

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/09/2026
NAME OF PROVIDER OR SUPPLIER Sherwood Oaks Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure residents were free and protected from abuse on one of one resident (Resident 6) per facility's policy and procedure, when an allegation of abuse was reported against a Certified Nurse Aid (CNA4). CNA 4 was not sent home but instead transferred to another area of the facility to continue working with care of other residents. This failure placed residents at risk for potential acts of abuse from the CNA. During an interview, on 6/9/26, at 2 p.m., with the Director of Staff Development (DSD), in the Director of Nursing (DON) office, the DSD stated that an allegation of abuse was reported CNA 2 on 6/8/26, at 12 p.m., involving CNA 4. The allegation was CNA 4 was brushing the hair of Resident 6 aggressively, roughly and hurriedly during care, at the same uttering profanities in Spanish in front of the resident and a fellow CNA. The DSD further stated, after the report from CNA 2 on 6/8/26, CNA4 was moved to another area of the facility away from Resident 6 and took care of other residents, until the end of the shift (7 a.m. - 3 p.m.). When DSD was asked why CNA 4 was not sent home instead, while the facility was initiating their investigation, the DSD had no response. During a review of the facility and policy (P&P), titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revision date September 2022, indicated, 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. During a telephone interview, on 6/10/26, at 8 a.m., with the facility Administrator (ADM), regarding the allegation of abuse against CNA 4 on 6/8/26, and of the CNA remaining in the facility while the investigation was ongoing. The ADM stated, facility staff did not follow/observe the facility P&P on abuse and abuse reporting. The ADM also concurred that any staff with allegations of abuse should be sent home/suspended pending investigation.		

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure allegations of abuse was reported and investigated by staff on three of three residents (Residents 2,3, and1).This failure placed residents in harm's way, unmonitored abusive action by staff and non-implementation of abuse policy by facility. During a telephone interview conducted on 6/9/26, at 11:15 a.m., with Certified Nurse Aid (CNA 2), CNA 2 stated, while assisting CNA3, who had provided care to Residents 2,3,1, on three occasions, CNA3 was rough.For Resident 2 (CNA 2 could not remember the date of the incident) while CNA 3 was changing the shirt of Resident 2, the resident who was nonverbal cried out in pain. CNA 2 stated, witnessing CNA3 grabbing Resident 2's nape (back of neck) roughly and forcibly thrust the neck and head forward, while changing the resident's shirt. CNA 2 reprimanded CNA 3 of the resident's rough handling but did not report the incident witnessed.For Resident 3 who is non-verbal and is cognitively impaired (CNA 2 does not remember the time of the incident), CNA 3 roughly turned Resident 3, from side to side during care. The resident who was nonverbal making grunting sounds. CNA 2, stated, the said incident was reported to Registered Nurse (RN2).CNA2 further stated on 6/7/26, at 5:30 a.m. to 6 a.m., CNA 3 was rendering peri care (private area) to Resident 1, and CNA 3 forcibly, aggressively, and roughly separated /spread Resident 1's legs and the resident cried out. CNA 2 reported the witnessed incident to RN 1.During an interview, on 6/9/26, at 7:30 a.m., RN 1 at the nursing station, RN 1 stated on 6/7/26, at approximately 5:30 a.m. to 6 a.m. CNA 2, reported witnessing CNA 3 aggressively, forcibly and roughly, separated/spread Resident 1's legs apart during care. when providing care. RN1 did not indicate starting an investigation of the reported incident. During a telephone interview, on 6/10/26, at 11:30 p.m., with RN 2, RN 2 confirmed on 6/5/26, CNA 2 reported, witnessing CNA 3 roughly turning Resident 3 from side to side during care and the resident who was nonverbal was making grunting sounds. RN 2 stated not reporting the incident to the facility's abuse coordinator (Administrator/designee). RN 2 further stated, the incident reported by CNA 2 was considered abuse and not being familiar with the facility abuse policy and procedure (P&P) and protocol on abuse reporting when there was an allegation of abuse.During a review of the facility and policy (P&P), titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revision date September 2022, indicated, 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.		