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	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Oaks Post Acute	830 East Chapel Street 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 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 one of three residents (Resident 1) received treatment for two pressure ulcers. This failure had the potential for the pressure ulcers to become worse and delay healing. Findings: During a review of Resident 1's admission Record (AR), [undated], the AR indicated in part, Resident 1 was admitted to the facility on [DATE] with diagnoses including, pressure ulcer of sacral region (base of the spine) stage 4 (most severe stage of a bedsore that is an open wound with extensive tissue damage that extends to muscle, bone, tendon, or other supporting structures), pressure induced deep tissue damage of left heel (a severe form of pressure ulcer where the injury originates beneath the skin's surface with damage to underlying soft tissue), Type 2 Diabetes Mellitus (the body cannot use insulin [a hormone which regulates the amount of glucose in the blood] correctly and sugar builds up in the blood), chronic kidney disease stage 4 (condition in which kidneys have moderate to severe damage and cannot filter blood as well as they should), acute respiratory failure with hypoxia (lungs cannot adequately oxygenate the blood, resulting in low blood oxygen levels (hypoxemia) without a significant increase in carbon dioxide levels), and bacteremia (presence of bacteria in the bloodstream). During a review of Resident 1's Order Summary Report (OSR), [undated], the OSR indicated in part, an order dated 5/23/25, Left heel dark purple discoloration pressure ulcer: Cleanse with NS. Pat dry. Apply triad cream to wound bed and cover with foam dressing. Change every day shift. An additional order dated 5/23/2025 indicated, Stage 4 pressure ulcer sacro-coccyx: Cleanse with NS. Pat dry. Apply hydrogel to wound bed. Cover with foam dressing. Change every day shift. During a concurrent interview and record review on 7/2/25 at 2:15 p.m. with the director of nurses (DON), Resident 1's Treatment Administration Record (TAR) schedule for May 2025 was reviewed. The TAR indicated, missing entries on 5/23/2025 and 5/24/2025 for Left heel dark purple discoloration pressure ulcer: Cleanse with NS. Pat dry. Apply triad cream to wound bed and cover with foam dressing. Change every day shift. Order Date 5/23/25 1444, and missing entries on 5/23/2025 and 5/24/2025 for Stage 4 pressure ulcer sacro-coccyx: Cleanse with NS. Pat dry. Apply hydrogel to wound bed. Cover with foam dressing. Change every day shift. Order Date 05/23/2025 1444. The DON verbalized blank indicates it wasn't done, and if it was done there should be a checkmark. The DON further stated, This is a new admit and it's the weekend. They should have been started. It's there already and supposed to be done. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, dated April 2018, P&P indicated 2. In addition, the nurse shall describe and document/report the following: (a) Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue .d) Current treatments, including support surfaces . According to Fundamental of Nursing, by [NAME] and [NAME], Eighth Edition, on page 336, under the section, Physicians' Orders indicated, Nurses follow physician orders unless they believe the orders are in error or harm patients.

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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 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** Based on interview and record review, the facility failed to ensure assessments and notifications of change in conditions were completed for one of three sampled residents (Resident 1) when: 1. A change in condition (COC) was not completed for Resident 1's right eye. 2. A post fall risk assessment was not completed. 3. Family was not notified of Resident 1's COCs. 4. Interdisciplinary Team (IDT) meeting was not conducted within 72 hours of Resident 1's COCs. These facility failures resulted Resident 1's medical record not reflecting accurate change in condition and assessment, family not notified of Resident 1's changes in conditions, hospice not notified of Resident 1's fall, delayed interdisciplinary team review of Resident 1's changes in conditions and had the potential for Resident 1 to not receive adequate care to meet Resident 1's highest practicable physical, mental, and psychosocial well-being. Findings: During a review of Resident 1's admission Record (AR), [undated], the AR indicated in part, Resident 1 was admitted to the facility on [DATE] with diagnoses including, pressure ulcer of sacral region (base of the spine) stage 4 (most severe stage of a bedsore that is an open wound with extensive tissue damage that extends to muscle, bone, tendon, or other supporting structures), pressure induced deep tissue damage of left heel (a severe form of pressure ulcer where the injury originates beneath the skin's surface with damage to underlying soft tissue), Type 2 Diabetes Mellitus (the body cannot use insulin [a hormone which regulates the amount of glucose in the blood] correctly and sugar builds up in the blood), chronic kidney disease stage 4 (condition in which kidneys have moderate to severe damage and cannot filter blood as well as they should), acute respiratory failure with hypoxia (lungs cannot adequately oxygenate the blood, resulting in low blood oxygen levels (hypoxemia) without a significant increase in carbon dioxide levels), and bacteremia (presence of bacteria in the bloodstream). 1. During an interview on 7/2/25 at 12:49 p.m., with Licensed Nurse (LN 1), LN 1 stated, I saw (Resident 1) when one eye was blood shot. I think therapy was telling me the resident was nauseous and was trying to throw up and when he looked back up his eye was red, so he was straining too hard. LN 1 further stated, It should be documented because it's a COC. During a concurrent interview and record review on 7/2/25 at 2:09 p.m. with the Director of Nursing (DON), Resident 1's medical record was reviewed. A Situation Background Assessment Recommendation (SBAR) (a document to provide essential, concise information regarding a change in condition) related to a change in Resident 1's right eye was not located in Resident 1's medical record. The DON verbalized there was no COC completed for Resident 1's eye, and there should be one. The DON further verbalized there was a notification on the same day that the doctor and hospice were notified, but there was no actual assessment and there should have been. The DON stated, For the COC it should have been written by the SBAR and there is none. (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 the facility's policy and procedure (P&P) titled, Change in Resident's Condition or Status, dated May 2017, the P&P indicated, 6. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. During a review of the facility's P&P titled, Charting and Documentation, dated 2001, the P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the IDT regarding the resident's condition and response to care .2) The following information is to be documented in the resident medical record .d) Changes in the resident's condition; e) Events, incidents or accidents involving the resident . 2. During an interview on 7/2/25 at 11 a.m. with the Director of Nursing (DON), DON stated Resident 1 fell one time on 5/31/2025 and was found sitting on the floor. During a concurrent interview and record review on 7/2/2025 at 2:09 p.m., with the DON, Resident 1's medical record was reviewed. A post fall assessment was not located in Resident 1's medical record. DON verbalized there's no policy that says you have to do a post fall assessment and further stated, The post fall assessment was not done for this patient, and it's something that should be done. I agree, and if we're doing it, it should be in our policy and procedure and unless I'm missing it, I didn't see any that talked about it . It's part of our orientation and education upon hire. During a review of Nurse Orientation Procedures and Documentation (NOPD), [undated], the NOPD indicated, Falls. 3) Assessment post fall. During a review of the facility's P&P titled, Assessing Falls and their Causes, dated March 2018, the P&P indicated, The purpose of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall . Performing a Post-Fall Evaluation: 1) After a first fall, a nurse and/or physical therapist will watch the resident attempt to rise from a chair without using his or her arms, walk several paces, and return to sitting, and will document the results of this effort . Documentation. When a resident falls, the following information should be recorded in the resident's medical record: 5) Completion of a falls risk assessment. 3. During a concurrent interview and record review on 7/2/25 at 11 a.m., with the DON, the facility's P&P titled, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Change in a Resident's Condition or Status, was reviewed. The P&P indicated, Policy Statement - Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status . Policy Interpretation and Implementation 2. Unless otherwise instructed by the resident, a nurse will notify the resident's represenative when: a. The resident is involved in any accident or incident that results in an injury . b. There is a significant change in the resident's physical . The DON stated Resident 1 fell one time, was found sitting on the floor, didn't complain of any pain. There was an incident after that, (Resident 1) was nauseated 2-3 days after and coughing and (Resident 1's) right eye was blood shot. The doctor was notified and Hospice was aware also. When Resident 1 fell, we notified hospice. Resident 1 fell on 5/31/25. DON stated, I'm not seeing that the family was notified . If a patient is alert and oriented we ask if they want their family notified. I'm not sure if the nurse had the conversation with the patient as to if they want family to be notified and it should have been done. No one other than hospice was notified of the fall. Resident 1 had blood shot eyes, and the hospice was notified. Both responsible parties should have been notified. The nurses note has doctor notified and (Name of Hospice) on 6/3/25. During an interview on 7/2/2025 at 12:49 p.m., with Licensed Nurse (LN 1), LN 1 stated If a patient falls, we notify the provider and family . It is standard practice at the facility to call family if a patient falls. 5. During a concurrent interview and record review on 7/2/225 at 2 p.m., with the DON, Resident 1's Interdisciplinary Team Note, dated 6/20/25 at 05:22 indicated, IDT MET: 06/17/2025 at 2 p.m. Patient had a fall incident on 5/31/25 at 3:45 p.m. MD/RP/(name) Hospice was notified of the incident. Patient also noted with right eye bloodshot (subconjunctival hemorrhage) on 6/3 (6/3/25) . Hospice and MD were notified by LN. Hospice notified RP . (family) from out of the area came to visit patient on 6/16, discussed with (family) the fall incident . Possible cause of red eye discussed with (family) . (family) in agreement with POC at this time. Hospice aware. DON stated, It (IDT meting) should be in 72 hours, so this wasn't done. I will take responsibility of that fall. During a review of the facility's P&P titled, Charting and Documentation, dated 2001, the P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .2) The following information is to be documented in the resident medical record .d) Changes in the resident's condition; e) Events, incidents or accidents involving the resident .