

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

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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 05/21/2026
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 23 sampled resident's (Resident 100) medications were secure and inaccessible to unauthorized staff and residents. This failure had the potential to cause medication errors, including residents ingesting incorrect medications. Findings: During an initial tour observation on 5/18/26, at 6 a.m., in room [ROOM NUMBER] A, a 3-ounce Antifungal Powder, a 59 ml. (milliliter) Body Lotion, and an unlabeled plastic cup in a kidney basin with an unidentified substance was observed on Resident 100's bedside table. During a concurrent interview and record review on 5/18/26, at 11 a.m., with the Assistant Director of Nursing (ADON), ADON reviewed Resident 100's electronic Medical Record (eMR) for Resident 100's Self-Administration Assessment (an evaluation by an interdisciplinary care team to determine if a resident can safely and accurately manage and take or apply their own medications). The ADON confirmed Resident 100 did not have a Self -Administration Assessment on file in her eMR and should not have any kind of medication(s) with her or in her room. During an interview, on 5/21/26, at 12:45 p.m., with licensed nurse (LN 1), LN 1 said medications should not be left at resident's bedside and all medications should be kept in the medication cart. During an interview, on 5/21/26, at 2:05 p.m., with the Director of Nursing (DON), DON stated, Medications are not allowed to be left in the resident's rooms. During a review of the facility policies and procedures (P&P) titled, Self-Administration of Medications, revision date February 2021, indicated, 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident and 9. All medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge.		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe food handling practices by not labeling resident food items stored in the resident refrigerator with the resident's name and the date of opening. This deficient practice created a potential risk for foodborne illness due to the inability to determine food ownership and product freshness. Findings: During an observation conducted on 5/19/26 at 10:30 a.m. of the resident refrigerator located in the clean linen room, three food items were found without resident identification or labeling. The unlabeled items included: One 64 oz bottle of [NAME] French Vanilla Coffee Creamer One 32 oz bottle of International Delight Coffee Creamer One 52 oz carton of Plant Oat Oatmilk During an interview on 5/19/26 at 10:35 a.m., with Infection Preventionist (IP), IP confirmed resident information was not placed on the 3 items and verbalized, the items were brought in by residents' families and should have been labeled with the resident's name. During an interview on 5/19/26 at 11:20 a.m., with Administrator (ADM), ADM verbalized, all items stored in the refrigerator are required to include resident information. During a review of the facility's policy and procedure (P&P) titled, Foods Brought by Family/Visitors, dated March 2022, P&P indicated that perishable foods must be stored in resealable containers with tightly fitting lids in a refrigerator, and that containers must be labeled with the resident's name, the item, and the use by date.		