

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055826	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Valley Oaks Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure staff provided resident care and services in accordance with professional standards of nursing practice when physician medication orders and instructions were not followed for three of six sampled residents (Residents 13, 6, and 3). These failures had the potential to result in unsafe nursing care practices which could compromise the health and safety of these residents. Findings: 1. During a review of Resident 13's admission Record (AR), dated 2/11/26, the AR indicated, Resident 13 is an [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses including, Chronic Obstructive Pulmonary Disease (COPD - a common lung disease causing restricted airflow and breathing problems), Paroxysmal Atrial Fibrillation (irregular heart rhythm), presence of a pacemaker (a small, battery-powered device that prevents the heart from beating too slow), and Essential Hypertension [HTN - high blood pressure (BP)]. During a review of Resident 13's Order Audit Report (OAR), dated 2/12/26, the OAR indicated, the medication order, Metoprolol Succinate [a medication that lowers BP and heart rate (HR)] . 25 milligrams (mg) give 0.5 (one-half) tablet by mouth one time a day for HTN Hold if SBP (systolic BP - the top number in a BP reading) less than (<) 110 or HR < 60, with an order date of 8/5/25. During a review of Resident 13's Medication Administration Records (MARs), for the months of November and December 2025 respectively, the staff administration documentation under the medication order, Metoprolol Succinate 25 mg were reviewed. The review indicated that staff failed to follow the medication order instructions when Resident 13 received the medication with SBP readings outside the ordered parameter on these dates: on 11/25/25 with a BP reading of 108/46, and on 12/27/25 with a BP reading of 108/67. During a concurrent interview and record review on 2/11/26 at 3:30 p.m. with the Director of Nursing (DON), Resident 13's MARs, for the months of November and December 2025, specific to staff administration documentation of the medication Metoprolol Succinate 25 mg were reviewed. DON verified the discrepancies found and acknowledged that staff did not follow physician orders and should have. 2. During a review of Resident 6's AR, dated 2/12/26, the AR indicated, Resident 6 is a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses including, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease (a condition where high blood sugar and high BP damage kidney filters), Essential Hypertension (high BP), and encounter for surgical aftercare following surgery of the circulatory system. During a review of Resident 6's OARs, dated 2/12/26, the OARs indicated the following physician orders: Monitor BP: SBP Goals 100-160, If SBP >160, administer Hydralazine (a medication primarily used to treat high BP) [see PRN (as needed)] every six (6) hours. (order date: 11/14/25), Hydralazine HCl Oral Tablet 25 mg . Give one (1) tablet by mouth every six (6) hours as needed for SBP over 160 (order date: 11/14/25), and Hydrocodone-Acetaminophen (a prescription medication used to relieve moderate to severe pain) Oral Tablet 5-325 mg . Give one (1) tablet by mouth every eight (8) hours as needed for severe pain 7-10/10 [a series of numbers used to rate pain intensity categorized as: mild (1-3), moderate (4-6), and severe (7-10)] (order date: 12/10/25). During a review of Resident 6's MAR for the month of November 2025, staff administration documentation for the orders, Monitor BP . and Hydralazine 25 mg ., were reviewed. Discrepancies were noted when Hydralazine 25 mg . was not (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered, as ordered, to manage Resident 6's elevated blood pressures on these specific dates/times: 11/15/25 at 1200, BP = 177/66, on 11/20/25 at 1800, BP = 202/90, and on 11/24/25 at 1800, BP = 176/71. During a review of Resident 6's MAR for the month of January 2026, staff administration documentation for the order, Hydrocodone 5-325 mg . give one tablet by mouth every eight (8) hours . was reviewed. The review indicated that staff did not follow instructions when to administer the medication to Resident 6 based on the resident's reported pain levels. The medication was administered to Resident 6, who reported a pain level of six (6) out of ten (10), on these dates: 1/2/26, 1/9/26, 1/15/26, 1/22/26, 1/23/26, and 1/25/26. During a concurrent interview and record review on 2/11/26 at 3:40 p.m. with the DON, Resident 6's MARs for the months of November 2025 and January 2026, specific to staff administration documentation for the orders, Monitor BP . Hydralazine 25 mg ., and Hydrocodone 5-325 mg were reviewed. DON confirmed the discrepancies found and acknowledged that staff should have thoroughly checked and followed physician orders. 3. During a review of Resident 3's AR, dated 2/12/26, the AR indicated, Resident 3 is a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including nondisplaced fracture of the second metatarsal bone, right foot, (fracture of the right midfoot), Stage 4 pressure ulcer of the right buttock (bed sore extending through the skin into the muscle, tendon or bone), and post-traumatic osteoarthritis (a disease that breaks down one or more joints in the body) of the right ankle and foot. During a review of Resident 3's OAR, dated 2/12/26, the OAR indicated, the medication order Hydrocodone-Acetaminophen Oral Tablet 10-325 mg (Hydrocodone-Acetaminophen) 'Controlled Drug' give one (1) tablet by mouth every four (4) hours for pain 1-6/10 and give one (1) tablet by mouth every eight (8) hours as needed for breakthrough pain related to pressure ulcer right buttock, stage 4 (order date: 10/7/25).During a review of Resident 3's MARs for the months of November and December 2025 respectively, staff administration documentation for the order, Hydrocodone 10-325 mg . give one (1) tablet by mouth every four (4) hours for pain 1-6/10 were reviewed. The review indicated that staff failed to follow specific order instructions and could have potentially undermedicated (given insufficient medication) Resident 3 when the medication was administered at reported pain levels between seven (7) to nine (9) out of ten (10) on these dates: 11/2, 11/3, 11/4, 11/7, 11/8, 11/9, 11/10, 11/16, 11/20, 11/21, 11/22, 11/23, 11/27, 11/28, 12/1, 12/2, 12/8, 12/9, 12/13, 12/14, 12/20, 12/21, 12/22, 12/23, and 12/24/25.During a concurrent interview and record review on 2/11/26 at 3:50 p.m. with the DON, Resident 3's MARs for the months of November and December 2025, under the staff administration documentation for the medication order, Hydrocodone 10-325 mg . give one (1) tablet by mouth every four (4) hours for pain 1-6/10. were reviewed. DON confirmed and acknowledged that staff did not follow the order instructions and should have reassessed Resident 3's pain levels before administering the medication. DON agreed staff not following the order instructions could have potentially resulted in ineffective pain management for Resident 3.During a review of the facility's policy and procedures (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated in part, Policy Statement . Medications are administered in a safe and timely manner and as prescribed. The P&P further indicated, Policy Interpretation and Implementation . 4) Medications are administered in accordance with prescriber orders, including any required time frame . 11) The following information is checked/verified for each resident prior to administering medications: a) Allergies to medications; and b) Vital signs, if necessary.A review of [NAME] and Perry's 7th Edition of Mosby's Fundamentals of Nursing, on page 419 under the section titled Legal Implications in Nursing Practice, it is stated that Nurses are obligated to follow physician orders unless they believe the orders are in error or would harm clients.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interviews, and record reviews, the facility failed to ensure identifiable information was secured and kept confidential when: one resident (Resident 51) patient identification sticker was left unattended on top of the locked medication cart. This failure had the potential to result in unauthorized access to protected health information (PHI) and a violation of the resident's right to privacy and confidentiality. During observation on 2/10/26 at 6:18 a.m. of [NAME] medication cart. One patient identification label on top of medication cart left unattended. During an interview on 2/10/26 at 7:14 a.m. with Charge Nurse. Charge nurse stated patient identification label should not be left unattended on cart. During a review of facility's Policy and Procedure (P&P) titled, HIPPPAA Compliance, dated 9/30/13. P&P indicated the facility will adopt guidelines and procedures that are compliant with the [Omnibus Health Insurance Portability and Accountability Act] HIPPPAA Privacy and Security Rules and other related HIPPPAA rules and the practices established by the rule as well as other applicable federal and state laws. Policies and Procedures and training will include at a minimum: .Access to {Protected Health Information} (PHI)- manual and electronic. During a review of facilities P&P titled, Protected Health Information (PHI), Safeguarding Electronic, dated 2001. P&P indicated This facility ensures the confidentiality, integrity and availability of all e-PHI created, maintained received or transmitted by our information system.		

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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 record review and interview, the facility failed to develop an individualized comprehensive care plans for two of four sampled residents (Residents 9 and 40) when: Resident 9 did not have an initial care plan addressing the use of Trazodone (a medication used to treat anti depressive disorder).Resident 40 did not have a care plan in place for Sacro coccyx pressure injury. These failures had the potential to affect residents' health and safety by not providing staff with appropriate guidance to meet identified needs. Findings: 1. During a review of Resident 9's admission Record (AR) dated 2/11/26, the AR indicated that Resident 9 is a [AGE] year-old male who was initially admitted to the facility on [DATE] with the following diagnoses: Moderate Protein-Calorie Malnutrition (a state of nutritional deficiency characterized by 5-10% weight loss in 6 months, BMI of 17.9-18.9, or 70-80% of ideal body weight); Dementia (progressive decline in cognitive function); Alcohol Dependence (a chronic condition where the body and mind rely on alcohol to function); Anxiety Disorder (persistent, excessive, and uncontrollable fear or worry); and Gastroesophageal Reflux Disease [a condition where stomach acid frequently flows back into the esophagus (the tube connecting the mouth and stomach)]. During a review of Resident 9's Order Summary Report (OSR), dated 2/11/26, the OSR indicated, the medication order Trazodone HCL (medication to treat depression with insomnia) 50 milligrams (mg) give 1 tablet by mouth at bedtime with an order date of 11/30/25. During a review of Resident 9's Care Plan (CP), CP indicated that the CP for Trazodone HCL was initiated on 1/28/26 and revised on 2/11/26. The review indicated that the facility failed to create a CP for Trazadone HCL on 11/30/25. During a concurrent interview and record review on 02/11/2026 at 10:00 a.m. with MDSC, Resident 9's CP indicated that a CP for Trazodone HCL was not initiated on 11/30/25. MDSC acknowledged that the facility should have initiated the CP for Trazodone on 11/30/25 the same date it was ordered. During a concurrent interview and record review on 02/11/2026 at 10:50 a.m. with DON, Resident 9's CP indicated that the CP for Trazodone HCL was not initiated on 11/30/25. DON acknowledged that the facility failed to create CP for Trazodone on 11/30/25 the same date it was ordered. 2. During a review of Resident 40's admission Record (AR), dated 2/11/26, the AR indicated, Resident 40 is an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses to include, Myelodysplastic Syndrome (blood cancer where bone marrow fails to produce sufficient healthy blood cells), Atrial Fibrillation (irregular heart rhythm), Transient Ischemic Attack (temporary blockage of blood flow to the brain), Megaloblastic Anemias (blood disorder). During a review of Resident 40's Progress Notes (PN), dated 2/11/26, the physician's PN indicated that wound number three, a sacrococcyx pressure injury, was unstageable with a date of service of 12/17/25. Subsequently, the wound assessment report dated 12/17/25 confirmed that the sacrococcyx pressure injury was assessed and treated. During a record review of Resident 40, CP indicated that there was no CP for sacrococcyx pressure injury created on 12/17/25. The review indicated that the facility failed to create a CP for the newly noted unstageable sacrococcyx pressure injury. During a concurrent interview and record review on 02/11/2026 4:25 at p.m. with DON, Resident 40's CP indicated that a CP for unstageable sacrococcyx pressure injury was not created on 12/17/25. DON acknowledged that facility failed to create CP for the unstageable sacrococcyx pressure injury on 12/17/25. During a review of the facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person Centered, revised March 2022, the P&P indicated in part, Policy Statement . A Comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P further indicated, Policy Interpretation and Implementation .1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.9. Care plan interventions (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that medications were stored in a sanitary manner and separated from non-medication and food items when: The facility failed to remove two unidentified and unlabeled medication tablets found in one of two medication carts (West Cart). 2. The facility failed to remove two open syringes from medication cart. 3. The facility failed to remove one open containers of pudding from the medication cart. 4. The facility failed to maintain original pharmacy packaging for one resident (Resident 64) when combined two syringes of Enoxaparin (a medication that treats or prevents blood clots) 40 mg (milligram)/0.4 ml (milliliter), expires on 03/2028 in same bag as four syringes of same medication expiring 8/2028. These failures had the potential to compromise resident safety and result in medication errors, cross-contamination, or the administration of adulterated or expired drugs. During an observation on 2/10/26 at 6:10 a.m. of one of two medication carts (West Cart). [NAME] cart observation: 1. Bottom drawer contained two unidentified unlabeled medications 2. Drawer for room [ROOM NUMBER]c drawer with open syringe 3.Top drawer open container of pudding During an observation on 2/10/26 at 6:53 a.m. of one of two medication carts (East Cart). East cart observation: 2. 1 open syringe in medication drawer 4. 2 syringes of Enoxaparin 40 mg/0.4, expires 03/2028 in same bag as 4 syringes of same medication expiring 8/28 2.1 open syringe in medication drawer During interview 2/10/26 at 7:14 a.m. with the Charge nurse. Charge nurse stated the two meds in bottom drawer not suppose to be there, no open syringes or open pudding in drawers and medication should be kept in the original bag for different expiration dates. During a review of facilities P&P titled, Storage of Medications, undated. P&P indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer recommendations or those of the supplier. A. the provider pharmacy dispenses medications in containers that meet legal requirements .Medications are kept in these containers. transfer of medications from one container to another is done only by the pharmacy. During a review of facilities P&P titled, Medication Destruction, undated. P&P indicated A. Tablets, capsules and liquids are disposed of in accordance with the provisions of the MWMA (Medical Waste Management Act). K. All medical waste pharmaceuticals shall be disposed of in accordance with the provisions of the MWMA.		