

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Cornerstone Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2550 9th Street Sanger, CA 93657	

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)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document the condition of one of two residents (Resident 2) upon discharge from the facility. This failure resulted in Resident 2's clinical record not containing details of his emergency discharge from the facility and events leading to why he was sent out by ambulance with police also being called to the facility. During a review of Resident 2's admission Record (AR), dated 1/21/26, the AR indicated Resident 2 was admitted to the facility on [DATE] and was discharged on 6/25/25. During a review of Resident 2's Progress Notes (PN), dated 6/25/26, the PN indicated, Resident was very aggressive to CNA [Certified Nursing Assistant] during care and hurt CNA wrist. DON [Director of Nursing] witness and called police. Resident was sent out approx. (approximately). 1030 am on gurney via emergency transportation. There were no further PN regarding this event. The PN was written by Licensed Vocational Nurse (LVN) 1. During a concurrent record review and interview on 1/29/26, at 2:35 p.m., with LVN 1, Resident 2's clinical record was reviewed. LVN 1 stated on 6/25/26, she was assigned to Resident 2's care. LVN 2 stated, That day, I don't really remember, my DON came in and dealt with the situation because I was passing medications. I was a brand new nurse. I didn't know I was supposed to make a 'SBAR' for that. (Note: SBAR is a standardized communication tool designed to facilitate the clear and efficient transfer of critical patient information between healthcare professionals. The acronym stands for: S - Situation: A concise statement of the current problem or the reason for the communication. B - Background: Relevant clinical context, such as the resident's admitting diagnosis, medical history, and recent medications. A - Assessment: An analysis of the situation based on clinical findings, vital signs, or the professional's interpretation of the issue. R - Recommendation: Specific requested actions, such as orders for tests, treatments, or an immediate evaluation. Purpose: It is primarily used during high-[NAME] moments like patient handoffs (shift changes), transfers between units, or when escalating a deteriorating patient's condition to a physician.) During a concurrent record review and interview on 1/29/26, at 2:40 p.m., with the Administrator, Resident 2's clinical record was reviewed. The Administrator stated the DON referenced in the 6/25/25 PN was no longer employed at the facility. The Administrator stated LVN 1 had started a 'SBAR', but it was incomplete. There should be notes about [Resident 2's] transfer. The Progress Note was incomplete, the 'SBAR' was incomplete, and [LVN 1] clearly did not complete this. During a review of the facility's Policy and Procedure (P&P) titled Transfer and Discharge, dated 12/19/22, the P&P indicated, Emergency Transfers/Discharges - initiated by the facility for medical reasons to an acute care setting, such as a hospital, for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified). Document assessment findings and other relevant information regarding the transfer in the medical record.</p>

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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