STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056353	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atterdag Care Center	636 Atterdag Road Solvang, CA 93463

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50707 Based on interview and record review, the facility failed to ensure the Physician Orders for Life-Sustaining Treatment (POLST- a form that documents a resident's treatment wishes in the event of a medical emergency) matched the electronic medical record (EMR) in one of one sampled resident (Resident 23). This failure had the potential to cause a delay in receiving or incorrectly administering life-sustaining treatments. Findings: During a review of Resident 23's Admission Record (AR), the AR indicated, Resident 23 is a [AGE] year-old female admitted on [DATE] with diagnosis of senile degeneration of the brain (a brain and nerve disorder characterized by a progressive decline in cognitive function [how a person thinks, behaves, and their ability to remember things], impacting memory, reasoning, and the ability to perform everyday activities). During a concurrent interview and record review on [DATE] at 10:01 a.m. with the Minimum Data Set Coordinator (MDS 1), Resident 23's POLST was reviewed. The POLST dated [DATE] indicated, do not attempt resuscitation (DNR). Resident 23's Order Summary Report (OSR) in the EMR was reviewed. The OSR indicated, a physician order for cardiopulmonary resuscitation (CPR) dated [DATE]. The MDS 1 acknowledged the records did not match and stated, The order did not get updated when the POLST was changed. The MDS 1 further indicated the orders in the EMR needed to be updated to reflect the resident's current wishes on the POLST. During a review of the facility's Policy and Procedure (P&P) titled, Life sustaining measures, Advanced Health Care Directives, dated [DATE], the P&P indicated, If the resident desires to be a 'do not resuscitate (DNR)' status, the physician shall review the request with the resident and/or surrogate and write the DNR order on the physician's order sheet.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49405 50707 Based on interview and record review, the facility failed to develop a care plan to address Restorative Nursing Assistant (RNA) services for one of three sampled resident (Resident 27). This failure had the potential for care and services not to be provided to Resident 27 that could potentially cause a decline in mobility and muscle strength. Findings: During a review of Resident 27's Admission Record (AR), the AR indicated, Resident 27 was admitted on [DATE] with diagnoses including muscle weakness (generalized), other abnormalities of gait (the way a person walks) and mobility, and repeated falls. During a concurrent interview and record review on 1/24/25 at 9:36 a.m. with the Minimum Data Set Coordinator (MDS 1), Resident 27's order summary report (OSR) was reviewed. The OSR indicated, RNA Range of Motion (active) right upper extremity AROM (active range of motion) / PROM (passive range of motion) exercises to maintain mobility RNA: Range of Motion (passive) right upper extremity AROM/PROM exercises to maintain mobility ordered on 12/31/24. Resident 27's care plans were also reviewed and there was no documented evidence of a care plan addressing RNA services. The MDS 1 stated, I do not see a care plan for RNA. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, dated 11/01/11,the P&P indicated, .all disciplines will have input on the care plan . Update each long-term care plan as new changes occur.

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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. 13095 Based on review of the medical record for resident, interview with the resident's nurse, and interview with the facility's Director of Nursing (DON) on 1/23/2025, regarding resident 247, the facility failed to ensure that Standards of Practice regarding Tachycardic pulses which resulted in abnormal results, had been addressed by the facility and medical staff. The facility also failed to develop a policy and procedure which identified tachycardia. This failure had the potential to put this resident at risk for a heart attack or a stroke. Findings: Review of resident 247's clinical record revealed that this resident, had an elevated Pulse recorded in the resident's medical record on the evening of 1/22/2025. This resident's pulse had been recorded as 103 beats per minute, which had been flagged in the nurse's computer as being highlighted in red by the facility's computer system to help bring this resident's elevated pulse to the nurse's attention. Review of the textbook, the Fundamentals of Nursing, 11th edition, which had been dated, 2023, (which represents the Standard of Nursing practice), on page 511 in table 29.4, stated: Acceptable ranges of Heart Rate, Adult: 60-100 (beats per minute). This confirmed that this resident's pulse had been truly elevated. The textbook also stated the following regarding pulses: Two common abnormalities in pulse rate are tachycardia and bradycardia. Tachycardia is an abnormally elevated heart rate, above 100 beats/minute in adults. This resident had meet the Standard definition for Tachycardia, which had not been addressed by the facility's administration, the facility's policies and procedures and the facility's nursing staff. Interview with the nurse who had been responsible for taking care of this resident, indicated that she had seen the resident's elevated pulse (103), but she did not recheck this resident's pulse again that day. During the interview with this medication nurse, she indicated that normally, we recheck the resident's pulse after the computer tells us that the resident's pulse had been elevated, to see whether the intervention that we provided, had worked to resolve the resident's out of range pulse. which was elevated according to the system (in red) indicating that the resident had a pulse of 103. This resident's pulse had not been retaken until the following day, on 1/23/2025, and pulse at this time remained elevated at 106 (even 3 mg of mercury) higher than the last pulse on the previous day. Interview again with the resident's medication nurse on 1/23/2024 at 3:00 pm revealed that no preventative actions had been taken by the facility to address this resident's elevated pulses/Tachycardia. During an interview with the DON on 1/23/2025 at 3:40 pm, the facility's DON confirmed that this resident's elevated pulse (Tachycardia) had not been address by facility staff for two days. The DON stated during a concurrent interview that: it would have been my expectation that this resident's elevated pulses would have been addressed as soon as they would have been identified. 49405

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13095 Based on review of the medical record for resident and interview with the facility's Director of Nursing (DON) on 1/23/2025, regarding resident 20's blood pressures, the facility had failed to ensure that this resident's blood pressure monitoring had been ordered by the resident's physician and not by the facility's nursing staff. The facility also failed to develop a policy and procedure which identified hypotension for the nursing staff. The facility's failure had the potential to put this resident at risk of severe hypotension which could result in ultimate organ failure and shock. Findings: Review of resident 20's clinical record revealed that this resident had been admitted to the facility on [DATE]. On revealed that this resident's physician had ordered, Coreg 6.25mg (a blood pressure medication) to be given twice daily for hypertension, please give with meals. without any blood pressure or pulse parameters on 9/11/2024. This resident continued to receive his Coreg from 9/12/2024 to 10/13/2024 without regard for the resident's blood pressure (BP) and pulse (P). Interview with the DON on 1/23/2025 at 3:45 pm confirmed that none of the facility's nurses had reached out to the resident's doctor to clarify if this blood pressure order needed clarification (as the order did not address the resident's BP and/or P). Further review of resident 20's medical record and interview with the facility's DON revealed that on 10/13/2024 at 4:10 pm, one of the facility's nurses revised this resident's BP medication on the Medication Administration Record (MAR) without obtaining direction from the resident's physician. The resident's MAR after 10/13/2024, now included recordings of a daily BP and a Pulse. Part of the concern was that nursing staff were not using the blood pressures and the pulses which were being taken by the nursing staff and using these parameters to determine whether the resident should be given his Coreg twice daily. During an interview with resident 20's medication nurse on 1/23/2025 at 3:45pm, the medication nurse was asked if she knew the definition of hypotension. The medication nurse then went to the Mayo Clinic and found the definition of hypotension and she found the following definition: Low blood pressure is a condition in which the force of the blood pushing against the artery walls is too low. It's also called hypotension. Blood pressure is measured in millimeters of mercury (mm Hg). In general, low blood pressure is a reading lower than 90/60 mm Hg. Review of resident 20's MAR from 10/13/2024 to 1/23/2025 revealed the following hypotensive episodes during which this resident received his BP medication: on10/16/2024 at 7:30 am (104/48), on10/23/2024 at 7:30 am (115/45), on11/13/2024 at 7:30 am (115/50), on11/13/2024 at 4:30 pm (102/49), on12/10/2024 at 7:30 am (104/43), on12/13/2024 at 7:30 am (97/46), on12/14/2024 at 4:30 pm (97/46), on12/23/2024 at 4:30 pm (102/46), on12/31/2024 at 4:30 pm (91/44). These example above show that this resident's blood pressure had already been low prior to recieving his blood pressure medication (Coreg) and the administration of this medication could have resulted in an abnormal drop in this resident's blood pressure which ultimately could have lead to this resident having vital organs not getting enough oxygen and nutrients, which could ultimately lead to this resident going into shock.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 50707 Based on interview and record review, the facility failed to monitor the medication refrigerator temperature twice a day and maintain the temperature within acceptable range. This failure had the potential for the residents to receive ineffective medications due to improper storage. Findings: During an interview on 1/21/25 at 3:26 p.m. with the Director of Nursing (DON), in the medication storage room, the DON stated the temperatures of the refrigerator in the medication storage room are monitored once a day in degrees Fahrenheit (F). During a concurrent interview and record review on 1/21/25 at 4:20 p.m., with the DON, Medical Room Refrigerator Temperature Monitoring Log (MRRTML), for October 2024, November 2024, and December 2024 were reviewed. The MRRTMLs indicated the following temperatures in Farenheit (F): 12/8/24: 34 degrees 11/14/24: 34 degrees 11/22/24: 34 degrees 11/24/24: 30 degrees 11/27/24: 32 degrees 11/28/24: 34 degrees 11/29/24: 34 degrees 11/30/24: 34 degrees 10/12/24: 32 degrees Additionally, the MRRTML indicated Report all temperatures that do not meet standards. Note corrective action. The DON acknowledged the temperature readings of the above said dates are below accepted temperature range of 36-46 degrees F and there is no documented evidence that there was any corrective action when the temperatures were noted out of range. During an interview on 1/24/25 at 12:07 p.m. with the DON, the DON confirmed influenza vaccines are stored in the medication room refrigerator and stated, Our policy states we should have been monitoring the temperature twice a day and we were not. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Medication Storage, storage of medication (California Specific), dated 01/23, the P&P indicated, Medications requiring 'refrigeration' or 'temperatures between 2 C (Celsius) (36 F) and 8 C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring . The temperature of any refrigerator that stores vaccines should be monitored and recorded twice daily.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28773 51706 Based on observation, record review, and interview the facility failed to ensure residents were provided a well-balanced, physician prescribed diet that met their nutritional needs when meal ticket and diet order did not match for seven (7) residents (Residents 7, 23, 29, 34, 35, 37, and 38). This failure had the potential for residents to receive incorrect diets and have nutritional deficits. Findings: During a concurent observation and interview in the kitchen on 1/21/25 starting at 11:45 a.m. with the Director of Dining Srvices (DDS), a lunch meal service was observed. Resident 33's meal ticket showed the resident was on a puree small portion diet. Further review of the meal ticket indicated, the resident was to receive a #6 scoop (5.33 ounces) of lamb. The DDS stated was not sure why the meal ticket showed #6 scoop, but they use half portions on all items when serving a small portion diet. During a concurrent interview and record review on 1/23/2025 at 10:56 a.m. with Registered Dietitian (RD), the PontClickCare (PCC) diet report electronic record was reviewed. The PCC indicated, there were diets that were not the same as on the meal ticket report. During an interview on 1/23/25 at 11:24 a.m. with the RD, the RD stated will run a diet type report from both PCC and [NAME] diet list every couple of months. RD stated there are diet discrepancies between those reports. During review of facility documents of the PCC diet report and the [NAME] meal ticket diet report on 1/23/2025 at 11:24 a.m., RD confirmed the following: Resident 7's PCC diet order indicated, Regular, Fortified. Resident 7's [NAME] meal ticket diet report indicated, Regular, Fortified, Small Portion. Resident 23's PCC diet order indicated, Regular, Fortified. Resident 29's [NAME] meal ticket diet report indicated, Regular, Fortified, Small Portion. Resident 29's PCC diet order indicated, Regular, Pureed. Resident 29's [NAME] meal ticket diet report indicated, Pureed, Small Portion. Resident 34's PCC diet order indicated, Regular, Easy to Chew. Resident 34's [NAME] meal ticket diet report indicated, Easy to Chew, Small Portion. Resident 35's PCC diet order indicated, Regular, Pureed, Fortified. Resident 35's [NAME] meal ticket diet report indicated, Regular, Pureed, Consistent Carbohydrate (CCHO), Fortified. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 37's PCC diet order indicated, Regular. Resident 37's [NAME] meal ticket diet report indicated, Regular, Small Portion. Resident 38's PCC diet order indicated, Regular, Easy to Chew, Chopped Meat. Resident 38's [NAME] meal ticket diet report indicated, Regular, Easy to Chew. During a review of the facility's Policy and Procedure (P&P) titled, Transmission of Diet Orders, dated 09/04/2018, the P&P indicated, 2. Upon admission or change of diet order, a Dietary Communication form should be completed, dated, signed by a Licensed Nurse, and sent to Dietary with a confirmation of the prescribed diet order and a copy goes in Dietary section of the chart .4. A tray card is prepared according to the prescribed diet and inserted in its proper place for tray setup.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28773 51706 Based on observation, interview and record review, the facility failed to ensure the menus were followed when: 1. The incorrect portion sizes for meat and vegetables were served for the puree diet during the lunch meal on 1/22/25 for four residents (Residents 2, 3, 29, 35); and 2. The incorrect portion sizes were served for one resident (Resident 30) for the lunch meal on 1/21/25. This failure has the potential to result in residents not having their nutritional needs met. Findings: 1. During a review of the facility document titled, Daily Spreadsheet, dated 1/22/25 for the lunch meal, the Daily Spreadsheet indicated, for the puree diet, #6 scoop (2/3 cup) [NAME] broil (red meat), 1 ounce gravy, #8 scoop (1/2 cup) puree potatoes, and #10 scoop (3/8 cup) puree zucchini. During a concurrent observation and record review on 1/22/25 at 11:49 a.m., the lunch meal service steamtable contained puree meat ([NAME] broil) with a #8 scoop (1/4 cup), puree zucchini with a #8 scoop and mashed potatoes with a #8 scoop. [NAME] 1 (C1) was observed using a #8 scoop for the puree diets. Residents 2, 3, 29 and 35 received their puree diets with the incorrect amounts of meat, potatoes and zucchini. Review of the residents meal tickets indicated: Resident 2 was on regular, pureed, mildly thick, fortified diet. Resident 3 was on consistent carbohydrates, pureed, regular diet. Resident 29 was on regular, pureed diet. Resident 35 was on special nutrition fortified, pureed diet. During an interview on 1/22/25 at 12:24 p.m. with C1, and the Director of Dietary Services (DDS), C1 confirmed using #8 scoops for the puree diets and #8 scoops were not the correct portion sizes for the meat and vegetable. The DDS confirmed C1 was supposed to use a #6 scoop for the meat and #10 scoop for the vegetable. 2. During a review of the facility document titled, Daily Spreadsheet, dated 1/21/25, the lunch meal indicated, the regular diet, regular portion was to receive 3 ounces baked cod with panko crust, #8 scoop (1/2 cup) sun dried tomato polenta, #8 scoop sauteed fresh spinach and a dinner roll. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of the lunch meal service starting at 11:45 a.m., C1 had two different scoops in the food products, #8 for regular portions and #12 scoops (1/3 cup) for small portions. C1 would scoop portions onto the plate depending on the diets called out by another kitchen staff. During an observation and review of the meal ticket for Resident 30, C1 portioned 1/2 serving of cod, #12 scoops of polenta and spinach on the plate which was placed on the tray and then into the meal cart. During a concurrent observation and interview on 1/21/25 at 12:20 p.m. with the Clinical Nutrition Coordiantor (CNC), Resident 30's plate was observed and meal ticket was reviewed. The CNC confirmed the portion sizes of the sides looked smaller than the other regular portion plates. CNC then asked C1 to portion another plate with regular portions for Resident 30. During a concurrent interview and record review on 1/23/25 at 10:56 a.m. with the Registered Dietitian (RD), the RD stated occasionally does an observation of tray accuracy or test tray but that is more about checking temperatures and that it had been awhile since she had done one of those. RD stated was not aware staff was not following menu portion sizes. Review of the daily spreadsheet indicated, portion sizes were not consistent day to day. RD stated was not aware that some says the portion sizes were different than on other days and confirmed they were not consistent. During an interview on 1/23/25 at 11:25 a.m. with the RD, RD stated expectation is that kitchen staff follow the menu daily spreadsheet and the portion sizes on the menu.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 28773 51706 Based on observation, interview and review of facility documents, the facility failed to ensure food was stored, prepared, distributed and served in accordance with professional standards for food service safety when: 1. The high temperature dish machine was not reaching 150 degrees Fahrenheit (F) for the wash cycle and 180 degrees F for the rinse cycle and the facility did not have a mechanism to verify the plate level temperature was reached according to their policy and procedure; and 2. [NAME] 2 (C2) did not change gloves after touching raw meat then touching other items. These failures resulted in equipment, utensils, dishware and silverware not being properly cleaned and sanitized and had the potential to result in the growth of microorganisms which can cause foodborne illness for the 49 residents eating food from the kitchen. Findings: 1. During a concurrent observation and interview on 1/21/25 at 10:35 a.m. with Dishwasher 1 (DW1), the last rack was observed being placed in the dish machine. DW 1 stated he knows the dish machine is working properly when the wash temperature is 150 degrees F and rinse temperature is 180 degrees F. The gauges on front showed 130 degrees F. During an observation of the lunch meal service on 1/21/25 at 11:45 a.m., [NAME] 1 (CK 1) was calibrating thermometers in an ice water bath. Surveyor put in surveyor thermometer (DeltaTrak min/max) to calibrate with facility thermometers. Surveyor's thermometer read 33 degrees F and facility thermometers was 32 degrees F. During a concurrent observation and interview on 1/22/25 at 9:16 a.m. with Dishwasher (DW) in presence of the Director of Dietary Services (DDS) at dish machine in main kitchen, the gauges indicated, wash and rinse temperatures approximately 130/132 degrees F. Towards the back of the dish machine there was another gauge that indicated, final rinse temperature was 180 degrees F. There was an Ecolab display that indicated, Refill Detergent and temperature of 133.1 degrees F. DW stated the rinse temperature needs to be 180 degrees F. Surveyor put the DeltaTrak min/max thermometer (waterproof thermometer that can be used for dish machines) in the dish machine on a rack with dishes when the dishes were going through. Surveyor thermometer showed 136.4 degrees F as the max temperature. Surveyor placed it through on the racks a second times and got a temperature of 137.9 degrees F. The DDS stated they use the display gauges on the dish machine and not the Ecolab display monitor. The DDS stated the facility did not have any way to verify temperatures and would follow up with Ecolab. During the review of the manufacturer's directions posted on the dish machine, showed the hot water sanitizing recommended minimum temperatures for wash was 150 degrees F, final rinse 180 degrees F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 1/23/25 at 09:19 a.m. with DDS and Maintenance Engineer (ME1) in main kitchen at dish machine, surveyor min/max thermometer temperature was 139 degrees F. ME1 stated pipe labeled final rinse is water supplied to machine with temp reading 175 degrees F. ME1 infrared thermometer temp on water inside paused dish machine and the reading was 119 degrees F and concurrent measurement with survey thermometer reading was 129.6 degrees F. DDS stated he would reach out to ecolab again and let them know it was an emergency. During an interview on 1/23/25 at 11:15 a.m. with the Ecolab Vender Technician (VT1), VT1 stated the surface temperature was 149 degrees F when he checked it and then stated the dish machine needed to be at 160 degrees F at the plate level for proper sanitation. VT1 stated this was his first time to facility and if it cannot be repaired, will provide sanitizer. VT1 was changing out the Ecolab display monitor at the time. VT1 confirmed contracted vendor should be coming to facility once per month. DDS confirmed vendor should be coming once per month. During a concurrent observation and interview in the presence of DDS on 1/23/25 at 12:30 p.m., Ecolab monitor showed 114 degrees F for the wash and 150 degrees F for the rinse. Surveyor ran the DeltaTrak thermometer through the dish machine a couple times, all max temperatures showed similar readings to 124. 9 degrees F. DDS drained the dish machine and restarted it, then the Ecolab monitor started showing temperatures of 140 degrees F for wash and rinse of 180 degrees F. DDS stated the verification strips would be in tomorrow morning and they would verify if the gauges were accurate. During an interview with the Registered Dietitian (RD) on 1/23/25 at 10:56 a.m., the RD stated she periodically goes into the kitchen to do inspections. RD stated she probably should be doing those monthly. During an interview on 1/23/25 at 11:24 a.m., with the RD stated was not aware of any problems with the dish machine. RD stated there were surface temperature devices to verify high temperature dish machine and she was not aware the facility had no way to verify temperatures of the gauges or that plate/surface level was met. RD stated she does periodic kitchen inspections and that means quarterly. RD stated she does not verify if the dish machine was meeting appropriate temperatures. During a concurrent interview and record review on 1/24/2025 at 10:10 a.m. with the DDS, the Dish machine Temperature Logs dated November 2024, December 2024, and January 2025 were reviewed. The Dish machine Temperature Log for November 2024 indicated five recordings of a final temp below 180F. The Dish machine Temperature Log for December 2024 indicated three recordings of final temp below 180F. DDS states was not made aware of low temperature readings. It is unclear if or when he checks the logs. During a review of the January Dish machine temperature logs, showed there was 13 times the wash temperature was not 150 degrees F. The January logs dated on the 21st showed for breakfast the wash temperature was 141 degrees F. The 22nd showed for breakfast the wash temperature was 149 degrees F and for the lunch meal it was 147 degrees F and dinner it was 145 degrees F. The log showed the code for adequate temperature for wash was 150 and rinse 180 or higher. Under Litmus strips it showed a zero with a line through it. During a review of Dishmachine Temperature Log dated November 2024, December 2024, and January 2024 the Dishmachine Temperature Log indicated missing weekly surface temperatures for all three months. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056353	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atterdag Care Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Eco lab Regular Service Call, the Regular Service Call indicated last service visit date of 11/29/2024 at 12:07 p.m. During a review of facility's policy and procedure titled Dishwashing Procedure dated 11/19/2019, the policy indicated, Once a week the Dietary Manager should check the accuracy of the gauges by sending a lollipop thermometer or a T-strip through the dish machine. It indicated the thermometer or test strip will measure surface or utensil temperature. Surface temperature is the temperature of the water that is contacting the dish, utensil, etc. Surface temperature should be 160 F or above. Wash, & rinse temperatures must be observed and logged during the dishwashing period 3 times a day. The rack level temperature must be logged once a week. Final Rinse Temperature [greater than or equal to] 180F. During a review of the facility's policy and procedure titled Recording of Dishmachine Temperatures, dated 08/29/2023, the policy indicated, Any inaccurate temperatures must be brought to the attention of the Director of Food and Nutrition Services or other clinically qualified nutrition professional immediately. 2. During an observation on 1/22/25 at 9:38 a.m. main kitchen griddle, C2 used gloved hands to repeatedly obtain raw meat from storage container, place on griddle, use tongs to remove meat, and placing cooked meat on pan with grate. Using same gloves, cooked meat was adjusted on pan with grate. At 10:04 a.m. C2 used same gloved hands to obtain more grates from stack of grates and rested tongs used for raw meat on grates. During an interview on 1/23/2025 at 11:24 a.m. with RD, RD stated the expectation of glove use would be staff would change them [gloves] after touching raw meat and would not want the same gloves when they touch raw meat and meat that is cooked even if it goes in oven for additional cooking. RD stated staff can get a false sense of security with gloves on their hands. According to the Food and Drug Administration (FDA) Food Code 2022, Annex 3, showed the failure of food-handlers to wash hands in certain situations (such as . handling raw meat .), wear clean disposable gloves, or use clean utensils is responsible for the foodborne transmission of these pathogens. According to the FDA Food Code 2022, Section 3-304.15 Gloves, Use Limitation. It showed if used, single-use gloves shall be used for only one task such as working with .or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056353	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atterdag Care Center	636 Atterdag Road Solvang, CA 93463

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 51706 Based on observation, interview and record review, the facility failed to ensure and validate the dishwashing machine was functioning properly and was in safe operating condition when the temperatures of the wash and rinse were not reaching manufacturer's directions. This failure had the potential to result in temperatures not reaching proper temperature levels which led to all the dishware, silverware, utensils, pots and pans not being sanitized to which can result in the growth of microorganisms which can lead to food borne illness for the highly susceptible population that was eating at the facility. The facility census was 49. Findings: During an observation on 1/22/25 at 9:17 a.m. in main kitchen at dishwashing station, dishwashing rinse temp gauge read 124F and dishwashing wash temp gauge read 128F. During an interview on 1/22/25 at 9:30 a.m. with Director of Dietary Services (DDS), the DDS states staff use display gauges on front of machine to confirm machine temperatures. DDS states they have no other method for temperature validation. During a concurrent observation and interview on 1/24/25 at 10:55 a.m. with DDS and Administrator (ADM) at main kitchen dish machine. DDS states that the indicator on the temperature test strips where to change from Navy to Bright Orange at temperature of 180F. Testing strips were cycled in dishwashing cycle and indicator line remained a darkened color. During an observation and interview on 1/24/25 at 11:48 a.m. with DDS and ADM a temperature test strip was submerged in a cup of 187F water with indicator strip changing to bright orange. Color change was confirmed by DDS and ADM. During a review of the facility's policy and procedure titled Recording of Dish machine Temperatures, dated 8/29/2023, the policy and procedure indicated Periodically the Director of Food and Nutrition Services or other clinically qualified professional should check the accuracy of the gauges by sending a thermal strip through the dishmachine. Report temperatures that are less than the required levels (See above) to the Director of Food and Nutrition Services or other clinically qualified nutrition professional and immediately convert to paper service until the temperature is corrected. During an interview on 1/24/25 at 3:00 p.m. with Vendor Technician (VT2), VT2 states temperature gauges for wash and rinse temperatures on dishwashing machine are not working and recommends replacement. According to the Food and Drug Administration (FDA) Food Code 2022, Section 6-501.11 Repairing, Physical Facilities shall be maintained in good repair.