

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2024
NAME OF PROVIDER OR SUPPLIER  Buena Vista Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40560</p> <p>Based on record review and interview, the facility failed to assist one of two sampled residents (Resident 1) in making an outside appointment, per a prescriber's order.</p> <p>This facility failure had the potential to result in a delay of care for Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record undated, indicated in part, Resident 1 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>During a review of Resident 1's Order Summary Report undated, indicated in part, an order dated 11/1/23, for Cataract (a medical condition which can cause blurry vision) evaluation by to [outside facility name] Ophthalmology clinic.</p> <p>During an interview on 4/15/24, starting at 3:48 p.m., with the Administrator (Admin 1), the Admin 1 confirmed the facility could not provide documentation indicating facility staff had attempted to make Resident 1's cataract evaluation/ophthalmology appointment prior to Resident 1 being discharged from the facility.</p> <p>During a review of the Job Description/Performance Evaluation form, for the job position of Social Services Assistant, dated 11/13/17, indicated in part, Key/ Essential Duties . Coordinates and sets up appointments including Dental, Podiatrist, Ophthalmologist, Psychiatrist.</p> <p>During a review of the facility's policy and procedure titled Resident Rights dated 10/22, indicated in part, The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.</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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