge Plan Documentation form, initiated on 7/31/2025 was reviewed. The Discharge Plan Documentation form indicated the facility staff did not complete the form prior to Resident 1's discharge. The DON stated Resident 1's Discharge Plan Documentation was not completed and was still in progress in Resident 1's electronic medical records. The DON stated the Discharge Plan Documentation form was a review of Resident 1's stay in the facility, all the services provided to Resident 1, and coordination and communication with Resident 1 regarding services that were needed after Resident 1's discharge. The DON stated the Discharge Plan should have been completed and provided to Resident 1 prior to Resident 1's discharge. The DON stated the facility's Discharge Planning Process policy was not followed. The DON stated there was a potential to increase risk for Resident 1's rehospitalization. During a record review of the facility-provided policy and procedure titled, Discharge Planning Process, last reviewed on 7/31/2025, the policy and procedure indicated, The Center must develop and implement an effective discharge planning process that focuses on the patient's/resident's (hereinafter

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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 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)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a person-centered care (CP, a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) for one of three sampled residents (Resident 1), by failing to: 1. Develop a care plan to address Resident 1's discharge planning. 2. Develop a care plan to address Resident 1's right wrist and distal forearm splint (a strip of rigid material used for supporting and immobilizing a broken bone when it has been set). These failures had the potential to delay care and negatively affect Resident 1's well-being. Findings: During a review of Resident 1's admission Record, the admission record indicated the facility admitted Resident 1 on 6/27/2025 with diagnoses including muscle weakness, polyneuropathy (damage to many nerves outside the brain and spine, causing weakness, numbness, tingling, and pain, typically starting in the feet and hands), unspecified fracture (a partial or complete break in a bone) of right lower leg, and unspecified fracture of right hand. During a review of Resident 1's general acute care hospital (GACH) records, dated 6/26/2025, the GACH record indicated Resident 1 had a right wrist and distal forearm splint. During a review of Resident 1's Occupational Therapy (OT) Evaluation form, dated 6/29/2025, the OT Evaluation form indicated Resident 1 had a wrist cast (a hard shell to immobilize a broken bone) or splint. During a review of Resident 1's Care Plan, initiated on 6/27/2025, the Care Plan indicated Resident 1 was at risk for falls related to right lower extremity weakness, manipulation under Anesthesia ([NAME], a non-invasive procedure used to break up scar tissue and improve movement) of right knee on 6/25/2025, and open reduction and internal fixation (ORIF- a surgical procedure to fix broken bones by realigning the fragments and stabilizing them with metal hardware) of right tibia (large, weight-bearing bone in the lower leg, connecting the knee to the ankle) on 6/4/2025. During a review of Resident 1's History and Physical (H&P), dated 7/6/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/8/2025, the MDS indicated Resident 1 had clear speech and was able to make self understood. The MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 used crutch (a long stick with a crosspiece at the top, used as support under the armpit by a person with an injury) to assist with mobility. was independent with personal hygiene and required supervision (helper provides verbal cues and/or touching assistance and assistance may be provided throughout the activity or intermittently) from the facility staff with toileting hygiene, showers, upper and lower body dressing. a. During a concurrent interview and record review on 12/11/2025 at 12:43 p.m. with the Director of Nursing (DON), Resident 1's Care Plan was reviewed. The Care Plan did not indicate discharge plan was initiated upon Resident 1's admission. The DON stated the facility failed to initiate discharge care plan for Resident 1. The DON stated the discharge Care Plan was the facility's plan for Resident 1's discharge arrangement and interventions to reach Resident 1's goals prior to discharge. The DON stated the failure to initiate a discharge care plan had the potential for Resident 1's goals not to be identified and met prior to discharge potentially increasing Resident 1's risk of rehospitalization. During a record review of the facility-provided policy and procedure titled, Discharge Planning Process, last reviewed on 7/31/2025, the policy and procedure indicated, The Center must develop and implement an effective discharge planning process that focuses on the patient's/resident's (hereinafter patient) discharge goals, preparation of patients to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable re-admissions. Definition: Discharge Planning is the process that generally begins on admission and involves identifying each patient's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the patient's stay to ensure a successful discharge. Discharge planning will begin upon admission and be completed as part of the Person-Centered Care Plan process. During a record review of the facility-provided policy and procedure titled, Person-Centered Care Plan, last reviewed on 7/31/2025, the policy and procedure indicated, The Center must develop and implement a person-centered care plan for each patient/resident (hereinafter patient) consistent with patient rights measurable objectives and timeframes to meet a patient's medical, nursing and mental and psychosocial needs and all services that meet professional standards of quality. Care plan includes measurable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs that are identified in comprehensive

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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 - Minimal harm or potential for actual harm Residents Affected - Some	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 - 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 one of three sampled residents (Resident 1) receive treatment and care in accordance with professional standards of practice to meet the resident's physical, mental, and psychosocial (relating to the interrelation of social factors and individual thoughts and behavior), by failing to: 1. Initiate Change of Condition (COC -major decline or improvement in a resident's status that will not resolve without intervention) form, notify the physician, and complete a post-fall assessment of Resident 1, when on 6/29/2025, at approximately 9:50 p.m., Resident 1 sustained a fall in the bathroom, in Room A (Resident 1's room). 2. Obtain orders from the physician for Resident 1's right wrist and distal forearm splint (a strip of rigid material used for supporting and immobilizing a broken bone when it has been set) care. 3. Coordinate and schedule Occupational Therapy (OT) and Physical Therapy (PT) appointments on the days when Resident 1 had scheduled outpatient medical appointments. These deficient practices had the potential to delay Resident 1's care and negatively affect Resident 1's well-being.Findings: During a review of Resident 1's admission Record, the admission record indicated the facility admitted Resident 1 on 6/27/2025 with diagnoses including muscle weakness, polyneuropathy (damage to many nerves outside the brain and spine, causing weakness, numbness, tingling, and pain, typically starting in the feet and hands), unspecified fracture (a partial or complete break in a bone) of right lower leg, and unspecified fracture of right hand. During a review of Resident 1's general acute care hospital (GACH) records, dated 6/26/2025, the GACH record indicated Resident 1 had a right wrist and distal forearm splint. During a review of Resident 1's Care Plan, initiated on 6/27/2025, the Care Plan indicated Resident 1 was at risk for falls related to right lower extremity weakness, manipulation under Anesthesia ([NAME], a non-invasive procedure used to break up scar tissue and improve movement) of right knee on 6/25/2025, and open reduction and internal fixation (ORIF- a surgical procedure to fix broken bones by realigning the fragments and stabilizing them with metal hardware) of right tibia (large, weight-bearing bone in the lower leg, connecting the knee to the ankle) on 6/4/2025. During a review of Resident 1's Care Plan, initiated on 6/28/2025, the Care Plan indicated Resident 1 required PT due to decreased bed mobility, decreased transfers, difficulty in walking, unsteadiness on feet, and generalized weakness. The Care Plan interventions indicated Resident 1 will receive PT five times a week for four weeks for bed mobility, transfers, gait training, and education on safety. During a review of Resident 1's History and Physical (H&P), dated 7/6/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/8/2025, the MDS indicated Resident 1 had clear speech and was able to make self understood. The MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 used crutch (a long stick with a crosspiece at the top, used as support under the armpit by a person with an injury) to assist with mobility. was independent with personal hygiene and required supervision (helper provides verbal cues and/or touching assistance and assistance may be provided throughout the activity or intermittently) from the facility staff with toileting hygiene, showers, upper and lower body dressing. a. During an interview on 12/10/2025 at 10:28 a.m. with Resident 1, Resident 1 stated that on 6/29/2025 (unable to recall exact time) upon entering the bathroom in Room A, Resident fell on her back. Resident 1 stated she (Resident 1) was using crutches for ambulation and upon entering the bathroom in Room A, she (Resident 1) fell after seeing cockroaches coming in her direction. Resident 1 stated she (Resident 1) called for help and facility staff member entered the room (unable to recall exact time) and assisted her (Resident 1) to the wheelchair that was in Room A. During a concurrent interview and record review on 12/10/2025 at 1:57 p.m. with Registered Nurse (RN) 2, Resident 1's Progress Note, dated 6/29/2025, timed at 9:50 p.m. was reviewed. The Progress Note indicated Resident 1 claimed she fell, and CNA 1 assisted Resident 1 back to wheelchair. The Progress Note indicated that CNA 1 stated that he (CNA) 1 had found Resident 1 sitting on the floor. RN 2 stated the incident noted in Resident 1's Progress Note on 6/29/2025 is considered an episode of fall. RN 2 stated the facility staff should have completed a physical and neurological assessment of Resident 1 after the fall incident. RN 2 stated the facility staff should have informed the physician about the incident and obtain necessary orders. RN 2 stated facility staff should have initiated COC form and monitored Resident 1 for 72 hours for possible post-fall complications. RN 2 stated there was no record to indicate that Resident 1 was assessed post fall. RN 2 stated there was no

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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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medical records for one of three sampled residents (Resident 1) were maintained in accordance with accepted professional standards and practice, complete, and accurately documented, by failing to: 1. Ensure facility staff did not sign Resident 1's Notice of Transfer or Discharge (a mandatory legal document formally informing the resident about the transfer or discharge, stating the reason for discharge or transfer, and their rights to appeal the decision) form to show that Resident 1 had received the Notice of Transfer or Discharge form prior to Resident 1's discharge on [DATE]. This deficient practice resulted in inaccurate documentation to misrepresent (give a false or misleading representation of usually with an intent to deceive) that Resident 1 had acknowledged receiving a copy of the The Notice of Transfer or Discharge form prior to Resident 1's discharge on [DATE]. 2. Ensure Resident 1's Fall Risk Assessment and Nursing Documentation were complete and did not contain contraindicating information. This deficient practice had the potential for inaccurate medical interventions for Resident 1. Findings: During a review of Resident 1's admission Record, the admission record indicated the facility admitted Resident 1 on 6/27/2025 with diagnoses including muscle weakness, polyneuropathy (damage to many nerves outside the brain and spine, causing weakness, numbness, tingling, and pain, typically starting in the feet and hands), unspecified fracture (a partial or complete break in a bone) of right lower leg, and unspecified fracture of right hand. During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 7/6/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/8/2025, the MDS indicated Resident 1 had clear speech and was able to make self understood. The MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 used crutch (a long stick with a crosspiece at the top, used as support under the armpit by a person with an injury) to assist with mobility. was independent with personal hygiene and required supervision (helper provides verbal cues and/or touching assistance and assistance may be provided throughout the activity or intermittently) from the facility staff with toileting hygiene, showers, upper and lower body dressing. a. During a review of Resident 1's Order Summary Report, the report indicated the following physician's order:-7/29/2025: Resident may discharge home on 7/31/2025 with home health services for Physical Therapy (PT)/Occupational Therapy (OT)/Registered Nurse for medication management and compliance. During a review of Resident 1's Progress Note, dated 7/31/2025, the Progress Note indicated Resident 1 was discharged home on 7/31/2025, at 11:30 a.m. During an interview on 12/10/2025 at 10:28 a. m. with Resident 1, Resident 1 stated that on 7/31/2025 (cannot recall exact time), Registered Nurse (RN) 3 approached Resident 1 in Room A (Resident 1's room) with blank Notice of Transfer or Discharge form and asked Resident 1 to sign the form prior to Resident 1's discharge to home. Resident 1 stated that she (Resident 1) told RN 3 that she (Resident 1) would like to review the completed form before signing. Resident 1 stated RN 3 left Room A with the blank form and did not return with the completed form for Resident 1 to review. Resident 1 stated that during the discharge process, while facility staff assisted her (Resident 1) to sit in the wheelchair to leave the facility, facility staff placed a packet with documents on the wheelchair's rear storage pocket. Resident 1 stated after returning home, she (Resident 1) reviewed the packet with documents and saw a signed Notice of Transfer or Discharge form. Resident 1 stated there was a signature where she (Resident 1) was supposed to sign to acknowledge that she had received a copy of the form. Resident 1 stated the facility staff did not give her (Resident 1) the completed form to review and did not discuss the content of the form with her (Resident 1) prior to discharge. Resident 1 stated she (Resident 1) did not sign the form and did not know whose signature was on the form. Resident 1 stated the facility staff falsified the form to make it look like she (Resident 1) received the Notice of Transfer or Discharge. During an interview on 12/15/2025 at 1:16 p.m. with RN 3, RN 3 stated that it was RN's responsibility to complete discharge documentation prior to resident's discharge, including the Notice of Transfer or Discharge form. RN 3 stated it was RN's responsibility to discuss the form with residents, explain the process of discharge and have the resident sign the form to acknowledge that they have received a copy of the form and that the form was explained to them. RN 3 stated she (RN 3) was working on 7/31/2025 during 7a.m.to 3 p.m. shift but cannot recall Resident 1 and Resident 1's discharge process. RN 3 stated