| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055826 | A. Building<br>B. Wing | 11/19/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Valley Oaks Post Acute | 830 E Chapel St<br>Santa Maria, CA 93454 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>46000<br><br>Based on record review and interview, the facility failed to submit the findings of an alleged abuse investigation to the State Survey Agency (Department) within five working days of the incident.<br><br>This failure had the potential to compromise resident's health and safety, and delay necessary actions to protect residents from abuse.<br><br>Findings:<br><br>Review of a facility report incident (FRI) submitted by the facility to the Department dated 9/30/24, indicated, an alleged abuse incident involving two residents, (Residents 1 and 2) that occurred on 9/29/24 at 5:30 p.m. The FRI indicated, [Resident 2] was yelling because [Resident 1] was in his bed. [Resident 1] kicked at [Resident 2] and made contact with his leg.<br><br>During an interview on 9/30/24 at 3:22 p.m. with the facility's administrator (ADM), the ADM confirmed an alleged abuse incident occurred on 9/29/24. The ADM indicated there would be an investigation into the incident between Residents 1 and 2.<br><br>During an interview on 11/18/24 at 12:10 p.m. with the ADM, the ADM stated the investigation was completed but the results were not submitted to the Department.<br><br>During a review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, revised July 2017, the P&P indicated, The administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46000<br><br>Based on interview and record review, the facility failed to ensure the Minimum Data Set ([MDS] a standardized tool that measures health status in nursing home residents) assessment accurately reflected the residents status for one of three sampled residents (Resident 1).<br><br>This failure resulted in the documentation of inaccurate assessments and had the potential for Resident 1's identified care needs to go unmet.<br><br>Findings:<br><br>Resident 1 was admitted to the facility on [DATE] with diagnoses including, dementia (loss of cognitive functioning; thinking, remembering, and reasoning and interferes with a person's daily life and activities), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), depression (a persistent feeling of sadness and loss of interest in activities) and hypertension (high blood pressure).<br><br>During a review of Resident 1's admission MDS - Section E -Behavior, dated 10/12/22, the MDS indicated, Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) = Behavior of this type occurred 1 to 3 days.<br><br>During a review of Resident 1's Nursing Progress Notes (NPN), dated 9/18/24, the NPN indicated, Change in Condition . Behavioral Status Evaluation: Physical aggression, Verbal aggression, Danger to self or others.<br><br>During a review of Resident 1's NPN dated 9/21/24, the NPN indicated, [Resident 1] became aggressive towards another resident.<br><br>During a review of Resident 1's NPN dated 9/30/24, the NPN indicated, [Resident 1] is on alert charting for kicking another resident in the leg after entering their room.<br><br>During a concurrent interview and record review on 11/19/24 at 11:55 a.m. with the facility's director of nursing (DON), Resident 1's NPN dated 9/18/24 was reviewed. The DON acknowledged Resident 1 exhibited a change in condition and showed aggressive behavior towards other residents in the facility.<br><br>During a review of Resident 1's MDS - Section E -Behavior, dated 10/4/24, the MDS indicated, Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) = Behavior not exhibited.<br><br>During a concurrent interview and record review on 11/19/24 at 12:10 p.m. with the facility's DON, Resident 1's MDS Section E Behavior dated 10/4/24 was reviewed. DON acknowledged Resident 1's MDS assessment and confirmed the assessment dated [DATE] did not accurately reflect the status of Resident 1's aggressive behavior. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46000<br><br>Based on record review and interview, the facility failed to follow their policy and procedure (P&P) to review and revise a person-centered comprehensive care plan for one of three residents (Resident 1) who exhibited aggressive behavior towards other residents.<br><br>This failure resulted in Resident 1 becoming aggressive and kicking another resident (Resident 2) in the leg and had the potential to place other residents at risk for serious injury.<br><br>Findings:<br><br>Resident 1 was admitted to the facility on [DATE] with diagnoses including Dementia (loss of cognitive functioning; thinking, remembering, and reasoning and interferes with a person's daily life and activities), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills), depression (a persistent feeling of sadness and loss of interest in activities) and hypertension (high blood pressure).<br><br>During a review of Resident 1's Nursing Progress Notes (NPN), dated 9/18/24, the NPN indicated, Change in Condition . Physical aggression, Verbal aggression, Danger to self or others.<br><br>During a review of Resident 1's NPN dated 9/21/24, the NPN indicated, [Resident 1] became aggressive towards another resident.<br><br>During a review of Resident 1's NPN dated 9/30/24, the NPN indicated, [Resident 1] is on alert charting for kicking another resident [Resident 2] in the leg after entering their room.<br><br>During a review of Resident 1's Care Plan ([CP] a document that summarizes how a patient's needs will be met, and their care will be managed), dated 10/11/22, the CP indicated, Exhibits behavioral symptoms (verbal, or physical aggressiveness, socially inappropriate, disruption as exhibited by anger towards staff, anger towards family, yelling out, striking out. The care plan further indicated, Revision on: 7/8/24.<br><br>During an interview on 9/30/24 at 3:49 p.m.,with the facility's director of nursing (DON), the DON confirmed Resident 1's care plan was not revised after Resident 1 had a change in status.<br><br>During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last revised March 2022, the P&P indicated, Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. |