| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056353 | A. Building<br>B. Wing | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Atterdag Care Center | 636 Atterdag Road<br>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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to revise a care plan for one of two sampled residents (Resident 1) after Resident had multiple falls on 2/17/26,3/4/26, and 3/10/26, This facility failure placed Resident 1 at higher risk for falls with injuries.During a review of the admission Record (AR) for Resident 1, admission date 8/26/24, The AR indicated Resident 1 was a [AGE] year old male with diagnosis including Senile Degeneration of the Brain (Progressive loss of cognitive function characterized by memory loss, confusion, behavioral changes, and impaired daily functions) and Alzheimer's Disease (Progressive, incurable disease causing brain shrinkage and neuron death characterized by memory loss, cognitive decline, and behavioral changes), Adjustment disorder with mixed anxiety and depressed mood, Abnormalities of gait and mobility.During a review of Resident 1's Post Fall Evaluation (PFE), dated 2/17/26, the PFE indicated Resident 1 experienced an unwitnessed fall on 2/17/26 at 3:45 P.M. The PFE also indicated in part Care Plan Focus: The resident has had an actual fall with More risk factors include lower body weakness, Vitamin D deficiency, difficulties with walking and balance, uses of medicines, vision problems, foot pain or poor footwear, throw rugs or clutter that can be tripped over, poor lighting, decreased muscle strength, sedentary lifestyle, cognitive impairment, incontinence, sudden condition changes such as fever, infection, delirium, anemia, arthritis, heart failure, neuro disorders. Goal: will identify injury x72 hours. Intervention: Neuro checks. Notify MD and POA monitor v.s. every shift x 72 hours monitor for pain notify MD if changes in quality or worsening pain immediate action taken to prevent fall, Notify POA and M.D. of any identified complications.During a review of Resident 1's PFE, dated 3/4/26, the PFE indicated Resident 1 experienced a fall on 3/4/26 at 3:45 P.M. The PFE also indicated the Care Plan Focus, Goals, and Interventions remain unchanged from the prior PFE dated 2/17/26.During a review of Resident 1's PFE, dated 3/10/26, the PFE indicated Resident 1 experienced an unwitnessed fall on 3/10/26 at 12:01 A.M. The PFE also indicated the Care Plan Focus, Goals, and Interventions remain unchanged from the prior PFE dated 2/17/26 and 3/4/26.During a concurrent interview and record review on 3/20/26 at 12:40 P.M. with the Director of Nursing (DON), Resident 1's Care Plan, initiated 9/6/24, had no focus, goals, or interventions revised following the reported falls on 2/17/26, 3/4/26, and 3/10/26. The DON agreed no care plan revisions were made following the three PFE's.During a review of the facility's policy and procedure titled, Fall Prevention Program, dated 9/24/12, indicated in part After any fall the licensed nurse will reassess the resident for fall risk and complete the Post Fall Evaluation. The licensed nurse will make an immediate decision as to applying an alarming device. The resident will be assessed by the IDT who will review the fall within 72 hours and will evaluate the need for a personal tab alarm or pressure pad alarm device in the wheelchair and/or for any other recommendation such as physical therapy, nonskid socks, etc. All interventions will be added to the fall care plan to prevent falls.During a review of the facility's policy and procedure titled Care Planning, revised 7/1/24, indicated in part To assure that all resident's care needs are identified through continuous assessments and that those needs are care planned with corresponding measurable objectives and adequate interventions. The policy also indicated in part 3. All newly<br>(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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| Atterdag Care Center | 636 Atterdag Road<br>Solvang, CA 93463 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | identified problems, including condition changes, are to be care planned by the licensed nurse or other health care professional who assessed/identified the problem first . 4. On a weekly basis when summaries are completed, the licensed staff nurse completing the summary should update the care plan with new interventions, and resident's response from previous interventions . 7. The care plan should address special issues, concerns or wishes of the resident. It should present a current picture of the resident and the care they need. |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy and procedure, the facility failed to ensure the medical record contained documentation for a reason as needed (PRN) medication was given for one of two sampled residents (Resident 1).This failure had the potential to result in an incomplete medical record for a resident medication administration requirement. During a review of the admission Record (AR) for Resident 1, admission date 8/26/24, The AR indicated Resident 1 was a [AGE] year old male with diagnosis including Senile Degeneration of the Brain (Progressive loss of cognitive function characterized by memory loss, confusion, behavioral changes, and impaired daily functions) and Alzheimer's Disease (Progressive, incurable disease causing brain shrinkage and neuron death characterized by memory loss, cognitive decline, and behavioral changes), Adjustment disorder with mixed anxiety and depressed mood.During a review of the Administration Record (MAR), dated 3/1/26-3/31/26, The Mar indicated a physician order of Lorazepam Tablet (a medication used to treat anxiety disorders, short term insomnia, and active seizures) Give 1 mg (milligram) by mouth every 2 hours as needed for MOD (moderate) - Severe anxiety M/B (manifested by) vomiting, SOB (shortness of breath), Restlessness. The MAR further indicates that a dose of this medication was administered on 3/17/26 at 5:57 A.M. The MAR and the medical record contain no notes as to the reason why the medication was given.During an interview on 3/20/26 at 12:40 P.M. with the Director of Nursing (DON), DON agreed the MAR for Resident 1 was without documentation for the reason of the administration of the PRN medication on 3/17/26 at 5:57 A.M.During a review of the facility's policy and procedure titled Medication Administration, revised 10/8/24, indicated in part When a PRN medication is given, it shall be charted on the Medication Administration Record. The nurse shall document the reason given, route of administration, date, and time. |