STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055830	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Maria Post Acute	425 East Barcellus Avenue Santa Maria, CA 93454

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 interview and record review, the facility failed to ensure one of one sampled residents (Resident 83) had a qualified licensed nurse perform their initial comprehensive nursing assessment.This failure had the potential for Resident 83 to not have a complete initial comprehensive nursing assessment and not have all their needs met.During a review of Resident 83's admission Record (AR), dated 7/25/25, the AR indicated, Resident 83 was a [AGE] year old, admitted [DATE] with diagnoses including, heart failure (the heart not able to pump enough blood to meet the body's needs), atrial flutter (uncoordinated beating of the heart), diabetes (the body is not able to turn food into energy), and cognitive communication deficit (problems with communication).During a review of Resident 83's Initial admission Record ([IAR] a comprehensive assessment,) dated 4/25/25, the IAR indicated, Neuro/Mental [brain function assessment].EENT [eye, ear, nose, mouth assessment]. Oral Assessment. Cardiovascular System [heart assessment]. Pulmonary System [breathing assessment]. Bowel and Bladder. Gastrointestinal System [digestive system]. Musculoskeletal System [muscle and bone system]. Current Infections. Behavior, were all signed by a LPN [licensed vocational nurse (LVN)]. Review of the California Association of Long-Term Care Medicine (CALTCM) website indicated, The RN is to perform the nursing process, which includes a clinical assessment. Similarly, the LVN has the authority to conduct basic patient assessments. The limitation is that, in California, the LVN is not allowed to conduct comprehensive health assessments.During a review of the facility's policy and procedure (P&P) titled, Admission, dated 2/2023, the P&P indicated, Licensed Nurse Procedure. Do a complete assessment of body systems and complete admission assessment form and nursing notes.During an interview on 7/24/25 at 4:42 p.m. with the Assistant Director of Nursing (ADON), the ADON stated there wasn't any evidence of the RN oversight during the admission assessment and there should have been. During a review of Barclays Official California Code of Regulations website indicated, The licensed vocational nurse performs services requiring technical and manual skills which include. Uses and practices basic assessment (data collection) . Performs basic nursing services.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure one of one sample residents (Resident 83), had a nursing note recorded in their medical record following the completion of the comprehensive assessment on admission to the facility.This failure resulted in an incomplete record of Resident 83's nursing home stay and had the potential to hinder communication among Resident 83's interdisciplinary team ([IDT], a group of healthcare professionals who work together to achieve resident comprehensive goals).During a review of the facility's policy and procedure (P&P) titled, Admission, dated 2/2023, the P&P indicated, Purpose. Obtain information about the resident to establish baseline data for the MDS and provide the basis for interdisciplinary assessment, care planning, and rehabilitation of each Resident. Licensed Nurses Procedure . Do a complete assessment of body systems and complete admission form and nursing notes. During a review of Resident 83's electronic medical record (eMR), no admission nursing note was found. During an on 7/24/25 at 4:42 p.m. with the Assistant Director of Nursing (ADON), the ADON stated he was aware there was no admission nursing note. ADON also stated there should have been one.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 6) had an appropriately sized waste bin for safely discarding used personal protective equipment (PPE), a gown worn over clothing for protecting the wearer from infection.This failure had the potential to result in the increased risk of spreading infection to residents, staff, and visitors.During an observation on 7/23/25 at 2:28 p.m. in Resident 6's room, there was a small, beige, uncovered, waste bin overflowing onto the floor with a discarded yellow PPE gown. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 1/2025, the P&P indicated, The infection prevention and control program is a facility-wide effort involving all disciplines and individuals. The facility will use effective methods for the safe storage, transport and disposal of garbage, refuse and infectious waste.During a concurrent observation and interview on 7/23/25 at 2:30 p.m. with a certified nursing assistant (CNA 1) in Resident 6's room, the waste bin with the discarded yellow PPE gown hanging out it and onto the floor was observed. CNA 1 stated Resident 6 was on enhanced transmission precautions (ETP) wearing of PPE gown and gloves to reduce the spread of multi-drug-resistant germs) and the gown should have been discarded into a larger trash can with a lid. During an interview on 7/23/25 at 2:35 p.m. with the Administrator (ADM), the ADM stated he was aware of the PPE gown hanging out of the waste bin because CNA 1 had informed him. ADM further stated the waste bin should have a lid on it.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to ensure two of two sampled residents (Residents 72 and 49) had a comfortable environment when foul smelling dirty linen was left in the linen cart in the hallway. This failure resulted in an uncomfortable living environment. During a review of the facility's policy and procedure (P&P) titled, Environmental Conditions / Environmental Rounds, dated 1/2025, the P&P indicated, It is the policy of this facility that the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.During an interview on 7/23/25 at 10:15 a.m. with Resident 72, Resident 72 stated the smell out in the hallway gets really bad when staff put dirtied linen in the hamper and leave it there. Resident 72 further stated the staff should at least take it down to the end of the hallway. During a concurrent observation and interview on 7/23/25 at 10:56 a.m. with a licensed nurse (LN 1), LN 1 stated there was a bad smell in the hallway. LN 1 pointed towards the blue linen collection bins, waved her hand and stated, It's probably coming from this area. LN1 confirmed the bad smell was coming from the dirty linen cart. During an interview on 7/23/25 at 11:10 a.m. with the Assistant Administrator (AADM), the AADM stated one of the residents had a bad stomach and the smell was probably from cleaning up the resident. AADM stated the dirty linen cart should have been removed from the resident area. During an interview on 7/24/25 at 9:04 a.m. with Resident 49, Resident 49 stated, The smell in the hallway gets to be too much at times. During a review of the facility's P&P titled, Laundry Services, dated 1/2025, the P&P indicated, Soiled linen should be removed from resident-care areas at least daily and may need to be removed more frequently.