STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555394	A. BUILDING _____ B. WING _____	**10/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BUENA VISTA CARE CENTER	**160 S PATTERSON AVE SANTA BARBARA, CA 93111**

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 careplans for falls when reviewed reflects the updated interventions for continuity of care by all staff in one of two residents (Resident 1). This failure had the potential for lack of care knowledge by staff on what new interventions to implement in preventing recurring falls on Resident 1. Findings: According to Nursing Fundamentals by Daniels, Grendell and Wilkins, second edition, 2010 p. 322, Documentation is the professional responsibility of all health care practitioners. It provides written evidence of the practitioner's accountability to the client, the institution, the profession, and society. Review of Potter and Perry, 7th Edition, Mosby's Fundamentals of Nursing, page 280 under Standard Nursing Interventions indicated Each plan of care will be totally unique to that client, with interventions individualized on the basis of the client's specific health problems. In the same reference on page 282 under Reviewing and Revising the Existing Nursing Care Plan indicated, An out-of-date or incorrect care plan compromises the quality of nursing care. Review of Potter and Perry, 7th Edition, Mosby's Fundamentals of Nursing, page 243 in the section titled, Data Documentation indicates, Observation and recording of client status is a legal and professional responsibility. The nurse practice acts in all states and the American Nurses Association Nursing's Social Policy Statement (2003) mandate, or require, accurate data collection and recording as independent functions essential to the role of the professional nurse. Review of the clinical record for Resident 1 indicated the resident has dementia with behavioral disturbance (memory loss with changes in behavior),[MEDICAL CONDITION] (surgically redirected passage of bowels to an outside pouch by the abdomen), decline in function, history of falls and a recent [MEDICAL CONDITION] hip. Further review of the clinical record indicated Resident 1 is ambulatory, can sit and stand by self, with confusion and lacks safety awareness. Resident 1 is on a low bed with locked wheels and wears a non skid socks/shoes. The physical therapy plan of care dated 7/22/20 stated the resident had history of falls, with severe confusion and poor safety awareness resulting to falls with current level of substantial /maximal assistance, helper does more than half of the effort. The SBAR (change in condition) report dated 7/26/20 indicated Resident 1 fell on [DATE] and 7/26/20. The fall on 7/26/20 occurred around 11 am with documentation of head involvement. The interventions listed in the SBAR included neurocheck, per protocol, monitor vital signs x 72 hours,monitor and check for pain bruising, changes in mental status, new onset of confusion sleepiness , agitation and inability to hold posture. The SBAR for 7/18/20 and 7/26/20 had documentation the fall careplan were updated and effective. The physical therapy progress notes dated 7/28/20 indicated in part highly recommended to provide the patient with increase safety awareness such as a chair alarm or a sitter to supervise the patient when awake to decrease the risk of falls . Review of Resident 1's careplan at risk for falls does not indicate what interventions were updated on 7/18/20 and 7/28/20 as stated in the SBAR. The physical therapy recommendations dated 7/28/20 were not noted in the careplan. During an interview on 7/29/2020 at 12:45 PM, licensed nurse (LN1) indicated the residents had multiple falls and every time a resident fall, they have to update the care plan. During an interview on 7/29/2020 at 1 PM, the Director of Nursing (DON) was not able to present documentation of careplan updates as mentioned on the SBAR dated 7/18/20 and 7/26/20. The facility policy and procedures titled Fall Management dated [DATE], indicated in part .When responding to a fall . to review, revise, and update care plan accordingly.

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.