

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

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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 06/30/2026
NAME OF PROVIDER OR SUPPLIER Santa Maria Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 orders to monitor Wander Guard (a wander management device that alarms) for proper placement and functioning for one of three residents (Resident 1) who was identified as an elopement risk. This facility failure compromised Resident 1's elopement prevention plan, placing the resident at an increased risk for unauthorized departure from the facility. Findings: During a review of Resident 1's admission Record (AR), dated 6/23/26, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that includes Schizophrenia (a chronic mental health condition that affects a person's thoughts, feelings, and behaviors), Unspecified Sequelae of Cerebral Infarction (a residual local and systemic damage that persists after tissue dies from a lack of blood flow), muscle weakness (reduced muscle strength), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis or weakness on the right side of the body caused by a stroke). The Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview of Mental Status (BIMS) score of 8 reflecting moderate cognitive impairment with episodes of forgetfulness. During a review of Resident 1's elopement evaluation, dated 12/17/25 indicated Resident 1 had a history of attempting to leave the facility, with expressions of desire to go home and pack belongings, stays by the exit doors and wanders. The evaluation identified a risk for wandering and elopement, with a plan to maintain Resident 1's safety. During a review of Resident 1's Physician's Order (PO) dated 2/14/26, PO indicated check Wander Guard location every shift and function every night shift. A review of Medication Administration Records (MAR), MAR indicated licensed staff failed to document the Wander Guard location on 3/7/26 and failed to document the Wander Guard functioning on 3/7/26 and 3/10/26 night shift. During a concurrent record review and phone interview conducted on 7/7/26 at 11:39 a.m. with Director of Nursing (DON), Resident 1's Medication Administration Record (MAR) dated March 2026 was reviewed. The MAR indicated that on 3/7/26, licensed staff failed to document the location of the Wander Guard. Additionally, on 3/7/26 and 3/10/26, licensed staff failed to document the functioning of the Wander Guard. DON acknowledged the documentation was missing on the identified dates and acknowledged the facility failed to follow the PO to monitor and document the Wander Guard placement and functioning. During a review of facility's policy and procedures (P&P) titled, Utilization of Wanderguard System revision date July 2017, the P&P indicated in part, Policy. Resident assessed as unsafe to exit the facility without supervision and assessed as at risk to do so, shall be monitored by our facility's Wanderguard system. This will assist in maintaining the resident's safety by utilization of the least restrictive means possible. The P&P further indicated, Procedure. 3) Each bracelet will be checked every night for proper function and be recorded in the resident's medication administration record (MAR).		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055563	Facility ID: 055563 If continuation sheet Page 1 of 2

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(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** Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided to prevent elopement for one of three sampled residents (Resident 1) when Resident 1, who was assessed as an elopement risk and provided with a Wander Guard (device that alarms), left the facility unmonitored. This facility failure compromised Resident 1's elopement prevention plan, placing the resident at an increased risk for accidents. Findings: During a review of Resident 1's admission Record (AR), dated 6/23/26, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that includes Schizophrenia (a chronic mental health condition that affects a person's thoughts, feelings, and behaviors), Unspecified Sequelae of Cerebral Infarction (a residual local and systemic damage that persists after tissue dies from a lack of blood flow), muscle weakness (reduced muscle strength), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis or weakness on the right side of the body caused by a stroke). The Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview of Mental Status (BIMS) score of 8 reflecting moderate cognitive impairment with episodes of forgetfulness. Further reviews showed Resident 1 needs supervision with mobility, specifically walking with the use of walkers and uses Wander Guard daily. During a review of Resident 1's elopement evaluation, dated 12/17/25 indicated Resident 1 had a history of attempting to leave the facility, with expressions of desire to go home and pack belongings, stays by the exit doors and wanders. The evaluation identified a risk for wandering and elopement, with a plan to maintain Resident 1's safety. During a review of Resident 1's Progress Notes (PN) dated 2/7/26, 2/13/26, 2/14/26, 2/15/25, 2/24/26 multiple episodes of elopement attempts were documented. Further review of the PN dated 3/8/26 revealed that Resident 1 successfully eloped from the facility and was found seated on a bench at the bus stop outside the facility, unsupervised at approximately 3:00 p.m. During a phone interview conducted on 6/30/26 at 11:07 a.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated was assigned to Resident 1 on 3/8/26. CNA 5 further stated was not aware that Resident 1 had eloped and was found outside the facility. During an interview on 6/30/26 at 11:46 a.m., with Registered Nurse Supervisor (RNS) in the Administrator's (ADM) office, RNS acknowledged that facility failed to keep Resident 1 safe when Resident 1 successfully eloped on 3/8/26. During an interview on 6/30/26 at 12:01 p.m., with Director of Nursing (DON) in the Administrator's office, DON stated that staff are expected to provide monitoring and supervision to Resident 1's assessed needs and elopement risk. DON further stated Wander Guards and door alarms supplement, but do not replace, the need of necessary supervision. DON acknowledged that facility failed to keep Resident 1 safe. During a review of facility's policy and procedures (P&P) titled, Safety and Supervision of Residents revision date July 2017, the P&P indicated in part, Policy Statement. Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P further indicated, Policy Interpretation and Implementation. Facility-Oriented Approach to Safety. 1) Our facility-oriented approach to safety address for groups of residents. Systems Approach to Safety. 1) The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. 2) Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.		