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 _____	**04/03/2020**

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation, interview, and record review, the facility failed to provide a safe and homelike environment for seven of seven sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6 and Resident 7) when: 1. Three cardboard boxes were blocking a closet door preventing Resident 1, Resident 2, Resident 3 and Resident 4, from accessing their personal belongings. 2. Resident 3 and Resident 4's clothes were stored together in a closet with no divider or labeling system with staff unable to determine who the clothes belonged to. 3. No documentation could be provided by the facility indicating Resident 7's personal belongings were inventoried upon admission to the facility. These facility failures resulted in resident's clothes being misplaced and denied four residents access to their personal belongings. Findings: 1. During an observation and concurrent interview on [DATE], at 3:55 p.m., in Residents 1-4 room, three cardboard boxes were stacked on top of each other preventing the closet door from opening. Certified nursing assistant (CNA 1) acknowledged the three cardboard boxes were preventing the closet door from being opened. 2. During an observation and concurrent interview on [DATE], at 3:55 p.m., at the closet shared by Resident 3 and Resident 4, there was no divider or labeling of resident clothing to indicate which clothes belonged to Resident 3 and which clothes belonged to Resident 4. CNA 1 stated that the closet was bad, and Whose clothes are whose? CNA 1 further acknowledged that clothes get mixed up about once a week. 3. During an interview on [DATE], at 3:00 p.m., the social services director (SSD) confirmed there was no inventory for Resident 7 in the resident's chart. The SSD acknowledged that, per facility policy, if a Resident's inventory goes missing, it should be recreated. During an interview on [DATE], at 5:41 p.m., the administrator (Admin 1) explained if a resident's inventory goes missing, the facility needs to start a new one as soon as it is identified missing. Admin 1 verbalized Resident 7's inventory should have been re-made by staff when it could not be located. During a review of the facility's policy and procedure titled Resident Rooms and Environment, dated 10/1/19, indicated in part The physical layout of the facility maximizes resident independence and does not pose a safety risk . Facility staff aim to create a personalized, homelike atmosphere, paying close attention to the following: Cleanliness and order; Private closet space in each resident room. During a review of the facility's policy and procedure titled Residents Rights Personal Property dated7/1/15, indicated in part The resident's personal belongings and clothing are inventoried and documented upon admission.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to maintain a sanitary environment for six of seven sampled residents (Residents 1-6) when clean clothes and supplies were stored with dirty clothes. This failure had the potential to result in the spread of infection from the use of contaminated clothing and supplies. Findings: During an observation and concurrent interview on [DATE], at 3:55 p.m., in the room shared by Resident 1, Resident 2, Resident 3, and Resident 4, certified nursing assistant (CNA 1) acknowledged the rooms closet contained both clean and dirty clothes and it was not clear which clothes were clean and which were dirty. CNA 1 further acknowledged there were packages of clean diapers stored on top of clothes, clean blankets stored with clothes, and a new container of sterile water (used for residents that need to wear humidified oxygen) on top of clothes. CNA 1 acknowledged this was an infection control risk. During an observation and concurrent interview on [DATE], at 4:10 p.m., in the room shared by Resident 5 and Resident 6, CNA 1 acknowledged open boxes of clean gloves were stored alongside dirty clothes and verbalized it was an infection control risk. During an interview on [DATE], at 5:23 p.m., the director of staff development (DSD) verbalized clean incontinence supplies should be stored in the facility's incontinence room, and clean supplies should not be kept in resident rooms unless there is an available, empty closet for them. During an observation and concurrent interview on [DATE] at 5:30 p.m., the DSD agreed that the closet shared by Resident 3 and Resident 4 contained clean clothes and clean supplies stored alongside dirty clothes. A review of the facility's policy, titled, Infection Prevention and Control Program, dated 1/1/17, indicated in part objectives of the facility's infection control policies and procedures included Maintain a safe, sanitary, and comfortable environment.

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.