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	01/09/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure the POLST (Physician Orders for Life-Sustaining Treatment -a medical document that translates treatment preferences into actionable medical orders) was signed by the Responsible Party (RP- one who has authority to make healthcare decisions) for one of 4 sampled residents (Resident 14).This failure had the potential to result in Resident 14's wishes regarding medical treatment not being followed.Findings:During a review of Resident 14's POLST (Physician Orders for Life-Sustaining Treatment [a medical document that translates treatment preferences into actionable medical orders]), dated 11/10/25, Resident 14 signed the POLST consenting to DNR (Do Not Attempt Resuscitation), Selective Treatment - goal of treating medical conditions while avoiding burdensome measures, Request transfer to hospital only if comfort needs cannot be met in current location, and Trial period of artificial nutrition, including feeding tubes.During a review of Resident 14's H&P (History and Physical) dated 11/11/25, the H&P indicated, The patient's ability to make health decision is absent.During a review of Resident 14's MDS (Minimum Data Set [a mandatory, standardized, comprehensive clinical assessment tool to evaluate residents' health, functional status, and needs, forming the basis for individualized care plans, quality monitoring, and Medicare reimbursement]), dated 11/17/25, Section C - Cognitive Patterns, Resident 14's BIMS score was 2, indicating severe impairment.During record review of Resident 14's medical record containing other consents signed by the RP (daughter), it was noted that the signature of the daughter was different from that of the signature appearing on the POLST form.During record review of the facility Policies and Procedures (P&P) titled, Advance Directives, revised September 2022, indicated, Definitions: e. Health care decision -making capacity - refers to possessing the ability (as defined by State law) to make decision regarding health care and related treatment choice and Decision -Making Capacity: 1. Upon admission the interdisciplinary team assesses the residents decision -making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity.During a concurrent interview and record review on 1/6/26, at 10:08 a.m., with LN 1, LN1 reviewed the POLST, H&P, and the MDS and confirmed it was the resident who signed the form and not the daughter who was the RP.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1.Develop a care plan and interventions for hearing impairment for one of two sampled residents (Resident 8). This failure had the potential for Resident 8's hearing impairment to worsen and thus impact the resident's quality of life.2.Implement care plan interventions for Resident 11 related to access to call light and repositioning in bed. This failure had the potential for Resident 11 not to receive the necessary care needed. 1.During a record review of Resident 8's comprehensive assessment, dated 12/04/25, this indicated Resident 8 was assessed to have hearing impairment.During an observation on 01/07/26 at10:55 a.m. Resident 8 was in the common area near the activity room reading a newspaper with no hearing aids. When greeted, Resident 8 just stared at this surveyor.During an interview on 01/08/26 at 10:45 a.m. with Resident 8's Responsible Party (RP), the RP stated Resident 8 can be moody if not wearing the hearing aids and can result to any communication gap and misunderstanding.During the interview on 01/09/26 at 10:30 a.m. with the Minimum Data Set (MDS) Nurse, MDS Nurse confirmed that on 12/18/25 Resident 8 was assessed to be hard of hearing.During the interview on 01/09/26 at 10:45 a.m. with a Licensed Nurse 4 (LN 4), LN 4 stated that there was no care plan initiated for Resident 8's assessed hearing impairment.During a concurrent interview and record review on 01/09/26 at 10:55 a.m. with the administrator (ADM), ADM reviewed Resident 8's clinical record and confirmed there was no care plan initiated for the identified hearing problem.During a review of facility's policies and procedures (P&P) titled Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required assessment and A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.2. During an observation on 1/6/26, at 10:20 a.m., the following were noted in room [ROOM NUMBER]B, Resident 11's call light was observed hanging on the overhead reading light fixture above Resident 11's head, beyond Resident 11's reach. Resident 11's bed alarm sensor was observed hanging on the right side of the bed below the quarter siderails, and Resident was positioned in an awkward angle. Resident 11 was lying in a supine (facing up) position, with the head of the bed elevated at a 30-degree angle. However, Resident 11's body was twisted to the right side of the bed at approximately a 50-degree angle.During an interview on 1/6/26, at 10:22 AM, in room [ROOM NUMBER] B with LN 1, LN 1 looked at the call lights, bed sensor alarm and Resident 11's position in bed and stated, The call light is not within reach of the resident and the bed alarm sensor is not where it needs to be, the resident also needs to be repositioned properly. During a review of the latest MDS (Minimum Data Set - Assessment tool) Quarterly Assessment, dated 10/17/22, Section C Cognitive Skills for Daily Decision Making indicated Severely impaired-never/rarely made decisions. Section F Functional Limitation in Range of Motion indicated, Upper Extremity Impairment on one side and Lower Extremity Impairment on one side. Section GG Functional Abilities and Goals indicated, Upper Extremity Impairment on one side and Lower Extremity Impairment on one side.During a review of Care Plan interventions, dated 11/26/25, indicated the following, Be sure the resident's call light is within reach . and Keep HOB elevated and promote proper body alignment when positioning .During a review of the facility Policy and Procedure, titled Repositioning revised May 3013, indicated, General Guidelines 3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning.

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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** Number of residents sampled: 4Number of residents cited: 1Based on observation, interview and record review, the facility failed to follow a mechanically altered diet order for one unsampled resident (Resident 53), who had dysphagia (difficulty swallowing), when staff served Resident 53 coffee without thickener.This failure had the potential to cause swallowing discomfort and/or aspiration (the accidental entry of a fluid or food into the airway or lungs) for Resident 53.During a review of Resident 53's clinical record, it indicated that Resident 53 was admitted to the facility on [DATE] with diagnoses that included Bell's Palsy.During an observation on 1/6/26 at 12:18 p.m. in the resident dining room, Resident 53 was served a meal tray by staff. As Resident 53 started eating without assistance, another staff member brought Resident 53 a cup of coffee, from which Resident 53 sipped.During a review of Resident 53's menu and attached strip of paper with diet order found next to meal tray, it indicated that resident 53 was to be served liquids with a Mildly Thick Liquids Level 2 consistency, which was highlighted in bright pink.During concurrent observation and interview on 1/6/25 at 12:20 p.m., CNA1 acknowledged that the coffee was not thickened as CNA1 stirred Resident 53's coffee with a spoon. The coffee appeared to have thin liquid consistency. CNA1 then walked away and returned with a Level 2 gel thickener packet, which was stirred into Resident 53's remaining coffee. During review of Resident 53's clinical record, the physician order dated 12/30/25 indicated .Minced and Moist, Level 5 texture, Mildly Thick - Level 2 consistency, Small sips of thin liquids OK with supervision. Under Section K - Swallowing/Nutritional Status of Resident 53's Minimum Data Set (MDS) completed on 12/23/25, C. Mechanically altered diet - require change in texture of food or liquids was checked as applied for On Admission and While a Resident. During a review of facility's policy and procedure (P&P) titled, #D211, Section: Clinical Nutrition Services, Subject: Thickened Liquids, dated 1/25, P&P indicated, POLICIES: .Liquids will be thickened to the degree specified in the physician or designee's orders. Listed under heading Food and Nutrition Department it states, Liquids that are not commercially thickened will be prepared by personnel per community specific process.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure:1. The Infection Prevention Control and Program (IPCP) standards and policies were reviewed at least annually. This failure had the potential for the facility to implement outdated infection control standards, policies, and protocols that can lead to an ineffective infection control program2. Staff followed manufacturer's instructions on cleaning and disinfecting a blood sugar monitor machine (glucometer). This failure had the potential for cross contamination of blood transmitted infections. During an interview on 01/08/26 at 11:30 a.m. with Infection Preventionist (IP), the IP stated the IPCP policies and procedures are online and that the Interdisciplinary Team (IDT) was responsible for reviewing the IPCP Policies and Procedures (P&P). The IP was unable to provide an answer as to when the policies should be reviewed and the last date it was reviewed. During the interview on 01/08/2026 at 2:43 p.m. with the Director of Nursing (DON), the DON confirmed there was no tracking system to determine when the last infection control policy was reviewed. During the review of facility's P&P titled Infection Prevention and Control Program dated October 2018, the P&P indicated the program is reviewed annually and updated as necessary. 2. During a concurrent observation and interview on 01/07/26 at 10:42 a.m. with a Licensed Nurse (LN 2), LN 2 was observed cleaning a glucometer. LN 2 stated Glucometer is sanitized with bleach, then left to air dry for a couple of minutes. LN 2 was unable to verbalize the correct bleach time to disinfect the glucometer. During the interview on 01/08/26 at 11:25 a.m. with the Infection Preventionist (IP), the IP stated that the dwell time was for 3 minutes for the bleach to be applied/used on the glucometer to disinfect the machine.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on record review and interview, the facility failed to ensure a patient care equipment, a glucometer (a device used for measuring the concentration of glucose in the blood for diabetics), was maintained in a safe operating condition.This failure had the potential to result in false blood sugar readings, compromising the health and well-being of residents.Findings:Based on interview and record review, the facility failed to ensure a glucometer (a device used for measuring the concentration of glucose in the blood for diabetics), was maintained in a safe operating condition.This failure had the potential to result in false blood sugar readings, compromising the health and well-being of residents.Findings:During a concurrent interview and record review on 1/7/26, at 10:01 a.m., a glucometer logbook (logbook where glucometer test check results are listed) for the month of December 2025 was missing glucometer test check result entries from 12/1/25 to 12/17/25. During a concurrent interview and record review on 1/7/26, at 10:01 a.m., with the Infection Preventionist (IP), the IP reviewed the glucometer log and was unable to provide an answer as to why the glucometer was not checked for 17 consecutive days. The IP further stated the glucometer should be checked daily by night shift (11 p.m. - 7 a.m.) but was not.During a review of the facility's competency checklist titled, Regulatory Review and Guidelines for QA/QC Protocols, indicated, Quality Control - on each day of use, two controls (high & normal) should be performed per instrument'.