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	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute	250 Fairview Rd Thousand Oaks, CA 91361

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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 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 52203 Based on observation, interview, and facility policy review, the facility failed to post the State Survey Agency contact information and a statement regarding a resident's right to file a complaint with the State Survey Agency. This failure had the potential to affect all 94 residents who resided at the facility. Findings included: A facility policy titled, Federal Posting Policy, version 05/2024, revealed, This policy ensures compliance with federal posting requirements for skilled nursing facilities. The facility will prominently display all federally mandated notices to inform employees, residents, and visitors of their rights and protections under federal law. This policy applies to all required postings in publicly accessible areas of the facility. The policy revealed that 1. Required Postings: included, A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with advance directive requirements. An observation on 02/05/2025 at 12:36 PM of the facility's bulletin board, located on the wall beside the nurses' station, revealed no evidence of a posting or statement that outlined the resident's right to file a complaint with the state survey agency. During interview on 02/05/2025 at 12:40 PM, Resident #32 (who had a Brief Interview for Mental Status [BIMS] score of 12, which indicated the resident had moderate cognitive impairment, per an admission Minimum Data Set [MDS] assessment, with an Assessment Reference Date [ARD] of 01/21/2025), stated they did not know whether they could file a complaint with the state agency about care at the facility. The resident stated they had not seen a posting or information with the state survey agency's contact information. During an interview on 02/05/2025 at 12:51 PM, Certified Nursing Assistant (CNA) #1 stated she was not aware of a posting in the facility with information on how a resident could file a complaint with the state survey agency. (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 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 02/05/2025 at 1:08 PM, the Director of Nursing (DON) stated if a resident had a complaint, they should complete a grievance form. The DON revealed there was no posting or information in the facility with the state survey agency's contact information or the residents' right to file a complaint. During a follow-up interview on 02/05/2025 at 2:46 PM, the DON stated she expected the facility to post all required information. During an interview on 02/06/2025 at 1:51 PM, the Administrator stated the facility reviewed to ensure everything was posted, monthly. He stated, Obviously we haven't done a good job with that. The Administrator said it was his expectation that all required data was posted.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37683 Based on interview, record review, and facility document and policy review, the facility failed to report a resident-to-resident abuse allegation to the State Agency within two hours of an incident for 2 (Resident #7 and Resident #39) of 3 residents reviewed for abuse. Specifically, on 01/27/2025, the police responded to the facility after Resident #39 reported that Resident #7 bumped into their wheelchair, then bumped the resident's knee. The facility Social Services Director (SSD) documented that she and the Administrator had a conversation with Resident #7 on 01/30/2025 about harassment of Resident #39; however, there was no documented evidence the facility notified the State Agency of a resident-to-resident abuse allegation until 02/05/2025. Findings included: A facility policy titled, Abuse Prevention, dated 12/31/2015, indicated, 1. All health practitioners and all employees in a long-term healthcare facility are mandated reports [sic] (Welfare and Institutions Code, Section 15630, Appendix IV). 2. Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse or neglect, or reasonably suspects abuse shall report known or suspected abuse. The policy revealed, 5. First responder or first staff member informed will be responsible for informing immediate supervisor and initiating incident report. 6. Any employee who suspects an alleged violation shall immediately notify the Administrator or designee. 7. The Administrator shall report all alleged or suspected violations to the appropriate state agencies immediately or within 24 hours (California H&S [Health and Safety] Code 1418. 91a) and Vice-President of Operations. Resident #39's Admission Record indicated the facility admitted the resident on 06/05/2019. According to the Admission Record, the resident had a medical history that included diagnoses of depression, other abnormalities of gait and mobility, and diffuse traumatic brain injury with loss of consciousness of unspecified duration. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/18/2024, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Per the MDS, Resident #39 had utilized a walker and a wheelchair during the assessment look-back period. The MDS revealed the resident had no behavioral symptoms during the assessment look-back period. Resident #39's Care Plan included a problem statement initiated 02/04/2025, that indicated the resident was at risk for emotional distress due to an alleged disagreement with another resident. Interventions (initiated 02/04/2025) directed staff to divert the resident's attention to pleasant thoughts, encourage the resident to participate in activities of choice, encourage the resident to verbalize feelings, notify the medical doctor of any significant changes, and obtain a psychiatric consultation as ordered by the physician. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7's Admission Record indicated the facility admitted the resident on 11/06/2021. According to the Admission Record, the resident had a medical history that included diagnoses of chronic pain syndrome, bipolar disorder, anxiety disorder, unsteadiness, and muscle weakness. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/10/2025, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Per the MDS, Resident #7 had utilized a walker and a wheelchair during the assessment look-back period. The MDS revealed the resident had no behavioral symptoms during the assessment look-back period Resident #7's Care Plan included a problem statement initiated 02/04/2025, that indicated the resident was at risk for emotional distress due to an alleged disagreement with another resident. Interventions (initiated 02/04/2025) directed staff to monitor interactions between the resident and the other party involved observe the resident for signs and symptoms of emotional distress, obtain a psychiatric consultation for further assessment and intervention, offer emotional support and reassurance, report to the medical doctor and document any signs of distress or further incidents, and separate the residents if necessary to prevent escalation. Resident #7's Social Service Note, dated 01/29/2025 at 1:22 PM, indicated the Social Services Director (SSD), Administrator, and Administrator in Training spoke with Resident #7 regarding claims that Resident #39 accused the resident of harassment. Per the note, Resident #7 stated that they had not harassed Resident #39 or any other resident of the facility and stated that Resident #39 was harassing them (Resident #7). The note revealed the SSD told Resident #7 that moving forward, they should not look at, have a conversation with, or interact with Resident #39 and that the SSD would contact the Ombudsman regarding the matter. A facility Report of Suspected Dependent Adult/Elder Abuse, dated 02/04/2025, revealed the facility reported to the State Agency that there was an alleged verbal disagreement between Resident #7 and Resident #39 and there was no physical injury. An addendum letter sent to the State Agency on 02/05/2025 revealed the incident occurred on 01/27/2025 at 4:40 PM. During an interview on 02/03/2025 at 1:56 PM, Resident #39 stated that the week prior, they were speaking with the Social Services Assistant (SSA), and they did not want to talk in the open because there were too many nosy people. Resident #39 stated that afterward, Resident #7 bumped into their wheelchair, then bumped their knee and said, You're not God. There's only one God. Resident #39 stated they were not hurt. According to Resident #39, they called 911 on 01/27/2025 at 7:55 PM about the incident. During a follow-up interview on 02/04/2025 at 10:31 AM, Resident #39 stated Resident #7 had never hurt them, but they still felt unsafe because they (Resident #7) want to start something with me and I never know what [Resident #7's] going to do next. During an interview on 02/05/2025 at 11:38 AM, Resident #69 stated Resident #7 bumped into Resident #39's chair. According to Resident #69, it was intentional, because Resident #7 changed their trajectory to do it. Resident #69 stated that staff were around, and they separated the residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/05/2025 at 12:37 PM, Resident #7 stated they did not bump into Resident #39's chair and stated, Check the cameras. Resident #7 also insisted that Resident #39 was bullying them. On 02/06/2025 at 11:05 AM, an attempt was made to contact Deputy #21, and the deputy was not on duty. During a telephone interview on 02/09/2025 at 11:55 PM, conducted after the survey exit date, Deputy #21 stated she responded to a call from the facility on 01/27/2025. Per the deputy, Resident #39 stated they were talking with a social worker, which halted the games residents were playing. Per the deputy, Resident #39 stated this made Resident #7 mad, and Resident #7 began staring down at Resident #39. Deputy #21 stated Resident #39 reported that several hours later, Resident #7 bumped into Resident #39's walker while Resident #39 was eating and said something like, Only God can judge you. Per Deputy #21, the incident did not meet the legal criteria for any type of elder abuse, crime, or threat, which was what she told the facility when she exited. She stated she completed an internal document, not a police report. She stated a week later, the facility requested a report, and she wrote a courtesy report. During an interview on 02/06/2025 at 12:10 PM, the SSA stated she first became aware of an incident on Wednesday (01/29/2025). Per the SSA, the sheriff's office came in on Monday night (01/27/2025). She stated she was notified that the residents had a disagreement and were not on good terms. She stated she knew that they did not like each other but nothing had ever happened between them. The SSA also stated that the incident occurred at night when most department heads were not in the facility. She stated anyone who witnessed it should have reported it to the Administrator. She stated per policy, abuse had to be reported to the abuse coordinator and a report had to be filed with the State Agency. The SSA stated they were monitoring Resident #39 because the resident initially stated that they felt unsafe. During an interview on 02/05/2025 at 2:40 PM, the SSD stated that to her knowledge, the residents' mutual dislike had never escalated to physical contact. During an interview on 02/06/2025 at 1:35 PM, the Director of Nursing (DON) stated she was notified of an incident on 01/27/2025. She stated she only knew that Resident #39 called the sheriff and that the police had given a report to a nurse that there was no crime or altercation. Per the DON, she was not notified that Resident #39 alleged there was a physical altercation. She stated she notified the Administrator. Per the DON, the facility did not report an abuse allegation based on the police's conclusion that there had been no altercation. During an interview on 02/06/2025 at 2:04 PM, the Operations Manager stated he learned of an incident on 01/27/2025, when the DON contacted him. He stated he knew there had been a verbal disagreement between the two residents, and that the police did not find grounds for any further action. He stated he was never told of a collision in the dining room. The Operations Manager stated he reported what he learned to the Administrator. Per the Operations Manager, the expectation was to report abuse allegations; however, the Administrator probably did not find that it rose to the level of abuse based on what the police said. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/06/2025 at 1:51 PM, the Administrator stated he was first made aware of an incident on 01/27/2025. He stated the Operations Manager informed him that the police were at the facility. According to the Administrator, the police spoke with Licensed Vocational Nuse (LVN) #14, who was on shift when the incident occurred. The Administrator stated that according to the police, there was a disagreement/dispute between the two residents; however, no altercation took place. The Administrator stated that LVN #14 also stated there was a disagreement/dispute and Resident #69 stated there was no altercation. According to the Administrator, he was not notified that Resident #7 collided with Resident #39's wheelchair. On 02/05/2025 at 3:30 PM, 02/06/2025 at 8:37 AM, and 02/06/2025 at 9:41 AM, attempts were made to reach LVN #14, who was working the evening shift of 01/27/2025. All attempts were unsuccessful. During a follow-up interview on 02/05/2025 at 8:46 AM, the Administrator stated he did not report the allegation from the previous week until 02/04/2025.

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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 37683 Based on interview, record review, and facility policy review, the facility failed to refer 1 (Resident #49) of 2 residents reviewed for Pre-Admission Screening and Resident Review (PASRR) for a Level II screening when Resident #49 was admitted with a diagnosis of psychosis and depression. Findings included: A facility policy titled, PASARR [Pre-Admission Screening and Resident Review, PASRR], dated 03/2024, indicated, a. The facility verifies with [sic] acute hospital if a Level I PASARR screen for potential admissions and readmissions, regardless of payer source, to determine if the individual meets the criteria for a MD [mental disorder], ID [intellectual disability] or RD [related disorders]. b. Before a patient can be transferred from a hospital, they must undergo a PASARR Level I screening. This initial screening is designed to identify individuals who may have mental illness (MI), intellectual disability (ID) or related conditions. The goal is to determine whether they require further evaluation (Level II) to assess the need for specialized services. c. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. Resident #49's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 10/16/2024, revealed the resident had no diagnosed serious mental illness, such as depressive disorder, anxiety disorder, panic disorder, schizophrenia/schizoaffective disorder, or symptoms of psychosis, delusions, and/or mood disturbance. The Level I PASRR revealed after observing the resident and reviewing the resident's records, there was no suspected mental illness. The PASRR also revealed the resident had not been prescribed any psychotic medications for a serious mental illness. An Admission Record revealed the facility admitted Resident #49 on 10/19/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of unspecified psychosis not due to a substance or known physiological condition and unspecified depression. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/25/2024, revealed Resident #49 had a Brief Interview for Mental Status (BIMS) of 5, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had active diagnoses of depression and psychotic disorder. The MDS revealed the resident had taken antipsychotic and antidepressant medications during the assessment's seven-day look-back period. Resident #49's Care Plan included a problem area initiated 10/19/2024, that indicated [Resident #49] has Psychosis. The Care Plan included a problem area initiated 10/21/2024, that indicated the resident required antidepressant medication related to depression. Resident #49's physician orders revealed an order for quetiapine fumarate oral tablet 100 milligrams (mg) with instructions to give one tablet by mouth at bedtime for psychosis, that started on 10/19/2024 and ended on 01/06/2025. Resident #49's Medication Review Report, revealed an order dated 01/13/2025 for quetiapine fumarate 50 mg with instructions to give one tablet by mouth at bedtime for psychosis. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/06/2025 at 9:51 AM, the Admission Director stated the hospital completed PASRRs and usually sent them to the facility via the PASRR portal. She stated the diagnosis was likely added on admission. The Admission Director revealed she did not know who was responsible for referring a resident for a PASRR when the resident had a new diagnosis of an SMI. During a follow-up interview on 02/06/2025 at 10:42 AM, the Admission Director revealed Resident #49 had a diagnosis of psychosis from the hospital. She revealed she probably missed the diagnosis since the resident was admitted to the facility on a weekend. During an interview on 02/06/2025 at 2:19 PM, the MDS Coordinator stated the facility received PASRRs from the hospital where they were completed. He stated his process for reviewing PASRRs included reviewing the resident's diagnosis list and resubmitting a PASRR if it did not match the diagnosis list. The MDS Coordinator stated Resident #49 was admitted on a weekend and the diagnosis got passed them. During an interview on 02/06/2025 at 1:35 PM, the Director of Nursing (DON) stated that on admission from the hospital, the Admission Director reviewed the resident's PASRR and the resident's diagnoses and medications. She stated the MDS Coordinator completed a second review. She stated that the admission PASRR did not capture Resident #49's diagnosis of psychosis. During an interview on 02/06/2025 at 1:51 PM, the Administrator stated that admissions staff reviewed new resident admissions to see if a Level II screening was required. He stated the facility missed Resident #49's psychosis diagnosis.