STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055826	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Oaks Post Acute	830 E Chapel St 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46884 Based on interview and record review, the facility failed to ensure one of three residents (Resident 1) received quality care when Resident 1 was admitted to the facility with a diagnosis of Type 2 Diabetes ([DM2] a chronic condition when blood sugar levels are persistently high [hyperglycemia]) and continued to have high blood glucose levels. This failure resulted in Resident 1 being transferred to the hospital and had the potential to contribute to the resident's death the following morning. Findings: During a review of Resident 1's Face Sheet, the Face Sheet indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included: DM2 with neuropathy (a type of nerve damage that can occur if you have diabetes), Chronic Obstructive Pulmonary Disease ([COPD] lung disease causing restricted airflow and breathing problems), Pneumonia (an infection of the lungs), atherosclerotic heart disease (a buildup of fats, cholesterol and other substances in the arteries), chronic kidney disease (kidneys are damaged and cannot filter blood as well as they should), congestive heart failure (heart muscle is weakened or damaged and cannot pump blood well), high blood pressure, transient ischemic attack (interruption in blood flow to the brain), and cerebral infarct (stroke-disrupted blood flow to the brain). During a review of Resident 1's documents from the acute hospital located in the facility's medical record for Resident 1 indicated, History & Physical (H&P), dated 12/31/24, the H&P indicated, Resident 1 had an active diagnosis of DM2. Under Additional Current Orders . insulin lispro sliding scale. In addition, under Assessment and Plan . resume lantus (a long-acting insulin used to control high blood sugar) 5 units daily and ssi (sliding scale insulin). Further review of documents from the acute hospital indicated, a physician progress note dated 1/5/25 under Assessment/Plan 3: dm2-continue lantus 5 units daily and ssi. A physician progress note dated 1/6/25, indicated, Resident 1 was on Lantus sliding scale. The medication reconciliation sheet from the acute hospital, dated 1/2/25 indicated, insulin lispro sliding scale. There was no discharge summary from the acute hospital in the facility's medical record for Resident 1. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/27/25 at 12:40 p.m. with the Director of Nursing (DON), Resident 1's Medical Record was reviewed. DON verbalized Resident 1 had a diagnosis of DM2 and was not admitted to the facility with an insulin sliding scale order, but they have a protocol in place to check the sugar and they checked it daily. The admission nurse put the resident on the protocol for finger stick checks. Our facility protocol is to call the doctor if the blood sugar result is over 400 and if it is below 70, we have a hypoglycemia protocol in place and we call the doctor. There were some high blood sugar results like 380 and it was more consistently high. It was 230 at some points and sugar checks are early in the morning at 6:30 a.m. Resident 1 was admitted for respiratory, maybe the flu. During a review of Resident 1's Progress Note, dated 1/14/25, by the Physician Assistant, the Progress Note indicated, This is an [AGE] year-old gentleman with significant past medical history of coronary artery disease with diastolic dysfunction, COPD, and multiple other medical issues who was admitted for shortness of breath. Patient was found to have COPD exacerbation with upper respiratory infection with rhinovirus. Medically, patient was treated and subsequently was sent here for further rehabilitation. The only mention of Resident 1 having DM2 is under the heading Current Medications, Glucose gel. Under Assessment/Plan there is no mention of a plan for Resident 1's DM2. The only mention of Resident 1 having DM2 is under the heading Current Medications, Glucose gel. Under Assessment/Plan there is no mention of a plan for Resident 1's DM2. During a review of Resident 1's Progress Notes, dated 1/15/25, the Progress Note indicated, Dr. (name) was notified at approximately 0550 because the resident ' s finger stick was HI. It was taken twice. Dr. (name) said to give him 10 units of Lispro and recheck in one hour. At approximately 0715 the finger stick was retaken and it still read out HI. Message left with Dr. The AM nurse was told about this resident ' s finger sticks and the insulin was given. She was told that the fingerstick was retaken and it read out HI. There was no order written or signed by the physician for the 10 units of Lispro. There were no further progress notes regarding Resident 1's glucose until 1/17/25. Resident 1's blood glucose level was documented on the MAR on 1/16/25 as 388. During a concurrent interview and record review on 1/27/25 at 1:05 p.m. with Licensed Nurse (LN 1) Resident 1's Medication Administration Record (MAR) was reviewed and indicated, blood sugar checks began on 1/9/25 with a result of 144 fasting. LN 1 further verbalized Resident 1's blood sugar kept getting higher, it was 252 the next day then 385 and the next day 390. Our standard is to notify the doctor if it is above 400. The night shift nurse notified the doctor on 1/15/25 at 5:58 a.m. and the order received from the doctor was to give 10 units of Lispro and check in one hour, then it was checked at 7:15 a.m. and it was reading HI and that was during shift change and Resident 1 was endorsed to the next nurse. LN 1 verbalized there was no further documentation about blood sugars until 1/17/25 when Resident 1's blood sugar had another high result and that is when they sent Resident 1 out. During a review of Resident 1's Health Status Note, created 1/25/25, the Note indicated Late entry, This note is a follow up to: 1/17/2025 06:55 Health Status note. Effective Date 1/18/25 at 01:21. Administered 10 units of Lispro as per order at 0645. Resident is alert and verbally responsive. Rechecked fingerstick at 0720am, result 482mg/dl. Oncoming nurse made aware. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Health Status Note, created 1/26/25, the Note indicated Late entry, This note is a follow up to: 1/17/2025 16:14 Health Status note. Effective Date 1/17/25 at 10:05. 7:30 Pt in bed, arousable. Breakfast being served to the residents. Around 8:15, pt in bed awake and responsive. Fingerstick re checked, high. MD was notified. Aware of the 10 units administered in the morning. MD stated he will do rounds. Around 9, pt awake in bed and stated he did not feel like eating. But routine morning meds given and tolerated well. VS WNL. O2 at 96 via NC. Fingerstick re checked at this time at 398. Around 9:40 MD in the facility was notified of patients events regarding his BS (blood sugar) . During a review of Resident 1's, Order Summary Report, dated 1/17/25, the Order indicated, Insulin Lispro subcutaneous Pen-Injector 200 unit/ml inject as per sliding scale . subcutaneously before meals for Hyperglycemia. Notify MD if BS <70 or >400; Insulin Lispro subcutaneous Pen-Injector 200 unit/ml inject as per sliding scale . subcutaneously at bedtime for Hyperglycemia . During a review of Resident 1's Weights and Vitals Summary (WVS), the WVS indicated, blood sugar results as follows: 1/9/25 - 144 mg/dl (milligrams per deciliter, a unit of measurement) at 6:38 a.m. 1/10/25 - 252 at 6:47 a.m. 1/11/25 - 385 at 6:30 a.m. 1/12/25 - 390 at 6:17 a.m. 1/13/25 - 296 at 6:30 a.m. 1/14/25 - 389 at 6:24 a.m. 1/15/25 - 498 at 6:10 a.m. 1/16/25 - 388 at 5:31 a.m. 1/17/25 - 500 at 6:03 a.m. During a review of American Medical Response (AMR), document, dated 1/17/25 at 9:48 a.m., the AMR indicated, The patient was found laying on his bed at the SNF. He was A/Ox0. Staff said he is normally A/Ox4. They said he wasn ' t acting normal and they checked his BG. They said it read High. I was unable to get a BG, ours read E-S. He was trauma. Skin signs were normal. Lung sounds rhonchi (low pitched rattling sound) No signs of vomiting. He had a clear open airway. Report and transfer care to the RN. During a review of Resident 1's Emergency Department (ED), document, dated 1/17/25, ED indicated, Reason for visit; clinical diagnosis: altered mental status . Medication list, home meds as of 1/17/25 insulin glargine order date 7/22/18, insulin Lispro order date 7/22/18 . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's hospital Discharge Summary, dated 1/18/25, the Discharge Summary indicated, Final diagnoses: 1. Diabetic ketoacidosis with coma. 2. Acute kidney injury related to diabetic ketoacidosis. 3. Ventricular tachycardia (serious heart rhythm disorder with a rapid, irregular heartbeat . Resident 1 (name) is an unfortunate [AGE] year-old man who presented to the ED from the nursing home he was rehabilitating at and was noted to have obtundation. He was sent to the ED and was found to be in diabetic ketoacidosis with his blood glucose at 862. He was with AKI (Acute Kidney Failure) as well with a creatinine of 2.5 and a BUN of 50 . he was extremely dehydrated, somnolent, not really responding to questions appropriately and confused. He was given IV fluid, started on insulin drip and admitted to the ICU. Overnight, the patient ' s blood glucose levels dropped into the 250 range . he had sporadic low blood pressures . later he was noted in the ICU to have persistent bradycardia into the 50's and then at 3:35 he developed ventricular tachycardia and subsequently asystole. Time of death was 3:38 a.m. on 1/18/25. During a review of the facility's policy and procedure (P&P) titled, Nursing care of the older adult with diabetes mellitus, revised November 2020, the P&P indicated, Purpose. To provide an overview of diabetes in the older adult, its symptoms and complications, and the principles of glucose monitoring. For further diabetes education and guidelines, refer to the provider orders and instructions as well as the American Diabetes Association, Standards of Medical Care in Diabetes. Symptoms associated with Diabetes 1) Hyperglycemia. Uncontrolled diabetes from lack of insulin or inadequate insulin results in hyperglycemia (blood sugar above target levels) . 2) Diabetic ketoacidosis (DKA) (diabetic coma). Ketoacidosis occurs when hyperglycemia is untreated and the cells begin to metabolize fat for energy . DKA is a life-threatening emergency that needs immediate medical attention . During a review of the facility's P&P titled, Attending Physician Responsibilities/Documentation, revised August 2014, the P&P indicated, The Attending Physicians shall be the primary practitioners responsible for providing medical services and coordinating the healthcare of each resident in the facility. Each attending physician will be responsible for the following: 1) Accepting responsibility for initial and subsequent resident care; 4) Providing appropriate resident care; 5) Providing appropriate, timely medical orders; Providing appropriate, timely, and pertinent documentation . Accepting Responsibility for Resident Care 1) The Attending Physician will assess new admissions in a timely fashion, according to the individual's medical stability. 2) The Attending Physician will seek, provide, and analyze information regarding a resident ' s current status, recent history, and medications and treatments to enable safe, effective continuing care . 2b) The review should be extensive enough to ensure that the current approach overall is consistent with the individual's medical condition, goals, prognosis, and wishes. Providing Appropriate Care 3) In consultation with facility staff, the Physician will identify appropriate treatments and services, consistent with each individual's diagnoses, condition, prognosis, and wishes .