

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  10/03/2025
NAME OF PROVIDER OR SUPPLIER  Buena Vista Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  160 South Patterson Avenue 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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided to prevent elopement for one of three sampled residents (Resident 1) when Resident 1, who was assessed as an elopement risk and provided with a Wander Guard (device that alarms), left the facility unmonitored. This failure placed Resident 1 at risk for injury or death. During a review of Resident 1's admission Record (AR), dated 10/2/25, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that includes unspecified Schizophrenia (a chronic mental health condition that affects a person's thoughts, feelings, and behaviors) and anxiety disorder (a feeling of fear, dread, and uneasiness). The Minimum Data Set (MDS) dated [DATE] indicated a Brief Interview of Mental Status (BIMS) score of 10, reflecting moderate cognitive impairment with episodes of forgetfulness. Further reviews showed Resident 1 was independent with mobility, specifically walking, and used a Wander Guard device daily. During a review of Resident 1's elopement evaluation, dated 8/1/25, indicated Resident 1 had a history of elopement, with expressions of desire to go home and pack belongings, stays by exit doors and wanders. The evaluation identified a risk for wandering and elopement, with a plan to maintain Resident 1's safety. During a review of Resident 1's physician's orders, dated 3/11/24, the orders revealed, there was an order for Wander Guard placement on left wrist and to be checked every shift. During a review of Resident 1's Care Plan (C/P) dated 8/2/25, tilted Risk for elopement identified, included checking the Wander Guard's placement and functionality as ordered. During an observation on 10/2/25 at 3:35 p.m. of the facility's front and back exit doors, two of the doors were equipped with Wander Guard sensors (a management system used at the facility to prevent residents with cognitive impairments from wandering into dangerous areas). The center of the building houses the main dining area that contains a door leading to a large back patio, which is the designated smoking area. The smoking area is surrounded by a fence approximately 6 ft. tall and has a padlocked iron gate, which leads to the rear parking lot connecting to the city streets. During a record review of the Facility Reported Incident (FRI) dated 10/1/25 indicated Resident 1 was missing between 7:30 a.m. and 7:45 a.m. and was later returned by police at 3:40 p.m. after being found at a shopping center. During a review of the facility record Situation Background Assessment Report (SBAR) dated 10/1/25 at 8:00 a.m., indicated certified nursing assistant (CNA 1), reported Resident 1 was not in their room for breakfast, and a search of the facility was initiated and was unable to locate Resident 1 responsible party (RP) and law enforcement were notified. During a review of Resident 1's Medication Administration Record (MAR) for the month of September 2025, showed the last function check of Resident 1's Wander Guard was on 9/25/25 and the MAR lacked any documentation of the ordered, every-shift placement checks for the Wander Guard ordered. During an interview on 10/2/25 at 4:20 p.m. with Licensed Nurse (LN 1), LN 1 stated Resident 1, when not in his room can be frequently seen at the smoking area. LN 1 stated the gate next to the smoking area in the back patio has no Wander Guard sensor but is always locked with a padlock. LN 1 clarified that there are two doors (front and back doors) that are equipped with Wander Guard sensors and confirmed there was no audible alarm heard from the doors that have the Wander Guard alarms between 7 a.m. and 8 a.m. on 10/1/25, when Resident 1 eloped. During an interview on 10/2/25 at 4:30 p.m., with Licensed Nurse (LN 2), LN 2 stated that on 10/1/25 at approximately 7:15 a.m., a Certified Nursing Assistant (CNA 1) reported Resident 1 was not in his room for breakfast and was not in the designated smoking area where he frequently goes. LN 2 confirmed Resident 1 wore a Wander Guard due to his elopement risk, but no alarm sounded on the morning of 10/1/25 between 7 a.m. and 8 a.m. LN 2 confirmed Resident 1 had a history of an elopement event last year in 2024 and that Wander Guard devices are checked weekly, every Thursday, by nursing staff. During a concurrent observation and interview on 10/2/25 at 4:50 p.m. with ADON, Resident 1 was observed from ADON's office during ADON's interview, smoking alone in the smoking area without any staff supervision. ADON was asked about who supervises the Residents in the smoking area, ADON stated that residents who are smokers and alert were assessed and educated about safe smoking and can smoke by themselves in the designated area and confirmed Resident 1 falls on that criterion. The facility failed to provide adequate supervision to prevent elopement while in the smoking area. During an interview on 10/2/25 at 5:00 p.m. with the Director of Nursing (DON), the DON stated that the facility had seven residents currently using Wander Guard devices and confirmed the devices are checked weekly by nursing staff and not every night shift as ordered. DON acknowledged she was also unaware of the Wander Guard</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>Based on observation, interview, and record review, the facility failed to perform daily functional testing of the Wander Guard system (an alert system worn on a resident's wrist that activates an audible alarm when passing doors equipped with sensors to prevent unsafe wandering) per manufacturer's instruction for use. This failure had the potential for seven residents using Wander Guard devices to elope from the facility without being detected. During the interview on 10/2/25 at 4:30 p.m. with licensed nurse (LN 2), LN 2 verified that Wander Guard devices are checked for functionality by nursing staff weekly every Thursday. During an interview on 10/2/25 at 5:00 p.m. with Director of Nursing (DON), DON stated there are seven (7) residents using Wander Guard devices and confirmed that the devices were checked weekly and not checked daily with results documented in the medical record. During a review of Wander Guard instructions for use, dated 2023, indicated, the devices should be tested daily thereafter, with results documented in the medical record. During the review of the facility's Policy and Procedure (P&amp;P) titled, Elopement Prevention/ Unsafe Wandering, dated 8/2025, the P&amp;P indicated, If the Wander Guard system is used, it will be tested on a regular basis (time not specified) for proper functionality.</p>		