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	12/03/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48380 Based on observation, interview, and record review, the facility failed to ensure one of two residents (Resident 1) was treated with dignity when the resident's behavior was escalating, and de-escalation techniques were not utilized. This failure had the potential to cause psychosocial harm to Resident 1 Findings: During an observation on 12/2/24 at 12 p.m. with the administrator (ADMIN), in the Admin's office, video footage dated 11/17/24 was observed. The video indicated, Resident 1 was at the nurse's station and a licensed nurse (LN 1) was on the phone behind the station. Resident 1 was cursing and reaching over the station to grab the phone while LN 1 continued to sit at the station. During an interview on 12/2/24 at 11:09 a.m. with licensed nurse (LN 1), LN 1 stated Resident 1 kept asking for medication, by shouting and cursing. LN 1 stated Resident 1's medications were late and was upset the medications were not given at a specific time. LN 1 stated Resident 1 kept coming up to the nurse's station upset, swearing, and cursing and requesting LN 2 who was in another room and continued medication pass while Resident 1 was at the nurses station continuing to esculate. LN 1 stated she called Resident 1's representative to see if she could calm her down, Resident 1 stood yelling at the nurse's station and demanded the phone, reached over the station to grab the phone that LN 1 was on and in the process of pulling her arm back, sustained a skin tear to her left arm. LN 1 denied Resident 1 her requests and did not employ any de-escalation techniques to calm Resident 1. LN 2 continued to give the rest of her assigned residents medications and did not offer Resident 1 her medications sooner causing Resident 1 to wait until last to recieve hers while escalating Resident 1 behaviors further. During an interview on 12/2/24 at 11:19 a.m. with LN 2, LN 2 stated she was Resident 1's primary nurse on 11/26/24 p.m. shift, which was the morning of 11/27/24. LN 2 stated she went into Resident 1's room to give Resident 2's medications and was explaining Resident 2's medications during administration. Resident 1 overheard the discussion and became upset and requested her medications. LN 2 stated to Resident 1 she was helping Resident 2 and told Resident 1 to relax, Resident 1 then called LN 2 a bitch. The activities director came in and tried to redirect Resident 1. LN 1 stated Resident 1 came to the nurse's station and called her a fat pig. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LN 2 stated she gave Resident 2's medications and left the room. Additionally, LN 2 continued medication administrations which escalated Resident 1's behaviors. LN 2 stated Resident 1 would follow her on medication pass to each room until Resident 1 received her medications. LN 2 stated she witnessed an altercation between LN 1 and Resident 1 when LN 1 asked Resident 1 to go back to her room and Resident 1 kept cursing. LN 2 stated LN 1 denied Resident 1 requests or any de-escalation. LN 2 stated she did not provide medications at that moment, the use of the phone or employ and de-escalation techniques other than asking Resident 1 to go back to her room. During an interview on 12/2/24 at 12:45 p.m. with the director of nursing (DON), the DON stated Resident 1 was alert and oriented, difficult to please at times and behaviors on 11/26/24 p.m. DON stated de-escalation techniques should have been utilized by LN 1 and LN 2. The DON stated staff have training in de-escalation training. During a concurrent interview and record review on 12/2/24 at 1:15 p.m. with ADMIN, the facility policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated revised April 2021 was reviewed. The P&P indicated in part . a facility wide commitment to support the following objective . Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. ADMIN stated de-escalation and compassion could have prevented the escalation of Resident 1's behavior on 1/26/24 p.m. shift and staff are trained in de-escalation.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 48380 Based on observation, interview, and record review, the facility failed to ensure a call light was functioning for one of two sampled residents (Resident 2). This failure had the potential to result in Resident 2 not having their needs met and sustain complications. Findings: During a concurrent observation and interview on 12/2/24 at 10:40 a.m. with Resident 2 in Resident 2 ' s room, Resident 2 stated staff did not come when the call light was pushed. Resident 2 pressed the call light and waited five minutes. There was no response, no ringing heard and the light outside of the room above the doorway was not lit. The call bell was observed not plugged into the wall. During a concurrent observation and interview on 12/2/24 at 10:45 a.m. in Resident 2 ' s room, with certified nursing assistant (CNA 1), CNA 1 stated could not hear the call bell ring and the light outside of the room above the doorway was not lit. CNA 1 observed call light plug was not plugged into the wall and stated the call light should always be plugged into the wall. During a concurrent interview and record review on 12/2/24 at 1 p.m. with the administrator (ADMIN), the facility ' s Policy & Procedure (P&P) titled, Answering the Call Light, dated revised September 2022 was reviewed. The P&P indicated in part .Be sure the call light is plugged in and functioning at all times . answer the call light immediately. The ADM stated call lights should always be functioning.