STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555023	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025

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

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and procedure and implement interventions of a fall care plan to ensure a bed alarm was turned on for one of three sampled residents (Resident 1) while Resident 1 was in bed.This facility failure resulted in Resident 1 getting out of bed, falling to the floor and sustaining an acute displaced right hip fracture (broken hip bone that moved so much a gap formed around the fracture).During a review of Resident 1's Face sheet, [undated], the Face sheet indicated, Resident 1 was admitted to the facility on [DATE] with the following diagnoses: Alzheimer's disease (brain disorder that causes memory loss, confusion, and other cognitive decline), unspecified dementia (loss of brain function), major depressive disorder (low mood, loss of interest or pleasure), recurrent mild muscle weakness, abnormalities of gait and mobility, essential hypertension (high blood pressure without a known cause), primary open-angle glaucoma (eye disease leading to gradual vision loss), fall on same level, presbycusis left ear (age-related hearing loss), history of falling.During an interview on 10/13/25 at 9:28 a.m. with the Director of Nursing (DON), the DON verbalized Resident 1 had an extended history of falls totaling 32 falls in five months when in assisted living, and has had nine falls since admission to the facility. The DON further verbalized Resident 1 had a witnessed fall on 9/27/25, and after that fall a bed alarm was placed. The DON stated, It was at change of shift. The nurse stated they believed the alarm was on, but the certified nursing assistant (CNA) that was involved couldn't recall if the bed alarm was set to on after changing (Resident 1) in bed. When CNAs change a resident, they turn it (bed alarm) off and whoever's attending to a resident at that moment is responsible for turning it on, and that would be either the CNA or the licensed nurse.During an interview on 10/13/25 at 10:50 a.m. with a Licensed Nurse (LN 1), LN 1 stated because (Resident 1) is falling, the resident has alarms. LN 1 further stated when you put the bed alarm on, it beeps and you can see with the light on the side of the bed that it's on, and the bed alarm needs to be turned on when you leave the resident.During an interview on 10/13/25 at 11:25 a.m. with the Assistant Director of Nursing (ADON), the ADON stated (Resident 1) is a fall risk and probably has fallen in the past and that's why we have alarms on. ADON verbalized was working when Resident 1 had the fall, name (LN 2) was the nurse on duty who did the assessment, and the fall was reported to me. ADON stated, I went in, and the resident was in bed, and we continued to assess him, and LN 2 communicated with the doctor about what happened and what symptoms he was showing. The doctor ordered a mobile x-ray. ADON verbalized then the resident started to grimace more, and didn't look like he was able to get comfortable. It was best to send him out for an evaluation. The ADON further stated, CNAs should be visually checking the alarms to make sure they are on if the resident is in bed or the tab alarm is on if they are in a chair, and it's CNAs and nurses who make sure alarms are on.During a concurrent interview and record review on 10/13/25 at 11:43 a.m. with the DON, Resident 1's Point of Care History, dated 9/28/25 was reviewed. The Point of (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

Printed: 04/08/2026
Form Approved OMB
No. 0938-0391

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Care History indicated, activate bed alarm when in bed and Tab alarm when in wheelchair for poor safety awareness [every shift] 9/28/25 5:21AM Done. 9/28/25 2:39PM Done. The DON verbalized the evening shift wasn't done because Resident 1 was sent out to the hospital about 3:40 p.m., and there's nothing to print. When asked if the checks for Resident 1's bed alarm were done on 9/28/2025 after the change of shift for the evening shift, the DON stated, No. The evening shift did not check that the bed alarm was on.It should be checked at the beginning of the shift and it wasn't.During an interview on 10/13/25 at 11:52 a.m. with a Certified Nursing Assistant (CNA1), CNA 1 stated, I was working on the day (Resident 1) fell. My shift ends at 3:30 p.m.That day when the resident fell, I can't remember if I set up the bed alarm or not .Me and the nurse were cleaning (Resident 1) in the bed .I can't remember if I set up the alarm .if we don't turn off the alarm it would be beeping because (the resident) moves back and forth, and when we were finished, I can't remember if we put the bed alarm back on or not .Every time we put the resident in bed, we have to turn the alarm on - whatever it is, the bed or floor alarm and if they are in the wheelchair.the bed alarm should have been turned back on. When asked when CNA 1 checks that residents' alarms are on, CNA 1 stated in the morning at start of the shift and when the resident is moved.During a concurrent interview and record review on 10/13/25 at 1:05 p.m. with the DON, the facility's Policy and Procedure (P&P) titled, Use of Resident Alarm devices, dated 12/19/24 was reviewed. The P&P indicated, To establish a consistent, safe, and person-centered approach to the use of resident alarm devices (tab alarms, chair/bed pad alarms, floor mat alarms, and siderail bed alarms) as part of individualized fall prevention strategies, while promoting resident dignity, autonomy, and compliance with federal and state regulations.2.1 Placement and set up Test alarm function before leaving the resident unattended.4.1 Nursing staff test each alarm at the start of every shift to ensure proper function. The DON stated, Yes, yes, I know, and further verbalized this facility P&P was not followed.During a telephone interview on 10/16/25 at 3:15 p.m. with LN 2, LN 2 stated I had heard (Resident 1) calling for help, and I was at the desk at the nurses' station and ran to his room. It was when he fell around 4:30 p.m. I did not go into his room before that.There were people in there with him until 3:30 p.m., because they were changing all the linens.I went in there, and he was on the floor, on the carpeted section, on his right side, and I didn't see the bed alarm on and there was no call light pressed. So there was nothing prior to that for me to be alarmed of, aside from him yelling for help. I looked at the bed to see if the alarm was on, and it wasn't. LN 2 verbalized bed alarms should be on when the resident is in bed, and you know a bed alarm is on when it's lit up green on the side panel of the bed. LN 2 further stated on initial assessment, he seemed shaken up, and there was no complaint of pain until later when we transferred him back to his bed, and that's when he said pain and hospital.During a review of Resident 1's Fall Risk Assessment, dated 7/21/25, the Fall Risk Assessment indicated, Mental Status/Level of Consciousness: Intermittent Confusion, Poor Recall, Judgement, Safety Awareness.Evaluation Fall Risk Score - Score of 10 or higher represents a high risk for falls. Total Fall Risk Score: 22.0000. Level: At Risk.Indicate Care Plan action taken. Continue Current Plan of Care.During a review of Resident 1's Care Plan History dated 07/1/2025 - 9/29/25, the Care Plan History indicated, Problem Start Date 10/31/2024.At Risk for falls. Goal Safety will be monitored and managed, Resident will remain free from injury. Approach Start Date 12/4/24 activate bed alarm when in bed and Tab alarm when in wheelchair for poor safety awareness. Special Instructions: for safety. Every Shift DAY, EVE, NIGHT.Discipline CNA, Licensed Nurse.During a review of Resident 1's Physician Order Report, dated 9/13/25 - 10/13/25, the Physician Order Report indicated, Start date 10/31/2024 activate bed alarm when in bed and Tab alarm when in wheelchair for poor safety awareness. Special instructions: for safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Every Shift; DAY, EVE, NIGHT. Chartable task in POC.During a review of Resident 1's Resident Progress Notes, dated 9/28/25, the Progress Notes indicated, At 1630 (4:30 p.m.), resident yelling for help and RN on duty immediately ran to resident's room and found resident lying on his right side on carpet outside the entrance of his bathroom. Resident was incontinent of bladder, appears resident got out of bed. No call light and/or bed alarm sounded.During a review of Resident 1's Resident Progress Notes, dated 9/30/25, the Progress Notes indicated, Post Fall documentation; Two falls within a 48-hour period.RN noted that his bed alarm/call light not activated.Contributing factors for occurrence include: poor safety awareness and loss of balance/gait problems, toileting status, Improper use of safety alarms.During a review of Resident 1's hospital History & Physical, (H&P) dated 9/28/25, the H&P indicated, Reason for admission: Mechanical ground level fall with displaced acute right hip fracture.Plan: Proceed with surgery tomorrow for open reduction, internal fixation of his right hip fracture.