STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055733	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valle Verde Health Facility	900 Calle DE Los Amigos Santa Barbara, CA 93105

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview and record review, the facility failed to prevent the development of an unstageable (a severe wound where the true depth and extent of tissue damage cannot be determined because the wound bed is completely obscured by dead tissue) pressure ulcer (localized damage to the skin and underlying soft tissue) in one of three sampled residents (Resident 1). Resident 1 was admitted to the facility with a left ankle-foot orthosis boot (AFO - a medical brace designed to support the ankle) status post-surgery and was found with an unstageable pressure ulcer on the left foot approximately 6 weeks later. This facility failure resulted in Resident 1 experiencing pain in the affected area (left foot) with psychosocial fear of losing a limb secondary to existing medical conditions (type 2 diabetes mellitus [Type 2 DM] - disease requiring daily insulin injections to manage blood sugar levels).During a review of Resident 1's medical records, the admission record (AR), dated 6/30/26, indicated an admission date of 4/27/26, for rehabilitation following a left ankle foot fracture (broken bone) post-surgery. The AR further indicated Resident 1's additional diagnoses included Type 2 DM and diabetic polyneuropathy (nerve damage caused by long-term high blood sugars). During a review of the Hospital Summary (HS), dated 4/27/26, the HS indicated Resident 1 was non-weight bearing (NWB- unable to put weight) on the left foot. The surgical site was intact, had no infection and the left lower foot was wrapped with an ACE bandage (a popular brand of stretchable, elasticized cloth wrap used to provide firm support, compress swollen joints and limit inflammation), with a recommendation to follow up with an orthopedist (a medical doctor who diagnoses, treats injuries, diseases, and conditions affecting bones, joints, ligaments, tendons, and muscles) in one to two weeks. The HS did not reflect any instructions for surgical care of the left foot. During a review of Resident 1's Physician's Orders (PO), dated 4/27/26, the PO indicates an order to monitor heels and coccyx (small, triangular bone at the base of the spine) every shift for seven days and that home medications and transfer orders were reconciled with admitting provider. The physician orders did not reflect any treatment specific to the left foot with the ACE bandage. During review of Resident 1's Nursing admission Assessment (NAA), dated 4/27/26, indicated unable to palpate pedal pulse to LLE (left lower extremity) has soft cast on (a medical support made of flexible fiberglass that provides protection and controlled support). The NAA has no documentation describing Resident 1's left foot surgical incision site and did not mention any treatments. During a review of Resident 1' care plan (CP) for skin integrity, dated 4/27/26, the CP indicated the potential risk for pressure ulcer, skin impairment and complication associated with preexisting skin breakdown related to .decreased mobility, DM2 (type 2 diabetes mellitus), polyneuropathy, and insulin and opioid use. The CP listed numerous interventions including weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (debris that leaks out of blood vessels or organs into nearby tissues, usually in response to inflammation or injury) and any other notable changes or observations if skin changes occur. During further review of Resident 1's medical record, a change of condition (COC), dated 6/11/26, was noted, indicating a pressure ulcer/injury to left heel and the wound was acquired in-house. During review of a wound consult note, dated 6/16/26 (after the COC), the note indicated Resident 1 had a left heel medical device related pressure injury at an unstageable stage, measuring 2.5 cm (centimeters) x 3 cm x UTD (unable to (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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	determine) and 15% (percent) eschar (a layer of dead, hardened tissue that develops over a severe wound). During an interview on 6/29/26 at 12:35 p.m. with Resident 1, Resident 1 stated staff provided poor care and did not remove the AFO to assess the skin since admission date of 4/27/26 to the facility until 6/11/26. Resident 1 stated the AFO was left on for several weeks despite frequently complaining to staff of left foot ankle pain. During the conversation, Resident 1 began to cry and stated having diabetes and being afraid of getting gangrene (death of body tissue caused by a loss of blood supply or a severe bacterial infection) or having a foot amputation for lack of care. During a review of the Minimum Data Set (MDS - a standardized assessment tool used to evaluate a resident's cognitive patterns, physical functioning, and treatments to create individualized care plans), dated 5/19/26, the MDS indicated Resident 1 had a BIMS score (brief interview for mental status - a short, standardized screening tool used to quickly assess a patient's cognitive function with scores ranging from 0 to 15; higher scores indicating better cognitive function) of 15 and had a surgical wound. During a review of undated facility policy and procedure (P&P), titled admission Assessment and Follow Up: Role of the Nurse, dated September 2012, the P&P indicated in part, .7. Conduct an admission assessment (history and physical), including. c. A list of active medical diagnoses and patient problems (such as recurrent falling or impaired mobility), especially those most related to reasons for admission to the facility. d. Current medications and treatments.8. Conduct a physical assessment, including the following systems: j. Skin. 12. Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. During a concurrent interview and record review on 6/29/26 with Registered Nurse (RN 1), RN 1 confirmed performing the NAA and stated Resident 1 was admitted with a surgical wound to left heel with an ACE wrap and an AFO. RN 1 further stated no physician orders regarding left heel treatment and wound consult were obtained during the admission process which is the protocol for residents with wounds or post-surgical incision sites. RN 1 added that weekly skin assessments were performed on Resident 1. During a review of the Weekly Assessments from 4/27/26-6/11/26, there was no indication Resident 1 had skin issues. RN 1 stated Resident 1's skin assessments were performed by having the resident wiggle toes and assessing the skin for redness or warmth around the AFO without removing or unwrapping the ACE bandage or removing the AFO. When RN 1 was asked what prompted the COC on 6/11/26, RN 1 stated Resident 1 was complaining of pain in the left foot and the registry nurse (not employed by the facility) assigned to the resident, removed the AFO and found a pressure wound to the left heel. The registry nurse reported the COC to Resident 1's attending physician. Further review of Resident 1's record lacked evidence that facility staff had obtained a follow-up appointment with an orthopedist, as recommended in the resident's hospital summary (in one to two weeks). There were no orthopedic or wound consult notes from 4/27/26 to 6/11/26. During a review of the facility policy and procedure (P&P), titled Prevention of Pressure Injuries (P&P), dated April 2020, the P&P indicated in part, Risk Assessment l. Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. During a subsequent phone interview with Registered Nurse Supervisor (RNS), RNS stated Resident 1 had been following up with the orthopedist, but the facility did not have any of the orthopedist visit notes. RNS was asked how staff did the skin assessments on Resident 1 without removing the ACE bandage or AFO, but RNS could not give an answer and said, that's a good question. RNS confirmed Resident 1 acquired in-house an unstageable pressure injury from an AFO that was left day and night, the AFO was not removed during daily or weekly skin assessments, and that no physician orders for the AFO and surgical incision care were obtained from 4/27/26 to 6/11/26. Physician orders for the unstageable pressure injury on Resident 1's left foot was obtained after it was discovered on 6/11/26.