STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555236	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marian Regional Medical Center D/P Snf	1530 East Cypress Way 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure portion of the MDS assessment (MDS - a tool used to assess residents in a nursing home) ccurately reflect the resident's medication status for two 2 of 16 sampled residents (Resident 11 & 39) at the time of the assessment. This facility failure has the potential to result in MDS misinformation which serves as the clinical basis for care planning and care delivery. Findings:1.During a review of Resident 11's clinical record, the History & Physical (H&P), dated 3/18/26, the H&P indicated, Resident 11 had a diagnosis of Hypertension (problems with blood pressure), osteoporosis (weak, brittle bones), depression (mental health condition causing persistent sadness and loss of interest in activities), and was hospitalized after sustaining a fracture of L5 (5th lumbar -back bones) due to a fall. Further review of the H&P indicated, a doctor's instruction to continue Zolpidem (medication given for sleep) 5 mg (milligram - unit of measurement) tab at bedtime.During a review of Resident 11's clinical record, the Physician's Orders (PO) and the Medication Administration Record (MAR), dated 3/26, were reviewed. The PO indicated, Resident 11 was admitted on [DATE], had an order for Zolpidem (medication given for sleep) 5 mg (milligram - unit of measurement) tab (tablet) q HS (bedtime) for insomnia (difficulty falling asleep), and the MAR showed that Resident 11 received the prescribed medication since Resident 11's admission to the facility.During a concurrent interview and record review on 4/15/26 at 10:39 a.m., with the MDS Coordinator (MDSC), Resident 11's section N of the MDS Assessment, Assessment Reference Date (ARD) 3/23/26 and did not show hypnotic medications taken by Resident 11. MDSC confirmed and acknowledged the inaccurate medication assessment. However, MDSC was unable to provide explanation for the inaccurate assessment.During a review of the facility's policies and procedure (P&P) for MDS section N, dated 10/25, the P&P indicated that, N0415 High Risk Drug Classes.Hypnotic: Check if there is an indication noted for all hypnotic medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days.) 2. During a review of Resident 39's clinical record, the PO and the MAR, dated 3/28, were reviewed. The PO indicated, Resident 39 had an order for Sulfamethoxazole-trimethoprim (a type of antibiotic medication) 1 tab PO every 12 hours for UTI (Urinary Tract Infection). The MAR indicated that Resident 39 received the medication as prescribed. During a concurrent interview and record review on 4/15/26 at 12:08 p.m. with the MDSC, Resident 39's MDS Assessment section N Assessment Reference Date (ARD) 3/29/26 and the PO and did not show an antibiotic medication was taken by the Resident 39. MDSC confirmed and acknowledged the inaccurate medication assessment. During a review of the facility's policies and procedure (P&P) for MDS section N, dated 10/25, the P&P indicated that, N0415 High Risk Drug Classes.Antibiotic: Check if an antibiotic medication was taken by the resident at any time during the 7 day look back period (or since admission/entry or reentry if less than 7 days.) During an interview on 4/16/26, at 10:35 a.m. with the Director of Nursing (DON), the DON confirmed and acknowledged the inaccurate MDS assessment for Resident 11 & 39.

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to maintain a medication error rate below 5%. When one of 18 sampled resident (Resident 26), received multiple sets of eye drops without the required time delay between administrations as result staff committed two errors out of 29 opportunities, resulting in a 6.9% error rate. This facility failure has the potential to result in causing patient harm.Finding:During a review of Resident 26's clinical record (CR), the CR indicated that Resident 26 was admitted to the facility on [DATE] with diagnoses that include hypertension (high blood pressure), congestive heart failure (CHF - condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), glaucoma (a group of eye diseases that damage the optic nerve-the cable connecting the eye to the brain-often due to high fluid pressure inside the eye). During an observation on 4/14/26 starting at 9:07 a.m., Licensed Nurse 2 (LN 2) was observed administering three eye drop medications to Resident 26. LN2 administered 1 drop of Brimonidine 2% ophthalmic (a prescription eye drop used to lower high pressure inside the eye that is caused by glaucoma) to Resident 26's left eye at 9:07 a.m., then administered 1 drop of Timolol 0.5% ophthalmic (prescription eye drop used to lower high pressure inside the eye) to Resident 26's left eye at 9:08 a.m., and lastly administered 1 drop of Dorzolamide 2% Ophthalmic (prescription eye drop used to lower high pressure inside the eye) to Resident 26's left eye at 9:08 a.m. All three eye drop medications were administered within a span of less than 2 minutes. During a concurrent interview and record review on 4/15/26 at 1:22 p.m., with the Director of Nursing (DON), the facility's medication guides that are easily accessible to the licensed nurses and integrated into the electronic Medication Administration Record (MAR) were reviewed. The following guides for each eye drop medication indicated: - The medication guide for Timolol ophthalmic, undated, indicated, if patients are using more than 1 ophthalmic formulation concurrently, at least 5 minutes should elapse between administration of the ophthalmic solutions and additional formulation(s) . - The medication guide for Brimonidine ophthalmic, undated, indicated, If more than one topical ophthalmic drug is being used, the products should be administered at least 5 minutes apart. - The medication guide for Dorzolamide ophthalmic, undated, indicated, If more than one topical ophthalmic drug is being used, the drugs should be administered at least 5 minutes apart. The DON confirmed the medication guides indicated the above-mentioned statements. During an interview on 4/16/26 at 11:43 a.m., with the Pharmacist (PHAR), the PHAR stated eye drop medications should be administered 3-5 minutes in between doses to allow the medication to absorb. PHAR explained that the eye can only hold a certain amount of liquid and if too many eye drops are administered in a short amount of time, the medication will roll out of the eye and not be absorbed. PHAR further stated if the eye drops are administered without adequate time sequence between drops, there is risk that the resident does not receive the full dose. PHAR confirmed the medication guides are based off manufacturer's instructions and stated we try out best to follow those guidelines.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medication cart was kept locked if unattended and medications were stored and discarded after after expiration date when:A medication cart was observed to be unlocked and unattended. Povidone-iodine swabsticks (sterile, single-use, 10% solution applicators designed for antiseptic skin preparation, minor wound care) was expired.These failures had the potential to result to unlimited access to the medications and decreased medication mechanisms.1. During a concurrent observation and interview on [DATE] at 10:30 a.m., with the Administrative Support Nurse (ASN), a medication cart in wing 300 parked between room [ROOM NUMBER] and room [ROOM NUMBER] was observed to be unlocked and unattended. The ASN confirmed the medication cart was unlocked and it should be kept locked while unattended. During an interview on [DATE] at 10:34 a.m., with Licensed Nurse (LN) 1, LN1 acknowledged the medication cart was unlocked while unattended and stated it should be locked. During a review of the facility's policy and procedure (P&P) titled Medication Services, dated [DATE], the P&P indicated, Stored drugs are only accessible only to licensed personnel. 2. During a concurrent observation and interview on [DATE] at 10:22 a.m. with ASN in the medication supply room in Wing 100, one box of Povidone-iodine swabstick was observed in one of the cabinets with an expiration date of 02/2026. ASN confirmed the box of Povidone-iodine swab sticks was expired and should have been discarded. During a concurrent observation and interview on [DATE] at 10:59 a.m. with ASN in front of the nurse's station in wing 300, four individual packets of Povidone-iodine swabstick were observed stored in the medication cart. Three of the four packets had expiration dates of 03/2026 and one packet had an expiration date of 02/2026. ASN confirmed all 4 packets are expired and should have been discarded. During a review of the facility's policy and procedure (P&P) titled Medication Services dated [DATE], the P&P indicated, a) Drugs will not be kept in stock after expiration date on the label.