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	12/17/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 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 one of two sampled residents (Resident 1): 1. Had a baseline care plan (BCP- initial instructions for care right after admission) developed for diabetes management. 2. Had BCP developed for abdominal binder (a wide, elastic compression belt worn around the abdomen) use. 3. Had BCP interventions (specific actions to be taken) that were applicable to Resident 1 regarding NPO (nothing by mouth) status. These failures resulted in Resident 1 being transferred to the hospital for elevated blood sugar and had the potential for choking or aspiration (food or liquids entering the lungs).During a review of Resident 1's admission Record (AR), the AR indicated, Resident 1 was a [AGE] year-old admitted to the facility on [DATE] with a primary diagnosis of cerebral infarction (stroke, loss of blood flow to a part of the brain) and secondary diagnoses of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control), dysphagia (difficulty swallowing) and gastrostomy tube (G-tube - feeding tube directly into the stomach). During a review of the facility's policy and procedure (P&P) titled, Baseline Care Plan, dated 1/2025, the P&P indicated, Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission. The baseline care plan includes the minimum healthcare information necessary to properly care for a resident, including. Physician orders. 1. During a review of Resident 1's Order Summary Report (OSR), dated 8/21/25 - 8/25/25, the ORS indicated, FSBS [finger stick blood sugar] Q [every] AC [before meals] &HS [bedtime]. Call MD if < 70 or >400. Monitor signs and symptoms of hyperglycemia [high blood sugar] . Monitor signs and symptoms of hypoglycemia [low blood sugar] . (Insulin Glargine) Inject 22 unit subcutaneously [under the skin] every 12 hours for DM2 [diabetes mellitus type 2]. During a review of Resident 1's Health Status Note (HSN), a late entry dated 9/2/25 at 1:24 p.m. for 8/25/25 at 4:22 p.m., the HSN indicated, Will send patient to hospital. Needs admission for fluids and diabetes control. During a concurrent interview and record review on 10/14/25 at 2:15 p.m. with the Director of Nursing (DON), Resident 1's BCPs were reviewed. DON stated there was no BCP for diabetes management and there should have been. 2. During a review of Resident 1's Wound Weekly Monitoring Assessment (WWMA), dated 8/22/25 at 3:36 p.m., the WWMA indicated, Resident wearing binder to prevent resident from pulling on peg tube [feeding tube inserted through the stomach]. During a concurrent interview and record review on 9/25/25 starting at 3:45 p.m. with a licensed nurse (LN1), Resident 1's BCPs were reviewed. LN1 stated there should have been a BCP for abdominal binder use and there wasn't. 3. During a review of Resident 1's BCP titled, Resident has the following dietary orders Resident is NPO [nothing by mouth]. Currently on G-tube [feeding tube directly into the stomach], date initiated 8/21/25, the BCP intervention indicated, Monitor meal intake. During a review of Resident 1's BCP titled, The resident is on Seroquel (Antipsychotic Medications) r/t [related to] psychosis manifested by: behaviors of agitation, date initiated 8/21/25, the BCP intervention indicated, Offer warm beverage of preference, such as warm milk or hot tea. According to Fundamentals of Nursing ([NAME] et al; Elsevier: 2023, p. 265), Choosing suitable nursing interventions requires applying your nursing knowledge and the best scientific evidence for a patient's health problems. During a concurrent interview and record review on 9/25/25 at 3:45 p.m. with LN1, Resident 1's BCPs titled Resident has the following dietary orders Resident is NPO. Currently on G-tube, and The resident is on Seroquel r/t psychosis manifested by: behaviors of agitation, dated 8/21/25 were reviewed. LN1 stated the interventions were not right and should have been changed. According to Fundamentals of Nursing ([NAME] et al; Elsevier: 2023, p. 399), Most computer documentation systems allow these care plans to be modified by creating individualized interventions and outcomes for each patient.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 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 one of two residents (Resident 1) was provided care according to accepted professional nursing standards (actions that ensure safe nursing practice) when the facility failed to: Develop a baseline care plan (BCP- initial instructions for care right after admission developed by using the nursing process) for diabetes management. 2. Develop care plans (CP- a detailed outline of health needs, goals, and preferences that guides care to ensure consistent and appropriate care) with resident specific interventions. 3. Clarify conflicting orders for the way to (route) administer medication. 4. Follow physician order for monitoring blood pressure (BP). 5. To communicate with the physician to clarify PRN (as needed) Seroquel order when ordered for an excessive duration without an end date and with conflicting physician indications for its use. 6. To include an intervention for a psychiatric assessment and a review of the results of the psychiatric assessment. 7. Ensure Licensed Vocational Nurses (LVNs) worked within their scope of practice (legally permitted actions based on their education, training, and licensure). As a result of these failures, Resident 1 was transferred to an acute care hospital due to abnormally high blood sugar (593) for evaluation and treatment and ultimately died.Findings:1. During a review of the facility's policy and procedure (P&P - expected employee conduct and detailed patient care instructions) titled, Baseline Care Plan, dated 1/25, the P&P indicated, The facility develops and implements a baseline care plan for each resident. that meet professional standards of quality care. based on the resident's admission orders, information available from the transferring provider. includes the minimum healthcare information necessary to properly care for a resident.During a concurrent interview and record review on [DATE] at 3:45 p.m. with LN1, Resident 1's Baseline Care Plans (BCPs), were reviewed. A BCP for diabetes management was not found. LN1 stated there should have been a BCP developed for diabetes management and there wasn't.During a concurrent interview and record review on [DATE] at 2:15 p.m. with DON, Resident 1's BCPs, were reviewed. DON stated there should have been a care plan developed for diabetes management and there wasn't.2. During a review of Resident 1's CPs, titled:- BCP [baseline care plan] Resident has the following dietary orders Resident is NPO [nothing by mouth]. Currently on G-tube, initiated [DATE], the CP indicated, Interventions (actions to be taken) . Monitor meal intake.- The resident is on Seroquel (Antipsychotic Medications), initiated [DATE], the CP indicated, Offer warm beverages of preference, such as warm milk or hot tea.During a concurrent interview and record review on [DATE] at 3:45 p.m. with LN1, Resident 1's CPs were reviewed. The CPs indicated Resident 1 was to have nothing by mouth. The CPs also indicated interventions to monitor meal intake and offer warm beverages of preference. LN1 stated, I should have changed those, interventions.During a concurrent interview and record review on [DATE] at 2 p. m. with the DON, Resident 1's CPs were reviewed. The CPs indicated Resident 1 was to have nothing by mouth. The CPs also indicated interventions to monitor meal intake and offer warm beverages of preference. DON stated the interventions were not specific to Resident 1.3. According to Fundamentals of Nursing ([NAME] et al; Elsevier: 2023, p. 648), It is essential to verify the accuracy of every medication you give to your patients with the patients' orders. If the medication order is incomplete, incorrect, or inappropriate or if there is a discrepancy between the original order and the information on the MAR, consult with the health care provider. Do not give a medication until you are certain that you can follow the seven rights of medication administration.During a review of the facility's P&P titled, Administering Medications, dated 3/23, the P&P indicated, To provide employees with guidelines for the safe and timely administration of medications per physician order. Medications must be administered in accordance with the orders.During a review of Resident 1's AR, Initial admission date [DATE], the AR indicated, Diagnosis. Dysphagia [difficulty swallowing].During a review of Resident 1's OSR, dated [DATE] - [DATE], the OSR indicated:-NPO diet [nothing by mouth]During a review of Resident 1's OSR, dated [DATE] to [DATE], the OSR indicated, Order Date [DATE]. Start Date [DATE]. NPO [nothing by mouth], and Enteral [through the feeding tube directly into the stomach] Feeding Order. Every shift Flush feeding tube 30 ml [milliliter] water before and after medication administration.During a concurrent interview and record review on [DATE] at 12 p.m. with DON, Resident 1's OSR, dated [DATE] to [DATE] and MAR, dated 8/25 were reviewed. DON stated that based on the documentation all the medications were given by mouth. DON also stated it should have been clarified with the physician whether to give the medications by mouth or feeding tube. DON further stated the issues were because of the nurses' inexperience.During a review of Resident 1's BCP titled, Resident has the

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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 - Actual harm 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 - 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 one of two residents (Resident 1) was provided quality care when the facility failed to: Administer Glargine (insulin used for regulating blood sugar) for 3 days, on 8/21 at 9 p.m., 8/22 at 9 a.m. and 9 p.m., and 8/23 at 9 a.m. 2. Notify/Communicate to the charge nurse and physician the missed doses of Glargine. 3. Acquire insulin to meet Resident 1's needs. 4. Administer Glargine from a properly labeled medication container. 5. Clarify the order for finger stick blood sugar (FSBS- a method of monitoring blood sugar levels) with the physician. 6. Failed to monitor blood glucose (BG- blood sugar). 7. Realize the need for monitoring blood sugar. As a result of these failures, Resident 1 was transferred to an acute care hospital due to abnormally high blood sugar (593) for evaluation and treatment and ultimately died. FindingsDuring a review of Resident 1's admission Record (AR), the AR indicated, Resident 1 was 65-years-old admitted to the facility on [DATE] with a primary diagnosis of cerebral infarction (stroke, loss of blood flow to a part of the brain) and secondary diagnoses diabetes mellitus (a disorder characterized by difficulty in blood sugar control), hypertension (high blood pressure), hemiplegia (paralysis of one side of the body), chronic myelogenous leukemia (a type of cancer), anemia (inadequate number of red blood cells), drug induced polyneuropathy (a painful condition caused by medications), atrial fibrillation (irregular heart beat), dysphagia (difficulty swallowing), gastrostomy tube (G-tube- feeding tube directly into the stomach), and other psychotic disorder not due to a substance or known physiological condition (the state of the body and how its different parts and systems are working).According to Fundamentals of Nursing ([NAME] et al; Elsevier: 2023, p. 328), Standards of nursing care reflect the knowledge and skill ordinarily possessed and used by nurses to perform within the scope of practice.1. According to Fundamentals of Nursing ([NAME] et al; Elsevier: 2023, p. 640), Administering medications requires unique nursing knowledge, clinical judgment, and skills. As a nurse you need to. administer medications correctly, and then closely monitor their effects.During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 3/23, the P&P indicated, Medications must be administered in accordance with the orders.During a review of Resident 1's Order Summary Report (OSR- a breakdown of all the orders placed for a specific time period), dated [DATE] - [DATE], the OSR indicated, Insulin Glargine. every 12 hours for DM2 [type 2 diabetes] . Start Date. [DATE].During a concurrent interview and record review on [DATE] at 12 p.m. with the Director of Nursing (DON), Resident 1's Medication Administration Record (MAR), dated 8/25 and Progress Notes (PN), dated [DATE] - [DATE] were reviewed. The DON stated the insulin was not given on [DATE]-[DATE], the insulin was first given on [DATE]. DON stated, These were significant medication errors.During a review of Resident 1's MAR, dated 8/25, the MAR indicated, Glargine (insulin) was ordered to be administered every 12 hours for diabetes mellitus starting at 9 p.m. on [DATE]. Glargine was not administered as ordered on 8/21 at 9 p.m., 8/22 at 9 a.m. and 9 p.m., and 8/23 at 9 a.m. Each of the boxes had a number nine indicating other / see NN [progress note]. During a review of Resident 1's PNs titled, Medication Administration Note, dated:- [DATE] at 9:41 p.m., the PN indicated Glargine (insulin) was not given due to new admission. The PN did not indicate if the nurse contacted the physician or pharmacist.- [DATE] at 9 a.m. and 9 p.m., no PNs indicating why Insulin Glargine was not administered was found. - [DATE] at 9 a.m., no PN indicating why Insulin Glargine was not administered was found. - [DATE] at 8:58 p.m., the PN indicated the Glargine was not available. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR), dated [DATE] at 5:57 p.m., the SBAR indicated, Situation - abnormal lab results. Glucose level 593, sent to ER per MD; Assessment - Received abnormal lab results and noted with elevated glucose level 593. MD notified and received orders to send out via regular ambulance.During a review of Resident 1's Health Status Note, dated [DATE] at 4:22 p.m., the PN indicated, Will send patient to hospital. Needs admission for fluids and diabetes control. 2. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 3/23, the P&P indicated, To provide employees with guidelines for the safe and timely administration of medications. Medications must be administered in accordance with the orders.During a concurrent interview and record review on [DATE] at 12 p.m. with the DON, Resident 1's MAR, dated 8/25 and PNs, dated [DATE] - [DATE] were reviewed. The DON stated the missed insulin doses were not reported to Resident 1's physician.During an interview on [DATE] at 1:15 p.m. with a licensed nurse (LN6), LN6 stated did not realize the physician needed to be notified when the insulin was not delivered and when Resident 1 missed doses of

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (continued on next page)

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F 0700 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 one of two sampled residents (Resident 1):1. Had appropriate alternatives to bed rails identified and tried.2. Was adequately assessed for bed rail use. 3. Had their bed and mattress assessed for bed rails (metal bars attached to the bed) prior to the bed rail installation. 4. Had the appropriately trained staff install the bedrails.These failures had the potential to result in an increased risk of entrapment (caught, trapped, entangled, or strangled in the space in or about the bed rail).Resident 1 was admitted to the facility on [DATE] with a primary diagnosis of cerebral infarction (type of stroke- brain cells die) and secondary diagnoses including flaccid (floppy and weak) hemiplegia (paralysis of one side of the body), muscle weakness, drug-induced polyneuropathy (nerve damage that occurs as a side effect of certain medications), dysphagia (swallowing difficulties) with gastrostomy (surgical opening in the abdomen to insert a feeding tube directly into the stomach for nutrition). During a review of the facility's policy and procedure (P&P) titled, Siderail-Bedrail Safety Evaluation, dated 3/23, the P&P indicated, The facility attempts to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails. 1. During a review of Resident 1's progress note (PN) titled, admission Summary, dated 8/21/25 at 9:08 p.m., the PN indicated, New patient arrived to the facility around 1915 [7:15 p.m.]. During a review of Resident 1's Bed/Side Rail Entrapment Risk Assessment (BSRERA), dated 8/21/25 at 7:52 p.m., the BSRERA indicated, Alternative Interventions. Low Bed. Upper body mechanics. During a review of Resident 1's Devices / Physical Restraint Assessment/ Re-evaluation (DPRAR), dated 8/28/25 for effective date 8/21/25 at 8:15 p.m., the DPRAR indicated, Less restrictive measures / alternatives attempted. No. During a concurrent interview and record review on 9/25/25 at 3:45 p.m. with a licensed nurse (LN1), Resident 1's BSRERA, dated 8/21/25 at 7:52 p.m. and DPRAR, dated 8/28/25 for effective date 8/21/25 at 8:15 p.m. were reviewed. LN1 stated No alternatives were attempted. LN1 also stated Resident 1's family requested the bed rails and LN1 complied to keep the family from complaining. During a review of the facility's P&P titled, Respect and Dignity - Physical Restraints, dated 3/23, the P&P indicated, The facility does not implement the use of a restraint at the resident or resident representative request in the absence of an evaluation and identification of a medical symptom that must be treated and includes the practitioner in the review and discussion. 2. According to Fundamentals of Nursing ([NAME] et al; Elsevier: 2023, p. 433), Side rails also can lead to patients becoming caught, trapped, entangled, or strangled, especially in those who are frail, elderly, or confused (FDA, 2017). Therefore, an assessment of a patient's mobility and responsiveness to instructions helps determine whether using a side rail is safe. During a review of Resident 1's PN titled, Health Status Note, dated 8/25/25 at 4:22 p.m., the PN indicated, A&OX0 [alert but not oriented to person, place, time, or situation]. Non-verbal. Unable to follow commands. During a review of Resident 1's PN titled, IDT [interdisciplinary team] Progress Note, date 8/22/25 at 4:08 p.m., the PN indicated, AOx0, cannot follow simple commands, does not follow with eyes, left facial droop, resident grips hard onto staff. Review of the U. S. Food and Drug Administration (FDA) website, https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-consumers-and-caregivers-about-adult-portable-bed-rails#:~:text=Some%20people%20are%20at%20a,Recommendations%20for%20Health%20Care%20Providers)., accessed on 11/7/25, indicated, Some people are at high-risk for entrapment, falls, or other injury from adult portable bed rails. High-risk people include those with pre-existing conditions such as confusion, restlessness, lack of muscle control, or a combination of these factors. Additionally, people who are cognitively impaired. from a medical condition, such as. stroke. are at a higher risk of entrapment and injury. Consider other alternatives when bed rails are not appropriate. Alternatives include roll guards, foam bumpers. using concave mattresses that can help reduce rolling off the bed. During a review of Resident 1's Bed / Side Rail IDT (BSRIDT), dated 8/21/25 at 7:52 p.m., the BSRIDT indicated, Why is a bed/ side rail being considered? . Patient / Resident request. During a review of Resident 1's Section GG - Functional Abilities - admission (SGGFAA), dated 8/25/25, the SGGFAA indicated, Resident 1 was dependent (resident does none of the effort to complete the activity) on staff to be able to roll left and right in bed, to move from sitting on the side of the bed to lying, to move from lying in bed to sitting, to move from sitting to standing, and to transfer to and from the bed to a chair. During a review of Resident 1's BSRERA, dated 8/21/25 at 7:52 p.m., the BSRERA indicated, Is the resident dependent for bed mobility [no response] . Does the resident display poor bed mobility or difficulty in

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 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 have competent nurses who possessed the knowledge, skills, and judgment required to provide safe care for one of two sampled residents (Resident 1), when the facility failed to ensure: Licensed nurses knew to contact the physician when they did not administer Glargine (insulin- medicine used to regulate blood glucose levels) as ordered. 2. Licensed nurses knew to communicate to the charge nurse the missed doses of Glargine. 3. Licensed nurses knew to contact the physician when the medication administration record did not include blood glucose monitoring. 4. Licensed nurses knew to clarify conflicting orders for how to (route) administer medication. For Resident 1, these facility failures resulted in unsafe nursing care and admission to the hospital for an avoidable decline.1. According to Fundamentals of Nursing ([NAME] et al; Elsevier: 2023, p. 640), Administering medications requires unique nursing knowledge, clinical judgement, and skills. Medication errors include. failing to administer a medication . When an error occurs, the patient's safety and well being are the top priorities. notify the health care provider of the incident as soon as possible. During a review of Resident 1's Medication Administration Record (MAR), dated 8/2025, the MAR indicated, Insulin Glargine. every 12 hours for DM2 [diabetes mellitus type 2] . start date 08/21/2025 2100 [at 9 p.m.]. The MAR also indicated 8/21/25 at 9 p.m., 8/22/25 at 9 a.m. and 9 p.m., and 8/23/25 at 9 a.m. and 9 p.m. to See Nurses Notes. During a review of Resident 1's progress notes (PN) titled, Administration Note, dated:- 8/21/25 at 9:41 p.m., the PN indicated, Insulin Glargine. New admission.- 8/22/25 no PNs were found for 9 a.m. or 9 p.m. missed doses.- 8/23/25 no PN was found for 9 a.m. missed dose.- 8/23/25 at 8:58 p.m., the PN indicated, Insulin Glargine. not available. During a concurrent interview and record review on 10/14/25 at 12 p.m. with the Director of Nursing (DON), Resident 1's MAR, dated 8/2025 and PNs, dated 8/21/25 - 8/25/25 were reviewed. DON stated the insulin was not given 8/21/25-8/23/25. DON next stated Resident 1's physician was not notified about the missed insulin doses. DON further stated the LNs did not know what to do. During an interview on 10/14/25 at 1:15 p.m. with a licensed nurse (LN6), LN6 stated LN6 did not realize they should have called the physician when Resident 1 missed doses of the insulin when it was not delivered from the pharmacy. 2. According to Fundamentals of Nursing ([NAME] et al; Elsevier: 2023, p. 271), A consultation is vital if you need to seek procedural assistance or clinical expertise for a specific problem to ensure a patient receives needed clinical interventions or insights. During a concurrent interview and record review on 10/14/25 at 12 p. m. with DON, Resident 1's MAR' was reviewed. The MAR indicated Glargine insulin was ordered to start on 8/21/25 at 9 p.m. DON stated the insulin was not given to Resident 1 until 8/24/25. DON also stated the new nurses did not know what to do and did not ask for help from the charge nurse. 3. Review of the National Institute of Health website, https://pubmed.ncbi.nlm.nih.gov/30969870/, accessed on 11/6/25, indicated, All nurses should be familiar with the importance of blood glucose monitoring. Appropriate and timely monitoring of blood glucose will allow for successful management of blood glucose that is out of target range. This will ensure ongoing patient safety. During a concurrent interview and record review on 10/14/25 at 12 p.m. with DON, Resident 1's MAR, dated 8/2025, was reviewed. The MAR indicated the order for FSBS monitoring did not appear on it. DON stated no blood sugar monitoring was done. During a concurrent interview and record review on 10/14/25 at 12 p.m. with the DON, Resident 1's Order Details (OD), dated 8/21/25 at 7:08 p.m., and MAR, dated 8/2025, were reviewed. The OD indicated, FSBS [finger stick blood sugar] Q [every] AC [before meals] & HS [at bedtime]. Call MD [physician] if < [less than] 70 or > [greater than] 400. The MAR indicated the FSBS order did not appear on the document. DON stated the FSBS was ordered incorrectly. DON also stated for Resident 1, the FSBS should have been clarified with the physician and ordered every six hours. DON next stated the OD computer entry for the FSBS did not indicate the scheduling details which would have made the order appear on the MAR. DON further stated the new nurses were not experienced to know the FSBS was needed. During a concurrent interview and record review on 10/14/25 at 1:15 p.m. with LN6, Resident 1's OD, dated 8/21/25 at 7:08 p.m., and MAR, dated 8/2025 were reviewed. LN6 stated inexperience was her reason for not clarifying the missing FSBS order with the physician. During the review of the Administrator's explanation letter (EL) titled, Training Competencies, undated, the EL indicated the LN's training competencies dated prior to 8/21/25 were unable to be located. During a review of Resident 1's PN titled, Health Status Note, a late entry dated 9/2/25 at 1:24 p.m. for 8/25/25 at 4:22 p.m., authored by Resident 1's physician, the PN indicated, Will send patient to hospital. Needs admission for fluids and

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	12/17/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) had complete and accurate documentation in their health record.This failure resulted in the planning and delivery of care based on inaccurate resident assessments.According to Fundamentals of Nursing ([NAME] et al; Elsevier: 2023, p. 389), Information in a patient's record provides a detailed account of the level of quality of care delivered. The quality of care, the standards of regulatory agencies and nursing practice, the reimbursement structure in the health care system, and legal guidelines make documentation and reporting an extremely important nursing responsibility. During an interview on 9/25/25 at 3:45 p.m. with a licensed nurse (LN1), LN1 stated LN1 texted the physician to clarify Resident 1's route of medication administration. LN1 stated there is no record of this text in Resident 1's medical record. During a concurrent interview and record review on 9/25/25 at 3:45 p.m. with LN1, Resident 1's:- Medicare Skilled Charting (MSC- details of the patient's condition, their response to treatments, and any changes), dated 8/21/25 at 8:25 p.m., was reviewed. The MSC indicated, Skilled Nursing Services. [none indicated]. LN1 stated it should have indicated diabetic care and enteral feeding care (nutrition through a tube into the stomach).- Bed / Side Rail Entrapment Risk Assessment (BSRRA), dated 8/21/25 was reviewed. The BSRRA indicated, alternatives attempted prior to bed/ side rales were a low bed and upper body mechanics. LN1 stated LN1 marked them as having been attempted when no alternatives were attempted. During a concurrent interview and record review on 10/14/25 at 1:15 p.m. with LN6, Resident 1's Medication Administration Record (MAR), dated 8/25 was reviewed. The MAR indicated, on 8/22 to 8/25/25 for the day administration time, Resident 1 had the same lying and sitting blood pressure recorded. LN6 stated the blood pressures were not accurate because the same blood pressure was used for lying and sitting. During a concurrent interview and record review on 10/14/25 at 2:15 p.m. with the Director of Nursing (DON), Resident 1's MSC, dated 8/21/25 at 8:25 p.m., BSRRA, dated 8/21/25, and MAR, dated 8/25 were reviewed. DON stated, Inaccurate charting documented. During a review of the facility's policy and procedure (P&P) titled, Documentation Policy, dated 3/23, the P&P indicated, It is the policy of this facility to document relevant findings in the clinical record.