STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555023	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Dorinda	300 Hot Springs Rd Santa Barbara, CA 93108

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. 35399 F656 Develop/Implement Comprehensive Care Plan S483.21(b) Comprehensive Care Plans S483.21(b)(1) Based on interview and record review, the facility failed to ensure Resident 1 ' s burn wound care plan included wound measurements and documentation requirements to monitor wound progression towards healing. This failure resulted in resident ' s burn wounds not being measured and documentation performed as required. Finding: During a concurrent review of Resident 1 ' s medical record and interview with the Director of Nursing (DON) on 10/15/24 at 2:00 p.m., the DON reported that on 10/5/24 a License Vocational Nurse (LVN) poured coffee into Resident 1 ' s mug. Resident 1 started sipping the coffee and then accidentally dropped the mug on his lap. Resident 1 sustained a third degree burn on both thighs. The DON reported weekly measurements and documentation of the wounds were performed. The burn wounds were only measured and documented on 10/6/24. The DON confirmed the record does not contain any other measurements and documentation of the resident ' s burn wounds. During a concurrent review of Resident 1 ' s burn wounds care plan and interview with the Assistant Director of Nursing (ADON) on 10/15/24 at 3:35 p.m., the care plan was asked where it indicates when the wounds need to be measured and/or documented weekly. The ADON reviewed the care plan thoroughly and stated I agree, this care plan does not say the wounds need to be measured and documented weekly . A review of the facility policy and procedure titled Documentation of Wounds and Skin Conditions, dated 10/26/23, indicated Resident skin conditions will be accurately assessed, treated, and documented until resolved. 6. Document weekly on the event until resolved.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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. 35399 F658 Services Provided Meet Professional Standards S483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on interview and record review, the facility failed to implement standards of practice when Resident 1 ' s burn wounds were not assessed and documented according to standards of practice and its policy. This failure resulted in resident ' s burn wounds only being assessed and documented only one time. Findings: According to the national institute of health NIH (2023) at https://www.nih.gov. The frequency of burn wound assessments depends on the stage of healing and the patient's needs. Initial assessment: Patients with burns should be seen the day after the injury to assess pain, adjust medication, and check dressing changes. Subsequent assessments: Patients are typically seen weekly until the wound heals. However, if there are concerns about pain control or wound care, the patient may need to be seen daily. A review of the facility policy and procedure titled Documentation of Wounds and Skin Conditions, dated 10/26/23, indicated Resident skin conditions will be accurately assessed, treated, and documented until resolved. 5. Open a Skin Integrity observation as indicated in the electronic health record EHR for each affected area that is expected to take 14 days or longer to resolve. Note: indicate the affected area in the short description. b. Skin integrity- non pressure ulcer for non-pressure skin problems. 6. Document weekly on the event until resolved. During a concurrent review of Resident 1 ' s medical record and interview with the Director of Nursing (DON) on 10/15/24 at 2:00 p.m., the DON reported that on 10/5/24 resident sustained a third degree burn on both thighs. The burn wounds were assessed and documented on 10/6/24. The DON confirmed the record does not contain any other documentation of the resident ' s burn wounds. The DON was asked how the facility assesses, monitors, and documents the progression of the burn wounds. The DON reported weekly documentation of the wounds are performed. The DON further explained their computer software system has an observation template to document and describe a wound initially, then, weekly thereafter or until wound is resolved. A copy of a blank Skin Integrity observation template was provided. Then, DON was asked if there was a completed observation documentation for Resident 1 ' s wounds. DON replied No, this resident does not have one (Skin Integrity observation documentation). No, we did not initiate the weekly observation for this resident and yes, we should have done it. The DON acknowledged Resident 1 ' s wounds will take longer than 14 days to resolve therefore they should have opened and document under the Skin Integrity observation/template documentation.