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	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Dorinda	300 Hot Springs Rd Santa Barbara, CA 93108

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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 - Minimal harm or potential for 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. 50657 Based on interview and record review, the facility failed to ensure the specific inappropriate behavior was documented for one of four sampled residents, (Resident 9) as stated in the careplan. This failure had the potential to inadequately identify what behavior needed to be monitored /planning of intervention to address the resident's inappropriate behavior. Findings: During a review of Resident 9's, Admission Record (AR), dated 07/20/21, the AR indicated, Resident 9 had diagnoses including, Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out daily activities) with late onset and major depressive disorder. During a review of Resident 9's, Care Plan, dated 10/01/24, the care plan indicated, Monitor and document episodes of inappropriate behavior directly/indirectly towards staff members. Special Instructions: Please be specific and document occurrence or quote in progress notes as well. Three Times A Day 02:00 PM, 10:00 PM, 06:00 AM. During a review Resident 9's, Medication Administration Record (MAR), dated 01/01/24 - 12/04/24, the MAR indicated inappropriate behavior episodes occurred on the following dates: one episode 03/14/24, one episode 03/17/24, one episode 06/21/24, four episodes 06/23/24, one episode 06/29/24, one episode 07/20/24, two episodes 07/28/24, one episode 08/04/24, one episode 08/11/24, one emailing staff episode 08/12/24, one episode 08/20/24, one episode 10/09/24, one episode 11/13/24, one episode 11/16/24, two episodes 11/22/24. During review of Resident 9's progress notes, dated 01/01/24 - 12/04/24, there was no specific documentation for the inappropriate behavior being monitored as instructed in the care plan/ special instructions. During an interview on 12/4/24 at 3:55 PM with Registered Nurse (RN3),RN3 acknowledged Resident 9 had incidents of inappropriate behavior on multiple occasions this year (2024). RN3 confirmed there were no progress notes detailing the specifics of the inappropriate behavior episodes.

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50657 Based on interview and record review, the facility failed to ensure a care plan for inappropriate behavior was updated to reflect episodes of inappropriate behaviors in one of four sampled residents (Resident 9) per facility's policy and procedure. This failure had the potential for the Resident 9's inappropriate behaviors to have no effective interventions in place which can affect the resident's daily interactions with others and vice versa affecting the quality of life in the facility. Findings: During a review of Resident 9's, Admission Record (AR), dated 07/20/21, the AR indicated, Resident 9 had diagnoses including, Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out daily activities) with late onset and major depressive disorder. During a review of Resident 9's, Medication Administration Record (MAR), dated 01/01/24 - 12/04/24, the MAR indicated inappropriate behavior episodes occurred on the following dates: one episode 03/14/24, one episode 03/17/24, one episode 06/21/24, four episodes 06/23/24, one episode 06/29/24, one episode 07/20/24, two episodes 07/28/24, one episode 08/04/24, one episode 08/11/24, one emailing staff episode 08/12/24, one episode 08/20/24, one episode 10/09/24, one episode 11/13/24, one episode 11/16/24, two episodes 11/22/24. During a review of Resident 9's, Care Plan titled, Behavioral Symptoms indicated, problem start date of 08/08/2022 and long-term goal target date was 10/12/2024. The care plan further indicated no update was done or initiated after 08/08/2022 During a review of the facility's, policy and procedure (P&P) titled, Person Centered/Comprehensive Care Plans, dated 01/24/2017, the P&P indicated, Procedure: Care plans will be revised as changes in the resident's condition dictates. A review of the care plan will be completed no less than quarterly. During a review of the facility's policy and procedure (P&P) titled, IDT Care Plan Meeting, dated 11/2/2023, the P&P indicated, Procedure: IDT members will report on current status and discuss needed changes in the resident's care plan based upon assessments and observations. During a review of Resident 9's interdisciplinary reports (IDR), dated from 10/31/23 - 10/01/24, monitoring of the resident's inappropriate behavior was not addressed in the IDT quarterly meeting notes. A concurrent interview and record review was conducted on 12/04/24 2:34 PM and 12/5/24 at 10:52 AM with Minimum Data Set Nurse (MDSN), the MDSN stated, Monitoring behaviors is not as accurate as it should. MDSN confirmed Resident 9's care plan for monitoring inappropriate behavior target goal date was 10/12/24 and was not updated on 09/30/24 when the quarterly MDS was done.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50657 Based on interview and record review, the facility failed to ensure a doctor's recommendation for a psychiatric consultation was followed up for implementation in one of four sampled residents (Resident # 9). This failure had the potential and risk for the resident's psychosocial health care needs to be unattended which can result in the deterioration of the physical, mental, and psychosocial well-being. Findings: Review of [NAME] and [NAME], seventh Edition, Mosby's Fundamentals of Nursing, page 336 in the section titled, Physician's Orders indicates, Nurses follow physician orders unless they believe the orders are in error or harm clients. Therefore, you need to assess all orders, and if you find one to be erroneous or harmful, clarification from the physician is necessary. During a review of Resident 9's, Admission Record (AR), dated 07/20/21, the AR indicated, diagnoses including, Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out daily activities) with late onset and major depressive disorder. During record review of Resident 9's social services notes (SSN), dated 10/13/22, the SSN indicated Resident requested to see a psychiatrist and upon clarification stated he sometimes feels depressed. During record review of Resident 9's physician notes, dated 10/17/2022 at 9:08 PM, the note indicated .OA Depression .Depression and feelings of De JaVu (a feeling of having already experienced the present situation). Psych consult. During record review of the nurses' notes, dated 10/17/22 at 10:41 PM, the note indicated, Seen by [attending physician] this pm, new orders received. Medical Doctor (MD) rec psych MD per resident's request for c/o Dejà [NAME]. During record review of Resident 9's medical record, no progress notes, consultation notes, or medical notes indicating Resident 9 was seen by a psychiatrist was located. During an interview on 12/04/24 at 03:24 PM with Registered Nurse (RN3) and Director of Nursing (DON), RN3 acknowledged Resident 9 requested a psychiatric consultation. RN3 said she forgot to order the psychiatric request (failed to put in an MD order). RN3 stated, I forgot to document it (referring to the resident requesting to see a psychiatrist).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32661 Based on observation, record review, and interview, the facility failed to ensure one of four sampled residents (Resident 15) development of a foot drop was monitored and assessed for appropriate intervention to prevent further decline in range of motion. This failure resulted in reduced mobility of the foot with potential for contractures (hardening and stiffening of muscle /bones). Findings: During an observation on 12/3/24, at 2:26 p.m., in room [ROOM NUMBER], Resident 15 was observed on bed, in a supine position (facing upwards) with feet on a pillow. The toes of both feet were noted to be flexed or extending, pointing towards the foot of the bed (outward) instead of upward (towards the ceiling). During a review of Resident 15's Physical Therapy Evaluation & Plan & Treatment, dated 2/11/22, under Musculoskeletal System Assessment, the AROM (Active Range of Motion) - (R) Ankle Dorsiflexion (upward or backward bending of a body part, often referring to a hand or foot) = WNL (Within Normal Limits); Plantar (sole of the foot/feet) Flexion (bending) = WNL. The AROM - (L) Ankle Dorsiflexion = WNL; Plantar Flexion = WNL. The Physical Therapy evaluation indicated Resident 15 had no extension or flexed feet on 2/11/22. (admission /initial assessment). During a review of Resident 15's Annual MDS (Minimum Data Set [process that provides a comprehensive assessment of resident's functional capabilities and helps nursing home staff identify health problems]), dated 4/10/24, indicated Resident 15 did not receive any kind of therapies from the Rehabilitation Department (OT (Occupational Therapy)/PT (Physical Therapy)/ST (Speech Therapy). During a review of Resident 15's Quarterly MDS, dated [DATE], Section GG indicated Resident is dependent on staff for mobility while Section O indicated Resident 15 did not receive any kind of therapies from the Rehabilitation Department (OT/PT/ST). During an interview with the assistant director of nursing (ADON), on 12/3/24, at 2:59 p.m., in the ADON's office, regarding the observed foot drop of Resident 15, the ADON reviewed the electronic rehabilitation records dated 2/11/22 and concurred the noted footdrop was new. The ADON indicated, the footdrop cause might be attributed to how the resident was positioned. The ADON added , I will call the doctor to get an order to have rehab evaluate the resident. During an interview with the Director of Rehabilitation (ReD), on 12/5/24, at 10:18 a.m., in the rehab room, the ReD concurred with the finding regarding Resident 15's footdrop, and that it should be reported to rehab for assessment and timely intervention.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32661 Based on record review, observation, and interview, the facility failed to ensure the change of shift narcotics reconciliation count was properly counted and signed by two licensed nurses to ensure accuracy of the narcotic/controlled medications. This failure had the potential to result in an inaccurate count and drug diversion (the illegal distribution or abuse of controlled prescription drugs) of controlled medications. Findings: During a medication pass observation, on 12/3/24, at 7:53 a.m., in the East Wing, first floor of the facility, the narcotic count book/log (a book/log recording the systemic monitoring, counting, and documentation of controlled medications/substances every start and end of each shift) for the month of November, was observed to be missing several signatures from both the incoming and outgoing licensed nurses. During record review, the following were noted. On November 21, 2024, the incoming 3-11 shift nurse failed to sign at the start and at the end of the shift. On November 21, 2024, the incoming 11-7 shift nurse failed to sign at the start of the shift and at the end of the shift on November 22, 2024, at 7 a.m. On November 22, 2024, the incoming 3-11 shift nurse failed to sign at the start of the shift. On November 31, 2024, the incoming 3-11 shift nurse failed to sign at the start and at the end of the shift. On November 31, 2024, the incoming 11-7 shift nurse failed to sign at the start of the shift. During an interview with RN 2, at 8 a.m., in the East Wing hallway, RN 2 reviewed the document and concurred with the finding. RN 2 stated, Yes, there are missing signatures in the narcotic count book. During a review of the facility's policy and procedure titled, Narcotic Medication Control, dated 4/7/17 and revised 10/22/23, indicated in part, 2. Narcotics will be counted daily at shift change by two licensed nurses ., b. On coming shift will count the narcotics and sign Narcotic Count Log under Nurse On column ., c. Outgoing shift will call out number of remaining medication as indicated on the individual medication count log and sign Narcotic Count Sheet under Nurse Off) column.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32661 Based on observation, interview, and record review, the facility failed to ensure biologicals were properly stored and labeled and the medications of discharged residents were properly stored, discarded , labeled per policy and procedure . This failure had the potential for biologicals, medications, medication items to be diverted. Findings: During a concurrent medication pass observation and interview, on 12/3/24, at 9:50 a.m., in the East Wing, first floor of the facility, with Registered nurse (RN 2), the following were noted in the 1 East medication cart (EMC). Five plastic containers of Polyethylene Glycol 3350 Powder for Solution (a laxative used to prevent constipation) had the respective room numbers written/labeled on the caps but were missing the open dates. One of the plastic bottles of Polyethylene Glycol 3350 Powder for Solution belonging to a discharged resident . RN 2 inspected the 5 plastic bottles of Polyethylene Glycol 3350 Powder for Solution and stated, The open dates were not labeled, and the bottle of the discharged resident should have been removed from the medication cart. During another concurrent observation and interview, on 12/3/24, at 10 a.m., at the first-floor nursing station medication room, with LVN 2, the following were noted. Three used insulin pens (a medication/hormone that lowers the level of glucose in the blood of diabetics) belonging to one discharged resident were in the medication refrigerator. The three insulin pens were NovoLOG Flex Pen 100 UNIT/1ML insulin pen, Insulin Glargine (LANTUS) 100 units/1 ml., and insulin aspart (NovoLOG) 100 units/1 ml. All three insulin pens were used but missing open dates. LVN 2 indicated the three insulin pens were for a resident who was transferred out/discharged to the hospital , and as to why it were still in the medication refrigerator at the nursing medication room , LN 2 had no response /explanation . During a review of the facility's policy and procedure titled, General Dose Preparation and Medication Administration, dated 12/1/07 and revised 4/30/24, indicated in part, 2.10 Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g., insulin, irrigation solutions, etc.). 2. 10.1 Facility staff may enter the expiration date based on date opened on the label of medications with shortened expiration dates. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No policy and procedure for medications brought from home or hospital or on discontinued medications was presented upon request .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43019 Based on observation, interview and record review, the facility failed to follow food safety requirements when: 1. Three (3) containers of prepared food were mislabeled as to date prepared of expiry date and is ante-dated (written date is one day after date of inspection) 2. One (1) of three (3) red buckets tested was below the recommended concentration of sanitizing solution. These failures has the potential for food borne illnesses affecting residents when safe refrigerated food are mislabelled, food has no use-by date, and sanitizing solutions are not safe when preparing foods. Findings: 1. During an observation on 12/02/24 at 11:36 a.m. at the kitchen freezer section, three stainless steel containers were identified. Two (2) containers with precut vegetables, and one (1) container with potatoes with spices, covered in clean [NAME] wrap and is labelled as 12/3/24. There is no evidence to indicate a date prepared or use by date. During an interview on 12/3/24 at 11:36 a.m. with Dietary Aide (DA1), DA verbalized that the staff who had previously worked on the weekend may have made a mistake and not checked on the date. DA 1 validates that there was no date prepared and use by date. During a review of Policy and Procedure (P&P) Titled: Storage of Food Supplies dated 11/04/24, the Storage of Food Supplies indicated in part . It is the policy of this facility to properly store dining service supplies in clean, appropriate containers at the proper temperature in the location and manner as prescribed by law . The following procedures are the responsibility of the dining services director: 11. Check foods in refrigerator to make sure they are properly covered. All prepared foods not in original containers must be covered, labelled, and dated. 13. Leftovers shall be tightly covered, stored appropriately and clearly labelled and dated. Leftovers shall be used within 72 hours and if not used within this time, will be properly discarded. 2. During a concurrent observation and interview on 12/03/24 at 10:13 a.m., testing of sanitizing solution used to clean surfaces of the kitchen in 3 Red Buckets were conducted with DA 2 with the following results: Bucket 1 400 ppm (unit of measure); Bucket 2 100 ppm; Bucket 3: 200 ppm. DA 2 states that the solution was changed early in the morning, cannot explain the discrepancy or difference in the test results. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview 12/03/24 at 2:30 p.m. with Sous Chef (SC), SC verbalized that the person in charge may have forgotten to change the solution or that the solution was diluted and that the sanitizing liquid may have lowered its potency. SC validates that disinfection process may be inadequate. During a review of P&P titled Red Sanitation Bucket Policy undated, the P&P indicated in part: Test solutions with test strips regularly to ensure they are maintaining the proper strength of sanitizer for food contact surfaces. There are three factors that influence the effectiveness of chemical sanitizers. 1. Concentration, recommended is from 200 ppm - 400 ppm.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47112 Based on interview and record review, the facility failed to run reports 1700D (employee report), 1702D (individual daily staffing report) and 1702S (staffing summary report) to ensure payroll-based journal (PBJ) data (a system for facilities to submit staffing information on a regular and frequent basis, ensuring accuracy) was received by the Center for Medicare and Medicaid (CMS). This failure resulted in CMS not receiving registered nurse (RN) hours and licensed nursing coverage data for the month of June 2024. Findings: During a review of PBJ Staffing Data Report CASPER (Certification And Survey Provider Enhanced Reports) Report 1705D, Quarter 3 2024 (April 1 - June 30) run 11/25/2024 indicated, One Star Staffing Rating, No RN hours, and failure to have licensed nursing coverage 24 hours/day. During an interview on 12/4/24 at 10:30 a.m. with the Director of Nursing (DON), DON verbalized they are responsible for sending staffing information to CMS, also verbalizing they were not aware of the reports to run to ensure CMS received data sent. During a review of the facility's policy and procedure (P&P) titled, PBJ Process dated 1/15/24, the P&P indicated, After the data is submitted the DON generates a report from CASPER to verify that the data has been submitted.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32661 Based on observation, interview, and record review, the facility failed to ensure proper handwashing was observed in between vital signs taking and medication pass by one of one nurse (RN 2). This failure had the potential to result in cross contamination and spread of infections to residents , compromising their wellbeing. Findings: During an observation on 12/3/24, at 9:18 a.m., with RN 2, in Unit 1 East, RN 2 was observed using a hand sanitizer on the wall, sanitized his hands and donned surgical gloves, before knocking and entering room [ROOM NUMBER]A with the vital sign machine on wheels. RN 2 failed to sanitize the vital signs machine which was observed previously used on another resident. RN 2 then proceeded to take the resident's vital signs. Subsequently, RN 2 completed the task of obtaining the residents vital signs and proceeded to wheel the vital signs machine out of the room. RN 2 once again, failed to sanitize the vital signs machine after use. RN 2 doffed and disposed of the surgical gloves, failed to hand sanitize and proceeded to prepare the residents medications. RN 2 took the prepared medications, re-entered room [ROOM NUMBER]A without hand sanitizing to administer the prepared medications. RN 2 exited the room and failed to hand sanitize before touching medication cart and proceeding to the next resident. During an observation on 12/3/24, at 9:45 a.m., RN 2 failed to observe hand hygiene etiquette before entering room [ROOM NUMBER]A to administer medications and after exiting room [ROOM NUMBER]A. The CDC (Centers for Disease Control and Prevention) article titled Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, indicated, CDC provides the following recommendations for hand hygiene in healthcare settings. 1) Immediately before touching a patient. 2) After touching a patient or patient's surroundings. 3) Immediately after glove removal. During a review of the facility's policy and procedure titled, Hand Hygiene, dated 2/27/17 and revised on 10/30/23, indicated in part, C. Decontaminate hands: 1. Before direct contact with residents .3. After contact with a residents intact skin. During a review of the facility's policy and procedure titled, General Dose Preparation and Medication Administration, dated 12/1/07 and revised 4/30/24, indicated in part, 1.1 Appropriate hand hygiene should be performed before and after direct resident contact.