

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555794	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Sherwood Oaks Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 250 Fairview Rd Thousand Oaks, CA 91361	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>40560</p> <p>Based on record review and interview, the facility failed to provide documentation indicating a care planned intervention for falls was carried out for one of two sampled residents (Resident 1).</p> <p>This failure had the potential to lead to negative outcomes for Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's Progress Notes dated 7/8/24, indicated in part on 7/6/24, at 3:20 a.m., CNA (certified nursing assistant) (CNA1) was walking by resident's room and observed the resident (Resident 1) sitting on the landing mat .Resident (Resident 1) was alert and stated that (Resident 1) got up to use the commode and lost (Resident 1) balance and fell , hitting the back of (Resident 1) head on the armrest of the commode .small laceration on the back of the head with bleeding .Resident (Resident 1) c/o (complaints of) pain on the back of the head 4/10 and right rib area 7/10. The progress note entry further indicated in part Resident (Resident 1) is at risk for further falls and injury due to non-compliance with safety precautions, transferring and ambulating without assistance. Resident (Resident 1) has a hx (history of) falling with displaced fracture .of left clavicle . (Resident 1) is incontinent (having no voluntary control) of bowel and bladder. With lack of coordination, muscle weakness and unsteady gait (walking).</p> <p>During a concurrent record review and interview, on 8/1/24, starting at 3:45 p.m., with the Director of Nursing (DON 1) and Medical Records Director (MRD 1), Resident 1's medical record was reviewed. Resident 1 had a fall care plan which indicated in part Resident (Resident 1) is at risk for falls with or without injury related to history of falls .7/6/24 - Evaluated at [Hospital Name] with Dx (diagnoses) of Acute Fracture Right 8th and 9th Ribs, Head Injury, Scalp Laceration (cut) with staples. Resident 1's care plan for falls indicated in part an intervention created on 7/6/24, to Check resident (Resident 1) at least every 2 hours and as needed and ask if (Resident 1) needs assistance with toileting. The DON 1 and MRD 1 were asked to provide documentation indicating this facility chosen care planned intervention was carried out. The DON 1 verbalized the facility could not provide documentation indicating this care planned intervention was carried out by staff, post Resident 1's return from the hospital.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered dated 2001, indicated in part A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p> <p>During a review of the facility's policy and procedure titled Falls and Fall Risk, Managing dated 2001, indicated in part The staff .will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with history of falls .the staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.</p>		