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	01/06/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46884 Based on record review, interview, and observation, the facility failed to ensure adequate supervision for one of three sampled residents (Resident 1), to prevent elopement. The facility identified Resident 1 to be at risk for elopement and implemented a wander guard system (a wander management system that uses wearable bracelets, sensors, and a technology platform to help keep residents safe) but failed to provide adequate supervision and Resident 1 eloped on 12/30/24. Resident 1 was found five blocks away from the facility, unaccompanied. This failure resulted in Resident 1 eloping from the facility without staff knowledge, posing a potential risk for harm. Findings: During a review of Resident 1's Admission Record, undated, the Admission Record indicated, Resident 1 was admitted to the facility on [DATE] with the following diagnoses, Unspecified dementia (loss of brain function), essential hypertension (high blood pressure), age related osteoporosis (bones become weak and fragile), major depressive disorder (low mood, loss of interest or pleasure), need for assistance with personal care, adjustment disorder with mixed disturbance of emotions and conduct (a mental health condition that involves a combination of emotional and behavioral issues), and unspecified fall. During a review of Resident 1's Minimum Data Set (MDS), (a standardized assessment tool that measures health status in nursing home residents) dated 9/13/2024, the MDS indicated, a Brief Interview for Mental Status ([BIMS] a standardized assessment that is used to help identify cognitive patterns of a resident) score of 0 for Resident 1. A BIMS score can range from 0 to 15, severely impaired (0-7 points), moderately impaired (8-12 points), or cognitively intact (13-15 points). During a review of Resident 1's Health and Physical (H&P), dated 9/23/24, the H&P indicated, Resident 1 is unable to care for him/herself, therefore he/she is a long term care resident. During a review of Resident 1's Order Summary Report (OSR), dated 6/26/20, the OSR indicated, a physician's order dated 7/9/20, Placement of wanderguard due to increased confusion, elopement, poor judgment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055563	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/06/2025
NAME OF PROVIDER OR SUPPLIER Santa Maria Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 820 W Cook St Santa Maria, CA 93458	

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F 0689 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, Utilization of Wanderguard system, dated April 2014, the P&P indicated, 2) The Wanderguard bracelet is to be placed on the resident's left wrist unless there exists a medical contraindication or other circumstance requiring an alternate location. In such a case the right wrist or lower extremities may be utilized .5) Door alarm panels are located at the front entrance to the facility and at the entrance from the back patio. These devices shall be tested by the environmental services department weekly to monitor the devices continue to perform appropriately. Necessary repairs shall be completed timely. During a review of WanderGuard BLUE v1.5 User & Deployment Guide (WGBDG) (wanderguard manual), dated March 2022, WGBDG indicated, We recommend that you test the Controller at the door once a day and make sure it locks and issues alarms as expected. Staff should also check the WGB system status lights at least daily to verify that there are no system errors .The WanderGuard BLUE Door Controller will alarm when all the following conditions are met at the same time: 1. The monitored door is opened, or in the case of passageways, motion is detected in the passageway near the WanderGuard BLUE Door Controller. 2. The WanderGuard BLUE Door Controller detects a valid signal from a bracelet that is worn by a monitored resident. During an interview on 1/6/25 at 10:47 a.m. with the administrator (ADMIN), ADMIN stated, (Resident 1) had the wanderguard on. The police found (Resident 1), and I picked the resident up and brought the resident back. ADMIN verbalized ADMIN didn't know if the front door wanderguard alarm sounded when Resident 1 eloped, and it wasn't reported by staff that they heard it. During a concurrent observation and interview on 1/6/2025 at 12:10 p.m. with director of nursing (DON) and ADMIN in the facility's front lobby, the facility's wanderguard door alarm was observed mounted on a wall by the facility's front door inside the facility's lobby. DON assisted Resident 4, in a wheelchair with a wanderguard bracelet located on the wheelchair, past the wanderguard door alarm through the facility's front door to exit the facility. DON assisted Resident 4 outside and back inside the facility's front door, passing by the wanderguard door alarm for a total of 6 times. The wanderguard door alarm sounded 3 out of 6 times. ADMIN stated, It should alarm every time no matter where the wander guard is located, on a wheelchair or on a person. ADMIN verbally agreed the wanderguard door alarm located inside the lobby at the facility's front door did not go off each time Resident 4 was assisted past the alarm with the wanderguard bracelet and further verbalized they can't rely on the alarm if it doesn't go off each time a resident goes out the door. During a concurrent observation and interview on 1/6/25 at 12:21 p.m. with DON in Resident 1's room, DON checked Resident 1's wrist and leg for a wanderguard bracelet. DON verbalized there was no wander guard on Resident 1, and it was only on Resident 1's wheelchair. The wander guard was located on the left backside of Resident 1's wheelchair. During an interview on 1/6/25 at 12:38 p.m. with licensed nurse (LN 1), LN 1 verbalized Resident 1 can get confused. When Resident 1 wheels self out of the room, Resident 1 can be redirected. The day prior to Resident 1's elopement, the resident stated was going to go next door to watch the football game, but LN 1 kept an eye on Resident 1 and could redirect the resident. Resident 1 eloped that night, and stated wanted to go to a basketball game, but it was a football game on that day. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/7/25 at 7:35 a.m. with LN 2, LN 2 verbalized before Resident 1 eloped that evening, at the beginning of LN 2's shift, LN 2 saw Resident 1 in their room, in bed, alert and watching TV. LN 2 verbalized Resident 1 would need help to transfer from the bed to the wheelchair. LN 2 last saw Resident 1 on 12/30/24 at 7:30 p.m., after report and around 8 p.m. A certified nurses asistant (CNA) told LN 2 Resident 1 wasn't in their room. LN 2 contacted police and family about 8:30 p.m. or 8:45 p.m. LN 2 stated, The nurse that I got report from told me that (Resident 1) was trying to go next door to watch a game. During a telephone interview on 1/7/25 at 3:15 p.m. with DON, DON stated the south side nurses check the front door wander guard alarm when they check the residents at night and there is no documentation that the tests have been done. During a telephone interview on 2/3/25 1:03 p.m., with Securitas health technician for wander guard system (TECH), TECH verbalized the wander guard system should alarm every time a resident with a wander guard exits through the door and if it doesn't then there's something wrong and they should call technical support and trouble shoot it. It should alarm every time.