STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055342	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THOUSAND OAKS POST ACUTE, LLC	**93 WEST AVENIDA DE LOS ARBOLES 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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician orders [REDACTED]. This facility failure had the potential for Resident 1 to experience disease complications and adverse effects from lack of necesary medication. Findings: According to Potter and Perry's, Fundamentals of Nursing Practice, eighth edition, on page 336, under, Physician order [REDACTED]. During a review of Resident 1's, Medication Administration Records (MARs), dated January 2020 to March 2020, the MARs indicated several days (1/7/20, 1/8/20, 1/20/20-1/22/20, 2/4/20, 2/5/20, 2/14/20, and 3/10/20) when the medication Nuplazid (a medication used to treat/control [MEDICAL CONDITIONS] (a non-motor symptom of [MEDICAL CONDITION] that causes patients to experience hallucinations and/or delusions) was not given by nursing staff. The MARs showed the number nine (9) was entered into the electronic record when the medication was not given. According to the, Chart Codes, of the MAR, the number 9 meant, Other/See Nurse Notes. Upon further record review, the comments made in reference to number 9 were, Not available, Not on hand follow up with pharmacy, or On order. During an interview on 4/9/20, at 9:20 a.m., with the Assistant Director of Nursing (ADON), the ADON agreed that professional standards of practice were not met. The ADON stated, When nursing receives the medication, they are kept in the med-cart, and let's incoming shift know about it .unfortunately, there were a lot of newly hired nurses, and they didn't know where to look .the medications were in the lowest cabinet and the staff didn't know the family was the one supplying the meds. The ADON further stated, There was a failure to follow the doctor's order to give Nuplazid. The ADON confirmed Resident 1 did not get the Nuplazid on 1/7/20, 1/8/20, 1/20/20-1/22/20, 2/4/20, 2/5/20, 2/14/20, and 3/10/20. During a subsequent interview on 4/10/20, at 9:30 a.m., with a Licensed Nurse (LN 1), the LN 1 confirmed there was a failure to follow physician orders [REDACTED]. The LN stated, I'll be honest, I usually don't do medications, as I am usually assigned to do treatments - I didn't know that the meds were at the bottom drawer. The LN 1 confirmed Resident 1 did not recieve the ordered doses of Nuplazid, on 1/7/20, 1/8/20, 1/20/20-1/22/20, 2/4/20, 2/5/20, 2/14/20, and 3/10/20.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.