STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055563	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Maria Post Acute	820 W Cook St Santa Maria, CA 93458

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 46884 Based on interview and record review, the facility failed to ensure one of three residents (Resident 1) Deep Tissue Injury (DTI) did not worsen and the resident did not develop further wounds. This failure resulted in the DTI becoming worse and the development of three additional pressure injuries, an additional hospital stay, and increased pain for Resident 1. Findings: During a review of Resident 1's Admission Record, dated 4/20/24, the Admission Record indicated, Resident 1 had diagnoses including, a pressure induced deep tissue damage (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of right heel, spiral fracture of right tibia (break in bone from a twisting motion), Type II Diabetes (a chronic condition that causes high blood sugar levels in the blood which can delay and/or complicate wound healing), hemiplegia (Total paralysis of one side of the body) following a cerebral infarction (stoke, damage to tissue in the brain) muscle weakness and abnormal gait (walking). During a review of Resident 1 ' s Nursing Admission Summary, dated 4/20/24, the Summary indicated, Resident 1 was discharged last week on 4/13/24. Resident 1 had a brace on her RLE (Right Lower Extremity) due to a fall at home after discharge. Resident 1 also had a Deep Tissue Injury (DTI) on her right heel, measured about 3 cm (centimeter) x 3 cm x 0.5 cm. During a concurrent interview and record review on 8/22/24 at 10:06 a.m. with a Licensed Nurse (LN 1), Resident 1 ' s Nursing Admission Summary, dated 4/20/24 was reviewed. LN 1 stated Resident 1 came in with a fracture of right tibia and had a cast which caused irritation and had a pressure ulcer from the cast located on the heel. The cast was a half cast covering the posterior lower extremity and had a Velcro strap that went over the top of the right foot to secure it and Velcro around the lower right leg. The admission nurse removed the half cast to assess the heel and noticed the DTI. The wound assessment on 5/29/24 indicated wound goes from the heel to right ankle. This was a change. Resident 1 came in with one wound and ended up with an additional three wounds. Wound 1 is the right heel (present during admission), Wound 2 lateral right ankle, Wound 3 posterior right ankle, and Wound 4 medial right ankle. During a review of an email from Central Coast Orthopedics to Dr. (Name of Dr.) dated 5/2/24, the email indicated, Per Dr. (Name of Dr.), okay to modify immobilizer and add padding. If needed call the Orthotist that placed the immobilizer. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Orders, dated 5/11/24, the Orders indicated, RLE (Right Lower Extremity) brace - do not modify or remove until follow-up with orthopedic surgeon. During a review of Resident 1 ' s Wound Consult Progress Notes (Notes), dated 4/23/24 through 5/28/24, the Notes indicated the following: 1) On 4/23/24 Right heel Deep Tissue Injury (DTI) measurements, 3 cm (centimeters) x 4 cm x 0 (Length x Width x Depth). Wound color purple/maroon, 100% epithelialization, and skin intact. 2) On 4/30/24 Right lateral heel is a chronic Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Assessment of the wound was the same as on 4/23/24. Treatment (Tx) for Wound: Cleanse wound with mild soap and water, apply calcium alginate, cover with foam dressing, change dressing every day and as needed. Other: Heel protector. 3) On 5/7/24 Right lateral heel measurements, 5 cm x 4 cm x 0 with 100% epithelialization. A second wound was identified, right ankle DTI, measurements 2.5 cm x 4 cm x 0, persistent non-blanchable, maroon or purple discoloration and a status of Not Healed. No drainage, 100% epithelialization. This came from a pressure placed by an orthopedic device which has now been removed. Will continue to monitor. Wound orders changed. Orders the same for both wounds - Cleanse with NS/water, Apply skin prep M, W, F, cover with foam dressing - pad areas of concern. 4) On 5/14/24 No change in assessments or treatment orders. 5) On 5/21/24 Wounds #1 and #2, no change in assessments or treatment orders. A third wound was identified, medial ankle DTI, measurements 3 cm x 2 cm x 0, persistent non-blanchable, maroon or purple discoloration and a status of Not Healed. No drainage, 100% epithelialization. Continue same tx. as ordered on 5/7/24 for all three wounds. 6) On 5/28/24 A fourth wound was identified, posterior ankle DTI, measurements 2.5 cm x 2 cm x 0. Wounds #1, #2 and #3 remain without change. Continue same wound tx. For all four wounds. During a review of Nurse Progress Notes (NPN), dated, 5/22/24 through 5/29/24, the NPN indicated the following: 1) On 5/22/24, the Resident has been having extensive pain and is non-compliant with positioning . She has a brace to be left on continuously to the right leg, until her next appointment with the surgeon. 2) On 5/23/24, continued increased redness/dark purple to medial/lateral ankle due to pressure from immobilizer brace; skin remains intact; foam cushion padding between skin and immobilizer for pressure reduction. (continued on next page)

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