STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055342	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thousand Oaks Post Acute, LLC	93 West Avenida DE Los Arboles Thousand Oaks, CA 91360

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 45741 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1) was treated with respect and dignity when the Certified Nursing Assistant (CNA) 1 repeatedly told Resident 1 to wait for a brief change. This failure had the potential to negatively impact Resident 1's sense of self-worth, self-esteem, and overall quality of life. Findings: During a review of Resident 1's Admission Record (AR), dated 11/27/24, the AR indicated, Resident 1 was admitted with diagnoses including encephalopathy (disturbance of brain function), Arthritis (swelling and tenderness of one or more joints), and muscle weakness. During a review of Resident 1's, MDS (Minimum Data Sheet - a federally mandated process of clinical assessment for nursing home patients) Assessment, dated 11/22/24, the MDS indicated, Section C - Brief Interview of Mental Status (BIMS) assessment indicated, Resident 1 had a BIMS Score of 10 (The BIMS assessment uses a points system that ranges from 0 to 15 points: 0 to 7 points suggests severe cognitive impairment, 8 to 12 points suggests moderate cognitive impairment, 13 to 15 points suggests that cognition is intact.) During a record review of Resident 1's MDS record dated 11/22/24, Resident 1's assessment for Toileting, indicated, Resident 1 is dependent (helper does all the effort to complete the activity). During an interview on 12/10/24 at 2 p.m. with Resident 1, Resident 1 verbalized had turned on her call light because assistance was needed for a brief change, a tall female staff member answered the call light, and told Resident 1 to wait for assigned CNA, [name of staff] and then turned off the call light. Resident 1 waited for a while and then turned on the call light again. The same staff came to Resident 1's room and again said to wait for [name of staff] and turned off the call light again. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/24 at 5 p.m. with CNA 1, CNA 1 verbalized that at the beginning of night shift, Resident 1 had called around 10:30 p.m. for a brief change. CNA 1 told Resident 1 to wait for the assigned CNA. Approximately 30 minutes later, she answered Resident 1's call light the second time and again told Resident 1 to wait for the assigned CNA. Then, 20 minutes later, Resident 1's CNA arrived and changed the brief. CNA 1 further stated that it is everyone's responsibility to answer residents call lights and provide the care residents need. CNA 1 stated that they were not aware Resident 1's CNA was going to be late. During an interview on 12/10/24 at 2:50 p.m. with Director of Staff Development (DSD), DSD stated the night shift starts from 10:30 p.m. - 6:30 a.m., and on 12/2/24, Resident 1's CNA did not arrive until around 11:30 pm, but all CNAs are responsible for answering the residents call lights and CNA 1 should have changed Resident 1's brief when requested assistance the first time. During an interview on 12/10/24 at 3:00 p.m. with Administrator (ADM), ADM verbalized CNA 1 went to Resident 1's room to answer the call light both times and told Resident 1 to wait for the assigned CNA. ADM further stated that CNA 1 should have changed Resident 1's brief rather than making the resident wait. During a review of the facility's policy and procedure (P&P) titled, Dignity and Respect, dated 3/2023, the P&P indicated, The facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.