STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055830	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA MARIA POST ACUTE	**425 E BARCELLUS AVE 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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure implementation of the care plan for fall prevention for one of two sampled residents (Resident 2). This facility failure had the potential for Resident 2 to have increased injuries from falls. Findings: The facility policy and procedure titled, Safety Devices (Pressure Pad Alarms for Bed/Wheelchairs), dated 2/02/20, indicated in part, Check and monitor pressure pad alarm for appropriate placement and functioning every shift and replace as needed. The facility policy and procedure titled, Fall Management System, dated 06/2019, indicated in part, It is the policy of this facility to provide each resident with appropriate assessments and interventions to prevent falls and to minimize complications if a fall occurs. During a review of the clinical record for Resident 2 the, Admission record, dated February 26, 2020, indicated Resident 2 had [DIAGNOSES REDACTED]. The, Order summary report, dated February 26, 2020, indicated in part, Pad alarm to bed and wheel chair to alert staff of unassisted transfers every shift. The care plan for falls, dated 11/15/2019, indicated in part, Pad alarm to bed and wheel chair to alert staff of unassisted transfers, check for proper placement and functioning every shift. The, Progress note, dated 2/24/2020 at 18:07, indicated Resident 2, Had a fall, and was, Sent to hospital for evaluation. The, Progress note, dated 2/25/20, indicated at the time of Resident 2's fall the, Pad alarm did not activate and when checked noted pad alarm cord broken. During an interview with a certified nursing assistant (CNA1), on 3/10/20, at 10:40 a.m., the CNA1 acknowledged they did not check pad alarm for appropriate placement and functioning as required in the care plan for Resident 2 and they should have. CNA1 stated, Technically we are suppossed to check it (the pad alarm) every shift. When asked if he had checkec the pad alarm at the start of his shift on 2/24/20 the day Resident 2 fell ? CNA1 stated, No.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.