STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055563	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Maria Post Acute	820 West Cook Street Santa Maria, CA 93458

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 ensure physician order as reflected in the care plan was followed for one of three sampled residents (Resident 1) when Licensed Nurse (LN1) failed to notify the physician of Resident 1's elevated blood glucose level of 369 mg/dL (milligrams per deciliter; a unit of measurement used to describe the concentration of glucose in the blood) with physician order to notify for blood glucose levels greater than 351 mg/dL. This failure placed Resident 1 at risk for possible effects of high blood glucose level with delayed medical evaluation and treatment. During a review of Resident 1's admission Record (AR), Resident 1 was identified as an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema (diabetes-related eye disease causing swelling that may impair vision), Type 2 diabetes mellitus with diabetic neuropathy (diabetes-related nerve damage), Type 2 diabetes mellitus with diabetic dermatitis (skin complications related to diabetes), Chronic obstructive pulmonary disease (COPD) (a chronic lung disease causing breathing difficulty), and Essential hypertension (high blood pressure). Review of Resident 1's comprehensive care plan revealed interventions related to diabetes management, including monitoring/documentation for signs and symptoms of hyperglycemia, monitoring blood glucose abnormalities, administering diabetic medications as ordered, and monitoring for diabetic complications. Despite the resident's diabetic care plan interventions and the physician order requiring physician notification for blood glucose levels greater than 351 mg/dL, the physician was not notified when Resident 1's blood glucose level reached 369 mg/dL on 4/13/26. During a concurrent interview and record review on 5/1/26 at 9:45 a.m. with Licensed Nurse (LN) 1, review of Resident 1's Medication Administration Record (MAR) dated 4/13/26 revealed a documented blood glucose level of 369 mg/dL during the 9:00 p.m. insulin administration pass. Review of the physician orders dated 4/08/26 at 2:54 p.m. revealed the following physician notification parameter: 351+ = Please notify provider of elevated blood sugars. During a review of the Resident 1's medical record revealed no documented nursing assessment, physician notification, physician response, follow-up intervention, or documented clinical monitoring related to the critically elevated blood glucose level. LN 1 additionally reviewed the facility's secure cell phone communication log and confirmed there was no documented communication from the responsible nurse to the physician regarding Resident 1's blood glucose level of 369 mg/dL. During an interview on 5/1/26 at 12:45 p.m., the Director of Nursing (DON) confirmed that after speaking with the nurse responsible for the MAR entry, the DON confirmed nurse acknowledging she did not notify the physician regarding the elevated blood glucose level despite the physician's order requiring notification. During a review of the facility's policy and procedure titled Change in a Resident's Condition or Status, revised 2021, the policy stated: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical or mental condition and/or status. The policy further stated that nursing staff are responsible for notifying the attending physician or physician on-call regarding changes in the resident's condition requiring physician involvement or intervention. A review of the facility policy titled Goals and Objectives, Care Plans, revised April 2019, revealed that when goals (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	and objectives are not achieved, the resident's clinical record will be documented as to why the resident's goals/objectives and what new goals and objectives/objective have established. The policy further stated that goals and objectives are reviewed and revised when there has been a significant change in the resident's condition and when desired outcomes have not been achieved. Review of [NAME] and [NAME], Fundamentals of Nursing, 7th Edition, page 419, under the section titled Legal Implications in Nursing Practice, indicated that nurses are obligated to carry out physician orders unless the order is believed to be erroneous or harmful to the resident.