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	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Maria Post Acute	820 West Cook Street 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure that the five day follow-up investigation report regarding two of two residents (Resident 1 and 2) altercation incident was completed and forwarded to the DepartmentThis failure is a violation of reporting requirements.During a record review of facility SOC 341 dated 4/2/26 (Form use to report of suspected dependent adult/elder abuse) indicated that on 4/1/26 the abuse coordinator was made aware of Resident 1 and Resident 2 altercations with no injuries.During a record review of Resident 1's Progress Notes (PN), dated 4/2/26 indicated that an investigation was initiated.On 4/14/26 at 11:58 a.m., 12:32 p.m., 12:45 p.m., and 12:50 p.m., the surveyor requested the complete fiveˆday investigation report related to the incident involving Resident 1 and Resident 2 from the Administrator (ADM). The ADM was unable to provide documentation showing that the investigation had been completed and reported within the required timeframe.During an interview conducted on 4/14/26 at 12:56 PM in the Director of Nursing's (DON) office, with both the ADM and DON present, the ADM confirmed that the investigation related to Resident 1 and Resident 2 had not been completed within the required five working days. The ADM stated, This is on me; I was not able to complete the investigation report until now.During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, the P&P indicated in part Policy Interpretation and Implementation, Follow-Up Report.1) Within five (5) business days of the incident, the administrator will provide a follow up investigation report.

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 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 observation, interview and record review, the facility failed to ensure, the facility's policy and procedures on Substance Use Disorder was implemented for two of two sampled residents (Residents 1 and 2) when the:Nursing Screening Assessment for substance abuse for two sampled residents (Residents 1 and 2) did not reflect the use of tobacco, alcohol, and drug use.Care plan for substance abuse for two of two sampled residents (Resident 1 and 2), did not include approaches, interventions, and addressing risks which could lead to an overdose while in the facility.These failures resulted in Residents 1 and 2 being found unresponsive secondary to drug overdose, requiring emergency medical interventions and hospitalization with potential for harm.Findings During a review of the facility reported incident dated 4/10/26, the report indicated on 4/9/26 at 5:30 p.m., the Certified Nursing Assistant (CNA) went into Resident 1's room and observed the resident to be unresponsive (not reacting to words or touch). The nurse was called to the room and per assessment, resident was with eyes rolled back in head, unresponsive to stimulus but breathing and cyanosis to lips (blueish discoloration due to lack of oxygen). Emergency protocol followed and residents were placed in rescue position (to side to open airway for breathing). 911 was called immediately.Naloxone (medication used to rapidly reverse the effects of Opioid -controlled drug in cases of overdose) was administered, and resident was transferred to the hospital at 5:35 p.m., via 911. Resident 1 was discharged back to the facility at approximately 11p.m., (4/9/26) with diagnosis of Opioid overdose. Resident 1 was interviewed and stated, Was provided a cigarette by roommate while outside and once smoked the cigarette, can't remember anything. During an interview on 4/13/26 at 11:10 a.m. with Licensed Vocational Nurse (LVN 2), LVN2 stated a CNA called out for help to the patient's room. Resident 1 was unresponsive and a nurse started sternal rubs (painful stimuli to the breastbone) and the residents' eyes rolled back. LVN 2 called emergency services. Resident 2, who occupies the same room, was found lethargic (a state of decreased alertness) but verbal (able to respond to words). A second, emergency service was requested. Paramedics arrived, assessed both residents and initiated transfer to the hospital. During an interview on 4/13/26 at 11:19 a.m. with LVN1, LVN1 stated, prior to the incident, Residents 1 and 2 were outside in the front area of the facility in wheelchairs. They both went back to their shared room. During a review of Resident 2's medical record, the Facesheet dated 4/1/26, indicated, an admission date of 4/1/26, and diagnosis including fracture of right femur (a severe injury to the right thighbone) and sternum (a long, flat, [NAME]-shaped bone located in the center of the chest) and history of opioid abuse (the misuse of prescription pain medication), and stimulant abuse (misuse of drugs that increases alertness of mind and body) and homelessness (lack of stable or permanent housing). During a review of the [Hospital Name] Discharge Summary dated 4/1/26, the discharge summary indicated diagnosis of surgical repair of right femur fracture, amphetamine (stimulant drug) and psychostimulant dependance and homelessness. During a review of the Nursing admission Screening/History dated 4/2/26, the section for Social History indicated, an entry of Unable to respond/no response for Tobacco, Alcohol and Drugs use. During a concurrent interview and record review on 4/13/26, at 12:00 p.m. with the DON Resident 2's care plan titled, History of Poly Substance Abuse, in Remission, dated 4/2/26, indicated interventions listed as follows: monitor for withdrawal symptoms (physical -mental symptoms when a person stops using abused substance), notify provider of any concerning symptoms, provide support. Further review of the care plan, no intervention or approaches were noted to address the resident's condition of amphetamine and psychostimulant dependence, nor interventions to prevent or minimize access to amphetamine or psychostimulant drugs. The DON confirmed no interventions to prevent obtaining any form of drugs while on remission, and no behavioral health care needs interventions. During a review of the facility reported incident dated 4/10/26 for Resident 2, the report indicated on 4/9/26 at approximately at 5:30 p.m., staff was assisting Resident 2's [Name] roommate when staff observed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the same symptoms being displayed by Resident 2, which was unresponsive, shallow breathing (short breathing), was not able to track with eyes, eyes were rolling back in head. Oxygen was applied, fire department and medical took over treatment. Resident 1 [Name] was aroused by paramedics and taken to the hospital, for further treatment.On investigation Resident 2 [Name] stated discovering a rice grain [in appearance] in clothes, broke into half and gave half to roommate [Resident 1],consumed half and doesn't remember anything after. During a review of Resident 1's [Hospital Name] Discharge Summary dated 4/7/26, indicated diagnosis of Amphetamines and Psychostimulant dependence uncontrolled Diabetes, Smoker and Homelessness. During a review of Nursing admission Screening/History for Resident 1, dated 4/7/26. admission screening indicated under social history, entry of unable to determine/ no response to tobacco, alcohol and drug use. During a review of the Emergency Department Physician Notes dated 4/9/26, at 6:55 p.m., indicated in part . Patient came secondary to be found unresponsive, patient went outside of care facility to smoke cigarette with one other patient. Patient knew the cigarette was glazed [wet] with Opioid, both people went back to their beds and found unresponsive. Was given Narcan [brand name for Naloxone] via nasal [thru nose] 4 mg. Patient with history of Polysubstance abuse. Diagnosis on discharge was Opioid overdose . During an interview with Resident 1 on 4/13/26, at 10:22 a.m. in residents' room, Resident 1 acknowledged having a current drug issue and explained that the incident happened in parking lot of the facility. The roommate [Resident 2] handed over a cigarette, and Resident 1 smoked about three quarters of the cigarette. Resident 1 stated, It did not have any glazing to indicate drugs in cigarette. Both then went back to the room. Resident 1 stated not feeling ill or heavy headed but just waiting for dinner, I did not feel drugged but later woke up with oxygen mask on. During a review of Resident 1's care plan titled, Care Report dated 4/2/26, included the following in part . History of polysubstance use, in remission, goal- will remain free from withdrawal symptoms during Skilled Nursing Facility (SNF) stay, interventions: monitor for withdrawal signs, notify provider for any concerning symptoms, social services consult for substance abuse and having support, and housing . in part. Further review of the care plan, no intervention or approaches were noted to address the resident's condition of amphetamine and psychostimulant dependence, nor interventions to prevent or minimize access to amphetamine or psychostimulant drugs. During a review of facilities policy and procedure (P&P) titled, Substance Use Disorder(SUD), dated November 2022, the P&P indicated, Residents who are admitted to the facility with substance use disorder (SUD) will receive the necessary behavior health care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being, provided by the facility. 1. Substance Use Disorder (SUD) is defined as recurrent use of alcohol and /or drugs that causes clinically ad functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work. 2. The behavioral health care needs of those with SUD or other serious mental health disorders are evaluated as part of the facility assessment. During the facility assessment the facility determines whether the capacity, services and staff skills are available to meet the needs of those with SUD or other serious mental health disorders. 3. All residents are screened for serious mental health disorders, intellectual disabilities and related condition prior to admission to determine if specialized services under the Preadmission screening and Resident Review (PASSARR) requirements are necessary. 4. The resident's history of substance use disorder and risk for using substances which could lead to an overdose while in the facility are identified to the extent possible and documented in the medical record. During an interview on 4/13/26 at 11:05 a.m. with DON and Administrator (ADM), the DON and ADM stated, the process for going outside the building, for Long term residents, staff know when to send a staff member with them, for short term need, staff or family should be with them. ADM stated No staff was present with both residents at time of incident.