

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055684	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025
NAME OF PROVIDER OR SUPPLIER The Californian		STREET ADDRESS, CITY, STATE, ZIP CODE 2225 DE LA Vina St Santa Barbara, CA 93105	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50707</p> <p>Based on interview and record review, the facility failed to develop a care plan for the use of the anticoagulant medication Apixaban (a medication that helps prevent blood clots) for one of two sampled residents (Resident 39).</p> <p>This failure could result in medication related adverse events and poor management of anticoagulation therapy for Resident 39.</p> <p>Findings:</p> <p>During a review of Resident 39's Admission Record (AR), the AR indicated, Resident 39 was admitted on [DATE] with diagnoses that included congestive heart failure (heart muscle doesn't pump blood as well as it should) and presence of cardiac pacemaker (a device implanted in the body to deliver electrical pulses to your heart).</p> <p>During a concurrent interview and record review on 3/28/25 at 9:36 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 39's electronic clinical record was reviewed. Review of Resident 39's Order Summary Report (OSR), dated 3/2025, the OSR indicated, a physician order for the medication Apixaban oral tablet 5mg (milligrams) two times a day for PPX (prophylaxis) DVT (deep vein thrombosis - a condition where a blood clot forms in a deep vein, typically in the lower legs). Further review of Resident 39's clinical record failed to indicate that a care plan was developed for the resident's use of this medication. The MDSC was unable to locate and produce a documented care plan for the resident's use of the said medication and stated, there is no care plan and there should be.</p> <p>During a review of the facility's policy and procedures (P&P) titled, Care Planning and Care Plans, dated 4/2024, the P&P indicated in part, Guidelines: 3. Patient care plans are to be initiated on admission of a patient and based on the physician's orders and assessments made of the patient . 4. The care plans are to be updated as the resident condition change and as revision is needed.</p>		

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43745</p> <p>Based on observation, interview, and record review, the facility failed to ensure physician orders were followed for two of two unsampled residents (Residents 29 and 14) when:</p> <ol style="list-style-type: none"> 1. Resident 29's apical pulse (AP - heartbeat that is felt or heard at the apex [top] of the heart, located on the left side of the chest) rate was not checked, as ordered, prior to receiving a blood pressure medication. 2. Resident 14's medical record had no documented intervention, as ordered, during two episodes when the resident had alarmingly low blood sugar readings. <p>These failures had the potential to result in Resident 29 and 14 not receiving the appropriate care and services which can affect their health and safety.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 29's, Admission Record (AR), dated 4/28/23, the AR indicated in part, Resident 29 is a [AGE] year-old male who was admitted to the facility on [DATE] with admission diagnoses including essential hypertension (high blood pressure), paroxysmal atrial fibrillation (fluttering of the heart) and peripheral venous insufficiency (a condition where the veins in the legs or arms become damaged, leading to poor blood flow back to the heart). <p>During a medication pass observation on 3/26/25 at 8:40 a.m., with licensed nurse (LN) 1, LN 1 was observed measuring Resident 29's blood pressure and radial pulse rate (heart rate and rhythm felt on the thumb side of the wrist) prior to administering a blood pressure medication. The blood pressure medication blister package read, Propanolol Hydrochloride .10 mg (milligram), give one tablet by mouth two times a day . hold if SBP (systolic blood pressure) < (less than) 110 or AP < 55.</p> <p>During a review of Resident 29's Order Summary (OS), dated 3/26/25, the OS indicated the physician order, Propanolol Hydrochloride oral tablet 10 mg, give one tablet by mouth two times a day .hold if SBP < 110 or AP < 55, dated 2/19/25.</p> <p>During a concurrent interview and record review, on 3/26/25 at 10:10 a.m., with LN 1, Resident 29's OS, dated 3/26/25 was reviewed. LN 1 was informed that the resident's Propanolol . order indicated a parameter to check the AP. LN 1 verified the order and verbalized that she usually checked the radial pulse. LN 1 acknowledged that she should have been measuring Resident 29's AP instead of his radial pulse rates.</p> <ol style="list-style-type: none"> 2. During a review of Resident 14's AR, dated 4/1/22, the AR indicated Resident 14 is an [AGE] year-old female who was admitted to the facility on [DATE] with admission diagnoses including Type 2 Diabetes Mellitus (a chronic disorder characterized by high blood sugar levels), essential hypertension and chronic kidney disease (a condition in which the kidneys gradually lose their function to filter the blood). <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 14's Medication Administration Record (MAR), for the month of March 2025, the MAR indicated the physician order, Novolog Flexpen Insulin (a medication that helps regulate blood sugar levels) .inject as per sliding scale (amount of insulin to be administered based on a person's blood sugar level): if 0 - 70 = 0 unit; if responsive give milk or (OJ) orange juice; if unresponsive, give glucagon (a medication that can treat severe low blood sugar) . The MAR indicated further that on 3/23/25 at 11:30 a.m., Resident 14's blood sugar level was 11, documented by licensed nurse (LN) 2, and on 3/25/25 at 6:30 a.m., the blood sugar level was 60, documented by licensed nurse (LN) 3.</p> <p>During a concurrent interview and record review on 3/26/25 at 10:40 a.m., with the Director of Nursing (DON) and LN 2, Resident 14's medical record was reviewed. DON and LN 2 were informed that a review of Resident 14's MAR, for March 2025, under the medication order Novolog Flexpen Insulin sliding scale ., Resident 14's blood sugar level on 3/23/25 at 11:30 a.m., was 11 as documented by LN 2. A review of Resident 14's, e-MAR Progress Notes, for 3/23/35 failed to indicate documentation of any ordered interventions done to address the low blood sugar level. LN 2 acknowledged the finding but verbalized that the documented result was an error and should have documented the blood sugar level as 118. There was no documentation found in the medical record to correct the error.</p> <p>During a concurrent interview and record review on 3/26/25 at 2:09 p.m., with the DON, DON verbalized speaking to LN 3 regarding Resident 14's low blood sugar level taken on 3/25/25 at 6:30 a.m. LN 3 apparently notified the resident's physician of the low blood sugar reading, and the resident was given orange juice but failed to document the interventions in the resident's medical record. DON acknowledged LN 3 should have documented these interventions.</p> <p>During a review of the facility's policy and procedures (P&P), titled Medication Administration General Guidelines, dated 5/2016, the P&P indicated in part, Medication Administration .1) Medications are administered in accordance with written orders of the prescriber . 2) Obtain and record any vital signs necessary prior to medication administration . The P&P indicated further, Documentation .1) The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given .</p> <p>During a review of the facility's P&P titled, Resident Care Vital Signs, dated 6/2024, the P&P indicated in part, Vital signs upon which the administration of medications or treatments are conditioned shall be performed as required and the results recorded, i.e. digoxin (medication used to treat heart failure) based on apical pulse rate, antihypertensive agents based on blood pressure .</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50707</p> <p>Based on observation, interview, and record review, the facility failed to ensure oxygen tubing for one of two sampled residents (Resident 98) was labeled and dated.</p> <p>This failure had the potential to result in cross-contamination (the transfer of harmful bacteria) for residents in an already compromised condition.</p> <p>Findings:</p> <p>During review of Resident 98's Admission Record (AD), the AD indicated Resident 98 was admitted on [DATE] with diagnoses that included, chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing) and dependence on supplemental oxygen.</p> <p>During a concurrent observation and interview on 3/25/25 at 11:45 a.m., with the Infection Preventionist (IP) in Resident 98's room, Resident 98 was observed wearing a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) connected to an oxygen concentrator (a medical device used to deliver oxygen) without a label on the nasal cannula tubing. IP stated Resident 98's nasal cannula tubing was not labeled or dated and it should be.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled Nasal Cannula, Nebulizer, and Humidifier Change and Usage, dated 2/2024, the P&P indicated, Procedure: 1. Ensure that all nasal cannula/nebulizer tubing are changed /replaced in a timely manner .4. Timely manner means to be changed weekly on Sunday 11-7 shifts. 5. Nasal Cannulas/nebulizer tubings are to be labeled with date of placement as well as patients room number.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43745</p> <p>Based on observation, interview, record review, the facility failed to ensure kitchen and food storage sanitation was maintained when:</p> <ol style="list-style-type: none"> 1. Kitchen staff personal belongings (i.e., jacket and purse) were found inside the dry food storage room. 2. The low-temperature dish machine was operating without proper chemical sanitation. <p>These failures increased the risk of food-borne illnesses to its vulnerable residents as a result of potential food contamination and improperly sanitized dishware.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on [DATE] at 9:34 a.m., inside the facility's dry food storage room, with dietary staff (DS) 1, staff personal belongings including a jacket and a purse, were found inside a bin located in one of the lower storage racks. DS 1 verbalized that staff personal belongings should not be stored in any of the food storage areas. <p>During a review of the facility's policy and procedures (P&P) titled, Section F: Safety and Sanitation .1. Employee Responsibility for Safety, undated, the P&P indicated in part, Procedure .22) Employees are not allowed to bring personal items including but not limited to cell phones, purses, make-up bags, etc., into food service production areas.</p> <ol style="list-style-type: none"> 2. During a concurrent observation and interview on [DATE] at 9:45 a.m., with DS 1, the facility kitchen's low-temperature dish machine was observed during its operation. DS 1 explained that a chemical solution (i. e., chlorine) was used during the dish machine's final rinse phase to ensure the effective sanitation of dishes, cups and eating utensils used by residents. After the dish machine's normal wash and rinse cycle, DS 1 proceeded to check for the chemical solution's concentration on the dishware using a test strip. DS 1 compared the test strip color with the color chart on the test strip container. The result of the color comparison indicated the chemical solution concentration was measured at 10 ppm (parts per million - a unit of measurement that describes the concentration of a substance in a solution or mixture). DS 1 verbalized that the minimum chemical solution concentration should be at 50 ppm. <p>DS 1 ran the dish machine for another wash and rinse cycle to retest the chemical solution's concentration. The test strip result measured the same at 10 ppm. The test strip was verified not to be expired. DS 1 acknowledged that the chemical solution's concentration was low.</p> <p>During an interview on [DATE] at 10:55 a.m., with the facility Administrator (ADM), ADM was informed of the issue with the dish machine. ADM acknowledged the issue with the dish machine.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P titled, Section F: Safety and Sanitation .10. Ware Washing, undated, the P&P indicated in part, Policy .Utensils, dishes, beverage containers, pots and pans, flatware used for the preparation, service or storage of food will be cleaned and sanitized after each use. The P&P indicated further, Procedure .A. Mechanical Washing .Low temp machine XXX,d+[DATE] degrees Fahrenheit (F) with chemical sanitizer . Rinse must provide 50 to 100 ppm hypochlorite (chlorine) on the dish surface. Verify with a test strip prior to washing dishes for each meal.</p>		