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 _____	07/16/2020

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 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's Grievance Official failed to take immediate action by not preventing a certified nursing assistant (CNA 1) to care for Resident 1, in effort to prevent further potential violations of resident's right (to be free from abuse) while the alleged abuse violation was being investigated. This failure resulted in Resident 1 experiencing psychological distress when CNA 1 provided care to resident the following nights after the alleged abuse incident. Finding: During an interview with Resident 1 on 6/12/20 at 2:25 p.m., resident was awake and alert to name, date, month, year, birthdate, and knew the name of the United States president. Resident reported a grievance at the facility because several nights ago (6/8/20) three staff (LN 1, LN 2 and CNA 1) came into her room, Ripped the blankets off, inserted a catheter to get a urine specimen. Two of the staff opened her legs, Rough. Resident 1 started screaming for staff to stop. The women indentified as CNA 1 by Resident 1, held her down and told her to be quiet. Resident 1 stated, I felt raped. I'm an old woman and my skin down there (vagina) is very tender. Resident 1 indicated reporting the incident to ensure the staff involved in the incident were not allowed to take care of her again. One of the staff involved in the incident again identified as CNA1 by Resident 1, was assigned to take care of her on the following nights. Resident 1 stated, This was unbelievable she (CNA 1) was still allowed to care for me and allowed into my room after what she did to me .I was nervous, afraid and upset when I saw that woman (CNA 1) again in my room. During an interview with the grievance official (GO), on 6/18/20, at 8:54 a.m., the GO reported completing a resident grievance investigation report for Resident 1, on 6/9/20, at 6:00 p.m. On 6/9/20, at 7:10 p.m., the DON and the GO had interview Resident 1 and were made aware of the alleged abuse incident details. The DON and the GO reviewed the resident's record to find out which staff were involved. On the same evening, the DON spoke over the phone with the LN 1 who disclosed that the LN 2, and CNA 1 both were present during the alleged abuse incident. According to the GO, Resident 1 was, Very nervous, bothered, frantic and felt violated when resident told them her incident story. The DON and the GO met with Resident 1 later that evening to notify resident the staff involved in the incident will no longer be caring of her. The GO confirmed no immediate action had been taken to protect Resident 1, since one of the accused staff (CNA 1) was allowed to care for Resident 1 the following night on 6/9/20, after the alleged abuse incident on 6/8/2020. During an interview with CNA 1, on 6/24/20, at 6:10 p.m., CNA 1 confirmed working and caring for Resident 1 on 6/8/20 and 6/9/20 night shift, from 11 p.m. to 7:30 a.m. A Progress Note, created by licensed nurse (LN 1), dated 6/8/20 at 6:30 a.m., indicated LN 1 performed a catheter procedure on Resident 1with LN 2 and CNA 1 both present. A review of the West Wing Assignment, from 11PM to 7AM, for June 8, 2020 indicated LN 1, LN 2 and CNA 1 were assigned to care for residents in room [ROOM NUMBER] AB, which was Resident 1's room. A review of the West Wing Assignment, from 11PM to 7AM, for June 9, 2020 indicated CNA 1 was assigned again to care for residents in room [ROOM NUMBER] AB, (Resident 1's room). The facility's policy and procedure titled, Grievances and Complaints, dated 4/16/19, indicated in part under, V111 (A) i, Upon receiving a resident grievance/complaint form, the Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to protect one of two sampled residents (Resident 1) from further potential harm, after resident reported an alleged abuse violation while the violation was under investigation, as per their policy and procedure. This failure had the potential for further resident harm. Finding: The facility's policy and procedure titled, Abuse Prevention and Prohibition Program, dated 1/30/20, indicated in part, under V111, (A) The facility protects residents from any harm that could result from abuse investigations. (B) Facility staff members accused of committing abuse against a resident are suspended until the investigation is complete and the findings have been reviewed by the administrator .(i) Staff members alleged to have committed abuse against a resident will not be reinstated to their regular assignment until the abuse investigation is complete. A Progress Note, created by licensed nurse (LN 1), dated 6/8/20 at 6:30 a.m., indicated LN 1 performed a catheter procedure on Resident 1 with both LN 2 and certified nursing assistant (CNA 1) present. A review of the West Wing Assignment, from 11PM to 7AM, for June 8, 2020 indicated LN 1, LN 2 and CNA 1 were assigned to care for residents in room [ROOM NUMBER] AB, which was Resident 1's room. A review of the West Wing Assignment, from 11PM to 7AM, for June 9, 2020 indicated CNA 1 was assigned again to care for residents in room [ROOM NUMBER] AB, (Resident 1's room). A review of the daily timecard punches for LN 1 indicated, LN 1 worked on Sunday 6/7/20 from 11:17 p.m. to 7:54 a.m., Monday 6/8/20 from 11:18 p.m. to 7:20 a.m., Tuesday 6/9/20 from 11:20 p.m. to 7:12 a.m. A review of the daily timecard punches for LN 2 indicated, LN 2 worked on Sunday 6/7/20 from 10:55 p.m. to 8:00 a.m., Monday 6/8/20 from 10:58 p.m. to 8:05 a.m., Tuesday 6/9/20 from 10:58 p.m. to 8:00 a.m. A review of the daily timecard punches for CNA 1 indicated, CNA 1 worked on Sunday 6/7/20 from 11:17 p.m. to 7:47 a.m., Monday 6/8/20 from 11:15 p.m. to 7:40 a.m., Tuesday 6/9/20 from 11:20 p.m. to 7:36 a.m. A review of the Allegation of Abuse Memo, dated 6/12/20, the administrator documented the details of the alleged abuse violation. During an interview with Resident 1, on 6/12/20 at 2:25 p.m., resident was awake and alert to name, date, month, year, birthdate, and knew the name of the United States president. Resident 1 reported several nights ago (6/8/20) three staff members identified as (Licensed nurse L N 1, LN 2 and certified nursing assistant CNA 1) came into her room, Ripped the blankets off, inserted a catheter to get a urine specimen. Two of the staff identified byt Resident 1 as LN 1 and LN 2 opened her legs Rough. Resident 1 started screaming for staff to stop. The woman identified by Resident 1 as CNA 1, held her down and told her to be quiet. Resident 1 stated, I felt raped. I'm an old woman and my skin down there (vagina) is very tender. Resident 1 stated I was nervous, afraid and upset when I saw that woman (CNA 1) again in my room. During an interview with the social services director (SSD), on 6/18/20, at 8:54 a.m., the SSD reported that on 6/9/20 at around 7:10 p.m., the DON and the SSD had interview Resident 1 and were made aware of the alleged abuse incident details. The DON and the SSD reviewed the resident's record to find out which staff were involved. According to the SSD, Resident 1 was, Very nervous, bothered, frantic and felt violated when Resident 1 told them the alleged abuse incident details. The DON and the SSD met with Resident 1, later that evening, to notify resident the staff involved in the incident will no longer be caring for her. The SSD acknowledged the accused staff (LN 1, LN 2 and CNA 1) should have not been assigned to care for Resident 1 until the investigation was complete. During an interview with CNA 1 on 6/24/20 at 6:10 p.m., CNA 1 confirmed working and caring for Resident 1 on 6/8/20 and 6/9/20 evening from 11 p.m. to 7:30 a.m., after the alleged abuse report and while the investigation was in progress. During an interview with licensed nurse LN 1 on 6/17/20 at 10:36 a.m., LN 1 confirmed not being suspended from work after the alleged abuse report and while the investigation was in progress. During an interview with licensed nurse LN 2 on 6/18/20 at 10:36 a.m., LN 2 confirmed

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.

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 _____	**07/16/2020**

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) not being suspended from work after the alleged abuse report and while the investigation was in progress.