

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  01/14/2026
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 - Minimal harm or potential for actual harm  Residents Affected - Few	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure licensed nurses (LNs) completed wound assessments and developed a care plan that included treatment and monitoring of a surgical incision for 1 of three sampled residents (Resident 1) upon admission to the facility. This failure had the potential to result in delayed healing and infection to Resident 1's surgical wound. During a review of Resident 1's History and Physical (H&amp;P), dated 12/10/24, the H&amp;P indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included post fall, had a subdural hematoma (collection of blood between brain and outer surface), and status post craniotomy (surgical procedure that temporarily removes part of skull). During a review of Resident 1's Progress Notes (PN), dated 12/6/24, this indicated, Body assessment done upon admission and noted the following: Right head surgical incision. Skin issue: #001: New skin issue. Location: Right temporal area. Laterality/Orientation: Right. Issue type: Surgical wound. Wound was present on admission. Measurement not documented as part of this assessment. Reason measurements not documented as part of this assessment-Resident will want it to be done another day will want to rest. On further review of the PN, documentation from 12/6/24 through 12/11/24, the above notes Skin issue: 001: New skin issue. Location: Right temporal area. Laterality/Orientation: Right. Issue type: Surgical wound. Wound was present on admission. Measurement not documented as part of this assessment. Reason measurements not documented as part of this assessment-Resident will want it to be done another day will want to rest. was repeated on LN entries during these dates. There was no evidence of wound measurements and/or description of the incision. There was no care plan developed to indicate treatment or care, no hand-off reports or documentation for continuity of care among staff, and no notification made to the physician about the surgical wound incision. During an interview on 12/18/25 at 2:40 p.m., with Registered Nurse (RN 1), RN 1 stated to have completed admissions of residents to this facility. RN 1 further stated the process that was followed if a resident had wounds was to notify the treatment nurse and a full assessment would be performed within 24 hours upon admission; RN 1 also stated .the doctor and family are notified of wounds.admission nurse checks the incision or wounds on admission and takes the measurements and documents what was seen. nurses check the wounds once a shift.nurses monitor and document in the medical record.nothing has changed on how to do wound assessments.During an interview on 12/18/25 at 2:50 p.m. with Director of Nursing (DON), DON agreed Resident 1's medical record was missing the assessment of the surgical wound.During an interview on 1/14/26 at 12:00 p.m. with the DON, DON agreed, there was no care plan developed for Resident 1's surgical incision; and the expectation was, if an incision and wound was present upon admission, the resident's medical record should have monitoring, assessments and care plans.During a review of the facility's policy and procedure (P&amp;P) titled, Care Plan, Comprehensive, dated 8/2014, .PROCEDURE 1. The Care Plan is individualized by identified resident problems, unique characteristics, strengths and individual needs.3. The care plan</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>becomes a comprehensive tool for the Interdisciplinary Team (IDT) to utilize as a reference for resident specific problems and approaches to establish guidance on meeting the individual needs of the resident.</p>