

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Atterdag Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 636 Atterdag Road Solvang, CA 93463	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure documentation by Social Services Designee (SSD) was completed for one of three sampled residents (Resident 1) medical records regarding allegations of abuse involving Resident 1. This facility failure resulted in Resident 1's medical record not accurately reflecting SSD follow-up on abuse allegations, potentially impacting the adequacy of care for Resident 1. During a review of Resident 1's admission Record, [undated], the admission Record indicated, Resident 1 was 94 years-old, admitted to the facility on [DATE] with the following diagnoses: senile degeneration of brain (decline in cognitive abilities that occurs with aging), generalized anxiety disorder (mental condition with excessive or unrealistic anxiety about two or more aspects of life), schizoaffective disorder bipolar type (a mental health condition that combines symptoms of schizophrenia [chronic mental health condition that affects a person's thoughts, feelings, and behavior] and bipolar disorder [chronic mental health condition characterized by extreme mood swings between mania (highs) and depression (lows)]), weakness, vascular dementia (impaired supply of blood to the brain with a decline in cognitive abilities), unspecified lack of coordination, cognitive communication deficit (communication challenge from problems with thinking), muscle weakness, essential tremor (brain disorder causing shaking of parts of body), mild cognitive impairment (not obvious but noticeable changes in cognitive function), macular degeneration (distortion or loss of central vision), cerebral ischemia (decreased blood flow to the brain), drug induced secondary parkinsonism (movement disorder), Diabetes Mellitus type 2 (body doesn't produce enough insulin [hormone] to regulate blood sugar levels), and history of falling. During an interview on 10/8/2025 at 11:56 a.m. with the SSD, SSD verbalized was aware of abuse allegations involving Resident 1. SSD stated, I did try talking to (Resident 1), but the resident can be challenging and dismissed me, but I observed him the rest of the day and he went about his normal routine. Resident 1 didn't mention anything and didn't give any feedback and was dismissive. SSD further stated, Since there wasn't any feedback, I didn't make a note, and I should have. During a review of Job Description Title Social Services Designee, revised 9/4/2025, Job Description Title Social Services Designee indicated Position Summary: Counsels and aids individuals and families who require assistance. Interviews new residents to assess their psychosocial needs. Obtains information such as medical, psychological and social factors contributing to the resident's situation and evaluates the resident's capabilities. Counsels residents individually or with family regarding assessment plans. Aids residents to improve social functioning. Essential Job Functions and Responsibilities . Provides resident services . one-on-one support, grief process . Acts as a liaison to family members, communicating resident needs, and social service concerns to families . Documents Social Service needs in ACC [abbreviation of facility] Medical Charts. Helps in bridging positive psychology between levels of care and assists with transitions . make reports and maintain files as required by state and federal regulations. During a review of the facility's Policy and Procedure (P&P) titled, Progress Notes, dated 9/26/2012, the P&P indicated, Each discipline shall be responsible for documenting the resident's progress according to regulation and the facility requirement. 1) All disciplines at this (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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility shall document progress notes in the appropriate section of the chart according to professional standards and regulations. Progress notes shall reflect resident's current status, progress or lack of progress, changes in condition, and adjustments to facility etc. 3) All progress notes shall be headed with the title of the person documenting the note i.e. physician note, nursing note, social service note, activity note, dietary note etc. 5) Progress notes shall be documented in a timely manner. Record Keeping Progress notes shall be maintained in the resident's medical record.		