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	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Dorinda	300 Hot Springs Road 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and procedure and implement interventions of a fall care plan to ensure a bed alarm was turned on for one of three sampled residents (Resident 1) while Resident 1 was in bed.This facility failure resulted in Resident 1 getting out of bed, falling to the floor and sustaining an acute displaced right hip fracture (broken hip bone that moved so much a gap formed around the fracture).During a review of Resident 1's Face sheet, [undated], the Face sheet indicated, Resident 1 was admitted to the facility on [DATE] with the following diagnoses: Alzheimer's disease (brain disorder that causes memory loss, confusion, and other cognitive decline), unspecified dementia (loss of brain function), major depressive disorder (low mood, loss of interest or pleasure), recurrent mild muscle weakness, abnormalities of gait and mobility, essential hypertension (high blood pressure without a known cause), primary open-angle glaucoma (eye disease leading to gradual vision loss), fall on same level, presbycusis left ear (age-related hearing loss), history of falling.During an interview on 10/13/25 at 9:28 a.m. with the Director of Nursing (DON), the DON verbalized Resident 1 had an extended history of falls totaling 32 falls in five months when in assisted living, and has had nine falls since admission to the facility. The DON further verbalized Resident 1 had a witnessed fall on 9/27/25, and after that fall a bed alarm was placed. The DON stated, It was at change of shift. The nurse stated they believed the alarm was on, but the certified nursing assistant (CNA) that was involved couldn't recall if the bed alarm was set to on after changing (Resident 1) in bed. When CNAs change a resident, they turn it (bed alarm) off and whoever's attending to a resident at that moment is responsible for turning it on, and that would be either the CNA or the licensed nurse.During an interview on 10/13/25 at 10:50 a.m. with a Licensed Nurse (LN 1), LN 1 stated because (Resident 1) is falling, the resident has alarms. LN 1 further stated when you put the bed alarm on, it beeps and you can see with the light on the side of the bed that it's on, and the bed alarm needs to be turned on when you leave the resident.During an interview on 10/13/25 at 11:25 a.m. with the Assistant Director of Nursing (ADON), the ADON stated (Resident 1) is a fall risk and probably has fallen in the past and that's why we have alarms on. ADON verbalized was working when Resident 1 had the fall, name (LN 2) was the nurse on duty who did the assessment, and the fall was reported to me. ADON stated, I went in, and the resident was in bed, and we continued to assess him, and LN 2 communicated with the doctor about what happened and what symptoms he was showing. The doctor ordered a mobile x-ray. ADON verbalized then the resident started to grimace more, and didn't look like he was able to get comfortable. It was best to send him out for an evaluation. The ADON further stated, CNAs should be visually checking the alarms to make sure they are on if the resident is in bed or the tab alarm is on if they are in a chair, and it's CNAs and nurses who make sure alarms are on.During a concurrent interview and record review on 10/13/25 at 11:43 a.m. with the DON, Resident 1's Point of Care History, dated 9/28/25 was reviewed. The Point of Care History indicated, activate bed alarm when in bed and Tab alarm when in wheelchair for poor safety awareness [every shift] 9/28/25 5:21AM Done. 9/28/25 2:39PM Done. The DON verbalized the evening shift wasn't done because Resident 1 was sent out to the hospital about 3:40 p.m., and there's nothing to print. When asked if the checks for Resident 1's bed alarm were done on 9/28/2025 after the change of shift for the evening shift, the DON stated, No. The evening shift did not check that the bed alarm was on.It should be checked at the beginning of the shift and it wasn't.During an interview on 10/13/25 at 11:52 a.m. with a Certified Nursing Assistant (CNA1), CNA 1 stated, I was working on the day (Resident 1) fell. My shift ends at 3:30 p.m.That day when the resident fell, I can't remember if I set up the bed alarm or not .Me and the nurse were cleaning (Resident 1) in the bed .I can't remember if I set up the alarm .if we don't turn off the alarm it would be beeping because (the resident) moves back and forth, and when we were finished, I can't remember if we put the bed alarm back on or not .Every time we put the resident in bed, we have to turn the alarm on - whatever it is, the bed or floor alarm and if they are in the wheelchair.the bed alarm should have been turned back on. When asked when CNA 1 checks that residents' alarms are on, CNA 1 stated in the morning at start of the shift and when the resident is moved.During a concurrent interview and record review on 10/13/25 at 1:05 p.m. with the DON, the facility's Policy and Procedure (P&P) titled, Use of Resident Alarm devices, dated 12/19/24 was reviewed. The P&P indicated, To establish a consistent, safe, and person-centered approach to the use of resident alarm devices (tab alarms, chair/bed pad alarms, floor mat alarms, and siderail bed alarms) as part of individualized fall prevention strategies, while promoting resident