

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Thousand Oaks Post Acute, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility had a medication error rate of 16.67% when five medication errors occurred out of 30 opportunities during the medication administration observation for two of ten residents (Residents 86 and 23). These failures in medication administration resulted in medications not being given according to the physician's orders and had the potential for Residents 86 and 23 to experience inadequate management of conditions or side effects such as upset stomach and nausea. Findings: 1. During a medication pass observation on 7/6/26, at 8:49 AM, outside of Resident 86's room, Licensed Vocational Nurse 1 (LVN 1) was observed preparing nine medications for Resident 86. The medications included eight pills, including one tablet of Ocular Vitamins (multivitamin for eye health) and one tablet of metoprolol tartrate (generic for Lopressor, a medication to treat high blood pressure) 25 milligrams (mg). LVN 1 did not give Resident 86 any liquid medications. LVN 1 gave Resident 86 a glass of water with the medications. LVN 1 did not offer food with Resident 86's medications. A review of Resident 86's Medication Review Report, dated 7/7/26, indicated Resident 86 had a physician's order, dated 6/22/26, for metoprolol tartrate 25 mg, Give 25 mg by mouth two times a day for HTN [hypertension, high blood pressure]. Give with food. A review of Resident 86's Medication Review Report, dated 7/7/26, indicated Resident 86 had a physician's order, dated 6/22/26, for Ocular Vitamins, Give 2 tablet by mouth one time a day for Supplement. A review of Resident 86's Medication Review Report, dated 7/7/26, indicated Resident 86 had a physician's order, dated 6/22/26, for chlorhexidine gluconate (prescription mouthwash to treat gum disease) 0.12% solution, Give 15 ml [milliliters] by mouth two times a day for Oral [mouth] care for 1 Month. During an interview on 7/6/26, at 1:53 PM, with LVN 1, LVN 1 stated he did not give chlorhexidine oral solution to Resident 86 during the medication pass observation. LVN 1 stated he was supposed to give Resident 86 the chlorhexidine oral solution during the morning medication pass observation. LVN 1 further stated he only gave one tablet of Ocular Vitamins to Resident 86, instead of two tablets as ordered by the physician. LVN 1 stated he administered Resident 86's metoprolol tartrate after breakfast. LVN 1 stated metoprolol tartrate was supposed to be given with food. LVN 1 further stated he was supposed to offer Resident 86 a snack to take with the metoprolol tartrate to follow the orders. During a phone interview on 7/9/26, at 10:51 AM, with the Consultant Pharmacist (CP), the CP stated metoprolol tartrate was given with food to decrease gastrointestinal (GI, referring to the digestive tract, including the stomach and intestines) side effects. The CP stated the concern was the blood pressure dropping too quickly if metoprolol tartrate was given without food. A review of the Prescribing Information (PI, detailed description of a medication that is available to clinicians) for metoprolol tartrate tablets, dated 1/31/24, retrieved from DailyMed, indicated, Metoprolol tartrate tablets should be taken with or immediately following meals. 2. During a medication pass observation on 7/6/26, at 4:12 PM, outside of Resident 23's room, LVN 2 was observed preparing five medications for Resident 23. The medications included two tablets of ibuprofen (generic for Advil, pain medication) (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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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	200 mg, total dose 400 mg, and two tablets of acetaminophen (generic for Tylenol, pain medication) 325 mg, total dose 650 mg. LVN 2 did not offer food with Resident 23's medications. A review of Resident 23's Medication Review Report, dated 7/7/26, indicated Resident 23 had a physician's order, dated 11/15/25, for acetaminophen 325 mg, Give 2 tablet by mouth every 4 hours as needed for mild pain 1-3/10. A review of Resident 23's Medication Review Report, dated 7/7/26, indicated Resident 23 had a physician's order, dated 6/30/26, for ibuprofen 200 mg, Give 200 mg by mouth every 4 hours as needed for breakthrough pain.give with food. During an interview on 7/6/26, at 4:38 PM, with LVN 2, LVN 2 stated Resident 23's ibuprofen orders indicated to give one tablet. LVN 2 stated she gave two tablets of ibuprofen to Resident 23. LVN 2 also stated Resident 23's orders indicated to give ibuprofen with food. LVN 2 stated she did not give ibuprofen with food as ordered. LVN 2 further stated Resident 23's pain score for the afternoon medication pass was five out of 10. LVN 2 confirmed the acetaminophen was supposed to be given for a pain score between one and three. LVN 2 stated she gave acetaminophen because Resident 23 did not have pain medication for a pain score of five. During an interview on 7/7/26, at 3:02 PM, with Registered Nurse 1 (RN 1), RN 1 stated pain medications were only supposed to be administered to residents with a pain score within the ordered range. During an interview on 7/7/26, at 3:05 PM, with RN 1, RN 1 stated the expectation was for nurses to administer medications correctly by checking for the right patient, the right dosage, right indication, and the right parameters. During an interview on 7/8/26, at 2:56 PM, with the Director of Nursing (DON), the DON stated Resident 23 was only supposed to get one tablet of ibuprofen during the medication pass observation. The DON stated nurses were supposed to follow the doctor's orders. Regarding the acetaminophen, the DON stated nurses were supposed to call the doctor for a pain score outside of the medication orders. The DON stated Resident 23 was not supposed to get acetaminophen for a pain score of five. During an interview on 7/8/26, at 3:00 PM, with the DON, the DON stated medications ordered to give with food needed to be given during a mealtime or with a snack. The DON also stated it was not appropriate for a nurse to omit giving medications or to give the wrong dose. The DON stated the expectation was for nurses to administer medications as ordered. During a phone interview on 7/9/26, at 10:55 AM, with the CP, the CP stated ibuprofen should be given with food to minimize gastrointestinal side effects, such as upset stomach and nausea. The CP also stated administering acetaminophen when the pain score was out of the ordered range was a medication error. During a phone interview on 7/9/26, at 10:59 AM, with the CP, the CP stated it was not appropriate for residents to miss medications or for nurses to not follow the prescriber's orders. A review of the facility's policy and procedure (P&P) titled, Medication Errors, revised January 2026, indicated, Medication Error.administration of medications or biologicals which are not in accordance with.The prescriber's order.Manufacturer's specifications regarding the preparation and administration of the medication. The P&P further indicated the following: Unauthorized medication error: Facility administers a medication dose not authorized for the resident. Dose error: Facility administers to the resident a medication dose that is greater than or less than the amount ordered by the Physician/Prescriber. Administration time error: Facility administers to the resident a medication greater than sixty (60) minutes from its scheduled administration time or if administration exceeds the time in relation to meals. and Omission error: Facility fails to administer an ordered dose to the resident. A review of the facility's P&P titled, IIA2: Medication Administration - General Guidelines, dated October 2012, indicated, FIVE RIGHTS - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. The P&P further indicated, Medications are administered in accordance with written orders of the prescriber. A review of the facility's P&P titled, 72313 Administration of Medications and Treatments dated December 2024, indicated, Medications and treatments shall be administered as prescribed.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to appropriately store food for food service safety when:1. Food was not properly labeled in two of four facility freezers (Freezer 2 and Freezer 3).2. Food was not properly labeled in two of two resident refrigerators (West Wing Refrigerator and East Wing Refrigerator).3. Employee food items were being stored inside one of two resident refrigerators (West Wing Refrigerator).These failures had the potential for expired foods to be served to the residents, which could cause illness and for residents to be exposed to foodborne disease through contamination of resident food items.Findings:1. During a concurrent kitchen observation tour and interview on 7/6/26, at 8:30 AM, with the Dietary Supervisor (DS), the following was observed inside the kitchen:a. Freezer 2: One unopened and unlabeled plastic pack of individually wrapped sliced cheese with no expiration date.b. Freezer 3: Three unopened and unlabeled plastic bags of waffles without expiration dates.The DS confirmed the unopened individually wrapped cheese and the three unopened plastic bags of waffles did not have expiration dates and needed to be labeled before placing them inside the freezer.A review of the facility's policy and procedure (P&P) titled, Refrigerators and Freezers, revised 1/2025, indicated, . 7. All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Expiration dates on unopened food will be observed and use by dates indicated once food is opened.2. During a concurrent observation tour and interview on 7/6/26, at 9:18 AM, with the DS, in a locked room in the East Wing, five unopened and unlabeled 500 milliliter (ml- volume of measurement) Pedialyte bottles were observed inside the residents' refrigerator. The DS stated all the food inside the East Wing Refrigerator must be labeled.During a concurrent observation tour and interview on 7/10/16, at 10:30 AM, with Registered Nurse 2 (RN 2), in a locked room in the [NAME] Wing, one unopened and unlabeled Ensure plus bottle was found inside the residents' refrigerator. RN 2 confirmed the Ensure plus bottle must be labeled when placed inside the [NAME] Wing Refrigerator.A review of the facility's P&P titled, Use and Storage of Food Brought to Resident, revised 6/2025, indicated, . Storage Guidelines. Perishable items may be: a. Stored in the facility's refrigerator/freezer, with resident's name and date.3.During a concurrent observation tour and interview on 7/6/26, at 9:12 AM, with the DS, in a locked room in the [NAME] Wing, one unopened and unlabeled humus food item and one unlabeled lunch bag with food inside was observed in the [NAME] Wing Refrigerator. The DS stated the items belonged to an employee and no employee food items should be placed inside the residents' refrigerator.During a concurrent observation and interview on 7/7/26, at 10:24 AM, with the RN 1, in a locked room in the [NAME] Wing, one opened container of potato salad with an employee's name was found inside the residents' refrigerator. RN1 stated the [NAME] Wing Refrigerator was for residents only and any food placed by staff must be tossed out.A review of the undated sign posted on the outside of the residents' refrigerator in the [NAME] Wing indicated, Attention Staff- supplements and resident food only! Absolutely no staff food/drinks. Food must have resident's name, room number, date food brought into facility. Food must be discarded after 72 hours. Undated/Unlabeled food will be tossed. Any staff food/drinks will be tossed! Please use staff refrigerator in break room.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review the facility failed to keep the door of one of one trash compactor closed.This failure had the potential to attract pests to the exposed trash, which could then spread disease to residents and staff in the facility. Findings:During a concurrent observation tour and interview on 7/6/26, at 8:30 AM, with Kitchen Staff (KS), in the outdoor garbage collection area, the trash compactor door was left open and trash was exposed. KS confirmed the trash compactor lid must be closed all the time.During an additional observation tour and interview on 7/8/26, at 8:35 AM, with the Dietary Supervisor (DS), in the outdoor garbage collection area, the trash compactor door was left open, leaving trash at the bottom exposed. The DS stated all kitchen trash went to the compactor and confirmed the trash compactor door must always remain closed.A review of the facility's policy and procedure (P&P) titled, Dispose of Garbage and Refuse, revised 1/2025, indicated, . 1. Garbage and refuse containers are maintained in good condition (no leaks) and waste is properly contained in dumpsters or compactors with lids covered.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care in a manner that promoted residents' dignity and respect for two of 24 sampled residents (Resident 121 and 108) when:1. A Facility Staff (FS) fed Resident 121 while standing and not at eye level.2. Two unopened bottles of Ensure Plus labeled with another resident's name were found on the table of Resident 108. These failures violated residents 121 and 108's right to be treated with respect and dignity and had the potential to affect the residents' sense of self-worth and self-esteem.Findings: 1. A review of Resident 121's admission RECORD (front page of the chart that contains a summary of basic information about the resident) dated 7/7/26, indicated the resident was readmitted to the facility on [DATE] with diagnoses that included adult failure to thrive (a state of undernutrition delayed physical growth where an individual fails to gain weight at the expected rate), anemia (condition characterized by a lack of enough healthy red blood cells), and muscle weakness. A review of Resident 121's HISTORY AND PHYSICAL (H&P) dated 7/7/26, indicated the resident had the capacity to understand and make decisions. During an observation on 7/6/26, at 12:15 PM, inside Resident 121's room, Resident 121 was lying on her bed. The bed was placed in a low position with the head of bed elevated. FS was observed standing over Resident 121 while feeding her. Resident 121's neck was hyperextended (stretched beyond normal upright position) while being fed. FS stood over the resident and assisted her with her meal until Resident 121 finished her lunch at around 12:24 PM. ^^ During an interview on 7/6/26, at 12:28 PM, with FS, FS acknowledged the findings and stated staff were expected to sit and be at eye level with residents while assisting with their meals. FS also stated this was important to make the residents feel invited, comfortable, and calm while eating. FS further stated that it was not acceptable and undignified to stand over Resident 121 while feeding her. During an interview on 7/7/26, at 10:24 AM, with Registered Nurse 2 (RN 2), RN 2 stated staff were expected to feed residents at eye level. RN 2 also stated it was not acceptable to stand over the residents because it did not provide dignity and respect for the residents. During an interview on 7/7/26, at 11:30 AM, with the Director of Nursing (DON), the DON stated it was her expectation for staff to sit down and be at eye level with the residents while providing feeding assistance. The DON stated this was important to establish connections, provide a home-like environment, and promote dignity and respect for the residents. 2. A review of Resident 108's admission RECORD indicated Resident 108 was admitted to the facility on [DATE], with diagnoses which included generalized muscle weakness, difficulty in walking, and depression. A review of Resident 108's H&P, dated 6/26/26, indicated Resident 108 had the capacity to (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understand and make decisions. A review of Resident 108's Order Summary Report dated 7/4/26, indicated Resident 108 had a current physician's order for Ensure Plus one time a day for supplement. During an observation tour and concurrent interview on 7/6/26, at 11:00 AM, with Resident 108, inside Resident 108's room, two unopened bottles of Ensure Plus labeled with another resident's name (Resident 63) were found on Resident 108's bedside table. Resident 108 stated she was upset and confirmed the two unopened bottles of Ensure Plus did not belong to her. During an observation and interview on 7/6/26, at 11:00 AM, with Certified Nursing Assistant 1 (CNA 1), in Resident 108's room, CNA 1 confirmed the two unopened Ensure Plus bottles were labeled with Resident 63's name and were wrongly placed in Resident 108's room. During an interview on 7/6/26, at 4:11 PM, with RN 1, RN 1 stated the two unopened bottles of Ensure Plus found in Resident 108's room labeled for Resident 63 were not supposed to be there. A review of the facility's Policy & Procedure (P&P) titled RESIDENT RIGHTS, revised January 2025, indicated POLICY STATEMENT: Residents in long term care facilities have rights guaranteed to them under Federal and State law including the right to a dignified existence, self-determination, and communication with and access to persons and services. Employees shall treat residents with kindness, dignity and respect. A review of the facility's P&P titled DIGNITY AND RESPECT, revised January 2026, indicated POLICY STATEMENT: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. INTENT: To provide staff with guidelines to ensure residents are treated with kindness, respect, and dignity. Guidelines: 1. 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. 5. Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self worth.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 8) was free from unnecessary psychotropic medications (medications that affect brain activities associated with mental processes and behavior) when Resident 8 received an as needed (PRN) psychotropic medication for more than 14 days. This failure resulted in Resident 8 receiving an as needed psychotropic medication for an extended time period and had a risk of medication side effects, such as drowsiness and confusion. Findings: A review of Resident 8's admission Record, dated 7/9/26, indicated Resident 8 was initially admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record further indicated diagnoses of Other Specified Anxiety Disorders with an Onset Date of 4/22/26. A review of Resident 8's Orders, dated 5/21/25, indicated Resident 8 had a physician's order for alprazolam (generic for Xanax, a psychotropic medication to treat anxiety) 0.25 milligrams (mg), Give 1 tablet by mouth every 8 hours as needed for restlessness. The alprazolam orders were discontinued on 6/17/25. A review of Resident 8's Medication Administration Record (MAR, legal document used to track the medications a patient has been given), dated 5/1/25 - 5/31/25, indicated Resident 8 received three doses of PRN alprazolam in May 2025 on the following dates and times: 5/27/25 at 10:55 PM 5/29/25 at 12:25 AM 5/31/25 at 8:00 PM A review of Resident 8's Medication Administration Record, dated 6/1/25 - 6/30/25, indicated Resident 8 received nine doses of PRN alprazolam in June 2025 on the following dates and times: 6/2/25 at 8:00 PM 6/5/25 at 11:48 PM 6/7/25 at 8:00 PM 6/8/25 at 7:30 PM 6/9/25 at 8:00 PM 6/10/25 at 7:30 PM 6/13/25 at 11:51 PM 6/15/25 at 8:45 PM 6/16/25 at 7:30 PM During a phone interview on 7/9/26, at 11:00 AM, with the Consultant Pharmacist (CP), the CP stated initial orders for PRN psychotropic medications had a 14-day limit. The CP stated the physician could re-evaluate the resident for new orders after the initial 14-day treatment. During a concurrent interview and record review on 7/9/26, at 11:17 AM, with the Director of Nursing (DON), Resident 8's Orders, dated 5/21/25, were reviewed. The DON stated initial PRN psychotropic medication orders were supposed to be for a maximum of 14 days. The DON stated the orders, dated 5/21/25, were the first time the physician ordered as needed (PRN) alprazolam for Resident 8. The DON stated the alprazolam was ordered for 27 days. During a concurrent interview and record review on 7/9/26, at 2:13 PM, with the DON, the facility's policy and procedure (P&P) titled, Dignity and Respect Psychoactive Medications, dated January 2025, was reviewed. The policy indicated, PRN orders for psychotropic drugs shall be limited to 14 days. The DON stated new PRN psychotropic medication orders, like the orders for Resident 8, needed to be limited to 14 days. The DON stated the risk of a longer time frame was overmedicating the resident. The DON stated the facility and prescriber were responsible for ensuring the 14-day limit for PRN psychotropic medications was implemented. A review of the Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for alprazolam tablets, dated 5/31/24, retrieved from DailyMed (internet database operated by the U.S. National Library of Medicine providing labeling for prescription and nonprescription drugs) indicated alprazolam adverse reactions included Drowsiness. Fatigue and Tiredness .Confusional state.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely completion of the Discharge Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment for one of three sampled residents (Resident 71) reviewed for Resident Assessments. This failure had the potential to result in inadequate monitoring of Residents 71's progress and decline and a lack of resident specific information to CMS for payment and quality measure monitoring. Findings: A review of Resident 71's admission RECORD (front page of the chart that contains a summary of basic information about the resident) dated 7/8/26, indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (loss of mental function such as thinking, memory, and reasoning skills), hypertension (high blood pressure), and muscle weakness. A review of Resident 71's Physician Telephone order dated 2/16/26, indicated, Order Summary: May transfer to hospital for further evaluation. A review of Resident 71's discharge MDS assessment, with an Assessment Reference Date (ARD - a specific date that serves as the end point of the look back or observation period for capturing a resident's clinical condition) of 2/16/26, indicated, Section (Sec.) A0310F was coded 11 (Discharge assessment-return anticipated) and Sec. Z0500B (Date Registered Nurse (RN) Assessment Coordinator signed assessment as complete) was dated 4/8/26. During a concurrent interview and record review on 7/8/26, at 3:18 PM, with the Director of Nursing (DON), the DON reviewed Resident 71's MDS assessments in the electronic health record and stated the discharge MDS assessment with an ARD of 2/16/26 was completed on 4/8/26. The DON also stated the discharge MDS assessment should have been completed within 14 days of the discharge date. The DON stated it was not acceptable and should have been completed in a timely manner. The DON further stated that the Resident Assessment Instrument (RAI) submission timelines were not followed. The Centers for Medicare & Medicaid Services (CMS)'s Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2025, indicated .Chapter 2: Assessments for the RAI. Discharge Assessment-return anticipated (non-Comprehensive). MDS Completion Date (Item Z0500B) No Later Than. discharge date + 14 calendar days. A review of the facility's MDS Lead (RN) Job Description, dated December 2016, indicated, .Summary: The MDS Lead (RN) is responsible for managing the timely completion of accurate assessments and interdisciplinary care plans that meet Federal and State guidelines. Roles and Responsibilities: Oversee/complete assessments, Minimum Data Set (MDS) and care plans for residents. Monitor completion of MDS by other disciplines within timeframes prescribed by regulatory guidelines. Manage accurate, timely completion of the MDS information for residents.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident's hearing status in the comprehensive admission MDS (MDS- a federally mandated resident assessment tool) assessment was accurately coded per Resident Assessment Instrument (RAI- comprehensive assessment and care planning process used by nursing home) guidelines for one of 24 sampled residents (Resident 33). This failure had the potential for Resident 33 not to receive the necessary care, treatment, and services to attain his highest practicable level of functioning. Findings: A review of Resident 33's admission RECORD (front page of the chart that contains a summary of basic information about the resident) dated 7/8/26, indicated the resident was readmitted to the facility on [DATE]. During an initial tour observation and interview on 7/6/26, at 1:05 PM, inside Resident 33's room, with Resident 33 and his responsible party (RP), Resident 33 was awake and verbally responsive while lying on his bed. Resident 33 asked for the question to be repeated and stated he had bad hearing. The RP stated Resident 33 was hard of hearing for years now and had been using hearing aids. During an observation and interview on 7/8/26, at 9:11 AM, in the hallway outside Resident 33's room, with Facility Staff (FS), FS leaned forward closer to Resident 33 during their conversation. FS stated Resident 33 had hearing problems because he would ask her to repeat what she just said. During an interview on 7/8/26, at 9:21 AM, in the hallway outside Resident 33's room, with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 33 could verbalize his needs but was hard of hearing. CNA 2 also stated Resident 33 verbalized he could not hear her, and she would have to repeat herself while talking to the resident. During an interview on 7/8/26, at 10:08 AM, with the Speech Language Pathologist (SLP- health care professional that diagnoses and treats conditions that affect one's ability to communicate and swallow), the SLP stated one of the challenges when working with Resident 33 was his hearing difficulties. The SLP also stated Resident 33 would ask her to speak louder because he could not hear her. During an interview on 7/8/26, at 10:13 AM, with the Certified Occupational Therapy Assistant (COTA- licensed professional that helps patients to develop, recover, and improve the skills needed for daily living), the COTA stated he had to repeat verbal cues, speak clearly, and face Resident 33 while working with him because he was hard of hearing. A review of Resident 33's admission MDS assessment with an Assessment Reference Date (ARD- a specific date that serves as the end point of the look back or observation period for capturing a resident's clinical condition) of 6/5/26, Section (Sec.) B0200 (Hearing) was coded 0 indicating hearing was adequate. During a concurrent interview and record review on 7/8/26, at 10:23 AM with the MDS Coordinator (MDSC), the MDSC reviewed Resident 33's comprehensive admission assessment with an ARD of 6/5/26, the MDSC stated Sec. B (Hearing, Speech, and Vision) was completed by the Social Services Department. The MDSC also stated that the look-back period for this section was from 6/1-5/26. A review of Resident 33's Activity Participation Review assessment dated [DATE], indicated, 5a. Ability to hear. Moderate difficulty was marked. During a concurrent interview and record review on 7/8/26, at 10:37 AM, with the Social Services Director (SSD), the SSD reviewed Resident 33's comprehensive admission assessment and stated she completed Section B of the MDS assessment. The SSD also stated the RAI guidelines should be followed when coding MDS assessments. During a subsequent interview and record review on 7/8/26, at 10:44 AM, with the SSD, the SSD reviewed the RAI guidelines in coding Section B and stated Resident 33's hearing status was not coded accurately because she only based it on her assessment. The SSD also stated that accuracy of assessments was important in the development of Resident 33's plan of care. The SSD (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Thousand Oaks Post Acute, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 93 West Avenida DE Los Arboles Thousand Oaks, CA 91360	
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	also stated that when an assessment was not completed accurately, there was a possibility of a delay in the provision of the resident's care needs. During a concurrent interview and record review on 7/9/26, at 3:12 PM, with the Director of Nursing (DON), the DON reviewed Resident 33's Sec. B of the comprehensive admission assessment and the RAI guidelines in coding resident's hearing status and stated it was her expectation that assessments be coded accurately following the RAI guidelines. The DON also stated that the RAI manual was not followed in this case. The DON further stated that an accurate assessment of Resident 33 was important because the care plan depended on it. The Centers for Medicare & Medicaid Services (CMS)'s Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2025, indicated .Chapter 3: MDS Items (B). B0200: Hearing. Steps for Assessment 1. Ensure that the resident is using their normal hearing appliance if they have one. 2. Interview the resident and ask about hearing function in different situations. 3. Observe the resident during your verbal interactions and when they interact with others throughout the day. 4. Think through how you can best communicate with the resident. For example, you may need to speak more clearly, use a louder tone. The resident may need to see your face to understand what you are saying. All of these are cues that there is a hearing problem. 5. Review the medical record. 6. Consult the resident's family, caregivers, direct care staff, activities personnel, and speech or hearing specialist. Coding Instructions. Code 0, adequate. Code 1, minimal difficulty. . Code 2, moderate difficulty. Code 3, highly impaired. A review of the facility's Social Services Director Job Description, dated October 2016, indicated, .Roles and Responsibilities: . Keeps abreast of current federal and state regulations, as well as professional standards. Participates in. resident assessments. A review of the facility's Policy and Procedure (P&P) titled DOCUMENTATION POLICY, revised January 2025, indicated POLICY: 1. It is the policy of this facility to document relevant findings in the clinical record. 3. The facility utilizes assessment sheets, flow sheets, progress notes. and other mandated assessments as required by State and Federal Regulations. Resident Assessments. These assessments are validated and reliable in accordance with RAI standards as set forth by CMS. A review of the facility's P&P titled Resident Assessment, revised January 2026, indicated POLICY STATEMENT: Initially and periodically, the facility conducts a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. INTENT To ensure the facility uses the Resident Assessment Instrument (RAI) in accordance with specified format and timeframes in conducting comprehensive assessments. GUIDELINES: 1. The facility develops a comprehensive assessment of a resident's needs, strengths, goals, life history, and preference using the Resident Assessment Instrument (RAI) provided by CMS. 3. The assessment minimally includes the following. Communication. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR- a federal requirement to help ensure individuals who have a mental disorder or intellectual disability are not inappropriately placed in nursing homes for long term care) was accurately completed for one of three sampled residents (Resident 62) reviewed for PASRR. This failure had the potential for Residents 62 not to receive the most appropriate care and services for his needs. Findings: 1. A review of Resident 62's admission RECORD (front page of the chart that contains a summary of basic information about the resident) dated 7/8/26, indicated the resident was admitted to the facility on [DATE] with diagnoses that included psychotic disorder (mental illness typically characterized by radical changes in personality, impaired functioning, and a distorted or nonexistent sense of objective reality), chronic kidney disease, and muscle weakness. A review of Resident 62's comprehensive admission Minimum Data Set (MDS - a federally mandated resident assessment tool) with an Assessment Reference Date (ARD- a specific date that serves as the end point of the look back or observation period for capturing a resident's clinical condition) of 4/24/26, indicated, Section I- Active Diagnoses. I5950 Psychotic Disorder. was marked X- indicating the presence of this condition. A review of Resident 62's PASRR Level 1 Screening dated 5/11/26, indicated, .11. Diagnosed Serious Mental Illness. Does the individual have a diagnosed Serious Mental Illness disorder such as symptoms of psychosis.? This question was marked No and the diagnoses selection for Schizophrenia (a severe brain disorder in which people interpret reality abnormally)/Schizoaffective Disorder (chronic mental health condition characterized by schizophrenia and mood disorder [temporary, generalized state of feelings and emotions] symptoms), or symptoms of Psychosis was left blank. During a concurrent interview and record review on 7/8/26, at 2:10 PM, with the Director of Nursing (DON), the DON reviewed Resident 62's admission record, Sec. I of the comprehensive admission MDS assessment, and PASRR and stated that the PASRR dated 5/11/26 was inaccurately filled out. The DON stated it was her expectation for Resident 62's PASRR to be accurately completed so that further evaluations, appropriate recommendations, interventions and placement for the resident would be provided. A review of the facility's Policy and Procedure (P&P) titled Preadmission SCREENING AND RESIDENT REVIEW (PASRR), revised January 2026, indicated POLICY STATEMENT: The facility ensures each resident is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission to the extent possible, and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate. Mental Disorder (MD). (i) Diagnosis. This mental disorder is: a. other psychotic disorder. Preadmission Screening and Resident Review (PASARR). PASARR requires that: 1. All applicants to a Medicaid-certified nursing facility are evaluated for a serious mental disorder. 2. Are offered the most appropriate setting for their needs. 3. Receive the services they need in those settings. GUIDELINES. 9. Individuals who have or are suspected to have MD may not be admitted to a Medicaid-certified nursing facility unless approved based on Level II PASARR evaluation and determination. 13. Level II PASARR is a comprehensive evaluation conducted by appropriate state designation authority. determines the appropriate setting for the individual, and recommends what, if any, specialized services and/or rehabilitative services the individual needs. 20. The facility is required to provide all other care and services appropriate to the resident's condition. A review of the facility's MDS Lead (RN) Job Description, dated December 2016, indicated, .Summary: The MDS Lead (RN) is responsible for managing the timely completion of accurate assessments and interdisciplinary (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plans that meet Federal and State guidelines.Roles and Responsibilities:.Facilitate the correction of errors immediately and retransmit the assessment. Facilitate the completion and updating of resident care plans to reflect the residents' most current needs. Lead facility staff education.and the coordination of obtaining accurate documentation from direct care staff.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for hearing impairment for one of 24 sampled residents (Resident 33). This failure had the potential to delay Resident 33's care, treatment, and services to maintain or improve his hearing abilities. Findings: A review of Resident 33's admission RECORD (front page of the chart that contains a summary of basic information about the resident) dated 7/8/26, indicated the resident was readmitted to the facility on [DATE]. During an initial tour observation and interview on 7/6/26, at 1:05 PM, inside Resident 33's room, with Resident 33 and his responsible party (RP), Resident 33 was awake and verbally responsive while lying on his bed. Resident 33 asked for the question to be repeated and stated he had bad hearing. The RP stated Resident 33 was hard of hearing for years now and had been using hearing aids. During an interview on 7/8/26, at 9:21 AM, in the hallway outside Resident 33's room, with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 33 could verbalize his needs but was hard of hearing. CNA 2 also stated Resident 33 verbalized he could not hear her, and she would have to repeat herself while talking to the resident. During an interview on 7/8/26, at 10:08 AM, with the Speech Language Pathologist (SLP- health care professional that diagnoses and treats conditions that affect one's ability to communicate and swallow), the SLP stated one of the challenges when working with Resident 33 was his hearing difficulties. The SLP also stated Resident 33 would ask her to speak louder because he could not hear her. During a concurrent interview and record review on 7/8/26, at 10:58 AM, with the MDS Coordinator (MDSC), the MDSC reviewed Resident 33's electronic health records and stated there was no documented evidence that a comprehensive care plan was developed for Resident 33's hearing impairment. The MDSC also stated that hearing impairment needed to be addressed, and the development of a care plan was important to monitor Resident 33's hearing progress or decline. During a concurrent interview and record review on 7/8/26, at 11:14 AM with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 33's electronic health records and acknowledged that Resident 33 had no care plan for his hearing impairment. The ADON also stated it was her expectation that when a problem existed, staff should develop a comprehensive care plan to identify, implement, and follow through with interventions to meet the needs of the residents. During an interview on 7/9/26, at 3:15 PM, with the Director of Nursing (DON), the DON stated that a hearing impairment care plan should have been developed for Resident 33. The DON also stated that care plans were important to address resident's issues so appropriate care could be provided. A review of the facility's Policy and Procedure (P&P) titled COMPREHENSIVE CARE PLANS-TIMING, revised January 2026, indicated POLICY STATEMENT: Each resident has a person-centered, comprehensive care plan, developed, reviewed, and revised by the facility interdisciplinary team including the resident and resident representative. GUIDELINES: 1. The comprehensive care plan is completed by the interdisciplinary team. The interdisciplinary team reviews and revises the comprehensive care plan after each assessment. 3. The comprehensive care plan is developed within seven days of completion of the comprehensive assessment, reviewed and revised after each assessment. 4. The comprehensive care plan must be completed no more than 21 days after admission. -Cross reference to F641		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure the appropriate use of lidocaine patches (medication to treat pain), when the nursing staff failed to remove lidocaine patches after 12 hours per manufacturer recommendations for one out of ten residents (Resident 86) during the medication administration observation. This failure had the potential for Resident 86 to receive an excessive dose of lidocaine which could result in side effects, including swelling and skin irritation. Findings: During a medication pass observation on 7/6/26, at 9:06 AM, in Resident 86's room, Licensed Vocational Nurse 1 (LVN 1) was observed administering nine medications to Resident 86. Resident 86 was lying in bed. The medications included one lidocaine 5% (percent, medication strength) patch. LVN 1 removed Resident 86's blanket to expose Resident 86's right knee. There was a patch labeled 7/5 and initialed on the right knee. LVN 1 stated this was the old lidocaine patch. LVN 1 removed the old patch before applying the new lidocaine patch. During a continued medication pass observation on 7/6/26, at 9:09 AM, in Resident 86's room, LVN 1 removed Resident 86's blanket to expose Resident 86's left knee. There was a patch labeled 7/5 and initialed on the left knee. LVN 1 removed the old lidocaine patch before applying the new patch. LVN 1 stated the left knee patch had the same initials and handwriting as the patch on the right knee. A review of Resident 86's Medication Review Report, dated 7/7/26, indicated Resident 86 had a physician's order, dated 6/29/26, for Lidoderm (brand name for lidocaine) 5% patch, Apply to each knee topically [on the skin] in the morning for knee osteoarthritis [pain in the joints] apply one patch to each knee. During a concurrent interview and record review on 7/7/26, at 8:50 AM, with LVN 1, Resident 86's Medication Administration Record (MAR, legal document used to track the medications a patient has been given), dated 7/1/26 - 7/7/26, was reviewed. The MAR indicated Resident 86's lidocaine patches were applied on 7/5/26 during the 9:00 AM medication pass. LVN 1 stated the lidocaine patches applied in the morning on 7/5/26 were left on overnight before the medication pass observation on 7/6/26. LVN 1 further stated the lidocaine patch orders were incomplete because they did not include instructions to remove the patch at night. LVN 1 stated the facility got new orders to remove the lidocaine patch after 12 hours after the morning medication pass observation on 7/6/26. During an interview on 7/7/26, at 3:02 PM, with Registered Nurse 1 (RN 1), RN 1 stated lidocaine patches were only supposed to be applied for 12 hours. RN 1 stated a lidocaine patch applied to a resident at 9:00 AM should be removed at 9:00 PM the same day. RN 1 stated orders for lidocaine patches needed to include scheduled times for application and removal. During an interview on 7/8/26, at 2:51 PM, with the Director of Nursing (DON), the DON stated the guideline was for lidocaine patches to remain on a resident for 12 hours and then 12 hours off. The DON stated the expectation was for lidocaine patches to be removed 12 hours after application even if not written in the physician's order. During a phone interview on 7/9/26, at 10:46 AM, with the Consultant Pharmacist (CP), the CP stated proper administration of lidocaine patches was to have 12 hours on the skin, followed by 12 hours off. The CP stated this was the approved manufacturer dosing. The CP stated skin irritation was a possibility if the lidocaine patch was left on for over 12 hours. The CP confirmed the expectation was for lidocaine patches to be removed after 12 hours. A review of the Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for Lidoderm 5% patch, dated 2/1/10, retrieved from DailyMed (internet database operated by the U.S. National Library of Medicine providing labeling for prescription and nonprescription drugs) indicated: .Apply LIDODERM to intact skin to cover the most painful area. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Apply up to three patches, only once for up to 12 hours within a 24-hour period. and .Excessive dosing by applying LIDODERM to larger areas or for longer than the recommended wearing time could result in increased absorption of lidocaine and high blood concentrations, leading to serious adverse effects.Systemic [affecting the entire body] adverse effects of lidocaine.including.confusion, dizziness, drowsiness.tremors, convulsions, unconsciousness. and .the skin at the site of application may develop blisters, bruising, burning sensation.discoloration, edema (swelling).irritation. A review of the facility's policy and procedures (P&P) titled, Medication Errors, revised January 2026, indicated, Medication Error.administration of medications or biologicals which are not in accordance with.Manufacturer's specifications regarding the preparation and administration of the medication.		

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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. Based on observation, interview, and record review, the facility failed to ensure medical records were kept in accordance with professional standards of practice for one of ten residents (Resident 23) observed during the medication administration observation, when Resident 23's pain scores were incorrectly documented in the medical record. This failure resulted in inaccurate documentation of Resident 23's pain which could cause inaccurate clinical assessment of pain management medications. Findings: During a medication pass observation on 7/6/26, at 4:12 PM, at Resident 23's bedside, Licensed Vocational Nurse 2 (LVN 2) was observed administering five medications to Resident 23. The medications included two tablets of acetaminophen (generic for Tylenol, pain medication) 325 milligrams (mg), total dose 650 mg, and two tablets of ibuprofen (generic for Advil, pain medication) 200 mg, total dose 400 mg. A review of Resident 23's Medication Review Report, dated 7/7/26, indicated Resident 23 had a physician's order, dated 11/15/25, for acetaminophen 325 mg, Give 2 tablet by mouth every 4 hours as needed for mild pain 1-3/10. A review of Resident 23's Medication Review Report, dated 7/7/26, indicated Resident 23 had a physician's order, dated 6/30/26, for ibuprofen 200 mg, Give 200 mg by mouth every 4 hours as needed for breakthrough pain. During an interview on 7/6/26, at 4:38 PM, with LVN 2, LVN 2 stated Resident 23's pain score for the afternoon medication pass was five out of 10. LVN 2 confirmed the acetaminophen was supposed to be given for a pain score between one and three. LVN 2 stated she had to enter a pain score between one and three on the medication administration record (MAR, legal document used to track the medications a patient has been given). LVN 2 stated she gave acetaminophen because Resident 23 did not have pain medication for a pain score of five. A review of Resident 23's Medication Administration Record, dated 7/1/26 - 7/7/26, indicated Resident 23 received a dose of as needed (PRN) acetaminophen on 7/6/26 at 4:22 PM, with a documented pain score of two. The record also indicated Resident 23 received a dose of PRN ibuprofen on 7/6/26 at 4:21 PM, with a documented pain score of four. During an interview on 7/8/26, at 2:56 PM, with the Director of Nursing (DON), the DON stated it was not acceptable to document a pain score of two when Resident 23's actual pain score was five. The DON stated a nurse was supposed to call the doctor for a pain score outside of the medication orders. During a phone interview on 7/9/26, at 10:58 AM, with the Consultant Pharmacist (CP), the CP stated it was not appropriate for a nurse to document an incorrect pain score in Resident 23's medical record. The CP stated nurses needed to accurately document the resident's complaints of pain. The CP stated all providers were expected to accurately document the resident's condition. The CP stated inaccurate information could affect the evaluation of Resident 23's pain management therapy. During a concurrent interview and record review on 7/9/26, at 3:42 PM, with the DON, the facility's policy and procedure (P&P) titled, Accuracy of Assessments, revised January 2026, was reviewed. The policy indicated, The appropriate, qualified health professionals correctly document the resident's medical, functional problems and identify resident strengths to maintain or improve medical status. The P&P titled, Services Provided Meet Professional Standards, revised January 2026, was also reviewed. The policy indicated, The services provided or arranged by the facility meet professional standards of quality. The DON agreed accurate documentation in the medical record was a professional standard. The DON stated both policies addressed the inaccurate pain score documentation in Resident 23's medical record and verified it was not acceptable practice. A review of the facility's P&P titled, Pain Assessment and Management, revised January 2025, indicated, The facility provides pain management to residents who require such services, consistent (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with professional standards of practice. The policy also indicated, The ongoing evaluation of the status (presence, increase or reduction) of a resident's pain is vital, including the response to interventions to prevent or manage pain. A review of the facility's P&P titled, IIA2: Medication Administration - General Guidelines, dated October 2012, indicated, When PRN [as needed] medications are administered, the following documentation is provided. Complaints or symptoms for which the medication was given.		