

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 10/20/2025
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)
F 0656 Level of Harm - 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. (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 0656 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a comprehensive, person-centered care plan (a plan that includes clear goals to meet a resident's needs) in one of two sampled residents (Resident 1) with known alcohol dependence (a chronic disease in which a person craves alcoholic drinks and is unable to control his or her drinking), alcohol abuse and opioid dependence (the persistent urge to use legal and illegal drugs that reduce the intensity of pain signals). These failures had the potential of Resident 1 not having the coping mechanisms and support needed to prevent the use of illicit drug use (drugs that are illegal to produce, sell, or possess, or use in an illegal or inappropriate manner) and resulted in Resident 1 having a heroin (highly addictive, illegal opioid drug with high potential for abuse and no accepted medical use) drug overdose. During a review of Resident 1's admission Record (AR), [undated], the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included alcohol abuse, alcohol dependence with withdrawal and opioid dependence. Review of Resident 1's admission Minimum Data Set (MDS - a standardized assessment and screening tool) indicated, a Brief Interview of Mental Status (BIMS), score of 15. BIMS is a measurement of cognitive abilities that ranges from 0 to 15 with scores of 13-15 classified as having no significant cognitive impairment). Resident 1's History and Physical (H&P), dated 5/8/25, indicated in part, Alcohol abuse with risk of withdrawal possible. Ativan prn (as needed) to be given. Patient will be referred to County Supportive Group. During a review of Resident 1's Progress Notes (PN), dated 5/6/25 at 2:45 p.m., the PN indicated in part, admitted this [AGE] year old brought in by significant other, ambulatory with walker, from independent living facility [name of facility]. DX (diagnoses) .ETOH (alcohol), heroin and drug abuse .Alert, able to follow commands, disoriented to date, cries out a lot. (Resident 1) apparently was in an independent living situation but unable to function independently anymore. [Resident] requires supervision and cueing, and encouragement to fulfill task. During review of Resident 1's Interdisciplinary Team (IDT) meeting note, dated 5/13/25, The IDT indicated in part, Resident 1's responsible person (RP) mentioned it was unsafe for Resident 1 to live alone due to (Resident 1's) drinking problem. The RP also mentioned that Resident 1 needed a monthly injection to stop the substance abuse craving. During a review of Resident 1's SBAR (situation, background, assessment, recommendation) - Fall Report of Incident form, dated 6/2/25, the SBAR form indicated in part, Resident 1 had an unwitnessed fall Lying on back with head face up .minimal response with deep stimulation.MD (Medical Doctor) notified with order to transfer to hospital .Paramedics unable to arouse.Nasal Narcan (a medication that can rapidly reverse the effects of an opioid overdose) x 2 given.Finally woke up after 20 mins (minutes). Transport to hospital via ambulance. Insulin syringe found in patient's (Resident 1) pocket. Review of Resident 1's ED (Emergency Department) After Visit Summary (AVS), dated 6/02/25, the ED AVS indicated in part, You've (Resident 1) been treated for an overdose of opiates, such as a prescription pain medicine or heroin. During a concurrent record review and interview on 9/25/25 at 9:56 a.m. with the Social Services Director (SSD), Resident 1's Care Plan (CP) and H&P were reviewed. The SSD stated that facility staff did not identify community support groups or county programs for Resident 1 to attend and did not develop and sign a behavior contract with initiatives to assist the resident in staying clean and sober. Furthermore, the SSD acknowledged Resident 1 was not provided and/or assisted in obtaining substance use treatment services, such as behavioral health services, medication-assisted treatment (MAT), or alcoholic/narcotics anonymous meetings to achieve/maintain sobriety as indicated in the CP and in the H&P for the diagnoses of alcohol dependence, alcohol abuse, and opioid dependence. During a concurrent record review and interview on 9/25/25 at 10:50 a.m. with the Assistant Director of Nursing (ADON), Resident 1's IDT note, dated 5/13/2025 and CP for .current/recent history of substance abuse/dependence with heroin., dated 5/06/25 were reviewed. The IDT note indicated in part, Resident 1 .will need a monthly injection so that Resident 1 will not have the craving for substance abuse. The ADON stated there was no documentation in the progress notes or order summary indicating Resident 1 had received the monthly injections for substance abuse and would need to request the records from the [Facility's Name] public health center. The care plan interventions for .current/recent history of substance abuse/dependence with heroin. indicated: staff will monitor for signs of cravings or substance seeking for substance/alcohol for enhanced observation and support, staff will monitor resident's room for any signs of possible substance use (drug paraphernalia) and perform routine room searches, staff will work with resident to identify signs of cravings, relapse, and use and to identify coping mechanisms to reduce</p>		