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 _____	**03/11/2020**

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement fall prevention interventions per facility policy for one resident (Resident 1), after a fall with injury. This failure had the potential to result in Resident 1 sustaining another fall with possible injury. Findings: A review of the facility's policy, titled, Fall Management Program, revised 2/25/18, indicated: The IDT (Interdisciplinary team) will meet within 72 hours of a fall. The IDT will review and document: i: Summary of event following a fall; ii. Root cause analysis; iii. Referrals, as necessary; and iv. Interventions to prevent future falls. A review of the Incident Description for Resident 1, revised 2/3/20 at 7:32 p.m., indicated the resident sustained [REDACTED]. record, on 2/21/20, at 1:43 p.m., the DSD acknowledged Resident 1 fell and broke a bone on 2/2/20, had surgery in the hospital, and then returned to the facility on [DATE]. The DSD acknowledged the IDT first met on 2/13/20, five days after the resident returned to the facility. The DSD acknowledged that the IDT did not meet within 72 hours of the fall, as required by the facility policy. The DSD verbalized the purpose of an IDT meeting was to determine which interventions would be put in place after an incident. The DSD acknowledged there was a five-day gap from when Resident 1 returned to the facility to when recommended fall precautions were put in place. The DSD acknowledged Resident 1 was at higher risk for a fall from [DATE] to 2/13/20. A review of the IDT progress note, dated 2/13/20 at 5:53 p.m., indicated Resident 1's fall was discussed on 2/13/20 and recommendations included a Tab alarm on the bed and wheelchair to alert staff that the resident is trying to get out of bed without assistance, and floor mats on both sides of the bed. The plan also included Bowel and bladder training for 14 days. A review of the physician orders [REDACTED]., indicated nine interventions to be done by staff with the goal of preventing falls for Resident 1. The care plan indicated a start date of 2/13/20.

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