

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555857	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Oakview Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 3557 Campus Drive Thousand Oaks, CA 91360	
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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record reviews, the facility failed to ensure written bed-hold notice was provided to the resident representative at the time of transfer to the hospital for 1 of 12 sampled residents (Resident 51). This failure had the potential to prevent the resident representative from understanding the duration of the bed hold policy and the resident's rights to return to the facility. During a review of Resident 51's admission Record (AR), dated 7/16/26, the AR indicated, Resident 51 was admitted in the facility on 5/2/26. During a review of Resident 51's Progress Note (PN), dated 5/26/26, the note indicated, Resident 51 was transferred to hospital for further evaluations. During a review of Resident 51's admission Note (AN), dated 5/27/26, the note indicated staff spoke with Resident 51's wife regarding holding the resident's bed. The wife declined to hold the bed. The record did not contain evidence that written bed hold notice was provided directly to Resident 51 or the resident representative at the time of transfer. During an interview on 7/16/2026 at 10:48 AM with admission Director, AD stated she did not provide written bed-hold notices to residents or their representatives and only contacted families verbally to remind them of the facility's bed-hold policy. During an interview on 7/16/2026 at 11:09 AM with Licensed Vocational Nurse (LVN 1), LVN 1 stated the written notice was included in the transfer documents that accompanied Resident 51 to the hospital. LVN 1 acknowledged the notice was not provided directly to the resident representative. During a concurrent interview and record review on 7/16/26 at 11:30 AM, with the Director of Nursing (DON), the facility's bed hold notice policy was reviewed. The policy directed staff to include the written notice with the resident's transfer documents but did not require the notice to be provided to both the resident and resident representative at the time of transfer. DON acknowledged this practice and stated staff did not routinely provide written notice because they did not know whether the resident would return the same day and some resident representative did not want to pay privately to hold the bed.		

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure specific diagnoses were included in the MDS (Minimum Data Set - a health status screening and assessment tool used for all residents of long term care nursing facilities) assessment for 1 of 12 sampled residents (Resident 22). This oversight resulted in an inaccurate representation of Resident 22's health condition and could potentially introduce risks to the resident's health and safety. During a review of Resident 22's hospital records, prior to admission to this facility, the Emergency Provider Report (emergency room physician documentation that details a patient's urgent medical visit, assessment findings, diagnoses and treatment plan), dated 5/16/26, indicated in part Resident 22's Past Medical History including a diagnosis of Chronic Iatrogenic Constipation (infrequent, hard stools caused by medications or medical treatments). The report also listed Resident 22's Home Medications including Methylnaltrexone Bromide (a medication used to treat chronic constipation caused by narcotic pain medications), and Prucalopride Succinate (a medication used to treat Chronic Idiopathic [of unknown cause] Constipation). During a review of Resident 22's admission Record (AR), dated 7/16/26, the AR indicated in part that Resident 22 is a [AGE] year-old male who was admitted to the facility on [DATE] with admitting diagnoses including gastroesophageal reflux disease (GERD - a chronic digestive condition where stomach acid repeatedly flows back into the esophagus), diverticulitis (a condition when the lining of the large intestine becomes inflamed or infected), and UNSPECIFIED constipation. During a review of Resident 22's Order Summary Report (OSR - list of physician orders), dated 7/16/26, the OSR indicated the medication orders: Methylnaltrexone Bromide, give 450 mg (milligram) by mouth one time a day for blocking opioid (narcotic) effects to reduce constipation and Prucalopride Succinate oral tablet 2 mg, give one (1) tablet by mouth in the morning for chronic idiopathic constipation, give before breakfast. During a review of Resident 22's MDS Assessment, Section I - Active Diagnoses, with an assessment reference date of 5/30/26, the assessment failed to indicate the diagnoses of chronic iatrogenic constipation and chronic idiopathic constipation despite the resident having ongoing treatment for these conditions. A review of the Centers for Medicare and Medicaid Services (CMS - a federal agency within the United States Department of Health and Human Services [DHHS] that actively inspects and reports on every nursing home in the United States) Resident Assessment Instrument (RAI) Version 3.0 Manual, under Section I: Active Diagnoses (Other), Coding Tips indicated, The following indicators may assist assessors in determining whether a diagnosis should be coded as active in the MDS. In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease. ongoing therapy with medications or other interventions to manage a condition that requires monitoring. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition. During a concurrent interview and record review on 7/16/26 at 11:37 a.m., with the Director of Nursing (DON) and MDS Coordinator (MDSC), Resident 22's clinical records were reviewed. DON and MDSC confirmed that a diagnosis of UNSPECIFIED CONSTIPATION was listed in Resident 22's AR, dated 7/16/26. However, a further review of the resident's clinical records, including past hospital records, revealed that the resident is currently prescribed medications indicated for two specific constipation types: chronic iatrogenic and chronic idiopathic. DON and MDSC also acknowledged that these two types were not documented in Resident 22's MDS Assessment, dated 5/30/26. After consulting the CMS RAI Version 3.0 Manual's Section I: Active Diagnoses, DON and (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDSC agreed that these specific constipation types should have been included in the resident's list of active diagnoses list to accurately reflect Resident's 22's current health status.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a comprehensive care plan addressing anticoagulant medication use and the associated risk for bleeding for one of 12 sampled residents (Resident 17). This failure had the potential for staff to be unaware of the interventions necessary to monitor for and reduce the risk of bleeding complications. During a review of the facility's policy and procedure (P&P) titled, Nursing Services - Care Plan, dated 10/24/25, the P&P indicated, The facility shall implement each patient's care plan according to patient needs, physician orders, resident preferences, and facility protocols as indicated. During a review of Resident 17's admission Record (AR), dated 7/15/26, the AR indicated, Resident 17 was admitted to the facility on [DATE] with diagnoses that includes fracture of left femur (a broken left thighbone) and atrial fibrillation (an irregular and often very fast heartbeat). During a review of Resident 17's, Physician Order (PO), dated 6/25/26, the PO indicated Apixaban (blood thinner) Oral tablet 2.5 mg (Milligram). Give 1 tablet by mouth two times a day for deep vein thrombosis prophylaxis (preventing blood clots in the deep veins, usually in the legs). During a concurrent interview and Resident 17's comprehensive care plan on 7/15/26 at 1:17 PM., with the Director of Nursing, showed Resident 17's comprehensive care plan did not address the resident's anticoagulant medication use or the associated risk for bleeding related to apixaban therapy and DON confirmed the care plan.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the care plan on self-administration of medications was updated accordingly based on staff evaluation and resident preferences for 1 of 12 sampled residents (Resident 47). This failure had the potential to negatively affect Resident 47's responsiveness to care and treatment. During a review of Resident 47's admission Record (AR), dated 7/16/26, the AR indicated in part that Resident 47 is a [AGE] year-old female who was initially admitted to the facility on [DATE], with admitting diagnoses including chronic diastolic congestive heart failure (a condition where the heart becomes stiff and can not relax properly between beats), gastroesophageal reflux disease (GERD - a chronic digestive condition where stomach acid repeatedly flows back into the esophagus), and dependence on supplemental oxygen. During a review of Resident 47's Care Plan Reports, the reports indicated a care plan was initiated on 4/21/23 and subsequently revised on 3/7/25, which focused on Resident 22's Right/need/desire to exercise self-determination as evidenced by administering her eye drops, Cepacol lozenges (instant acting sore throat relief), and Tums (a common antacid used to rapidly relieve heart burn, acid indigestion, and sour stomach) tablets on her own and keeping them in her nightstand. She also likes to hold on to her medication by bedside to take at her own time. The care plan has not been updated since 3/7/25. During a review of Resident 47's Medication Administration Record (MAR), for July 2026, the MAR indicated the medication orders, Tums. 500 mg (milligram), give one (1) tablet by mouth as needed for unsupervised self-administration (coded as U-SA) two times a day (order date: 3/15/24) and Cepacol mouth/throat lozenge 15-2.3 mg. give one (1) lozenge by mouth every two hours as needed. unsupervised self-administration, allow lozenge to dissolve slowly in mouth (order date: 4/11/23). Staff continues to document the administration of these medications as U-SA. During a review of Resident 47's Self-Administration of Medications evaluations dated 1/20/26 and 4/21/6 respectively, staff evaluations of Resident 47's ability to self-administer her medications were reviewed. As of 1/20/26, Resident 47's evaluation indicated: Resident has the ability to self-administer meds/treatments. Resident is trainable to self-administer with supervision, and Resident is self-trainable to self-administer independently. As of the most recent evaluation dated 4/21/26, Resident 47 responded NO to the question, Does the resident express an interest in self-administration of medication? During a concurrent interview and record review on 7/15/26 at 3:33 p.m. with the Director of Nursing (DON), Resident 47's clinical record was reviewed. DON verified that Resident 47's most recent self-administration of medication evaluation, dated 4/21/26, clearly documented that Resident 47 declined the opportunity to self-administer her medications. Additionally, DON confirmed and acknowledged that Resident 47's care plan and medication orders pertaining to unsupervised self-administration of medications should have been revised to accurately reflect the resident's current evaluation and expressed preferences. During a review of the facility's policy and procedures (P&P) titled Nursing Services - Care Plan, revised 10/24/25, the P&P indicated in part, The facility shall implement each patient's care plan according to patient's needs, physician orders, resident preferences and facility protocols as indicated.		