STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555794	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute	250 Fairview Road 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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide respiratory care services consistent with professional standards of practice when:Facility staff were unaware a Bilevel Positive Airway Pressure (BiPAP or BPAP - a non-invasive ventilator used to assist breathing by delivering pressurized air through a mask using a higher pressure level for inhalation and a lower pressure level for exhalation, to improve oxygen levels and reduce carbon dioxide) was beeping/alarming (alarm was not audible) and not delivering the prescribed therapeutic effect in one of two residents (Resident 1).Facility did not have an operator manual onsite or readily accessible to refer for troubleshooting guidance for an alarming BiPAP.Oxygen flow rate was not accurately set to administer oxygen as ordered by the physician (MD) in two of three residents (Resident 2 and Resident 3).MD orders for oxygen administration were unclear and inaccurate in one of three residents (Resident 1).Facility failed to follow its own policy documentation requirements for General Assessment. These failures have the potential to place residents at risk for unattended breathing difficulty which can result in further compromised conditions and adverse health outcomes.1.During review of Resident 1's admission Record (AR), dated 4/2/26, the AR indicated Resident 1 was admitted to the facility with diagnoses that include chronic obstructive pulmonary disease with acute exacerbation (worsening of respiratory symptoms such as difficulty breathing, chronic cough, and/or an increase in the volume and/or thickness of milky or foul-smelling sputum that results in needing additional therapy), acute and chronic respiratory failure with hypoxia (a failure of the lungs to adequately oxygenate the blood), and facioscapulohumeral muscular dystrophy (a genetic muscle disorder that causes progressive wasting or thinning of muscles in the face, shoulder blades, and upper arms). Resident 1's brief interview of mental status score (BIMS - a measurement of cognitive abilities that ranges from 0 to 15 with scores of 13-15 classified as having no significant cognitive impairment) was 15. During a concurrent observation and interview on 4/6/26 at 2:54 p.m. with Resident 1, the front of the BiPAP machine was facing the wall with the back of the machine facing the resident's right side. The BiPAP was displaying a message that indicated Attention: Leak detected, check your system setup and all connections. There was no audible beeping sound. Resident 1 stated the BiPAP beeps when there is an air leak. Resident 1 stated being unaware the BiPAP was displaying a leak detection message at that time. Resident 1 acknowledged not being able to hear the beeping sound. The attention message displayed non-stop for approximately 15-20 minutes with no staff awareness or intervention. During a concurrent observation and interview on 4/6/26 at 3:25 p.m. with Licensed Nurse (LN 1) inside Resident 1's room, LN 1 was asked to verify the BiPAP monitor. LN 1 said the BiPAP was leaking a little. LN 1 stepped out of the resident's room to get Registered Nurse (LN 2) to troubleshoot the BiPAP alarm. During a concurrent observation and interview on 4/6/26 at 3:36 p.m. with LN 2, LN 2 re-adjusted Resident 1's BiPAP face mask. The face mask was removed and reapplied, and the face mask straps were adjusted, however, the BiPAP continued displaying a leak warning with no audible beeping sound. LN 2 acknowledged the BiPAP was displaying a leak warning with no audible beep to alert the resident or staff. During an interview on 4/7/26 at 12:30 p.m. with Respiratory Therapist (RT), RT stated the alarms are intended to inform (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff when there are issues with the BiPAP's function. RT stated that a resident may not be receiving the prescribed therapeutic dose if frequent leak detection alarms go unattended by staff. During a concurrent observation and interview on 4/7/26 at 2:02 p.m. with Director of Nursing (DON) and Respiratory Therapist (RT), inside Resident 1's room, the BiPAP settings were verified. RT indicated the audible alarms (beep/beeping) were enabled and functioning. DON acknowledged the BiPAP alarms were hard to hear with the facility background noise. 2. During a concurrent observation and review on 4/6/26 at 4 p.m., Resident 1 was observed on oxygen via nasal cannula and no longer using the BiPAP. Review of Resident 1's Order Summary (OS), dated 4/2/26, indicates in part, BiPAP via face mask with oxygen at 2 liters per minute (LPM) on every 1 p.m. and off every 5 p.m. total of 5 hours of treatment. During an interview on 4/6/26 at 4:06 p.m. with LN 2, LN 2 was asked why Resident 1 was not on the BiPAP as ordered by the physician. LN 2 stated the BiPAP kept displaying an air leak was detected that could not be resolved after readjusting the face mask multiple times. LN 2 stated the BiPAP supplier was contacted for troubleshooting guidance and was waiting for a return call. LN 2 was asked for the BiPAP operator's manual but instead LN 2 provided the manual for the BiPAP face mask. LN 2 stated the operator manual was not inside Resident 1's room. During an interview on 4/7/26 at 9:45 a.m. with Director of Nursing (DON), DON stated the facility should have an operator manual available so staff can refer to for use and troubleshooting. DON acknowledged the facility did not have an operator manual for Resident 1's BiPAP. Review of facility policy and procedure (P&P) titled, CPAP/BiPAP Support, dated March 2015, indicates in part, Review and follow manufacturer's instructions for CPAP machine setup and oxygen delivery. 3. During an observation inside Resident 3's room on 4/7/26 at 11:20 a.m., Resident 3's oxygen concentrator was set at 1.5 LPM. During a concurrent observation and record review on 4/7/26 at 11:30 a.m. with Registered Nurse (RNS) inside Resident 3's room, RNS acknowledged Resident 3's oxygen concentrator setting was set at 1.5 LPM. Subsequently, RNS verified Resident 3's oxygen order in the electronic medical system and said, it should be set at 2 LPM. Review of Resident 3's oxygen order, dated 3/1/26, indicates in part Routine oxygen inhalation at 2 LPM via nasal cannula every shift. During an observation inside Resident 2's room on 4/7/26 at 12:14 p.m., Resident 2's oxygen concentrator was set at 3.5 LPM. During a concurrent observation and record review on 4/7/26 at 12:14 p.m. inside Resident 2's room with Licensed Nurse (LN 3), LN 3 was asked to verify Resident 2's oxygen concentrator setting. LN 3 slightly bent over to look at the oxygen concentrator and said it was set at 4 LPM. LN 3 was asked to get at eye level and read the setting again. LN 3 acknowledged it was at 3.5 LPM. During review of Resident 2's oxygen order, dated 10/9/25, LN 3 acknowledged the order is for 4 LPM. Review of [NAME] and [NAME], 7th Edition, Mosby's Fundamentals of Nursing, page 419 in the section titled, Legal Implications in Nursing Practice indicates, Nurses are obligated to follow physician order unless they believe the orders are in error or would harm clients. 4. During a concurrent interview and review on 4/7/26 at 12:21 P.M., with Licensed Nurse (LN 5). LN 5 stated being assigned Resident 1 on 4/6/26 but did not recall the resident being on the BiPAP in the afternoon. LN 5 stated that Resident 1 did not need to be on BiPAP during the hours of 1 p.m. to 5 p.m. LN 5 reviewed Resident 1's OS and indicated the physician orders for the BiPAP and oxygen were unclear. During a concurrent interview and record review on 4/7/26 at 2:02 p.m. with Director of Nursing (DON), Resident 1's oxygen and BiPAP orders, dated 4/2/26 were reviewed. The orders indicated the following: Routine oxygen at 2 LPM via nasal cannula when not on BiPAP. BiPAP via face mask with oxygen at (2 LPM) on every 1 p.m. and off every 5 p.m. total of 5 hours of treatment.remove per schedule. BiPAP via face mask with oxygen at (2 LPM) on every 8 p.m. and off every 8 a.m. total of 12 hours of treatment.and remove per schedule.DON stated the orders were clear and that Resident 1 should be without oxygen or BiPAP during 5 p.m. - 6 p.m. DON was asked why the oxygen order indicated routine oxygen.when not on BiPAP , DON re-stated the resident should be without oxygen or BiPAP between 5 p.m. to 6 p.m. during dinner time. DON contacted the ordering physician via telephone on 4/7/26 at 2:31 p.m. to clarify the order. The physician stated that Resident (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 should be on the BiPAP everyday 1 p.m. - 5 p.m. and again 8 p.m. - 8 a.m. AND be on 2 LPM of continuous oxygen for 24 hours. During a concurrent interview and review on 4/7/26 at 2:35 p.m. with Licensed Nurse (LN 6), Resident 1's oxygen and BiPAP orders, dated 4/2/26 were reviewed. LN 6 acknowledged entering the oxygen order at 2 LPM for 1 p.m. to 5 p.m. instead of 1 p.m. to 6 p.m. Review of [NAME] and [NAME], seventh Edition, Mosby's Fundamentals of Nursing, page 336 in the section titled, Physician's Orders indicates, Nurses follow physician orders unless they believe the orders are in error or harm clients. Therefore, you need to assess all orders, and if you find one to be erroneous or harmful, clarification from the physician is necessary. 5. During an interview on 4/7/26 at 2:40 p.m. with DON, the DON was asked for documentation on general assessments prior to BiPAP procedures. The DON could not provide the requested documentation. During a review of the facility's policy and procedure (P&P) titled, CPAP (a continuous positive airway pressure device that uses mild air pressure, delivered through a mask, to keep the airways open)/BiPAP Support, dated March 2015, the P&P indicates in part, Document the following in the resident's medical record:1. General assessment (including vital signs, oxygen saturation, respiratory, circulatory and gastrointestinal status) prior to procedure;2. Time CPAP was started and duration of the therapy;3. Mode and settings for the CPAP/IPAP (inspiratory positive airway pressure - a setting in the BiPAP that provides higher air pressure during inhalation to assist breathing, help open airways, increase oxygenation, and reduce breathing effort)/EPAP (expiratory positive airway pressure - a small nasal devices that creates resistance when breathing out);4. Oxygen concentration and flow, if used;5. How the resident tolerated the procedure; and6. Oxygen saturation during therapy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to ensure infection control practices were implemented when a nebulizer mask (a medical device worn over the nose and mouth to deliver liquid medication directly into the airways as a fine mist) used for breathing treatments was not stored in a manner to maintain hygiene and prevent contamination in one of three residents (Resident 1). This facility failure had the potential to result in cross-contamination (the transfer of harmful bacteria) that could impact a resident's health and safety and cause preventable HAIs (Healthcare Associated Infections) for a resident in an already compromised condition During review of Resident 1's admission Record (AR), dated 4/2/26, the AR indicated Resident 1 was admitted to the facility with diagnoses that include chronic obstructive pulmonary disease with acute exacerbation (worsening of respiratory symptoms such as difficulty breathing, chronic cough, and/or an increase in the volume and/or thickness of milky or foul-smelling sputum that results in needing additional therapy), acute and chronic respiratory failure with hypoxia (a failure of the lungs to adequately oxygenate the blood), and facioscapulohumeral muscular dystrophy (a genetic muscle disorder that causes progressive wasting or thinning of muscles in the face, shoulder blades, and upper arms). Resident 1's brief interview of mental status score (BIMS - a measurement of cognitive abilities that ranges from 0 to 15 with scores of 13-15 classified as having no significant cognitive impairment) was 15. During an observation on 4/6/26 at 2:54 p.m., Resident 1's nebulizer mask and tubing were observed on a shelf, uncovered. During a review of Resident 1's Medication Review Report (MRR) dated 4/6/26, the MRR indicated ipratropium-albuterol inhalation solution (inhaled medication used to relaxing muscles in the airways to improve breathing) orally via nebulizer (machine that converts liquid medication into a fine mist (aerosol) for direct inhalation into the lungs and respiratory tract using a machine called a nebulizer) 3 mg (milligrams - a unit of mass or weight)/3 mL (milliliters - a measure of volume) every two hours as needed for chest congestion. During a concurrent observation and interview on 4/6/26 at 3:25 p.m. inside Resident 1's room with Licensed Vocational Nurse (LN 1), LN 1 acknowledged the nebulizer equipment (tubing and nasal mask) were on the shelf, uncovered, and not properly stored per the facility's policy. During a review of the facility's policy and procedure (P&P) titled Departmental (Respiratory Therapy) - Prevention of Infection, dated February 2026, the P&P indicates in part, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, among residents and staff. Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use.