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 _____	**09/24/2020**

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 Resident 1 received an assessment before going to a scheduled gastrointestinal (GI) appointment. This failure resulted in Resident 1 having an unassessed change in condition resulting to an emergency room (ER) visit. Findings: During a review of Resident 1's Admission Record, dated 10/28/19, the record indicated a history of [MEDICAL CONDITION] (condition in which the heart does not pump blood well), [MEDICAL CONDITIONS] (an infection caused by [MEDICAL CONDITION] that attacks the liver and leads to inflammation), diabetes (chronic condition that affects the way the body processes blood sugar), and high blood pressure. During an interview on 9/8/20, at 11:30 a.m., with Resident 1, Resident 1 indicated having some kind of bacterial infection and always has nausea, vomiting and diarrhea with abdomen getting big, requiring draining out of fluids and consultation with a gastrointestinal (GI) specialist . When asked about 8/20/20, the day for the resident's GI appointment, Resident 1 indicated not feeling well, having diarrhea and getting too many blood pressure pills as given by facility staff. Resident 1 verbalized, By the time I got to the bus for my ride it hit me fast! During a review of Resident 1's Physician Orders, dated 8/20/20, the orders indicated Resident 1 had a GI consult scheduled at 2:00 p.m. During an interview on 9/10/20 at 11:04 a.m., with licensed nurse (LN 1), LN 1 indicated taking care of Resident 1 before but not on 8/20/20 the day of the GI consult appointment. LN 1 indicated Resident 1 should have a blood pressure checked before medications are given and rechecked again in the afternoon. LN 1 confirmed Resident 1 should have had a head to toe assessment and blood pressure check before going to an appointment, upon return, and documentation of assessment in the progress notes. During a review of Resident 1's Medication Administration Record [REDACTED]. During a review of Resident 1's Comprehensive Care Plan dated 1/10/20, the care plan indicated in part . The resident has [MEDICAL CONDITION] related to [MEDICAL CONDITION] (irregular rapid heart beat that commonly causes poor blood flow) , hypertension (high blood pressure), and lifestyle choices . the goal indicated the resident will be free from signs and symptoms of complications of cardiac problems . the interventions indicated to give all cardiac medications as ordered by the physician .monitor and document side effects .report adverse reactions to the physician .give medication for hypertension and document the response to medication and any side effects . monitor blood pressure and notify physician of any abnormal readings. During a review of Resident 1's Comprehensive Care Plan dated 1/10/20, the care plan indicated in part . The resident has an alteration in hematological (about the blood and blood disorders) status related to [MEDICAL CONDITION] (lack of red blood cells), GI bleed, chronic ascites (excess abdominal fluid related to liver disease) requiring paracentesis (to remove excess fluid from the abdomen) . the goal indicated the resident will remain free of complications related to altered hematological status .the interventions indicated to give medications as ordered monitor for side effects and effectiveness .observe/document/report as needed the following signs and symptoms of [MEDICAL CONDITION]: pallor, fatigue, dizziness, [MEDICAL CONDITION], headache, palpitations, weakness, feeling of cold, low hemoglobin, shortness of breath on exertion, sore tongue, chest pain, tinnitus, headache, changes in mental status. During a review of Resident 1's Nursing Progress Notes, dated 8/20/20, there was no documentation about the response and or effectiveness of the medications that were given that morning per the care plan interventions. During a review of Resident 1's Nursing Progress Notes dated 8/20/20 at 3:08 p.m., the notes indicated the facility got a call from the GI physician's office about Resident 1. Resident 1's blood pressure was 63/49, the heart rate was 79, and the resident was ashen/gray color, pale, dizzy, and vomiting. During a review of Resident 1's Nursing progress notes dated 8/20/20 at 4:39 p.m., the notes indicated Resident 1 had been transferred to the hospital. During a concurrent interview and record review on 9/15/20 at 11:29 a.m., with the director of nursing (DON), Resident 1's Nursing Progress Notes dated 8/20/20 were reviewed. The DON acknowledged there was no documentation of an assessment for Resident 1 before the 2:00 appointment on 8/20/20. The DON acknowledged there were no other vital signs taken for the resident since 8:00 a.m. The DON indicated expecting at least a note when a resident leaves the facility to indicate a state of wellbeing and vital signs are stable. The DON confirmed there should have been an assessment. During an interview on 9/16/20 at 5:15 p.m., with licensed nurse (LN 2), LN 2 verbalized not knowing Resident 1 had an outside appointment on 8/20/20 at 2:00 p.m LN 2 indicated there is poor communication at the facility. LN 2 further indicated if the resident's appointment was known, LN2 would have taken Resident 1's vital signs, documented an assessment, and printed out a resident profile sheet with current medications, to give to the provider. During a review of the facility's undated policy and procedure titled Care Plan, Comprehensive indicated in part . The care plan is directed toward achieving and maintaining optimal status of health, functional ability, and quality of life.

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.