

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/14/2026
NAME OF PROVIDER OR SUPPLIER  Brier Oak on Sunset		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to implement their policy and procedure on ensuring the medications in the facility were checked and maintained by failing to: a. Ensure one of 15 locked e-kit (e-kit - a pre-packed set of medications used in emergency situations) medication boxes did not contain expired medications. The intramuscular (IM - medication administered into a muscle) e-kit medication box located at station 2 had an expired medication in it for 75 days. b. Ensure the licensed nurses checked 15 out of 15 e-kits in the facility every shift. c. Ensure licensed nurses disposed of the medications of one of four sampled residents (Resident 4) within 90 days after discharge. Resident 4's medications were in the facility for 179 days after the resident was discharged from the facility. d. Ensure two licensed nurses signed off at the disposition of residents' medications on two out of three nurse stations. These deficient practices had the potential for medication errors and non-authorized access to residents' medications. Findings: During a review of Resident 4's admission Record (undated), the admission Record indicated the facility admitted Resident 4 on 7/23/2025 with diagnoses including nontraumatic intracerebral hemorrhage (a sudden, spontaneous bleeding directly into the brain tissue not caused by a head injury or surgery), cerebral edema (a dangerous swelling of the brain caused by fluid buildup within the brain tissue), and atelectasis (the collapse of a lung or part of a lung). During a review of Resident 4's Discharge summary, dated [DATE], the Discharge Summary indicated the resident expired (died) on 7/28/2025. During a review of facility-provided Summary of Nurse Consultant Services, dated 12/30/2025, the Summary of Nurse Consultant Services indicated services provided included medication room and storage review. emergency kits and refrigerator checked. check disposition, refill and delivery logs. During a concurrent observation and interview on 1/14/2026 at 11:24 a.m. with Registered Nurse (RN) 1, RN 1 opened the locked medication room in nurse station 2 and observed five locked e-kits. RN 1 stated the locked IM e-kit indicated a bacteriostatic water (a sterile water with a small amount of alcohol used to dissolve or dilute medicines for injection) 30 milliliters (ml - unit of measurement) in slot number 20 had an expiration date on 11/1/2025. RN 1 stated she did not check the e-kit. RN 1 stated expired medications had the potential to be contaminated and lose effectiveness. RN 1 could not locate the e-kit log in nurse station 2. Observed a white paper bag on the top shelf of a five-shelved cabinet in the locked medication room. RN 1 stated the white paper bag had Resident 4's medications in it. RN 1 stated Resident 4 was discharged from the facility (date was not specified). RN 1 stated Resident 4's medications should be disposed of after the resident was discharged and documented in the Medication Disposition Record and Pass Log. RN 1 stated every nurse station had a Medication Disposition Record and Pass Log. RN 1 stated she could not locate nurse station 2's Medication Disposition Record and Pass Logs. During an interview on 1/14/2026 at 11:50 a.m. with RN 2, RN 2 stated RN 1 had the key to the facility's medication rooms. RN 2 stated she did not check the e-kits in nurse</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  056056	Facility ID:  056056  If continuation sheet Page 1 of 2

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>stations 1, 2, and 3. During an observation and interview on 1/14/2026 at 11:54 a.m. and concurrent record review of the facility's Medication Disposition Record and Pass Log, dated 10/13/2025, reviewed with RN 1, RN 1 stated nurse station 3's Medication Disposition Record and Pass Log indicated two medications were disposed of in waste management. RN 1 stated the documented disposed medications did not indicate the signature of another licensed nurse as a witness. RN 1 stated two licensed nurses' signatures were required to dispose of medication to ensure the disposed medication was accurate. RN 1 stated unwitnessed medication disposition had the potential for medications to be stolen. RN 1 opened the locked medication room in nurse station 3 and observed five locked e-kits. RN 1 could not locate the e-kit log in nurse station 3. During a concurrent observation and interview on 1/14/2026 at 12:04 p.m. with RN 1, RN 1 opened the locked medication room in nurse station 1 and observed five locked e-kits. RN 1 could not locate the e-kit log in nurse station 1. During an interview on 1/14/2026 at 12:17 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the licensed nurses should check the units' e-kits every shift. LVN 1 stated that he did not consistently perform visual checks on the e-kits in nurse station 2 and nurse station 3. LVN 1 stated there were no e-kit logs in the facility. During an interview on 1/14/2026 at 3:43 p.m. and concurrent record review of the facility's Medication Disposition Record and Pass Log, dated 10/19/2025, reviewed with the Director of Nursing (DON), the DON stated nurse station 1's Medication Disposition Record and Pass Log indicated five medications were disposed of in a trash bin. The DON stated the trash bin was not an option as a method of disposition for medications. The DON stated the five documented disposed medications did not indicate the signature of another licensed nurse as a witness. The DON stated medications of discharged residents should be disposed within 90 days after discharge. The DON stated medications should be disposed in the waste management bin for incineration and required two licensed nurses to prevent medication errors and diversions. The DON stated the facility failed to follow the process of proper medication disposal. The DON stated e-kits should be checked every shift to ensure the emergency medications were not expired and the e-kit was intact. The facility did not provide documented evidence that the 15 e-kits were checked every shift. The DON stated expired medications in the e-kit had the potential to cause the medication to be ineffective. The DON stated the facility failed to ensure the e-kits were free from expired medications. During a review of the facility-provided Pharmacy Services Agreement, dated 8/1/2024, the Pharmacy Services Agreement indicated . pharmacy will centrally furnish and replenish, on a regular basis the emergency kit that will be stored at facility. During a review of the facility's policy and procedure (PnP) titled, Medication Ordering and Receiving from Pharmacy, last reviewed on 7/31/2025, the PnP indicated c. the dispensing pharmacy supplies emergency. medications according to the dispensing pharmacy provider agreement. g. the emergency supply is maintained at a designated secure area along with a list of supply content. o. the kits are checked by a pharmacist at least monthly. During a review of the facility's PnP titled, Disposal of Medications and Medication-Related Supplies, last reviewed on 7/31/2025, the PnP indicated discontinued medications and medications left in the facility after a resident's discharge. are destroyed. The PnP indicated non-controlled medication distraction occurs in the presence of two licensed nurses. The PnP indicated the nurse(s) and /or pharmacist witnessing the destruction ensure that the following information is entered on the medication disposition form. amount of medication destroyed. signatures of witnesses. The PnP indicated medication is destroyed within 90 days from the date the medication was discontinued.</p>		