

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

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

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 06/10/2024
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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity and respect for one of two sampled residents (Resident 52) when Resident 52's urinary catheter (flexible tube inserted into bladder to drain urine) bag was not covered and was visible to residents and visitors to see. This failure had the potential to violate Resident 52's privacy and dignity. Findings: During a concurrent observation and interview on 6/3/24 at 9:50 a.m. in Resident 52's room, Resident 52 was sitting up in his wheelchair at bedside with a urinary catheter bag hanging underneath the wheelchair uncovered. The urine bag was visible when entering the room and the bag was filled with yellow urine. Resident 54 stated he needed the urinary catheter because he was not able to void (urinate) but could not remember how long he had the urinary catheter. Resident 54 stated he did not know staff had been hanging the catheter bag without a cover for everyone to see. During a review of Resident 54's Admission Record (AR-a document with personal identifiable and medical information), dated 6/6/24, the AR indicated Resident 54 was admitted to the facility on [DATE] with diagnoses which included, hemiplegia (muscle weakness or partial paralysis[complete or partial loss of muscle function]) and hemiparesis (one-sided muscle weakness), obstructive and reflux uropathy (obstructed urinary flow) and benign prostatic hyperplasia (enlarged prostate gland). During an observation on 6/4/24 at 8:10 a.m. in Resident 52's room, Resident 52's catheter bag was hanging on the bed frame uncovered, facing the door. The catheter bag was visible and easily seen from the doorway. During a concurrent observation and interview on 6/4/24 at 8:15 a.m. with Certified Nursing Assistant (CNA) 1, in Resident 54's room, Resident 54's urinary catheter bag was hanging on the bed frame without a privacy bag (bag cover) covering it. CNA 1 stated the urine bag was supposed to be always placed in a privacy bag. CNA 1 stated it was Resident 54's right to have his privacy and dignity respected. CNA 1 stated she should have placed Resident 54's urinary catheter bag in a privacy bag because it was easily seen by anyone entering the room. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056100	Facility ID: 056100 If continuation sheet Page 1 of 59

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 06/10/2024
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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/24 at 11:52 a.m. with the Director of Staff Development (DSD), the DSD stated her expectation was for CNAs to place urinary catheter bag in a privacy bag regardless of whether resident is laying in bed or up in wheelchair. The DSD stated there were other residents, staff and visitors walking by and could easily see the catheter bag, the DSD stated . It is a dignity issue for the resident . During an interview on 6/6/24 at 8:22 a.m. with Infection Preventionist (IP- works to prevent germs from spreading within the facility), the IP stated all nursing staff were in-serviced on making sure urinary catheter bags were placed in a privacy bag. The IP stated the expectation was to change the privacy bag as needed and provide resident privacy. The IP stated not placing the urinary catheter bag in a privacy bag was a dignity issue. During an interview on 6/6/24 at 10:15 a.m. with Licensed Vocation Nurse (LVN) 1, LVN 1 stated the CNAs had to make sure catheter bags are placed in a privacy bag. LVN 1 stated staff had to respect resident privacy. LVN 1 stated it was a dignity issue for urinary catheter bag to be exposed and for everyone walking by to see. During an interview on 6/10/24 at 8:49 a.m. with the Director of Nursing (DON), the DON stated her expectation was for nursing staff to make sure urinary catheter bags were covered with privacy bag. The DON stated it was a dignity issue having the urinary catheter bags out for everyone to see. During a review of the facility's policy and procedure titled Dignity, dated 2/2021, the P&P indicated, . Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem . Residents are treated with dignity and respect at all times . Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity . for example . helping the resident to keep urinary catheter bags covered .		

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 06/10/2024
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)		
F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48424 Based on observation, interview, and record review the facility failed to post the most recent survey results in a place readily accessible to residents and their representatives when the facility survey binder did contain the survey results for the year 2022. This failure had the potential to violate the rights of residents and their representatives to be informed of previous survey results. Findings: During an observation on 6/6/24 at 8:35 a.m. a binder labeled Survey Binder was located in a holder labeled Survey Findings folder on the wall in between the administrator's office and the nurses station. The binder did not contain recertification survey results for the year 2022, which was the facility's last recertification survey. During a concurrent interview and record review on 6/6/24 at 8:40 a.m. with the Administrator (ADM), the Survey Binder was reviewed. The ADM stated, the binder did not have the results of the previous survey done in 2022. The ADM stated the previous survey results should have been in an easily accessible area like in the nurses station. The ADM stated the previous recertification survey results were kept in a separate unlabeled binder in his office. The ADM stated having the previous surveys findings allowed the residents and their family members to view the survey results independently. During an interview 6/7/24 at 10:24 a.m. with the Director of Nursing (DON), the DON stated the previous recertification survey results should have been available in a highly visible area. The DON stated if the previous survey results weren't made readily available to everyone, residents and family members would not know the results of the last survey. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, dated 8/09, the P&P indicated, . 1. Federal and state laws guarantee certain basic right to all residents of this facility. These rights include the resident's right to: . f. examine survey results .		

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 06/10/2024
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424 Based on observation, interview, and record review the facility failed to ensure a clean and homelike environment was provided for five of 14 sampled residents (Residents 8, 44, 56, 85 and 96) when: 1. The ceiling in Resident 8, 44, and 56's room had a hole with water stains surrounding it and peeling cracked paint. 2. Resident 85's wall mounted light pull string was in dis-repair and Resident 85 was using a plastic bag to control the light. 3. One light bulb on Resident 96's wall mounted light was not working. These failures resulted in an environment that was not homelike for Residents 8, 44, 56, 85 and 96. Findings: 1. During a review of Resident 8's Minimum Data Set (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 5/28/24, the MDS indicated, a Brief Interview for Mental Status (BIMS- an assessment of cognitive function) score of seven (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 8 had severe cognitive impairment. During a review of Resident 44's MDS, dated [DATE], the MDS indicated a BIMS score of one indicating Resident 44 had severe cognitive impairment. During a review of Resident 56's MDS, dated [DATE], the MDS indicated a BIMS score of six indicating Resident 56 had severe cognitive impairment. During a concurrent observation and interview on 6/5/24 at 11:05 a.m. with Certified Nursing Assistant (CNA) 10 in Resident 8, 44, and 56's room, the ceiling had a hole with water stains surrounding it and peeling cracked paint. CNA 10 stated the ceiling looked chipped and cracked. CNA 10 stated the ceiling looked like it had water damage due to the water stain. CNA 10 stated the condition of the ceiling did not promote a homelike environment. CNA 10 stated it was important to have an intact ceiling in the room because the room was the Residents' home. During a concurrent observation and interview on 6/5/24 at 11:19 a.m. with the Maintenance Supervisor (MS) in Resident 8,44, and 56's room, the ceiling had a hole with water stains surrounding it and peeling cracked paint. The MS stated there was existing water damage in the ceiling from a previous leak. The MS stated the hole and chipped paint needed to be fixed. The MS stated the ceiling should have been fixed a while ago. The MS stated the condition of the ceiling did not promote a homelike environment. The MS stated the ceiling should have been in a good homelike condition because it was important to have an intact ceiling so the residents can feel at home. (continued on next page)		

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 06/10/2024
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/7/24 at 10:38 a.m. with the Director of Nursing (DON), the DON stated the ceiling in Resident 8, 44, and 56's room should have been in a clean and intact condition. The DON stated the room was not homelike in its current condition. The DON stated it was important to have a the ceiling in a homelike condition because it was where Residents 8, 44, and 56 lived, it was their home. The DON stated the residents in the room were not cognitively intact. The DON stated if a cognitively intact resident had been in the room, they might have expressed concerns about the condition of the ceiling and felt uncomfortable staying in their room. During a review of the facility's Policy and Procedure (P&P) titled Homelike Environment, dated 5/2014, the P&P indicated, . Resident are provided with a safe, clean, comfortable, and homelike environment . 1. Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 2. The facility staff shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. cleanliness and order . During a review of the facility's Maintenance Director Job Description, dated 11/1/2016, the job description indicated, . Position Summary. Responsible for the building, the equipment and other materials located in and around the physical property. Implementing and planning and organizing system to maintain the operations of the property and maintain it in good, clean, and safe order . Essential Duties . Must have skills to work and lead . remodels including sheetrock installation and repair, mudding, patching, taping and painting . Maintain a safe and secure environment for all staff, residents and guests, following established safety standards . 48430 2. During an observation 6/4/24 at 3:32 p.m. in Resident 85's room, Resident 85's wall mounted light had a shortened pull string on the left side with a garbage bag tied to the short pull string acting as an extension. During a concurrent interview and record review on 6/5/24 at 11:36 a.m. with the Maintenance Facility Director (MFD), the Maintenance Log (ML) dated from January to June 2024 was reviewed. The ML indicated, there was no record of the missing light pull string logged. MFD stated, he did not know about the missing/broken cord on Resident 85's wall mounted light. MFD stated, That particular one [missing cord] isn't marked in here. MFD states, it [missing cord] should have been logged so it could be repaired. 3. During an interview on 6/4/24 at 3:20 p.m. with Resident 96, Resident 96 stated the bottom light in his wall mounted light was not working. During a concurrent observation and interview on 6/4/24 at 3:32 p.m. with Resident 96, in his room, the bottom light of the wall mounted light fixture was not working. Resident 96 stated, the bottom bulb had been burned out. Resident 96 stated, he had been telling the staff since February about the light but still had not been repaired. During an interview on 6/5/24 at 11:36 a.m. with the MFD, the MFD stated he did not know about the burned-out bulb for Resident 96's wall mounted light. MFD stated, the burned-out bulb should have been repaired. (continued on next page)		

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 06/10/2024
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/7/24 at 10:01 a.m. with the Director of Nursing (DON), the DON stated, the broken light should have been fixed. The DON stated, her expectation was for equipment being used by the residents to be in good working order. The DON stated having burned out lights do not make for a homelike environment. The DON stated, falls could have resulted due to insufficient lighting in the room. During a review of the facility's Maintenance Log (ML), the ML dated 4/21/24 indicated, 5B1 light doesn't work. During a review of the facility's P&P titled, Homelike Environment, dated February 2021, the P&P indicated, . Residents are provided . comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and homelike environment . sufficient general lighting in resident-use areas; even light levels . During a review of the facility's P&P titled, Maintenance Service, dated December 2009, the P&P indicated, . The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a . operable manner at all times . Functions of the maintenance personnel include . maintaining lighting levels that are comfortable, and assuring .lights are in good working order .		

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 06/10/2024
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)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on interview and record review, the facility failed to ensure the Minimum Data Set assessment (MDS-assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status of one of five sampled residents (Resident 64) when Resident 64's anxiety (feeling of fear, dread, and uneasiness) diagnosis was not accurately coded on the MDS assessment. This failure had the potential to result in Resident 64's care needs not met. Findings: During a review of Resident 64's Admission Record (document with resident demographic and medical diagnosis information), dated 6/6/24, indicated Resident 64 was admitted in the facility on 10/9/23 with diagnoses which included unspecified psychosis (mental health problem that causes people to perceive or interpret things differently from those around them) and dementia (loss of cognitive functioning-thinking, remembering, and reasoning). During a review of Resident 64's, Physician Order, undated, the Physician Order, indicated, . busPIRone HCl [hydrochloride-acid salt] Oral Tablet 10 MG [milligram-unit of measurement] (Buspirone HCl) Give 1[one] tablet by mouth two times a day for anxiety . During a review of Resident 64's Progress Note, undated, the Progress Note, indicated, . DOS [date of service] 2/2/2024 . History of Present Illness: . Anxiety: managed with Alprazolam [medication used to treat anxiety] . DIAGNOSIS AND ASSESSMENT . ICD Codes [diagnosis codes] . F41.9 Anxiety . During a concurrent interview and record review on 6/6/24 at 11:45 a.m. Resident 64's quarterly MDS assessment dated [DATE], section N (medications) and section I (active diagnosis) was reviewed by the Minimum Data Set Nurse (MDSN). The MDSN stated Resident 64 received antianxiety medication since 11/23. MDSN stated Resident 64 was started on alprazolam as needed in 11/23 then started on routine buspirone on 2/16/24. MDSN stated Resident 64's use of antianxiety medication was coded on the MDS assessment, but diagnosis of anxiety was not coded in the MDS assessment. MDSN stated Resident 64's anxiety diagnosis should have been coded in the MDS assessment but was not coded. The MDSN stated Resident 64's MDS was inaccurately coded. During an interview on 6/10/24 at 8:55 a.m. with the Director of Nursing (DON), the DON stated the MDSN and other staff who completed the MDS assessment needed to ensure resident assessments were complete and accurate. DON stated MDSN should have added and accurately coded the diagnosis of anxiety knowing Resident 64 was taking antianxiety medication. DON stated the MDSN was responsible in making sure resident's diagnoses were complete and accurate. DON stated the facility did not have a policy and procedure on MDS assessment, all assessments was based on Resident Assessment Instrument (RAI-core set of screening, clinical, and functional status elements including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid). (continued on next page)		

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

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

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 06/10/2024
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)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of professional guideline titled, Long Term Care Facility Resident Assessment Instrument version 1.18.11 Manual (RAI- core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid) dated 10/23, indicated, . Physician-documented diagnoses . that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments . Medical record sources for physician diagnoses include progress notes .		

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 06/10/2024
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40641 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan for six of 21 sampled residents (Residents 18, 40, 44, 22, 55, and 74) when: 1. Resident 18 did not have a care plan for the use of anticoagulant (medication used to prevent blood clot) medication. This failure placed Resident 18 at a potential risk for bleeding which could lead to serious health condition. 2. Resident 40 did not have a care plan for her non-compliance to use proper footwear when ambulating. This failure placed Resident 40 at a potential risk for accidents like falling which could lead to injury like fracture (bone break). 3. A floor mat was not placed on the floor next to Resident 44's bed as indicated in the care plan. This Failure had the potential to cause Resident 44 to be injured during a fall. 4. There were no care plans developed for Resident 22, 55, and 74's prescribed antibiotics. This failure resulted in the Resident 22, 55, and 74 not having a comprehensive person-centered care plan. Findings: 1. During a concurrent observation and interview on 6/3/24 at 12:30 p.m. in Resident 18's room, Resident 18 was sitting up in her wheelchair at bedside, her lunch tray was set up in front of her. Resident 18 did not respond to questions asked. During a review of Resident 18's Admission Record (AR-a document with personal identifiable and medical information), dated 6/6/24, the AR indicated, Resident 18 was admitted on [DATE] with diagnoses which included cerebral infarction (result of disrupted blood flow to the brain) and muscle weakness. During a review of Resident 18's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 5/6/24, indicated the Brief Interview for Mental Status (BIMS) score was 1 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 18 was severely impaired in daily decision making. During a concurrent interview and record review on 6/5/24 at 1:40 p.m. with Minimum Data Set Coordinator Nurse (MDSN), Resident 18's physician orders was reviewed. MDSN stated Resident 18's apixaban (anticoagulant medication) medication was started on 5/31/24. MDSN stated she did not find a care plan for the use of anticoagulant medication. MDSN stated the licensed nurse who received the order should have initiated a care plan. MDSN stated care plan should have been started and completed within 24 hours after receiving the order and started the medication. MDSN stated care plan was very important to monitor for bleeding and or bruising due to the use of anticoagulant medication. (continued on next page)		

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 06/10/2024
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/5/24 at 3:15 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 reviewed Resident 18's medication orders and stated Resident 18 was receiving anticoagulant medication. LVN 1 stated Resident 18's apixaban was ordered on 5/31/24 for cerebral infarction (disrupted blood flow to the brain). LVN 1 stated she did not find a care plan for Resident 18's use of apixaban. LVN 1 stated there should have been a care plan developed within 24 hours of receiving the order and starting the medication by the licensed nurse who received the order. During an interview on 6/10/24 at 9:15 a.m. with the Director of Nursing (DON), the DON stated her expectation was for the licensed nurse receiving the order to have initiated a care plan to monitor for any side effects of the medication. DON stated care plans were specific and personalized for each resident needs. 2. During a concurrent observation and interview on 6/3/24 at 12:35 p.m. in Resident 40's room, Resident 40 was observed sitting at the edge of her bed eating lunch and watching TV. Resident 40 was wearing regular socks and observed several pairs of footwear underneath the over the bed table. Resident 40 stated she walked around in the facility hallway using a walker and did not have any issues or complaints. During a review of Resident 40's Admission Record, dated 6/6/24, the AR indicated Resident 40 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, fibromyalgia (long-term condition that involves widespread body pain and tiredness) and personal history of traumatic fracture (break in bone). During a review of Resident 40's Minimum Data Set assessment (MDS), dated [DATE], the MDS indicated the BIMS score was six out of 15, which indicated Resident 40 was severely impaired in daily decision making. During an observation on 6/4/24 at 9:12 a.m. in the hallway in front of the nursing station, Resident 40 was observed ambulating using a walker and was wearing regular socks and no footwear. During a concurrent observation and interview on 6/4/24 at 9:20 a.m. with Rehabilitative Nursing Assistant (RNA), Resident 40 was walking in the hallway with no footwear. RNA stated Resident 40 was walking in the hallway wearing regular socks only. RNA stated Resident 40 was frequently seen walking in the hallway and not wearing the appropriate footwear like shoes or non skid socks. RNA stated she asked Resident 40 a few times to go back in her room to put on a shoe or a non-slid socks but Resident 40 refused. RNA stated she remembered reporting to the nurse about Resident 40 walking on the hallway and not wearing appropriate footwear. RNA stated Resident 40 was at risk of tripping and falling because she prefers wearing regular socks only when ambulating. During a concurrent interview and record review on 6/5/24 at 3:30 p.m. with LVN 1, LVN 1 stated a CNA reported to her the previous day (6/4/24) about Resident 40 walking in the hallway wearing regular socks only and tried talking to Resident 40 to put on a non-slid socks or a closed shoe but Resident 40 refused. LVN 1 stated Resident 40 was non-compliant at times with care and refused to wear non-skid socks and shoes when walking outside of her room. Resident 40's care plans were reviewed. LVN 1 stated she did not find a care plan to address Resident 40's non-compliance. LVN 1 stated there should have been a care plan for Resident 40's history of non-compliance in not wearing the appropriate footwear when ambulating. (continued on next page)		

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 06/10/2024
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/24 at 9:15 a.m. with the DON, the DON stated Resident 40 was sometimes observed walking in the hallway wearing regular socks and not wearing shoes. DON stated Resident 40 was very independent with her ADL's (skills required to manage one's basic physical needs, including personal hygiene or grooming, dressing, toileting, transferring or ambulating and eating) and does her own thing. DON stated Resident 40 had episodes of non-compliance and should have been care planned. DON stated Resident 40 was at risk of accidents like tripping and falling which could lead to fracture. During a review of facility's policy and procedure (P&P) titled, Care Plans - Comprehensive, dated 9/10, the P&P indicated, . The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS . comprehensive care plan is designed to: a. Incorporate identified problem areas . Incorporate risk factors associated with identified problems . Reflect resident's expressed wishes regarding care . treatment goals, timetables and objectives in measurable outcomes . 48424 3. During a review of Resident 44's Admission Record, dated 4/12/19 , the AR indicated Resident 44 had the following diagnoses: Parkinson's Disease (condition which affects the body's movements), Dysarthria (difficulty speaking due to muscle weakness) and anarthria (a complete loss of speech), Alzheimer's Disease (condition where someone cannot remember things), and Glaucoma (eye disease which causes vision loss and blindness). During a review of Resident 44's Minimum Data Set, dated [DATE], the MDS indicated a Brief Interview for Metal Status score of one, indicating Resident 44 had severe cognitive impairment. During an observation on 6/3/24 at 10:48 a.m. in Resident 44's room, Resident 44's bed was seen in the lowest position with no fall mats in place. During a concurrent observation and interview on 6/6/24 at 10:12 a.m. with CNA 9 in Resident 44's room, no fall mats were seen on either side of Resident 44's bed. CNA 9 stated housekeeping removed the mats to clean them. CNA 9 stated Resident 44 was a fall risk. CNA 9 stated Resident 44 fell frequently. CNA 9 stated Resident 44 should have had fall mats placed on the right side of her bed in order to minimize any injuries which could happen from her falling. During an interview on 6/6/24 with the Housekeeping Supervisor (HS), the HS stated when housekeeping staff clean fall mats they clean them in the room. The HS stated housekeeping staff do not take fall mats out of the room for regular cleaning. The HS stated the floor mats were cleaned every day when the rooms were cleaned. The HS stated it only took five to seven minutes to clean a floor mat. The HS stated if a room was scheduled to be deep cleaned then they took the floor mats out but Resident 44's room was not scheduled for a deep clean until 6/12/24. The HS stated no one had asked housekeeping staff to clean Resident 44's fall mat. The HS stated there was no fall mat present by Resident 44's bed for the whole week. The HS stated housekeeping staff knew to not remove any floor mats because it posed a risk for injury to residents who had fall tendencies. During a review of the facility's document titled, Deep Clean Calendar, dated 6/24, the calendar indicated Resident 44's room was scheduled for a deep cleaning on 6/12/24. (continued on next page)		

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 06/10/2024
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/6/24 at 3:08 p.m. with Licensed Vocation Nurse (LVN) 6, Resident 44's Care Plan was reviewed. The Care Plan indicated Resident 44 was to have a floor mat placed on her right side LVN 6 stated Resident 44 should have had fall mats on the right side of her bed as indicated on her care plan. LVN 6 stated all staff were responsible for ensuring care plans were being followed. LVN 6 stated Resident 44 could have fallen and injured herself if she didn't have her fall mat in place. LVN 6 stated the care plan was not followed for Resident 44. During an interview on 6/7/24 at 10:24 a.m. with the Director of Nursing (DON), the DON stated nurses were responsible for making and updating the care plans. The DON stated care plans were important to monitor and manage resident conditions. The DON stated Resident 44 should have had her fall mat in place at all times in order to minimize any risk for injuries. The DON stated if the floor mat needed to be removed for cleaning reasons, staff should have placed a replacement mat in Resident 44's room. The DON stated the care plan was not followed for Resident 44. During a review of the facility's policy and procedure (P&P) titled, Care Plans-Comprehensive, dated 9/2010, the P&P indicated, . an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident medical, nursing, mental and psychological needs is developed for each resident . 1. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS . 3. Each resident's comprehensive care plan is designed to: a. incorporate identified problem areas; B. incorporate risk factors associated with identified problems . e. reflect treatment goals timetables and objectives and measurable outcomes . g. Aid in preventing or reducing declines in the residence functional status and/or functional levels . During a review of the facility's LVN Job Description, dated 11/1/2016, the document indicated . The LVN is responsible for assisting with resident care . Responsible for all documentation as required . Works towards maintaining each resident's self-respect, personal dignity, personal safety . Observe residents and collect data pertinent to resident care. Communicate all relevant resident information with physicians and other healthcare professionals as needed Maintain a safe and secure environment for all . residents . 48430 4. During a concurrent interview and record review on 6/6/24 at 3:28 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 55's Medication Administration Record (MAR), dated 6/1/24-6/30/24 was reviewed. The MAR indicated, . Vancomycin [a medication to treat infections] . Oral [by mouth] Capsule [a small, swallowable container that holds medicine] 125 MG [milligrams-a unit of measurement] . for C-Diff [a type of bacteria [microscopic organism] Prophylaxis [prevention of disease] . dated 06/05/2024 at 0800. LVN 2 stated, there were no specific care plans (CP- a summary of an individual's health conditions and treatment plans) for vancomycin to be used as a prophylaxis. LVN 2 stated, the CP should have been put in by a nurse to specify the medicine's use. During a concurrent interview and record review on 6/6/24 at 6:07 p.m. with the Minimum Data Set Nurse (MDSN) 1, Resident 55's CP, dated June 2024 was reviewed. MDSN 1 stated, nurses usually started a CP and the MDSN reviewed it. MDSN 1 stated, there was no CP for the vancomycin prophylaxis. MDSN 1 stated, yes, there should have been [a CP]. MDSN 1 stated, a CP was important because the medications effectiveness and any side effects could be monitored during the duration of the treatment. (continued on next page)		

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 06/10/2024
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/6/24 at 10:25 a.m. with the Director of Nursing (DON), the DON stated, a CP was put in on 6/6/2024 but the CP should have been put in when the medication was started and not a day or two later. The DON stated, care plans were important so the medication's effectiveness or side effects could be monitored and to determine if the goals and interventions were followed by the nurses. During a concurrent interview and record review on 6/6/24 at 5:41 p.m. with LVN 2, Resident 74's Orders, dated 6/3/2024 was reviewed. LVN 2 stated, Resident 74 was on Doxycycline (a type of antibiotic medication) 100 MG . two times a day for pus on the open stoma (a surgically made hole on the body) for 4 weeks . During a concurrent interview and record review on 6/6/24 at 5:46 p.m. with LVN 2, Resident 74's CP, dated June 2024 was reviewed. LVN 2 stated, there are no CP for Resident 74's use of doxycycline found. During an interview on 6/6/24 at 6:00 p.m. with MDSN 1, MDSN 1 stated, He [Resident 74] does not [have a CP for doxycycline.] Yes, he should [have a CP]. MDSN 1 stated, it was important to have a CP to monitor the effectiveness of an antibiotic and to determine if the infection was improving and to monitor for any side effects related to antibiotic use. MDSN 1 stated, I didn't know about this [doxycycline]. MDSN 1 stated, any nurse could put in a CP but it was the responsibility of the MDSN to ensure a CP was there. During an interview on 6/7/24 at 10:38 a.m. with the DON, the DON stated, there were no CP for the doxycycline and there should have been one. The DON stated, As soon as an order for medications are put it, a CP should immediately be put in. During a concurrent interview and record review on 6/6/24 at 6:07 p.m. with MDSN 1, Resident 22's MAR, dated 6/1/2024-6/30/2024 was reviewed. The MAR indicated, an order for (Rifaximin brand name) 550 mg was started on 12/11/2023. MDSN 1 stated, the (Rifaximin brand name) was an antibiotic (a medication used against bacteria). During a concurrent interview and record review on 6/6/24 at 6:07 p.m., with the MDSN 1, Resident 22's CP, dated June 2024 was reviewed. MDSN 1 stated, No, there's no care plan for that [Rifaximin brand name]. MDSN 1 stated, there should have been a care plan for use of (Rifaximin brand name). During an interview on 6/7/24 at 10:44 a.m. with LVN 4, LVN 4 stated, she cannot find a CP for the (Rifaximin brand name). LVN 4 stated, any antibiotic use required a CP to be put in. During an interview on 6/7/24 at 10:44 a.m. with the DON, the DON stated, I don't see that specific medication [Rifaximin brand name] in the care plan. The DON stated, there isn't a CP for (Rifaximin brand name) and there should have been one. The DON stated, a CP was necessary to know the goals and interventions of the resident while on the medication. The DON stated, monitoring of the side effects of the medications was also an important purpose of having a CP. During a review of the facility's policy and procedure (P&P) titled, Managing Infections, dated March 2018, the P&P indicated, The nursing staff . will monitor the progress of a resident with an infection until it is resolved . (continued on next page)		

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

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

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 06/10/2024
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Care Plans-Comprehensive, dated September 2010, the P&P indicated, . Our facility's Care Planning/Interdisciplinary Team, . develops and maintains a comprehensive care plan for each resident . Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change . The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: . When there has been a significant change in the resident's condition . During a review of the facility's Job Description (JB) for MDS, dated [DATE], the JB indicated, . The primary purpose of your job position is to conduct and coordinate the development and completion of the resident assessment . Performance Expectations-Zero File Errors . Essential Duties-Maintain and periodically update . care plan . coordinate the development of a written plan of care (comprehensive) for each resident that identifies the problems/needs of the resident, indicate the care to be given, goals to be accomplished .for each element of care . During a review of the facility's JB for Licensed Vocational Nurse, dated 12/01/2022, the JB indicated, . Medical Care Functions . Confer with the Care Planning Team in the development of the care plan .		

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 06/10/2024
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)		
F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41166 Based on observation, interview and record review, the facility failed to ensure accurate documentation of a mental health diagnosis for 1 of 28 sampled residents (Resident 75) based on standards of practice when Resident 75's medical record was marked with schizoaffective disorder (a mental health disorder marked by a major mood episode and a break down between thought, emotion, and behavior) as a diagnosis for use of quetiapine (brand name used- an antipsychotic [mind altering] medication used to treat mental disease) and aripiprazole (brand name used, antipsychotic) with no prior history of such diagnosis. This failure resulted in Resident 75 being inappropriately administered aripiprazole and quetiapine, which resulted in adverse events including weight gain. Findings: During an observation on 6/5/24 4:36 p.m., in Resident 75's room, Resident 75 was observed lying on right side in his bed watching television. When asked how he was doing, Resident 75 responded, by pointing to his ears and stating he couldn't hear too good in a loud voice. During a review of Resident 75's Hospital Medical Records (HMR) dated, 11/19/22, the HMR indicated, History of Present Illness . Per son, patient has underlying memory issues but has not had formal evaluation . Assessment: Per [son], their father lives alone though they tried to convince him to live with them but pt [patient] preferred to live by himself . Principal Diagnosis Cerebellar CVA [cerebral vascular accident happens when blood supply stops to the part of the brain that helps with body movement, eye movement, and balance] . Active Problem List . ataxia [loss of coordination] . During a review of Resident 75's Face Sheet (FS a document containing resident's personal information), dated 6/7/24, Resident 75's FS indicated, Resident 75 was admitted to the facility on [DATE] with diagnoses including ataxia following cerebral infarction, (CVA) and cerebellar stroke syndrome (CVA in certain area of the brain). During an interview on 6/6/24 at 10:38 a.m., with Resident 75's Responsible Party (RP) 2, RP 2 stated he was previously told his father, Resident 75, had dementia. RP 2 stated that the facility however, told him that Resident 75 had Schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves, and may seem like they have lost touch with reality), that is why Resident 75 was being administered medication. RP 2 stated he thought it was dementia because people like Resident 75 didn't have short term memory but had long term memory. RP 2 stated, I guess they were having problems with him, he would get angry, and he wouldn't let them help him, they said it wouldn't harm him, it would help him be calm, it was last year or year before, I'm not sure. RP 2 stated, Resident 75 slept a lot more and didn't want to eat. RP 2 stated, He was always active then all of sudden he started getting tired, not wanting to get up and sleeping a lot and the food too, not wanting to eat I think started happening last year. RP 2 stated he has had to go to the facility to talk to Resident 75 and get him to understand the facility is there to help him and shared with the facility to tell Resident 75 that everything is all right, they're his friends and they're there to help him and he's safe. (continued on next page)		

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 06/10/2024
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)		
F 0658 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 75's Minimum Data Set (MDS) (assessment and care screening of a patient) dated 12/1/22, 2/28/23, and 5/30/23, Resident 75's MDS indicated Resident 75 did not have a diagnosis for psychiatric or mood disorder including bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme highs to lows) or schizophrenia, and Resident 75 did not have a history of hallucinations (when one thinks something they see, hear, smell, touch or taste is real, but it's not or delusions (inability to distinguish what is real and what seems to be real). During a review of Resident 75's Physician Orders (PO) and Medication Administration Record (MAR) dated 2/23, 5/23, 6/23, 7/23, 8/23 2/24, 3/24, for aripiprazole, Resident 75's PO and MAR indicated for: Aripiprazole 2 mg (milligram unit of measure) daily for bipolar disorder manifested by slamming door shut, barricading door and jumping on bed 3/4/23 to 3/9/23 Aripiprazole 2 mg twice daily for bipolar disorder manifested by slamming door shut, barricading door, and jumping on bed 3/9/23 to 5/9/23 Aripiprazole 5 mg daily for schizoaffective disorder 6/29/23 to 7/13/23 Aripiprazole 5 mg twice daily for schizoaffective disorder 7/13/23 to 10/24/23 Aripiprazole 2 mg twice daily for schizoaffective disorder 10/24/23 to 5/6/24 Aripiprazole 2 mg daily for schizoaffective disorder 5/6/24 to 5/22/24 Aripiprazole 2 mg every other day for 5 days for schizoaffective disorder 5/22/24 to 5/27/24 During a review of Resident 75's PO and MAR for Quetiapine, Resident PO and MAR dated 2/23, 5/23, 6/23, 7/23, 8/23 2/24, 3/24, for quetiapine, Resident 75's PO and MAR indicated for: Quetiapine 50 mg every 12 hours for schizoaffective disorder manifested by pacing down the hallways and yelling I own this building, I run this place and trying to hit everyone 5/4/23 to 7/11/23 Quetiapine 100 mg every 12 hours for schizoaffective disorder 7/11/23 to 10/24/23 Quetiapine 75 mg by mouth every 12 hours for schizoaffective disorder 10/23/23 to 2/6/24 Quetiapine 50 mg by mouth every 12 hours for schizoaffective disorder 2/6/24 to 5/6/24 Quetiapine 25 mg every 12 hours for schizoaffective disorder 5/6/24 to 5/30/24 Quetiapine 12.5 mg at bedtime for schizoaffective disorder 5/30/24 to present (continued on next page)		

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 06/10/2024
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)		
F 0658 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/6/24 at 2:53 p.m. with Certified Nursing Assistant (CNA) 8, CNA 8 stated she had cared for Resident 75 for on and off for almost 2 years. CNA 8 stated when Resident 75 was first admitted on [DATE], he was more alert, would get into his wheelchair, go to the dining room; Resident 75 didn't have as many falls and ate a lot better. CNA 8 stated she observed a big change in Resident 75 after he experienced COVID 19 (highly contagious respiratory disease cause by coronavirus) positive symptoms (December 2023); Resident 75 stopped eating for a little bit, and wanted to lay down, not wanting to get up or go to dining room. CNA 8 stated, she did not notice Resident 75 to have hallucination or delusions during her care. CNA 8 stated Resident 75 would look at staff confused and ask why everybody was in his house, say he wanted everybody out of his house, and ask for his family. During a review of Resident 75's Nursing Progress Notes (NPN), Resident 75's NPN indicated on: 11/29/22 12:14 p.m. Resident new admit. Resident alert and oriented x [for] 3 [measure for alertness and orientation]. Resident refused to get VS [vital signs medical signs that indicate the status of the body's vital functions] @ [at] 1100. Resident is non compliant and stated he is going to get up and walk home. Redirected resident to stay and get the help that he needs. Resident appears to not want to be here. Will cont. [continue] to monitor. 12/1/22 4:23 p.m. Writer was in room with resident and resident states they want to kill themselves, life is not living anymore and talks about past friend who killed themselves. CNA was also present and writer counted that resident repeated taking own life seven times approximately every other minute. Writer tried to talk to resident but resident is hard of hearing and does not comprehending. Resident kept going back to story of friend taking their own life and then resident states about taking own life. Writer inform DSD [Director of Staff Development], DON [Director of Nursing], Nurse and dinning services. Resident has one on one and on plastic utensils for 72 hours. 12/29/22 12:20 p.m. Resident is in bed watching the rain outside his window while having lunch. He is in a cheerful mood. Bed is in the lowest position along with call light/ bed control in his reach. He is telling the nursing team fond memories of his dog in the rain. His son did visit and will try to bring a photo the next time he visits him. 1/2/23 6:26 a.m. Resident is in a happy mood. A sign has been placed at his door to inform him that his son has his dog. He does enjoy talking to the noc [overnight] nursing team about life and his fond family memories. 1/20/23 10:50 a.m. Resident is S/P [status post after] room change to [room number]. He is adjusting well to his new room. He is in bed looking out the window and watching his tv. The bed is in the lowest position along with his bed controls being in his reach. He reports no pain or discomforts at this time. 1/21/23 10:56 a.m. Resident is S/P room change to [room number] He is adjusting well to his new room. He is in bed looking out the window and watching his tv. The bed is in the lowest position along with his bed controls being in his reach. He reports no pain or discomforts at this time. He keeps asking about his dog and is redirected by the staff. 1/24/23 3:22 p.m. Resident is S/P room change. He is adjusting well to room change. He has his call light and bed controls in his reach with his bed in the lowest position. He is in in his bed. (continued on next page)		

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 06/10/2024
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)		
F 0658 Level of Harm - Actual harm Residents Affected - Few	2/2/23 2:42 a.m. Writer observed resident resident getting into his roommates face telling him to get out of his room. Resident was educated on personal space and sharing the room. 2/2/23 4:57 a.m. Resident is upset to have another person in his room. He stated to the nursing team that he pays for this room and want to be alone in it. Writer educated the resident on the sharing of the room. He is upset and demanding that the other resident be moved out now. 2/13/23 9:59 p.m. Resident would mostly yell when he is hungry then shuts his door loudly which made another resident upset with the loud noise. He would also close the bathroom door so loud and his door closet. When resident is told about not shutting the doors, resident yells back at staff. 2/17/23 3:59 a.m. Resident continues to come out of room and ask about his dog and slam the room door. He reports his pain to be 0\10 with no discomforts. He has been offered several snacks and is now in his room watching the tv. 2/19/23 8:10 a.m. Writer along with the CNA staff have offered x3 to help the the resident change his clothing and to take a bed bath. He has refused x3 [three times] and yelled at the staff to get the hell out of his room now. Writer encouraged the resident to use a lower tone and to use his call light if he is in need of aid. 2/19/23 12:23 p.m. Resident is in bed having his lunch. He reports no pain or discomfort at this time. Bed is in the lowest position with call light and bed controls in his reach. Resident is able to make his needs known to the nursing team. He has been ambulating in the facility with ease with his non skid foot wear. He went outside with he writer to get some fresh air and look at he trees . He got excited when he saw all of the cars driving by. Call light and bed controls are in his reach. resident was offered aid to change his clothing he refused x3 again. 2/21/23 2:16 a.m. Resident is in his wheel chair looking for his dog at this time. He has been offered snack which he has eaten. He reports his pain to be none with no discomfort/ distress at this time. Writer did encourage him to wear non skid foot wear and to use the call light for aid. Writer did offer to help the resident change his clothing. Resident refused x 3. 2/25/23 11:59 a.m. Resident is on charting for s/p fall, no delayed injuries noted. Resident is alert. No new skin issues noted. Resident is in bed watching the tv and calling out for his dog. His call light/ bed control are within reach. He is s/p room change and is adjusting well to this new room. His son [RP 2] came to visit today. he was upset that he was not notified of his father being moved to another room. He informed the writer that the communication between the facility and family needs to greatly improve. Writer informed RP that this matter would be brought to the social service attention. 2/28/23 1:15 a.m. Resident is up opening his screen door yelling. Writer informed the resident that his dog was gone with his son. He was asked about pain he said no pain. Resident was given a snack. He is now in bed watching the tv. He was reminded to wear non skid footwear and to use his call light for aid. (continued on next page)		

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 06/10/2024
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)		
F 0658 Level of Harm - Actual harm Residents Affected - Few	3/2/23 6:11 a.m. Resident is up opening his screen door yelling out for his dog. Writer informed the resident that his dog was gone with his son. He was asked about pain he said no pain. Resident was given a snack. He is now in bed watching the tv. He was reminded to wear non skid footwear and to use his call light for aid. 3/3/23 2:02 a.m. Upon the NOC med pass. Writer was informed by the CNA on the wing of the resident slamming the restroom door in her face and striking her on the left shoulder. Writer asked the resident what was going on. He stated to the writer why is he in my bathroom? I pay rent here. Get him out of my house. Writer informed the reside that they all live here together. Along with sharing this space in the restroom. A snack was offered. Resident was helped back to his bed. Call light is in reach. Bed is in the lowest position. Writer asked resident if he was having any pain or discomfort. He replied no I'm fine just get him out of here. CNA did fill out an incident report. Writer did encourage he resident to keep his hands to himself. 3/3/23 2:13 p.m. Resident is being aggressive and getting into residents faces for being in common areas such as the hall way and restroom. He is not easily redirected until he feels as if he is getting his point across. He has been reminded of personal space and to keep his hands to himself and off others. resident was asked if he was in pain or having discomforts he responded with no I'm fine. Writer has placed his bed in the lowest position with the wheels being locked. A tv program of his choice is also playing. Resident is in a happy mood at this time. 3/4/23 3:14 a.m. Resident is being aggressive and getting into other residents/ staff faces for being in common areas such as the hallway and restroom. He is not easily redirected. He has been reminded of personal space and to keep his hands to himself and off others. Writer asked the resident was asked if he was in pain or having discomforts he responded with no. Writer is walking with the resident in the facility and looking outside with him to calm him talking about dogs and the war. Writer has placed his bed in the lowest position with the wheels being locked. A tv program of his choice is also playing. Resident is content and in bed. 3/4/23 3:20 p.m. Resident has a new order for [Brand name] Oral Tablet 2 MG (Aripiprazole) for Bipolar Disorder. Resident has been put on the medication due to behaviors. Resident MD [doctor] was contacted and was described the resident's behaviors and manifestations. Resident has such Manifestations Slamming Door Shut, Barricading door and Jumping on bed and has visual Hallucinations of seeing a dog and other humans. Resident MD gave the orders for this medications along with a DX [diagnosis] of Bipolar Disorder to support the medication order. Resident is self RP and aware of this new order of the medication. 3/5/23 00:11 a.m. Upon writers rounds the resident was in the hallway yelling for his dog. Writer informed the resident that his dog was with his son and that people are trying to sleep. Resident informed the writer that he don't care we are all nuts. Writer informed the resident that he was safe and being cared for. The resident was asked if he was in pain or having discomforts he responded with no. Writer has placed his bed in the lowest position with the wheels being locked. A tv program of his choice is on. Writer offered the resident a snack. He told writer thank you and sat on his bed. (continued on next page)		

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 06/10/2024
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)		
F 0658 Level of Harm - Actual harm Residents Affected - Few	6/23/23 2:06 a.m. Resident is up walking he halls of the wing. Going into other rooms demanding that the resident get the [expletive] out of his house or his sister will kick their ass. Writer informed the resident of personal space and using respectful language when talking to others. Resident has been redirected to the common areas of the facility. When asked about his pain he reports that he is fine and we need to get out of his house. Resident is in the common room watching the tv and having snacks. 6/26/23 2:06 a.m. Resident is up walking [the] halls of B wing. Going into the other rooms looking for his dog and questioning why all these people are here? He is demanding that we all leave his [expletive] trailer. Writer informed the resident of personal space and using respectful language when talking to others. Resident has been redirected to the common areas of the facility. When asked about his pain he reports that he is ok. Resident is in the common room watching the tv with other residents and having snacks. He has on his non skid footwear. His bed is in the lowest position with his call light in reach. 6/26/23 1:03 p.m. The resident is being aggressive and keeps wanting to leave the facility. Keeps asking bankruptcy and how it will effect his life. The writer redirected the resident he is in the facility at this time for rehab. Snacks and coffee was provided and offered him to join the other residents for coffee social. Resident is enjoying coffee in the dining room with other residents and is watching Tv. He is relaxed and calm. During a concurrent interview and record review on 6/6/24 at 3:22 p.m., with MDS Nurse (MDSN) 1, Resident 75's Preadmission Screening and Resident Review (PASRR federal regulation that requires all individual being considered for admission to a Medicaid certified nursing facility be screened prior to admission, to determine if the person has, or is suspected of having, a mental illness, intellectual disability, or related condition) dated 11/29/22, Resident 75's PASRR was reviewed. Resident 75's PASRR indicated, . no serious mental illness . result of level I screening . negative. MDSN 1 acknowledged Resident 75's PASRR was conducted upon admission to the facility. During a telephone interview on 6/6/24 at 3:34 p.m., with Psychologist (PSYCH), when asked about Resident 75's diagnosis of schizoaffective disorder, PSYCH stated he did not have a copy of the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 (handbook that contains criteria for diagnosing mental disorders and is used by healthcare professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders) to review the criteria for diagnosis, and his best guess was that he carried the diagnosis forward and did not make the diagnosis. (continued on next page)		

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 06/10/2024
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)		
F 0658 Level of Harm - Actual harm Residents Affected - Few	During a concurrent telephone interview and record review on 6/6/24 at 4:15 p.m., with Physician (PHY) 1, PHY 1 stated Resident 75 had diagnoses including dementia, hearing loss, post CVA and hypertension. When asked why Resident 75's diagnosis of dementia was not updated on Resident 75's electronic medical record or Minimum Data Set (MDS -a standardized comprehensive assessment and care planning tool), PHY 1 stated, If you look at my notes, I mentioned it a few times, its what the clinicians see, it should be there some place. PHY 1 stated he did not diagnose Resident 75 with schizoaffective disorder, and that it came from a psychiatrist. During a review of Resident 75's Nursing Progress Note (NPN) dated 5/24/23, Resident 75's NPN indicated, Writer contacted [Physician] by phone to notify him of the resident recent behaviors of getting into other residents' personal space, making threats and his non sleeping pattern. MD [PHY 1] gave new medication orders. MD gave orders for [Quetiapine brand name] 50 mg every 12 hours. MD was asked what diagnosis MD would like to give for this medication. MD stated schizoaffective disorder. PHY 1 stated he gave the schizoaffective disorder diagnosis and that with schizophrenia, there was no chemical test. PHY 1 stated he had to use something else to justify putting Resident 75 on those medications. When asked why Resident 75 concurrently on aripiprazole and quetiapine, PHY 1 stated that was bad practice and he didn't think he would put Resident 75 on two antipsychotics at the same time. PHY 1 stated he doubted he authenticated the orders and would increase the dose of one, and not both. PHY 1 stated side effects would include falls, and requested the orders be sent to him. PHY 1 stated Resident 75 was on hospice (program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease), and he didn't ask for hospice and didn't know why Resident 75 was on hospice. During a review of DSM 5 criteria for schizoaffective disorder, the DSM 5 criteria indicated, Criterion A (an uninterrupted period of illness during which there is a major mood episode [depressive or manic] concurrent with Criterion A1 [at least 2 of the following, each present for a significant portion of time during a 1 month period [or less if successfully treated]. At least 1 of these must be 1, 2, or 3: 1. Delusions 2. Hallucinations 3. Disorganized speech 4. Grossly disorganized or catatonic behavior [lack of movement and communication] 5. Negative symptoms [diminished emotional expression]); Criterion B (delusions or hallucinations for at least 2 weeks in the absence of a major mood episode [depressive or manic] during the lifetime duration of the illness); Criterion C (symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness); Criterion D (the disturbance is not attributable to the effects of a substance or another medical condition). During an interview on 6/6/24 on 4:29 p.m., with MDSN 1, MDSN 1 was unable to provide a PASRR for Resident 75 upon initiation of aripiprazole for a mental illness. MDSN 1 stated a PASRR should have been completed when Resident 75 was given a new psychiatric diagnosis. MDSN 1 stated it was important to ensure that the facility was still the appropriate place for the resident to be. During an interview on 6/7/24 at 9:36 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 75 was moved to a private room to give him a change of scenery because it was difficult for him to have a roommate. Resident 75 would get agitated a lot and behaviors were escalating when he tried to jump over the fence and become physically aggressive. LVN 3 stated Resident 75 did better in the private room, and she (LVN 3) did not observe some of the behaviors that was said to have been happening in the other wing. LVN 3 stated Resident 75 often asked to go home. LVN 3 stated she was unaware why Resident 75 was moved to a room with another resident. During a review of Resident 75's Physician Progress Notes (PPN), dated 2/19/23 and 3/19/23, the PPN dated 2/19/23 indicated, Dementia suspected and the PPN dated 3/19/23 indicated, Dementia. (continued on next page)		

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 06/10/2024
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)		
F 0658 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 6/7/24 at 10:09 a.m., with LVN 3, Resident 75's FS dated 6/7/24 and HMR dated 11/19/22 were reviewed. LVN 3 was unable to provide documentation of Resident 75's diagnosis of dementia among Resident 75's list of diagnoses. LVN 3 stated that for symptoms like forgetfulness, the psychiatrist came in and evaluated resident. LVN 3 acknowledged Resident 75 was forgetful. LVN 3 acknowledged Resident 75's HMR indicated Resident 75 had underlying memory issues. LVN 3 acknowledged Resident 75's concurrent orders for antipsychotic medications quetiapine and aripiprazole. When asked about an evaluation or assessment from a physician or mental health provider for diagnosing Resident 75's with schizoaffective and bipolar disorders, LVN 3 was unable to provide documentation. LVN 3 stated she or the CNAs that worked during her shift had not observed Resident 75 experiencing hallucinations, however Resident 75 had been observed to be forgetful, confused and agitated. During a concurrent telephone interview and record review on 6/7/24 at 3 p.m., with Registered Dietician (RD) 2, Resident 75's Weights and Vitals Summary Log (WVSL) dated 11/1/22 to 6/30/24 and Dietician Progress Notes (DPN) dated 12/29/22, 4/4/23, 6/9/23, 7/7/23, and 10/2/23 were reviewed. Resident 75's weight log indicated, 12/7/22 111 lbs [pounds], 2/13/23 115 lbs, 3/2/23 122 lbs, 4/4/23 125 lbs, 5/1/23 126 lbs, 6/5/23 132 lbs, 7/4/23 135 lbs, 8/1/23 140 lbs, 9/4/23 139 lbs, 10/2/23 143 lbs, 11/6/23 145 lbs, 12/1/23 144 lbs, 1/2/24 143 lbs, 2/13/24 113 lbs, 3/1/24 114 lbs, 4/1/24 106 lbs, 5/4/24 104 lbs 6/2/24 108 lbs. RD 2 acknowledged Resident 75's weight gain and stated Resident 75's ideal body weight was 106 to 130, body max index (BMI indicates high body fat and screens for weight categories that may lead to health problems). A review of Resident 75's DPN dated 12/29/22 indicated, 4 lb weight gain since admission weight 12/7 [2022]111 lbs BMI: 4 normal . consuming 75 100% of meals. Good appetite noted attributing to weight gain. A review of Resident 75's DPN dated 4/4/23 indicated, 125 lb, non significant weight gain x [in] 1 month (3/2: 122 lbs) and significant 8.7% 10 lb weight gain x 3 months (1/4: 115 lb) BMI: 22.9 normal. Weight gain was desired. On house supplement TID [three times daily] attributing to weight gain. Social Services/Activities: On [Aripiprazole brand name] for bipolar which may cause weight gain . Recommend to reduce to 120 ml [milliliters] at dinner . A review of Resident 75's DPN dated 6/9/23 indicated, CBW [current body weight] 132 lbs 6/5, 4.8% 6 lb weight gain x 1 month (5/1 126 lbs, significant 8.2% 10 lbs weight gain x 3 months (3/2 122 lbs), significant 18.9% 21 lb weight gain x 6 month (12/7 111 lbs). BMI 24.1 normal. Weight gain desirable. Nursing: On [Quetiapine brand name] can contribute to weight gain. A review of Resident 75's DPN dated 7/7/23 indicated, CBW 135 lbs 7/4, 3 lb wt [weight] gain x 1 month (6/5 132 lbs), significant 8% 10 lb wt gain x 3 months (4/4 125 lbs), significant 17.4% 20 lb wt gain x 6 months (1/4 115 lbs). BMI 24.7 normal Previously discontinued house supplement last month in IDT [Interdisciplinary Team group of healthcare professionals from different fields working together to determine a patient's treatment plan] wt variance d/t [due to] adequate oral intake. Nursing: On [Quetiapine brand name]; potentially contributing to wt gain. Lipid panel and A1c [blood test about level of blood sugar over period of time] ordered by MD for this month. A1c 6.6% . MD advised to just watch his diet. (continued on next page)		

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 06/10/2024
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)		
F 0658 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 75's DPN dated 10/3/23 indicated, Value [weight] 143. Resident previously reviewed by IDT for significant wt change. Stable wt trend x 4 months. IDT to remain available and monitor on monthly weights. A review of Resident 75's DPN dated 11/6/23 indicated, CBW 145 lbs 11/6, wt gain x1 month (10/2 143 lbs), 5 lb wt gain x 3 months (8/1 140 lbs), significant 15.1% 19 lb wt gain x 6 months (5/1 126 lbs). BMI 26.5 overweight status . No additional supplements provided. RD 2 stated Resident 75 had a weight alert due to a significant weight gain during a six month period. RD 2 stated he was part of the IDT meetings and they looked at different medications such as antipsychotics that could cause weight gain. RD 2 stated, he did not see any indication in Resident 75's medical record that would indicate fluid retention due to medications or diagnosis. RD 2 stated he was aware antipsychotic medication could cause weight gain. RD 2 stated for patient on medications, he may speak to the physician to determine if there was a different medication the resident can try, and the physician could order a more beneficial medication for the resident without the weight gain. During a concurrent interview and record review on 6/10/24 at 8:31 a.m., with Minimum Data Set Nurse (MDSN), MDSN stated she was not aware Resident 75 had a diagnosis of dementia. MDSN stated if Resident 75's physician diagnosed Resident 75 with dementia, it should be added that same day into Resident 75's profile because that would be the day the diagnosis became active. MDSN stated MDS staff is expected to review Resident 75's chart and input any new diagnosis. MDSN stated this was important because it could affect Resident 75's care; if all of staff is not aware Resident 75 has dementia, they might not know how to approach him or that he needs a different kind of approach. During a concurrent interview and record review on 6/10/24 at 8:41 a.m., with Administrator in Training (AIT), Resident 75's PO for aripiprazole and quetiapine were reviewed. AIT acknowledged being the assistant director of nursing at that time and confirming an order for quetiapine 50 mg every 12 hours for schizoaffective disorder on 5/4/23. AIT stated Resident 75 was having behaviors and told a nursing staff to call PHY 1 and asked PHY 1 what diagnosis to put for Resident 75's order for quetiapine. AIT also acknowledged confirming all of Resident 75's quetiapine and aripiprazole orders including aripiprazole 2 mg by mouth once daily for bipolar disorder manifested by slamming door shut, barricading door, and jumping on bed, on 3/4/23 with PHY 1 and aripiprazole 5 mg by mouth once daily for schizoaffective disorder on 6/28/23. AIT stated he was aware that quetiapine and aripiprazole were both antipsychotic medications and acknowledged Resident 75 was concurrently administered both quetiapine and aripiprazole. AIT stated he presented all the information to PHY 1 and told PHY 1 all the medications Resident 75 was being administered and that was what PHY 1 gave the nursing staff. AIT stated, [Resident 75] was so unmanageable on our end]. AIT stated he did not remember Resident 75 having dementia and was aware some medications had black box warnings (highest safety related warning that medications can have assigned by the Food and Drug Administration, a federal government agency). (continued on next page)		

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 06/10/2024
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)		
F 0658 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 6/10/24 at 9:03 a.m., with Consultant Pharmacist (CRPH), CRPH acknowledged Resident 75 was administered aripiprazole twice daily. CRPH stated aripiprazole is usually given once daily because it is long acting. CRPH stated if aripiprazole was given twice daily, it would have more side effects and had not seen it used twice daily. CRPH stated if ordered twice daily, the expectation would be to ask the physician and confirm the order. CRPH stated concurrent administration of quetiapine and aripiprazole was not appropriate and the expectation would be to inform the physician because of increase side effects and therapy duplication. CRPH acknowledged antipsychotics can cause weight gain and stated weight gain was one of the major side effects of quetiapine. CRPH stated the expectation would be to ask the physician to gradually reduce the medication dosage to treat the resident's condition and lower the risk of side effect. CRPH stated the higher the dose, the higher the risk of side effect. CRPH stated doing a medication review to see if other medication that could cause weight gain and switching to other psychotropic medications that do not cause weight gain would also be an alternative. CRPH stated antipsychotics have a risk to increase blood sugars and fats. CRPH stated Resident 75 was not on any dementia medication and she was not aware Resident 75 had a diagnosis of dementia. During a telephone interview on 6/10/24 at 10:15 a.m., with Medical Director (MD), MD stated when there was a new diagnosis, facility is expected to update the resident's care plan. During an interview on 6/10/24 at 1:05 p.m., with DON, DON stated PHY 1 ordered antipsychotic medication and diagnosed Resident 75 with bipolar because Resident 75 was seeing his dog and other humans and had other behaviors. DON stated she was unaware aripiprazole was increase to twice daily and acknowledged aripiprazole was given once daily. DON acknowledged concurrent administration of quetiapine and aripiprazole was therapy duplication and stated the expectation was for nursing and pharmacy to clarify with the physician and monitor resi [TRUNCATED]		

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 06/10/2024
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)		
F 0685 Level of Harm - Actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41166 Based on observation, interview, and record review, the facility failed to ensure residents receive assistive devices to maintain hearing abilities for one of 28 sampled resident (Resident 75) when Resident 75 who was extremely hard of hearing, was assessed for the use of hearing aid, and was not provided with hearing aid. This failure resulted in Resident 75 not having hearing aid to maintain hearing for communication with staff regarding care needs and treatment, and compromise Resident 75's quality of life. Findings: During an observation on 6/5/24 at 4:36 p.m., in Resident 75's room, Resident 75 was observed lying on right side in his bed watching television. When asked how he was doing, Resident 75 responded, by pointing to his ears and stating he couldn't hear too good in a loud voice. During a review of Resident 75's Hospital Medical Records (HMR) dated, 11/19/22, the HMR indicated Resident 75 was an [AGE] year old male who was extremely hard of hearing. The HMR also indicated during a physical examination, Resident 75 was wearing a hearing aid in right ear. During a review of Resident 75's Face Sheet (FS - a document containing resident's personal information), dated 6/7/24 indicated, Resident 75's FS indicated Resident 75 was admitted to the facility on [DATE] with diagnoses including unspecified hearing loss, unspecified ear. During an interview on 6/6/24 at 2:36 p.m., with Certified Nursing Assistant (CNA) 8, CNA 8 stated Resident 75 was hard of hearing and if someone wanted to speak with him, they had to get close and speak in his ear. CNA 8 stated Resident 75 did not like staff getting close to him, so staff used their hands a lot. CNA 8 stated she did not know Resident 75 used hearing aids and had never seen him wear a hearing aid. During a review of Resident 75's Nursing Progress Notes (NPN), dated 11/29/22 at 12:14 p.m., the NPN indicated, Resident new admit. Resident alert and oriented x [for] 3 [measure for alertness and orientation]. Resident refused to get VS [vital signs medical signs that indicate the status of the body's vital functions] @ [at] 1100. Resident is non compliant and stated he is going to get up and walk home. Redirected resident to stay and get the help that he needs. Resident appears to not want to be here. Will cont. [continue] to monitor. During a review of Resident 75's Nursing Progress Notes (NPN), dated 12/1/22 at 4:23 p.m., the NPN indicated, .Writer tried to talk to resident but resident is hard of hearing and does not comprehending . (continued on next page)		

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 06/10/2024
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)		
F 0685 Level of Harm - Actual harm Residents Affected - Few	During a concurrent record review and interview on 6/6/24 at 4:39 p.m., with the Social Services Director (SSD), the SSD was unable to provide facility documentation of Resident 75 using hearing aids. The SSD stated Resident 75 had never had hearing aid at the facility. SSD stated upon admission on 11/28/24, the facility should have done a social service evaluation to include an assessment for hearing aids. The SSD stated the social service evaluation was not completed and Resident 75's need for a hearing aid was not assessed upon admission to the facility. During an interview on 6/7/24 at 9:50 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated staff had to speak to Resident 75 loudly when communicating. LVN 3 stated Resident 75 got agitated when asked to do activities of daily living, however Resident 75 would not go out of his way to have an altercation. LVN 3 stated Resident 75 did not have a communication board in his room. LVN 3 stated if Resident 75 was admitted to the facility and documents from other facility stated Resident 75 had hearing aids, upon admission, staff should have ensured Resident 75 had hearing aids, check Resident 75's belongings, and monitor Resident 75 to ensure hearing aids were put in daily. LVN 3 stated if the hearing aids were not in Resident 75's belongings upon admission to the facility, staff should have called the previous facility or hospital and asked the Responsible Party (RP) 2 to get clarification to see if hearing aids were lost or the information had changed. During an interview on 6/10/24 at 10:20 a.m., with Medical Director (MD), MD stated social services and nursing staff should have identified Resident 75 was using a hearing aid and should have assessed Resident 75 and developed a care plan for it. MD stated not assessing or care planning for Resident 75 could have impacted social activities, meals, and interaction with people, and could have led to isolation, and depression. During a concurrent interview and record review on 6/10/24 at 1:22 p.m., with Director of Nursing (DON), DON was unable to provide documentation of Resident 75's care plan for hearing aid and stated she was unaware Resident 75 used hearing aid. DON stated, I didn't see any when he came. DON stated hearing aid was important for Resident 75's daily routine care and if Resident 75 was hard of hearing, he could have misunderstood words.		

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 06/10/2024
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)		
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to provide foot care and make necessary podiatry appointments for three of six sampled residents (Residents 6, 64 and 81) when Residents' 6, 64 and 81 had long and thick toenails. This failure placed Residents 6, 64 and 81 at a potential risk for painful, ingrown toenails and infections which could affect Residents 6, 64 and 81's mobility. Findings: During a concurrent observation and interview on 6/3/24 at 12:40 p.m. in the hallway between the dining room and the nursing station, Resident 6 was observed sitting up in his wheelchair. Resident 61 was wearing slide sandals with open toes with really long toenails, curved downward. Resident 6 stated he did not remember when the foot doctor was in the facility and cut his toenails. Resident 6 stated the toenails did not hurt but it was hard to wear socks because the toenails got caught in the socks. During a review of Resident 6's Admission Record, (AR- document containing resident personal information) dated 6/10/24, the AR indicated, Resident 6 was readmitted to the facility on [DATE], with diagnosis which included rheumatoid bursitis (overuse or injury to the joint areas), muscle weakness and psychotic disorder (collection of symptoms that affect the mind, where there has been some loss of contact with reality). During a review of Resident 6's Minimum Data Set (MDS- a functional and cognitive abilities assessment) assessment, dated 4/5/24, indicated the Brief Interview for Mental Status (BIMS) score was 15 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 6 was cognitively intact in decision making. During a concurrent observation and interview on 6/3/24 at 9:48 a.m. in Resident 64's room, Resident 64 was lying in bed, watching TV. Resident 64's feet was uncovered and both feet had toenails that were thick and long. Resident 64's toenail on the right big toe appeared to be lifting from the middle with dried up dark drainage coming from the middle of the toenail. Resident 64 stated there was a foot doctor who came to the facility and took care of his toes but did not remember when the foot doctor saw him last. Resident 64 stated the foot doctor took care of his long toenails because they were thick and hard to cut. During a review of Resident 64's AR, dated 6/6/24, the AR indicated Resident 64 was admitted to the facility on [DATE], with diagnoses which included Parkinson's disease (a disorder of the central nervous system [includes the brain, spinal cord and a complex network of nerves] that affects movement, often including tremors), dysarthria (difficulty speaking because the muscles used for speech are weak), anarthria (complete loss of speech) and muscle weakness. During a review of Residents 64's MDS dated [DATE], the MDS indicated Resident 64's BIMS score was 8 which indicated Resident 64 had moderate impaired cognition in decision making. (continued on next page)		

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 06/10/2024
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)		
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/3/24 at 9:30 a.m. in Resident 81's room, Resident 81 was lying in bed, eyes open and talking to her roommate. Resident 81's feet were exposed. Resident 81's toenails were long and thick, with skin dry and flaky. Resident 81's left big toenail was thick with a discolored area covering the base of the toenails. Resident 81 stated she remembered a foot doctor saw her in the past and took care of her foot. Resident 81 stated she did not remember when the foot doctor last cut her toenails. Resident 81 stated, . I always make sure my feet are covered so other people do not see my feet and toenails because they are not nice to look at . During a review of Resident 81's AR, dated 6/10/24, the AR indicated Resident 81 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (disrupted blood to the brain), muscle weakness and tinea unguium (nail fungus). During a review of Residents 81's MDS, dated [DATE], the MDS indicated Resident 81's BIMS score was 13 which indicate Resident 81 was cognitively intact in decision making. During an interview on 6/6/24 at 12:48 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated there was a podiatrist who comes in to cut resident's toenails. CNA 1 stated the licensed nurse and or the social service designee (SSD) provided a list of residents needed to be seen by the podiatrist. CNA 1 stated CNAs did not cut toenails but during resident shower, a shower form was filled up for every resident who had a shower. CNA 1 stated the staff marked any issues identified during shower and it included long toenails. CNA 1 stated the shower form was then given to the nurse to sign or initial. CNA 1 stated she did not remember filling up a shower form for Residents 6, 64 and 81. During an interview on 6/7/24 at 2:27 p.m. with CNA 4, she stated during resident showers, toenails and fingernails were checked including any skin issues, marked in the shower form and given to the licensed nurse to sign. CNA 4 stated she let the nurse know when a resident had long toenails. CNA 4 stated the resident's name was added to the list for when the podiatrist came to the facility. During a concurrent interview and record review on 6/7/24 at 2:56 p.m. with the SSD, Resident 6, 64 and 81's podiatric and treatment record was reviewed. SSD stated Resident 6 was last seen by the podiatrist on 1/18/24 with no new order. SSD stated Resident 64 was seen by the podiatrist on 1/26/24 with no new order. Resident 81 was last seen on 3/29/24 with no new order. SSD stated he was responsible in contacting the podiatrist office to schedule for the podiatrist to go in the facility. SSD stated, . The podiatrist usually come every two to three months . SSD stated licensed nurses gave the podiatrist a list of residents needed to be seen. SSD stated he did not remember nursing staff asking him to get a hold of the podiatrist to see Residents 6, 64 and 81. SSD stated nail care was very important because it can cause skin tear when they start scratching which could result in infection. During an interview on 6/7/24 at 3:09 p.m. with Licensed Vocational Nurse (LVN) 2, she stated she did not remember any CNA reporting Residents 6, 64 and 81 needing their toenails cut and cleaned. LVN 2 stated CNAs marked any skin issues including toenails in the shower form when resident had their showers. LVN 2 stated the licensed nurses assessed residents and informed social service to include residents name in the list for the podiatrist to see when they come in the facility. LVN 2 stated the toenails of Resident 6, 64 and 81 were not acceptable and their toenails should have been taken care of and seen by a podiatrist. (continued on next page)		

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

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

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 06/10/2024
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)		
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/24 at 9:22 a.m. with the Director of Nursing (DON), DON stated, . Podiatrist comes every month and as needed . DON stated the SSD arranged for the podiatrist to come and the nursing staff got residents ready to be seen by the podiatrist. DON stated the unkept toenails of Residents 6, 64 and 81 was not acceptable and should have been taken care of. DON stated her expectation was for the nursing staff to communicate to SSD in order for the podiatrist to come and see residents. Review of facility's policy and procedure (P&P) titled, Foot Care, dated 3/18, the P&P indicated, . 1. Residents will be provided with foot care and treatment in accordance with professional standards of practice. 2. Overall foot care will include the care and treatment of medical conditions associated with foot conditions . 4. Trained staff may provide routine footcare (e.g., toenail clipping) within professional standards of practice for residents without complicating disease process .		

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 06/10/2024
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)		
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41166 Based on observation, interview, and record review, the facility failed to comprehensively assess the root cause of behavioral symptoms, develop and implement measurable goals and interventions to address the individualized care plan for 1 of 28 sampled resident (Resident 75), who was diagnosed with dementia (progressive decline in memory that affects the ability to perform everyday activities and interferes with daily functioning). This failure resulted in Resident 75 not receiving the appropriate treatment and services needed to meet his dementia care needs and achieve his highest level of functioning. Findings: During an observation on 6/5/24 4:36 p.m., in Resident 75's room, Resident 75 was observed lying on right side in his bed watching television. When asked how he was doing, Resident 75 responded, by pointing to his ears and stating he couldn't hear too good in a loud voice. During a review of Resident 75's Hospital Medical Records (HMR) dated, 11/19/22, the HMR indicated, History of Present Illness . Per son, patient has underlying memory issues but has not had formal evaluation . Assessment: Per [son], their father lives alone though they tried to convince him to live with them but pt [patient] preferred to live by himself . Principle Diagnosis Cerebellar CVA [cerebral vascular accident- happens when blood supply stops to the part of the brain that helps with body movement, eye movement, and balance] . Active Problem List . ataxia [loss of coordination] . During a review of Resident 75's Face Sheet (FS) (a documented containing resident's personal information), dated 6/7/24 indicated, Resident 75 was admitted to the facility on [DATE] with diagnoses including ataxia following cerebral infarction, and cerebellar stroke syndrome. During an interview on 6/6/24 at 10:38 a.m., with Resident 75's Responsible Party (RP) 2, RP 2 stated he was previously told his father, Resident 75, had dementia. RP 2 stated that the facility however, told him that Resident 75 had Schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves, and may seem like they have lost touch with reality), that is why Resident 75 was being administered medication. RP 2 stated he thought it was dementia because like Resident 75, they didn't have short term memory, but they had long term memory. RP 2 stated, I guess they were having problems with him, he would get angry, and he wouldn't let them help him, they said it wouldn't harm him, it would help him be calm it was last year or year before, I'm not sure. RP 2 stated, Resident 75 slept a lot more and didn't want to eat. RP 2 stated, He was always active then all of sudden he started getting tired, not wanting to get up and sleeping a lot and the food too, not wanting to eat I think started happening last year. RP 2 stated he has had to go to the facility to talk to Resident 75 and get him to understand the facility is there to help him and shared with the facility to tell Resident 75 that everything is all right, they're his friends and they're there to help him and he's safe. (continued on next page)		

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 06/10/2024
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)		
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/24 at 2:53 p.m. with Certified Nursing Assistant (CNA) 8, CNA 8 stated she had cared for Resident 75 for on and off for almost 2 years. CNA 8 stated, she did not notice Resident 75 to have hallucination or delusions during her care. CNA 8 stated Resident 75 would look at staff confused and ask why everybody was in his house, say he wanted everybody out of his house, and ask for his family. During a review of Resident 75's Nursing Progress Notes (NPN), Resident 75's NPN indicated on: 11/29/22 12:14 p.m. Resident new admit. Resident alert and oriented x3 [measure for alertness and orientation]. Resident refused to get VS [vital signs- medical signs that indicate the status of the body's vital functions] @ [at] 1100. Resident is non-compliant and stated he is going to get up and walk home. Redirected resident to stay and get the help that he needs. Resident appears to not want to be here. Will cont. [continue] to monitor. 12/1/22 4:23 p.m. Writer was in room with resident and resident states they want to kill themselves, life is not living anymore and talks about past friend who killed themselves. CNA was also present and writer counted that resident repeated taking own life seven times approximately every other minute. Writer tried to talk to resident but resident is hard of hearing and does not comprehending. Resident kept going back to story of friend taking their own life and then resident states about taking own life. Writer inform DSD [Director of Staff Development], DON [Director of Nursing], Nurse and dinning services. Resident has one-on-one and on plastic utensils for 72 hours. 12/29/22 12:20 p.m. Resident is in bed watching the rain outside his window while having lunch. He is in a cheerful mood. Bed is in the lowest position along with call light/ bed control in his reach. He is telling the nursing team fond memories of his dog in the rain. His son did visit and will try to bring a photo the next time he visits him. 1/2/23 6:26 a.m. Resident is in a happy mood. A sign has been placed at his door to inform him that his son has his dog. He does enjoy talking to the noc [overnight] nursing team about life and his fond family memories. 1/20/23 10:50 a.m. Resident is S/P [status post- after] room change to 6B2. He is adjusting well to his new room. He is in bed looking out the window and watching his tv. The bed is in the lowest position along with his bed controls being in his reach. He reports no pain or discomforts at this time. 1/21/23 10:56 a.m. Resident is S/P room change to 6B2. He is adjusting well to his new room. He is in bed looking out the window and watching his tv. The bed is in the lowest position along with his bed controls being in his reach. He reports no pain or discomforts at this time. He keeps asking about his dog and is redirected by the staff. 1/24/23 3:22 p.m. Resident is S/P room change. He is adjusting well to room change. He has his call light and bed controls in his reach with his bed in the lowest position. He is in in his bed. 2/2/23 2:42 a.m. Writer observed resident resident getting into his roommates face telling him to get out of his room. Resident was educated on personal space and sharing the room. (continued on next page)		

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 06/10/2024
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)		
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/2/23 4:57 a.m. Resident is upset to have another person in his room. He stated to the nursing team that he pays for this room and want to be alone in it. Writer educated the resident on the sharing of the room. He is upset and demanding that the other resident be moved out now. 2/13/23 9:59 p.m. Resident would mostly yell when he is hungry then shuts his door loudly which made another resident upset with the loud noise. He would also close the bathroom door so loud and his door closet. When resident is told about not shutting the doors, resident yells back at staff. 2/17/23 3:59 a.m. Resident continues to come out of room and ask about his dog and slam the room door. He reports his pain to be 0\10 with no discomforts. He has been offered several snacks and is now in his room watching the tv. 2/19/23 8:10 a.m. Writer along with the CNA staff have offered x3 to help the the resident change his clothing and to take a bed bath. He has refused x3 and yelled at the staff to get the hell out of his room now. Writer encouraged the resident to use a lower tone and to use his call light if he is in need of aid. 2/19/23 12:23 p.m. Resident is in bed having his lunch. He reports no pain or discomfort at this time. Bed is in the lowest position with call light and bed controls in his reach. Resident is able to make his needs known to the nursing team. He has been ambulating in the facility with ease with his non skid foot wear. He went outside with he writer to get some fresh air and look at he trees. He got excited when he saw all of the cars driving by. Call light and bed controls are in his reach. resident was offered aid to change his clothing he refused x 3 again. 2/21/23 2:16 a.m. Resident is in his wheel chair looking for his dog at this time. He has been offered snack which he has eaten. He reports his pain to be none with no discomfort/ distress at this time. Writer did encourage him to wear non skid foot wear and to use the call light for aid. Writer did offer to help the resident change his clothing. Resident refused x 3. 2/25/23 11:59 a.m. Resident is on charting for s/p fall, no delayed injuries noted. Resident is alert. No new skin issues noted. Resident is in bed watching the tv and calling out for his dog. His call light/ bed control are within reach. He is s/p room change and is adjusting well to this new room. His son [RP 2] came to visit today. he was upset that he was not notified of his father being moved to another room. He informed the writer that the communication between the facility and family needs to greatly improve. Writer informed RP that this matter would be brought to the social service attention. 2/28/23 1:15 a.m. Resident is up opening his screen door yelling. Writer informed the resident that his dog was gone with his son. He was asked about pain he said no pain. Resident was given a snack. He is now in bed watching the tv. He was reminded to wear non skid footwear and to use his call light for aid. 3/2/23 6:11 a.m. Resident is up opening his screen door yelling out for his dog. Writer informed the resident that his dog was gone with his son. He was asked about pain he said no pain. Resident was given a snack. He is now in bed watching the tv. He was reminded to wear non skid footwear and to use his call light for aid. (continued on next page)		

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 06/10/2024
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)		
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/3/23 2:02 a.m. Upon the NOC med pass. Writer was informed by the CNA on the wing of the resident slamming the restroom door in her face and striking her on the left shoulder. Writer asked the resident what was going on. He stated to the writer why is he in my bathroom? I pay rent here. Get him out of my house. Writer informed the reside that they all live here together. Along with sharing this space in the restroom. A snack was offered. Resident was helped back to his bed. Call light is in reach. Bed is in the lowest position. Writer asked resident if he was having any pain or discomfort. He replied no I'm fine just get him out of here. CNA did fill out an incident report. Writer did encourage he resident to keep his hands to himself. 3/3/23 2:13 p.m. Resident is being aggressive and getting into residents faces for being in common areas such as the hall way and restroom. He is not easily redirected until he feels as if he is getting his point across. He has been reminded of personal space and to keep his hands to himself and off others. resident was asked if he was in pain or having discomforts he responded with no I'm fine. Writer has placed his bed in the lowest position with the wheels being locked. A tv program of his choice is also playing. Resident is in a happy mood at this time. 3/4/23 3:14 a.m. Resident is being aggressive and getting into other residents/ staff faces for being in common areas such as the hallway and restroom. He is not easily redirected. He has been reminded of personal space and to keep his hands to himself and off others. Writer asked the resident was asked if he was in pain or having discomforts he responded with no. Writer is walking with the resident in the facility and looking outside with him to calm him talking about dogs and the war. Writer has placed his bed in the lowest position with the wheels being locked. A tv program of his choice is also playing. Resident is content and in bed. 3/4/23 3:20 p.m. Resident has a new order for [Aripiprazole brand name] Oral Tablet 2 MG for Bipolar Disorder. Resident has been put on the medication due to behaviors. Resident MD was contacted and was described the resident's behaviors and manifestations. Resident has such Manifestations Slamming Door Shut, Barricading door and Jumping on bed and has visual Hallucinations of seeing a dog and other humans. Resident MD gave the orders for this medications along with a DX [diagnosis] of Bipolar Disorder to support the medication order. Resident is self RP and aware of this new order of the medication. 3/5/23 00:11 a.m. Upon writers rounds the resident was in the hallway yelling for his dog. Writer informed the resident that his dog was with his son and that people are trying to sleep. Resident informed the writer that he don't care we are all nuts. Writer informed the resident that he was safe and being cared for. The resident was asked if he was in pain or having discomforts he responded with no. Writer has placed his bed in the lowest position with the wheels being locked. A tv program of his choice is on. Writer offered the resident a snack. He told writer thank you and sat on his bed. During a telephone interview on 6/6/24 at 4:15 p.m., with Physician (PHY) 1, PHY 1 stated Resident 75 had diagnoses including dementia, hearing loss, post CVA and hypertension. When asked why Resident 75's diagnosis of dementia was not updated on Resident 75's electronic medical record or Minimum Data Set (MDS- a standardized comprehensive assessment and care planning tool), PHY 1 stated, If you look at my notes, I mentioned it a few times, its what the clinicians see, it should be there some place. (continued on next page)		

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 06/10/2024
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)		
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 75's Physician Progress Notes (PPN), dated 2/19/23 and 3/19/23, the PPN dated 2/19/23 indicated, Dementia suspected and the PPN dated 3/19/23 indicated, Dementia. During a concurrent interview and record review on 6/7/24 at 10:01 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 75's FS was reviewed. LVN 3 was unable to provide documentation of Resident 75's diagnosis of dementia among Resident 75's list of diagnoses. LVN 3 stated that for symptoms like forgetfulness, the psychiatrist would come in and evaluate. LVN 3 acknowledged Resident 75 was forgetful. During a concurrent interview and record review on 6/7/24 at 10:50 a.m., with LVN 3, Resident 75's care plan was reviewed. LVN 3 was unable to provide documentation of an individualized care plan with measurable goals and interventions for Resident 75's memory loss/dementia. LVN 3 stated, If memory issues is impacting his day to day life, there should be a care plan. During a concurrent interview and record review on 6/10/24 at 8:31 a.m., with Minimum Data Set Nurse (MDSN), MDSN stated she was not aware Resident 75 had a diagnosis of dementia. MDSN stated if Resident 75's physician diagnosed Resident with dementia, it should be added that same day into Resident 75's profile because that would be the day the diagnosis became active. MDSN stated MDS was expected to review Resident 75's chart and input any new diagnosis. MDSN stated this was important because it could affect Resident 75's care; if all of staff was not aware Resident 75 has dementia, they might not know how to approach him or that he needed a different kind of approach. During a telephone interview on 6/10/24 at 9:46 a.m , with Consultant Pharmacist (CRPH), CRPH stated Resident 75 was not on any dementia medication and she was not aware Resident 75 had a diagnosis of dementia. During a telephone interview on 6/10/24 at 10:15 a.m., with Medical Director (MD), MD stated when there was a new diagnosis, facility was expected to update the resident's care plan. During an interview on 6/10/24 at 1:05 p.m., with Director of Nursing (DON), DON stated she was not aware Resident 75 had a diagnosis of dementia. DON stated when a physician wrote a diagnosis on a progress note, MDS was expected to review it and add it in the diagnosis sheet in the resident 's electronic health record, the staff evaluates whether Resident 75 needed medication, monitoring of behavior, and developed and implemented a dementia care plan. DON stated, Nobody was aware he had a dementia diagnosis; I didn't see any care plan in there, no treatment or services for dementia implemented. (continued on next page)		

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 06/10/2024
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)		
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Dementia- Clinical Protocol, the P&P indicated, .The IDT [group of healthcare professionals from different fields working together to determine a patient's treatment plan] will evaluate individuals with new or progressive cognitive impairment and help identify symptoms and findings that differentiate dementia from other causes . For the individual with confirmed dementia, the IDT will identify a resident-centered care plan to maximize remaining function and quality of life . The physician will order appropriate medications and other interventions to manage behavioral and psychiatric symptoms related to dementia based on pertinent clinical guidelines and regulatory expectations. Medications will be targeted to specific symptoms and will be used in the lowest possible doses for the shortest possible time, unless a clinical rationale for higher doses or longer-term use is documented . The staff will monitor the individual with dementia in condition and decline in function and will report these findings to the physician . During a review of the Publication titled The American Psychiatric Association [APA] Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia, dated 5/2016, the Publication indicated, . Development of a Comprehensive Treatment Plan Statement . 4. APA recommends that patients with dementia have a documented comprehensive treatment plan that includes appropriate person-centered nonpharmacological and pharmacological interventions, as indicated. Statement . 8. APA recommends that if a risk/benefit assessment favors the use of an antipsychotic for behavioral/psychological symptoms in patients with dementia, treatment should be initiated at a low dose to be titrated up to the minimum effective dose as tolerated. APA recommends that in patients with dementia with agitation or psychosis, if there is no clinically significant response after a 4-week trial of an adequate dose of an antipsychotic drug, the medication should be tapered and withdrawn. Statement . 12. APA recommends that in patients with dementia who show adequate response of behavioral/ psychological symptoms to treatment with an antipsychotic drug, an attempt to taper and withdraw the drug should be made within 4 months of initiation, unless the patient experienced a recurrence of symptoms with prior attempts at tapering of antipsychotic medication .		

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 06/10/2024
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)		
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** 41166 Based on observation, interview and record review, the facility failed to provide pharmaceutical services which ensured appropriate administration of medications to meet residents needs and have an adequate system for periodically reconciling controlled drugs (substances that have an accepted medical use and have a potential for abuse and may also lead to physical or psychological dependence), when: 1. The facility's injectable emergency kit (e-kit) did not have insulin medications available for emergency use for residents. 2. Residents 6 and 9's diclofenac (medication used to reduce pain and stiffness) gel 1% (concentration) were administered without the use of dosing stick provided by manufacturer. 3. The Director of Nursing (DON) did not have an adequate system to periodically reconcile controlled drugs and was unable to reconcile Resident 86's control substance log sheet (log sheet used to record dose, date of administration and nurse administering doses). These failures resulted in Residents 6 and 9 being at risk of receiving too little or too much of their prescribed medications, and the potential for drug diversion of controlled medications after nursing staff receive medications from the pharmacy. Findings: 1. During a concurrent observation and interview on 6/3/24 at 10:12 a.m., with Licensed Vocational Nurse (LVN) 3 in the medication room, a partially used injectable e-kit was observed in the medication refrigerator. LVN 3 acknowledged the e-kit was missing 4 injectable medications and stated the process was for nursing staff to call pharmacy before using the e-kit. During a concurrent interview and record review on 6/3/24 at 10:50 a.m. with DON, DON acknowledged the e-kit had been opened and used and stated once the e-kit was opened, nursing staff was expected to call pharmacy to replace the e-kit. DON stated the e-kit was typically replaced the next day. DON stated not replacing the e-kit timely could cause delay in a resident being receiving their medication. A review of the injectable e-kit records indicated, insulin lispro pen was removed from the e-kit and used for a resident on 5/11/24, insulin aspart pen was removed from the e-kit and used for a resident on 5/28/24, insulin regular pen was removed from the e-kit and used for a resident on 5/31/24, and insulin glargine pen was removed from the e-kit and used for a resident. During a review of the facility's Policy and Procedure (P&P) titled, Emergency Pharmacy Service and Emergency Kits, dated 1/22, the P&P indicated, . If exchanging kits, opened kits are replaced with sealed kits within 72 hours of opening. If replacing used medications, the replacement doses are added to the kit within 72 hours of opening . (continued on next page)		

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 06/10/2024
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During record review of Resident 6's Admission Record (AR- a document that provides resident contact details, a brief medical history), the AR indicated, Resident 6 was admitted to the facility on [DATE]. Resident 240's diagnoses included muscle weakness, pain. During record review of Resident 9's AR, the AR indicated, Resident 9 was admitted to the facility on [DATE]. Resident 9's diagnoses included muscle weakness, difficulty walking, hypertrophic osteoarthropathy (inflammation and enlargement of the ends of the fingers or toes accompanied by a downward curving and thickening of the nails). During a concurrent observation and interview on 6/3/24 at 4:01 p.m. with Director of Staff Development (DSD) and Clinical Leader (CL), Resident 6's partially used diclofenac 1% gel with unused dosing stick affixed to manufacturer package insert was observed in the C wing treatment cart. CL acknowledged diclofenac gel had been administered without the use of the dosing stick provided by the manufacturer. During a concurrent observation and interview on 6/3/24 at 4:12 p.m., with DSD and CL, Resident 9's two partially used diclofenac gel with unused dosing stick affixed to manufacturer package insert was observed in the D wing treatment card. CL and DSD acknowledged Resident 9's partially used diclofenac 1% gel was administered without the use of the dosing stick provided by the manufacturer. CL stated she wasn't sure how nursing staff was administering the diclofenac doses. During a record review of Resident 6's Physician Order (PO) for diclofenac gel 1%, the PO indicated an order date of 4/25/24, diclofenac gel 1%, apply 2 gram transdermally every 8 hours as needed for arthritis. During a record review of Resident 9's PO for diclofenac gel 1%, the PO indicated an order date of 11/24/23, diclofenac gel 1%, apply 2 grams to left shoulder topically every day and evening shift for pain. During a review of Resident 9's Medication Administration Record (MAR) dated 4/24, the MAR indicated Resident 9 was administered diclofenac gel 1% during the month of April 2024. During a review of Lexicomp, a nationally recognized database, the manufacturer for diclofenac gel 1% indicated, 1% formulation . Use dosing card to measure dose. Apply to affected area or joint and rub into skin gently, making sure to apply to entire affected area or joint. During a review of the facility's P&P titled, Medication Administration- General Guidelines, dated 1/22, the P&P indicated, . Medications are administered in accordance with written orders of the prescriber . 3. During a concurrent interview and record review on 6/4/24 at 2:03 p.m., with DON, the facility's Control Drug Destruction Log was reviewed. The log indicated the disposal date for the controlled drugs; however, the log did not indicate the quantity of controlled drugs that were disposed. DON acknowledged the log did not indicate the quantity of controlled drugs that were disposed. (continued on next page)		

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

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

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 06/10/2024
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/4/24 at 2:33 p.m., with DON, the pharmacy's Packing Slip (record of the quantity of controlled drugs delivered to facility from pharmacy) dated 4/10/24 for Resident 86's oxycodone-acetaminophen 5-325 mg (milligrams- unit of measurement) was reviewed. The Packing Slip indicated the pharmacy delivered 3 cards each containing 30 tablets of oxycodone-acetaminophen 5-325 mg on 4/10/24 and was received and signed by nursing staff. When asked about the accompanying control substance log sheet to track the administration of Resident 86's oxycodone-acetaminophen 5-325 mg tablets, DON was unable to provide documentation for 30 oxycodone 5-325 mg tablets administered to Resident 86. When asked about the facility's process for periodic reconciliation of controlled drugs, DON was unable to provide documentation for periodic reconciliation and stated the facility did not have a system in place. DON stated it was important to reconcile controlled drugs to make sure residents were getting medication and to prevent diversion.		

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 06/10/2024
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)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41166 Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for one of seven sampled residents (Resident 56) when Resident 56 did not have the appropriate monitoring for the use of levetiracetam (medication used to treat seizure disorders). This failure had the potential for Resident 56's levetiracetam level to be elevated and for Resident 56 to be administered levetiracetam unnecessarily. Findings: During a review of Resident 56's Admission Record (AR), dated 2/7/22, the AR indicated Resident 56 was an [AGE] year old female who was admitted on [DATE] to the facility. During an observation on 6/5/24 at 4:30 p.m., in Resident 56's room, Resident 56 was observed lying in bed with eyes closed. Resident 56 did not respond to her name when verbally called out twice. During a concurrent observation and interview on 6/6/24 at 8:59 a.m. Resident 56 was observed lying in her bed. Certified Nursing Assistant (CNA) 9 was present in room and translated Spanish to English for Resident 56. Resident 56 stated she was sick and had a sickness that stuck to her. When asked if she liked to go out of her room and participate in activities, Resident 56 shook her head no. CNA 9 stated Resident 56 had a history of seizures and had been hospitalized for seizures. During a record review of Resident 56's lab records for levetiracetam, Resident 56's lab records dated 3/5/23, indicated a levetiracetam level of 14.9, and on 5/10/23, a levetiracetam level of 3.6. During a record review of Resident 56's Physician Order (PO), dated 5/10/23, the PO indicated a discontinue order for levetiracetam 500 mg by mouth two times a day for seizures, and an order date of 5/10/23 for levetiracetam 750 mg by mouth two times a day. During an interview on 6/6/24 at 9:32 a.m., with Licensed Vocational Nurse (LVN) 5 acknowledged Resident 56 was currently being administered levetiracetam 750 mg twice daily. LVN 5 stated levetiracetam levels were not obtained for Resident 56 after the levetiracetam dose increase to 750 mg daily because Resident 56 was placed on hospice and the physician discontinued labs. LVN 5 was unable to provide documentation of physician orders for discontinued labs. During a telephone interview on 6/7/24 at 1:20 p.m., with Resident 56's Responsible Party (RP) 1, RP 1 stated Resident 56 had a seizure while in the facility, was put on seizure medication, and received therapy until Resident 56 had a second seizure. RP 1 stated Resident 56 was able to use wheelchair, but after a while she wasn't able to. RP 1 stated Resident 56 progressed more and more to where she could no longer get out of bed. During a record review of Resident 56's lab records for levetiracetam, Resident 56's lab records dated 6/7/24, indicated a levetiracetam level of 45.8. (continued on next page)		

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 06/10/2024
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)		
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/10/24 at 9:07 a.m., with Consultant Pharmacist (CRPH), CRPH stated for a change in dose of levetiracetam, the expectation was for the facility to order a lab and monitor to see if the resident was still having a seizure. CRPH stated an increased level could increase side effect and increase risk of fall. CRPH stated it was important to make sure the medication was beneficial to the resident. During an interview on 6/10/24 at 10:24 a.m., Medical Director (MD), MD stated pharmacy should have picked up on it and recommended a level. MD stated monitoring the therapeutic range of drug helped the physician titrate to appropriate dose and need of the patient. During an interview on 6/10/24 at 11:06 a.m., with Director of Nursing (DON), DON stated the physician did not give the facility an order to obtain labs. DON stated, if nursing staff observed Resident 56 experiencing symptoms or toxic effects of levetiracetam, they would follow up with the physician, but nursing staff did not observe any symptoms. During a review of Lexicomp, a nationally recognized database, the manufacturer for levetiracetam indicated, Laboratory alert level: 50 mcg [microgram- unit of measure]/mL [milliliter- unit of measure] . Therapeutic reference range: Note: There is no clear correlation with serum concentrations and efficacy or tolerability; base dosing on therapeutic response as opposed to serum concentrations; however, serum concentration monitoring may be useful in older adult patients, neonates, pregnant patients, and patients on enzyme-inducing drugs or with renal insufficiency due to the wide range of alterations in clearance . Nursing Physical Assessment/Monitoring . Monitor therapeutic response (seizure activity, force, type, duration) at beginning of therapy and periodically throughout. Monitor for CNS depression (somnolence [sleepiness] and fatigue), behavioral abnormalities (psychosis [severe mental disorder in which a person loses the ability to recognize reality or relate to others], hallucinations [here you sense an object, person, or event even though it is not really there or didn't happen], psychotic depression), and other behavioral symptoms (agitation, anger, aggression, irritability, hostility, anxiety, apathy [lack of feeling or emotion], emotional lability [rapid, often exaggerated changes in mood, where strong emotions or feelings occur], depersonalization [recurring feeling of being detached from one's body or mental processes], and depression).		

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 06/10/2024
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)		
F 0758 Level of Harm - Actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41166 Based on observation, interview and record review, the facility failed to ensure that one of nine sampled residents (Resident 75) were free from unnecessary psychotropic (drugs that affect brain activities associated with mental processes and behavior) medications when: 1. The facility did not attempt or implement resident specific non pharmacological interventions (behavioral intervention not based on medicine) prior to prescribing and administration of alprazolam (an antianxiety medication), Resident 75 was administered alprazolam unnecessarily. 2. The facility did not provide documented clinical rationale for administrating and increasing the dosage of aripiprazole (an antipsychotic mild altering drug to treat mental illness) and quetiapine (antipsychotic medication), and Resident 75 was administered aripiprazole and quetiapine unnecessarily. 3. The facility did not attempt or implement resident specific non pharmacological interventions prior to prescribing and administration of escitalopram (antidepressant medication), and Resident 75 was administered inappropriate dosage of escitalopram. These failures resulted in Resident 75 experiencing falls, weight gain, dysphagia (difficulty swallowing) and increased the potential for Resident 75 to be isolated. Findings: 1. During a review of Resident 75's Hospital Medical Records (HMR) dated, 11/19/22, the HMR indicated, History of Present Illness . Per son, patient [Resident 75] has underlying memory issues but has not had formal evaluation . Assessment: Per [son], their father [Resident 75] lives alone though they tried to convince him to live with them but pt [patient] preferred to live by himself . Principal Diagnosis Cerebellar CVA [cerebral vascular accident happens when blood supply stops to the part of the brain that helps with body movement, eye movement, and balance] . Active Problem List . ataxia [loss of coordination] . During a review of Resident 75's Face Sheet (FS- a document containing resident's personal information), dated 6/7/24, Resident 75's FS indicated, Resident 75, was an [AGE] year old male who was admitted to the facility on [DATE] with diagnoses including ataxia following cerebral infarction, (CVA) and cerebellar stroke syndrome (CVA affecting a certain part of the brain). During an interview on 6/6/24 at 10:38 a.m., with Resident 75's Responsible Party (RP) 2, RP 2 stated he has had to help Resident 75 to keep his balance. RP 2 stated Resident 75 was pretty good, able to walk on his own and noticed Resident 75 couldn't keep his balance after the falls. During a concurrent interview and record review on 6/7/24 at 11:28 a.m., with (Licensed Vocational Nurse (LVN) 3, Resident 75's Physician Orders (PO), Medication Administration Record (MAR) for alprazolam and Nursing Progress Notes (NPN) were reviewed. Resident 75's PO and MAR indicated: (continued on next page)		

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 06/10/2024
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)		
F 0758 Level of Harm - Actual harm Residents Affected - Few	Alprazolam 0.5 mg (milligrams unit of measure) by mouth every 12 hours for anxiety manifested by feeling panicky and getting in other residents and staffs' face while being around others 2/16/23 to 2/20/23 (order date to discontinue date) Alprazolam 1 mg by mouth every 12 hours for anxiety for feeling anxious manifested by feeling panicky and getting in other residents and staffs' faces while being around others 2/20/23 to 2/21/23 Alprazolam 0.5 mg by mouth every 12 hours for anxiety for feeling anxious manifested by feeling panicky and getting in other residents and staffs' faces while being around others 2/21/23 to 3/14/23 The review of Resident 75's NPN included: 2/20/23 12:43 a.m. At 1200 [a.m.] writer was called to resident's room by CNA [unknown], when writer entered the room resident was seen on the floor attempting to get himself back up. Resident was screaming at staff stating he wanted to go the restroom, but writer asked resident to be patient so that he may be assessed for any injuries. Writer then assessed resident for pain and resident reported a pain level of 0/10 [scale to measure pain, with 0 being least pain, 10 being most pain]. Head to toe assessment was performed, no superficial injuries noted. Resident refused to allow staff to use mechanical lift [device used to transfer a patient] to pick him up off the floor. Despite efforts of education and encouragement by staff resident stood up on his own and was then assisted to his wheelchair. Resident was then assisted to the restroom by CNA. [Physician [PHY] 1] was notified via in person @ [at] 1225, gave new orders to monitor for delayed injury x [for] 3 days. Writer left a message for Emergency Contact [RP 2] via telephone to call back. LVN 3 acknowledged Resident 75 experienced a fall on 2/19/23, just prior to midnight. LVN 3 stated the facility consultant pharmacist (CRPH) reviewed Resident 75's medication regimen on 2/20/23 and recommended an assessment of Resident 75's alprazolam as the medication could cause dizziness, and confusion. LVN 3 stated Resident 75's alprazolam dose was increased from 0.5 mg every 12 hours to 1 mg every 12 hours from 2/20/23 to 2/21/23 and decreased back to 0.5 mg every 12 hours from 2/21/23 to 3/14/23. LVN 3 acknowledged Resident 75 had received alprazolam 0.5 mg dosing prior to fall and stated, I'm not seeing a decrease in dose. LVN 3 stated alprazolam can cause confusion, dizziness, fatigue, and falls, and acknowledged Resident 75 experienced unsteady coordination following his stroke. LVN 3 acknowledged Resident 75 did not have a fall prior to alprazolam being ordered. During a review of Resident 75's MAR dated 2/1/23 to 2/28/23, Resident 75's MAR indicated Resident 75 was administered alprazolam 1 mg on 2/20/23 at 8 a.m., 8 p.m., 2/21/23 at 8 a.m., alprazolam 0.5 mg on 2/16/23 at 8 p.m., twice daily at 8 a.m. and 8 p.m. on 2/17/23, 2/18/23, 2/19/23, 2/20/23 at 8 a.m., 2/21/23 at 8 p.m., and twice daily at 8 a.m. and 8 p.m. from 2/22/23 to 2/28/3. During a concurrent interview and record review on 6/7/24 at 11:44 a.m., with LVN 3, Resident 75's Care Plan (CP) and MAR dated 2/1/23 to 2/28/23 were reviewed. LVN 3 was unable to provide monitoring and implementation of resident specific non pharmacological interventions for Resident 75's behaviors for anxiety prior to initiation of alprazolam. LVN 3 stated, there were lots of side effects from pharmacological (medicine) interventions, and staff should have used the least invasive treatment that was beneficial for Resident 75. During a review of Resident 75's Interim Medication Regimen Review (IMRR), dated 2/21/23, Resident 75's IMRR recommendation for alprazolam indicated, Anxiolytic [alprazolam] medication can cause sedation, respiratory depression, confusion, disorientation, dizziness, skeletal/muscle weakness, visual disturbances, fatigue. Please assess the ongoing need at this time, is a GDR [gradual dose reduction - slowly reduce dose to see if patient condition can be managed on lowest dose possible or if medication can be discontinued] warranted at this time. (continued on next page)		

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 06/10/2024
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)		
F 0758 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 6/10/24 at 9:12 a.m., with CRPH, CRPH stated Resident 75's alprazolam dose was not appropriate. CRPH stated, for elderly patient, limited to 0.75 mg per day. CRPH stated she would ask why patient was administered medication, inquire if patient had taken it before and inform physician that dose is too high for resident. CRPH stated, benzodiazepines [alprazolam] increase risk of fall, that's what we are always worried about, can cause dizziness, confusion. CRPH stated if a fall occurred, it was important to reassess whether the medication was causing problem and whether it was possible to lower the dose. During a review of Resident 75's CVA Care Plan (CP), dated 12/29/22, Resident 75's CVA CP indicated, [Resident 75] is at risk for . generalized weakness, altered balance/gait . Interventions/tasks . PT [physical therapy- help one move better or help strengthen weakened muscles], OT [occupational therapy- to help one improve ability to participate in daily activities] evaluate and treat as indicated . During a review of Lexicomp, a nationally recognized drug reference, the manufacturer for alprazolam indicated, Dosing: Older Adult Note: Avoid use; may be appropriate for severe generalized anxiety disorder. Immediate release: Oral: Use lower initial doses of 0.25 mg 2 to 3 times daily and titrate slowly . Debilitated [physically weak] patients: Use with caution in debilitated patients; use lower starting dose . Older adult patients: Older adults may be at an increased risk of death with use; risk has been found highest within the first 4 months of use in elderly dementia patients . Fall risk: Use with extreme caution in patients who are at risk of falls; benzodiazepines [anti anxiety drug] have been associated with falls and traumatic injury. 2. During an interview on 6/6/24 at 10:38 a.m., with Resident 75's RP 2, RP 2 stated he was previously told his father, Resident 75, had dementia. RP 2 stated that the facility however, told him that Resident 75 had Schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves, and may seem like they have lost touch with reality), that is why Resident 75 was being administered medications for his behavior. RP 2 stated he thought it was dementia because people like Resident 75 didn't have short term memory but had long term memory. RP 2 stated, I guess they were having problems with him, he would get angry, and he wouldn't let them help him, they said it wouldn't harm him, it would help him be calm, it was last year or year before, I'm not sure. During an interview on 6/6/24 at 2:53 p.m. with Certified Nursing Assistant (CNA) 8, CNA 8 stated she had cared for Resident 75 for on and off for almost 2 years. CNA 8 stated when Resident 75 was first admitted on [DATE], he was more alert, would get into his wheelchair, go to the dining room; Resident 75 didn't have as many falls and ate a lot better. CNA 8 stated, she did not notice Resident 75 to have hallucination or delusions during her care. CNA 8 stated Resident 75 would look at staff confused and ask why everybody was in his house, say he wanted everybody out of his house, and ask for his family. During a review of Resident 75's PO and MAR for aripiprazole, Resident 75's PO and MAR indicated: Aripiprazole 2 mg daily for bipolar disorder manifested by slamming door shut, barricading door and jumping on bed 3/4/23 to 3/9/23 Aripiprazole 2 mg twice daily for bipolar disorder manifested by slamming door shut, barricading door, and jumping on bed 3/9/23 to 5/9/23 (continued on next page)		

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 06/10/2024
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)		
F 0758 Level of Harm - Actual harm Residents Affected - Few	Aripiprazole 5 mg daily for schizoaffective (a mental health disorder marked by a major mood episode either manic or depressive that co occurs at the same time with symptoms of schizophrenia) disorder 6/29/23 to 7/13/23 Aripiprazole 5 mg twice daily for schizoaffective disorder 7/13/23 to 10/24/23 Aripiprazole 2 mg twice daily for schizoaffective disorder 10/24/23 to 5/6/24 Aripiprazole 2 mg daily for schizoaffective disorder 5/6/24 to 5/22/24 Aripiprazole 2 mg every other day for 5 days for schizoaffective disorder 5/22/24 to 5/27/24 During a review of Resident 75's PO and MAR for Quetiapine, Resident 75's PO and MAR indicated: Quetiapine 50 mg every 12 hours for schizoaffective disorder manifested by pacing down the hallways and yelling I own this building, I run this place and trying to hit everyone 5/4/23 to 7/11/23 Quetiapine 100 mg every 12 hours for schizoaffective disorder 7/11/23 to 10/24/23 Quetiapine 75 mg by mouth every 12 hours for schizoaffective disorder 10/23/23 to 2/6/24 Quetiapine 50 mg by mouth every 12 hours for schizoaffective disorder 2/6/24 to 5/6/24 Quetiapine 25 mg every 12 hours for schizoaffective disorder 5/6/24 to 5/30/24 Quetiapine 12.5 mg at bedtime for schizoaffective disorder 5/30/24 to present During a review of Resident 75's Nursing Progress Notes (NPN), Resident 75's NPN indicated on: 3/4/23 3:20 p.m. Resident [75] has a new order for [Brand name] Oral Tablet 2 MG (Aripiprazole) for Bipolar Disorder. Resident has been put on the medication due to behaviors. [PHY 1] was contacted and was described the resident's behaviors and manifestations. Resident has such Manifestations Slamming Door Shut, Barricading door and Jumping on bed and has visual Hallucinations of seeing a dog and other humans. [PHY 1] gave the orders for this medications along with a DX [diagnosis] of Bipolar Disorder to support the medication order. Resident is self RP and aware of this new order of the medication. 3/9/23 3:14 p.m. This order is outside of the recommended dose or frequency. [Brand name] Oral Tablet 2 MG (Aripiprazole) Give 1 tablet by mouth two times a day for Bipolar Disorder Manifested by Slamming Door Shut, Barricading door and Jumping on bed The frequency of 2 times per day exceeds the usual frequency of daily. 3/15/23 10:05 a.m. Resident medications have been changed from [Alprazolam brand name] to [Lorazepam brand name] due to medications being ineffective for the resident. Resident RP [2] was notified via phone of the changes and agreed. [PHY 1] gave the orders For [Lorazepam brand name] 0.5 mg every 12 hours. Will Continue to monitor for any side effects or any behaviors. (continued on next page)		

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 06/10/2024
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)		
F 0758 Level of Harm - Actual harm Residents Affected - Few	5/4/23 7:21 a.m. Writer contacted [PHY 1] by phone to notify him of the resident's recent behaviors of getting into other residents personal space, making threats and his non sleeping pattern. [PHY 1] gave new medication orders. [PHY 1] gave orders for [Quetiapine brand name] 50mg every 12 hours. [PHY 1] was asked what diagnosis [PHY 1] would like to give for this medication. [PHY 1] Stated Schizo effective Disorder. 7/10/23 7:49 a.m. Resident was seen by Psychologist [health professional that helps one address mental and behavioral issues] Face Face on 7/7/2023. No New Orders at this time. 7/11/23 1:36 a.m. Writer was informed of the resident going into other residents' room demanding that they leave and get the [expletive] out of his house now before his sister comes and kicks our asses. Writer contacted [RP 2] to speak to the resident to aid in calming him down. Writer spoke to son to provide information to the nights events. Resident is upset with the staff being in the facility. Resident keeps asking the staff when you leave are you gonna kill me. He is currently sitting at the nursing station in a chair. He is wearing his non skid footwear. Snacks have been offered. He reports no pain when asked. 7/11/23 6:23 a.m. Resident has had a substantial increase in behaviors. [PHY 1] was notified via phone. [PHY 1] Gave orders to increase [Quetiapine brand name] to 100 mg every 12 Hours. Resident was going to other resident's room telling them to get out of his house. Resident was trying to jump on beds and resident was screaming and everyone all night long. Resident was cussing at all the staff. Orders were carried out. Resident son [RP 2] was notified via phone of the changes in medications regimen. 7/12/23 2:22 a.m. Writer was informed by the CNA staff of the resident yelling get the [expletive] out of my house now. He is also going into other residents room demanding that they get the [expletive] out of his house now. Before his sister and brother come. Writer Resident is upset with the staff being in the facility. Resident keeps yelling and putting his fingers in the staff faces asking the staff when you leave. I will call the cops to arrest and shoot you guys. He is currently walking the halls of the facility. He is wearing his non skid footwear. Snacks have been offered. He reports no pain or any discomforts when asked. He just wants us out him house. 7/13/23 2:20 p.m. This order is outside of the recommended dose or frequency. [Brand name] Oral Tablet 5 MG (Aripiprazole) Give 1 tablet by mouth two times a day for Schizoaffective Disorder The frequency of 2 times per day exceeds the usual frequency of daily. During a concurrent interview and record review on 6/6/24 at 3:22 p.m., with MDS Nurse (MDSN) 1, Resident 75's Preadmission Screening and Resident Review (PASRR federal regulation that requires all individual being considered for admission to a Medicaid certified nursing facility be screened prior to admission, to determine if the person has, or is suspected of having, a mental illness, intellectual disability, or related condition) dated 11/29/22, Resident 75's PASRR was reviewed. Resident 75's PASRR indicated, . no serious mental illness . result of level I screening negative. MDSN 1 acknowledged Resident 75's PASRR was conducted upon admission to the facility. (continued on next page)		

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 06/10/2024
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)		
F 0758 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 6/6/24 at 3:34 p.m., with Psychologist (PSYCH), when asked about Resident 75's diagnosis of schizoaffective disorder, PSYCH stated he did not have a copy of the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 (handbook that contains criteria for diagnosing mental disorders and is used by healthcare professionals in the United States and much of the world as the authoritative guide to the diagnosis of mental disorders) to review the criteria for diagnosis, and his best guess was that he carried the diagnosis forward and did not diagnose Resident 75 with bipolar or schizoaffective disorder. During a review of Resident 75's Minimum Data Set (MDS) (assessment and care screening of a patient) dated 12/1/22, 2/28/23, and 5/30/23, Resident 75's MDS indicated Resident 75 did not have a diagnosis for psychiatric or mood disorder including bipolar disorder (a serious mental illness that causes unusual shifts in mood, ranging from extreme highs to lows) or schizophrenia, and Resident 75 did not have a history of hallucinations (when one thinks something they see, hear, smell, touch or taste is real, but it's not or delusions (inability to distinguish what is real and what seems to be real). During a concurrent telephone interview on 6/6/24 at 4:15 p.m., with PHY 1, PHY 1 stated Resident 75 had diagnoses including dementia, hearing loss, post CVA and hypertension. When asked why Resident 75's diagnosis of dementia was not updated on Resident 75's electronic medical record or Minimum Data Set (MDS a standardized comprehensive assessment and care planning tool), PHY 1 stated, If you look at my notes, I mentioned it a few times, its what the clinicians see, it should be there some place. PHY 1 stated he did not diagnose Resident 75 with schizoaffective disorder, and that it came from a psychiatrist. During a review of Resident 75's Nursing Progress Note (NPN) dated 5/24/23, Resident 75's NPN indicated, Writer contacted [PHY 1] by phone to notify him of the resident recent behaviors of getting into other residents' personal space, making threats and his non sleeping pattern. [PHY 1] gave new medication orders. MD gave orders for [Quetiapine brand name] 50 mg every 12 hours. MD was asked what diagnosis MD would like to give for this medication. MD stated schizoaffective disorder. PHY 1 stated he gave the schizoaffective disorder diagnosis and that with schizophrenia, there was no chemical test. PHY 1 stated he had use the diagnosis to justify putting Resident 75 on those medications. PHY 1 acknowledged he did not perform an evaluation of Resident 75 for bipolar disorder of schizoaffective disorder prior to Resident 75's diagnoses of bipolar disorder and schizoaffective disorder. When asked why Resident 75 concurrently on aripiprazole 5 mg twice daily from 7/13/23 to 10/24/23 and quetiapine 100 mg twice daily from 7/11/23 to 10/24/23, PHY 1 stated that was bad practice and he didn't think he would put Resident 75 on two antipsychotics (drugs that affects brain activities associated with mental processes and behavior) at the same time. PHY 1 stated he doubted he authenticated (verified) the orders and would increase the dose of one, and not both. PHY 1 stated side effects would include falls, and requested the orders be sent to him. PHY 1 stated Resident 75 was on hospice, and he didn't ask for hospice (program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease) and didn't know why Resident 75 was on hospice. During a review of Resident 75's PO dated 7/11/23 and 7/13/23, Resident 75's PO for aripiprazole and quetiapine indicated PHY 1 electronically authenticated the telephone orders for Resident 75's concurrent use of quetiapine and aripiprazole. (continued on next page)		

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 06/10/2024
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)		
F 0758 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 75's Physician Progress Notes (PPN), dated 2/19/23 and 3/19/23, the PPN dated 2/19/23 indicated, Dementia suspected and the PPN dated 3/19/23 indicated, Dementia. During a review of Resident 75's IDT Post Fall Review and Recommendation (PFRR) records, Resident 75's PFRR indicated Resident 75 suffered from falls on 7/31/23, 8/4/23, 8/16/23, 12/5/23, 2/25/24, 2/27/24, 3/5/24, 3/17/24 (2 falls), 3/19/24, 4/4/24. During a concurrent interview and record review on 6/7/24 at 10:09 a.m., with LVN 3, Resident 75's FS dated 6/7/24 and HMR dated 11/19/22 were reviewed. LVN 3 was unable to provide documentation of Resident 75's diagnosis of dementia among Resident 75's list of diagnoses. LVN 3 stated that for symptoms like forgetfulness, the psychiatrist would come in and evaluate. LVN 3 acknowledged Resident 75 was forgetful. LVN 3 acknowledged Resident 75's HMR indicated Resident 75 had underlying memory issues. During a concurrent telephone interview and record review on 6/7/24 at 3 p.m., with Registered Dietician (RD) 2, Resident 75's Weights and Vitals Summary Log (WVSL) dated 11/1/22 to 6/30/24 and Dietician Progress Notes (DPN) dated 12/29/22, 4/4/23, 6/9/23, 7/7/23, and 10/2/23 were reviewed. Resident 75's weight log indicated, 12/7/22 111 lbs [pounds], 2/13/23 115 lbs, 3/2/23 122 lbs, 4/4/23 125 lbs, 5/1/23 126 lbs, 6/5/23 132 lbs, 7/4/23 135 lbs, 8/1/23 140 lbs, 9/4/23 139 lbs, 10/2/23 143 lbs, 11/6/23 145 lbs, 12/1/23 144 lbs, 1/2/24 143 lbs, 2/13/24 113 lbs, 3/1/24 114 lbs, 4/1/24 106 lbs, 5/4/24 104 lbs 6/2/24 108 lbs. RD 2 acknowledged Resident 75's weight gain and stated Resident 75's ideal body weight was 106 to 130, body max index (BMI- indicates high body fat and screens for weight categories that may lead to health problems). A review of Resident 75's DPN dated 12/29/22 indicated, 4 lb weight gain since admission weight 12/7 111 lbs BMI: 4 normal consuming 75-100% of meals. Good appetite noted attributing to weight gain. A review of Resident 75's DPN dated 4/4/23 indicated, 125 lb, non-significant weight gain x [in] 1 month (3/2: 122 lbs) and significant 8.7% 10 lb weight gain x 3 months (1/4: 115 lb) BMI: 22.9 normal. Weight gain was desired. On house supplement TID [three times daily] attributing to weight gain. Social Services/Activities: On [Brand name] (aripiprazole) for bipolar which may cause weight gain . Recommend to reduce to 120 ml [milliliters] at dinner . A review of Resident 75's DPN dated 6/9/23 indicated, CBW 132 lbs 6/5, 4.8% 6 lb weight gain x 1 month (5/1 126 lbs, significant 8.2% 10 lbs weight gain x 3 months (3/2 122 lbs), significant 18.9% 21 lb weight gain x 6 month (12/7 111 lbs). BMI 24.1 normal. Weight gain desirable. Nursing: On [Quetiapine brand name]- can contribute to weight gain. A review of Resident 75's DPN dated 7/7/23 indicated, CBW [current body weight] 135 lbs 7/4, 3 lb wt [weight] gain x 1 month (6/5 132 lbs), significant 8% 10 lb wt gain x 3 months (4/4 125 lbs), significant 17.4% 20 lb wt gain x 6 months (1/4 115 lbs). BMI 24.7 normal Previously discontinued house supplement last month in IDT [Interdisciplinary Team- group of healthcare professionals from different fields working together to determine a patient's treatment plan] wt variance d/t [due to] adequate oral intake. Nursing: On [Quetiapine brand name]; potentially contributing to wt gain. Lipid panel and A1c ordered by MD for this month. A1c 6.6% . MD [PHY 1] advised to just watch his diet. (continued on next page)		

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 06/10/2024
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)		
F 0758 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 75's DPN dated 10/3/23 indicated, Value 143. Resident previously reviewed by IDT for significant wt change. Stable wt trend x 4 months. IDT to remain available and monitor on monthly weights. A review of Resident 75's DPN dated 11/6/23 indicated, CBW 145 lbs 11/6, wt gain x1 month (10/2 143 lbs), 5 lb wt gain x 3 months (8/1 140 lbs), significant 15.1% 19 lb wt gain x 6 months (5/1 126 lbs). BMI 26.5 overweight status . No additional supplements provided. RD 2 stated Resident 75 had a weight alert due to a significant weight gain during a six-month period. RD 2 stated he was part of the IDT meetings and they looked at different medications such as antipsychotics that could cause weight gain. RD 2 stated, he did not see any indication in Resident 75's medical record that would indicate fluid retention due to medications or diagnosis. RD 2 stated he was aware antipsychotic medication could cause weight gain. RD 2 stated for patient on medications, he may have spoken to the physician to determine if there was a different medication the resident can try, and the physician can order a more beneficial medication for the resident without the weight gain. During a concurrent interview and record review on 6/10/24 at 8:31 a.m., with Minimum Data Set Nurse (MDSN), MDSN stated she was not aware Resident 75 had a diagnosis of dementia. MDSN stated if Resident 75's physician diagnosed Resident 75 with dementia, it should be added that same day into Resident 75's profile because that would be the day the diagnosis became active. MDSN stated MDS staff is expected to review Resident 75's chart and input any new diagnosis. MDSN stated this was important because it could affect Resident 75's care; if all of staff is not aware Resident 75 has dementia, they might not know how to approach him or that he needs a different kind of approach. During a concurrent interview and record review on 6/10/24 at 8:41 a.m., with Administrator in Training (AIT), Resident 75's PO for aripiprazole and quetiapine were reviewed. AIT acknowledged being the assistant director of nursing at that time and confirming Resident 75's initial quetiapine order for 50 mg every 12 hours for schizoaffective disorder on 5/4/23. AIT stated Resident 75 was having behaviors and told a nursing staff to call PHY 1 and asked PHY 1 what diagnosis to put for Resident 75's order for quetiapine. AIT also acknowledged obtaining telephone orders for all of Resident 75's quetiapine and aripiprazole orders including aripiprazole 2 mg by mouth once daily for bipolar disorder manifested by slamming door shut, barricading door, and jumping on bed, on 3/4/23 with PHY 1, aripiprazole 5 mg by mouth once daily for schizoaffective disorder on 6/28/23, and aripiprazole 5 mg by mouth twice daily. AIT stated he was aware that quetiapine and aripiprazole were both antipsychotic medications and acknowledged Resident 75 was concurrently administered both quetiapine and aripiprazole. AIT acknowledged aripiprazole was not a twice daily dosing medication, and stated he presented all the information to PHY 1 and told PHY 1 all the medications Resident 75 was being administered and that is what PHY 1 gave the nursing staff. AIT stated, [Resident 75] was so unmanageable on our end. AIT was unable to provide documentation indicating clinical rationale for dose increases of aripiprazole and quetiapine. AIT stated he did not remember Resident 75 having dementia and was aware some medications had black box warnings (highest safety-related warning that medications can have assigned by the Food and Drug Administration, a federal government agency). (continued on next page)		

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 06/10/2024
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)		
F 0758 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 6/10/24 at 9:16 a.m., with CRPH, CRPH stated aripiprazole is long acting and given once daily. CRPH stated if aripiprazole is given twice daily, it has more side effects. CRPH stated she has not seen it used twice daily. CRPH acknowledged the concurrent use of quetiapine and aripiprazole was inappropriate and stated the physician should be notified of therapy duplication because the medications can cause side effects. CRPH stated a majority of antipsychotics can cause weight gain, and weight gain was a major side effect of quetiapine. CRPH stated the expectation was to ask the physician to do a gradual dose reduction, lower dose to treat patient condition and lower risk of side effect. CRPH stated she was not aware Resident 75 was diagnosed with dysphagia and acknowledged antipsychotics can induce dysphagia. CRPH stated dysphagia was difficulty swallowing and could contribute to Resident 75's weight loss because Resident 75 would not be able to eat. CRPH stated it was important to consider alternative medications that would not cause dysphagia and to see if another resident condition could be inducing dysphagia. CRPH stated she was not aware Resident 75 was diagnosed with dementia and had not seen any dementia medication. CRPH stated there was a boxed warning that antipsychotics increase risk of cardiovascular mortality rate in the elderly and because of that, the physician should evaluate risk versus benefit. During a review of Lexicomp, the manufacturer for aripiprazole indicated, Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Aripiprazole is not approved for the treatment of patients with dementia-related psychosis . Avoid for behavioral problems associated with dementia or delirium unless alternative nonpharmacologic therapies have failed and patient may harm self or others. If used, consider deprescribing attempts to assess continued need and/or lowest effective dose . Aripiprazole may cause extrapyramidal symptoms (EPS), also known as drug-induced movement disorders . EPS presenting as dysphagia, esophageal motility disorder, or pulmonary aspiration [food, drink or other material enter lung] have also been reported with antipsychotics, which may not be recognized as EPS . All drugs may cause side effects. However, many people may not have side effects or only have minor side effects. Call your doctor or get medical help if any of these side effects or any other side effects bother you or do not go away: . weight gain . During a review of Lexicomp, the manufacturer for quetiapine indicated, Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Quetiapine is not approved for the treatment of patients with dementia-related psychosis . Avoid for behavioral problems associated with dementia or delirium unless alternative nonpharmacologic therapies have failed and patient may harm self or others. If used, consider deprescribing attempts to assess continued need and/or lowest effective dose . Quetiapine may cause extrapyramidal symptoms (EPS), also known as drug-induced movement disorders . EPS presenting as dysphagia, esophageal motility disorder, or pulmonary aspiration [food, drink or other material enter lung] have also been reported with antipsychotics, which may not be recognized as EPS . All drugs may cause side effects. However, many people may not have side effects or only have minor side effects. Call your doctor or get medical help if any of these side effects or any other side effects bother you or do not go away: . weight gain . (continued on next page)		

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 06/10/2024
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)		
F 0758 Level of Harm - Actual harm Residents Affected - Few	During a review of the Publication titled The American Psychiatric Association [APA] Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia, dated 5/2016, the Publication indicated, Development of a Comprehensive Treatment Plan Statement 4. APA recommends that patients with dementia have a documented comprehensive treatment plan that includes appropriate person-centered nonpharmacological and pharmacological interventions, as indicated. Statement 8. APA recommends that if a risk/benefit assessment favors the use of an antipsychotic for behavioral/psychological symptoms in patients with dementia, treatment should be initiated at a low dose to be titrated up to the minimum effective dose as tolerated. APA recommends that in patients with dementia with agitation or psychosis, if there is no clinically significant response after a 4-week trial of an adequate dose of an antipsychotic drug [TRUNCATED]		

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 06/10/2024
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)		
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. 41166 Based on observation, interview and record review, the facility failed to ensure all medications used in the facility were properly labeled and discarded after the expiration date or discontinued date when: 1. In the C wing IV (intravenous- into the vein) medication cart, three 0.9% Normal Saline (mixture of salt and water used to replenish fluid and electrolytes) 100 ml (milliliter- unit of measure) bags in opened manufacturer overwrap packaging were observed without a use by date labeling. 2. In the D wing medication cart, Resident 76's discontinued nystatin cream (medication used to treat fungal infection) 15 GM (gram- unit of measurement) was observed not separated from medications that were in use for facility residents. 3. In the A wing medication cart, Residents 34 and 72's discontinued ondansetron (medication used for nausea) 4 mg (milligram- unit of measurement) medication cards, Resident 80's hydrocodone/acetaminophen (medication for pain) 5-325 mg (milligram- unit of measurement) and lorazepam 0.5 mg medication cards, and Resident 91's discontinued oxycodone/acetaminophen (medication for pain) 5-325 mg medication cards were found not separated from medications that were in use for facility residents, and Resident 55's partially used fluticasone 100 mcg (micrograms- unit of measurement) diskus (medication for lung inflammation) was observed without a use by date labeling. These failures had the potential for medications to be administered incorrectly causing an underdosing or overdosing of medications, or to be administered to the wrong residents causing harm to the resident. Findings: 1. During a concurrent observation and interview on 6/3/24 at 10:30 a.m. with Licensed Vocational Nurse (LVN) 3 at the C wing IV medication cart, an opened manufacturer overwrap bag containing three 100-ml 0.9% Normal Saline bags was observed without a use by date. LVN 3 stated, she did not know how long the manufacturer overwrap packaging had been opened. During an interview on 6/3/24 at 10:41 a.m. with Director of Nursing (DON), DON stated, the expectation was for nurses to give extra IV bags not used to the DON so the IV bags would not be used for other residents. DON stated, there was no way to tell when the IV bags in the opened manufacturer overwrap bag was opened. During a review of the 0.9% Normal Saline 100-ml bag manufacturer overwrap, the manufacturer instructions indicated, 4 UNITS . Do not remove units from overwrap until ready for use. Use all units promptly when pouch is opened. (continued on next page)		

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 06/10/2024
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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 6/3/24 at 4:12 p.m., with Director of Staff Development (DSD) and Clinical Leader (CL), at the D wing medication cart, Resident 76's discontinued nystatin-triamcinolone cream was observed in the medication cart, not separated from medications that were in use for facility residents. Resident 76's nystatin-triamcinolone cream label indicated apply to left groin every shift for 14 days. CL stated the nystatin order for Resident 76 was for 14 days. CL stated the expectation was for nursing staff to put discontinued medications in container for destruction. During an interview on 6/4/24 at 12:03 p.m. with DSD, DSD stated the expectation was for nurses to check orders with medication, so they knew when medications were to be discontinued, and removed from cart. DSD stated it was important because medications can be mistaken and potentially used for other residents. During a review of Resident 76's Physician Order (PO) for nystatin-triamcinolone, Resident 76's PO indicated an order date of 4/25/24, nystatin-triamcinolone cream, apply to left groin topically every shift for 14 days. 3. During a concurrent observation and interview on 6/4/4 at 10:03 a.m. with Registered Nurse (RN) 1, at the A wing medication cart, Residents 34 and 72's discontinued ondansetron 4 mg medication cards containing 6 tablets and 30 tablets respectively, were observed in the medication cart, Resident 80's discontinued hydrocodone/acetaminophen 5-325 mg medication card containing 16 tablets, lorazepam 0.5 mg medication card containing 30 tablets, and Resident 91's discontinued oxycodone/acetaminophen 5-325 mg medication card containing 17 tablets were found not separated from medications that were in use for facility residents, and Resident 55's fluticasone 100 mcg diskus was observed without a use by date labeling. Resident 34's ondansetron medication card containing 6 tablets, indicated ondansetron 4 mg every 8 hours as needed for nausea and vomiting for 3 days, and Resident 72's ondansetron medication card containing 30 tablets, indicated ondansetron 4 mg every 6 hours as needed for nausea and vomiting for 14 days. RN 1 stated both Residents 34 and 72's ondansetron orders had been discontinued. During a review of Resident 34's PO for ondansetron, the PO indicated an order date of 4/12/24, ondansetron tablet 4 mg by mouth every 8 hours as need for nausea and vomiting for 3 days. During a review of Resident 72's PO for ondansetron, the PO indicated an order date of 5/18/24, ondansetron tablet 4 mg by mouth every 6 hours as needed for nausea and vomiting for 14 days. During a review of Resident 55's PO for fluticasone 100 mcg diskus, the PO indicated, fluticasone diskus, inhale 2 puffs orally every 12 hours. When asked about the use by date for Resident 55's partially used fluticasone diskus, RN 1 stated once removed from the manufacturer overwrap, the discard date for fluticasone diskus was 45 days. RN 1 stated nursing staff was expected to count forward from date open to know when the medication expired so if nursing staff didn't know how many days for use by date, then a medication error was likely to occur. (continued on next page)		

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 06/10/2024
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)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the manufacturer's instructions outlined on the Resident 55's fluticasone instructions for use, the manufacturer instructions indicated, Read this information before you start using your fluticasone propionate diskus inhaler: take fluticasone propionate diskus out of the foil pouch just before you use it for the first time . Write the date you opened the foil pouch in the first blank line on the label. Write the use by date in the second blank line on the label . If you are using fluticasone propionate diskus 100 mcg or 250 mcg, that date is 2 months after the date you wrote in the first line. During an interview on 6/4/24 at 10:24 a.m., with RN 1, RN 1 stated she was unable to find active orders for Resident 80's hydrocodone/acetaminophen 5-325 mg and lorazepam 0.5 mg, and Resident 91's oxycodone/acetaminophen 5-325 mg. RN 1 stated the medications had been discontinued and Resident 91 was discharged from the facility on 6/1/24. During a review of Resident 80's hydrocodone/acetaminophen 5-325 mg PO order, the PO indicated an order date of 3/8/24, hydrocodone/acetaminophen 5-325 mg by mouth every 6 hours as needed for pain for 30 days. During a review of Resident 80's lorazepam 0.5 mg PO order, the PO indicated an order date of 2/16/24, lorazepam 0.5 mg by mouth every 8 hours as needed for anxiety for 30 days. During a review of Resident 91's oxycodone/acetaminophen 5-325 mg PO order, Resident 91's MAR indicated a start date of 4/18/24, oxycodone/acetaminophen 5-325 mg by mouth every 6 hours as needed for pain for 14 days. During an interview on 6/4/24 at 3:00 p.m., with DON, the DON stated nursing staff was expected to give discontinued narcotic medications (including hydrocodone/acetaminophen, oxycodone/acetaminophen) to DON for destruction, and non-narcotic medications separated in the medication room. DON sated it was important to remove discontinued medications from active medications so the medications would not be accidentally administered to residents. DON stated it was important to put both date open and use by dates on insulin, eye drops, and inhalers so nurses could remember when the medication expired and not administer the medication. During a review of the facility's Policy and Procedure (P&P) titled, Disposal of Medications and Medication-Related Supplies, dated 1/22, the P&P indicated, Medications are removed from the medication cart or active supply immediately upon receipt of an order to discontinue (to avoid inadvertent administration).		

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 06/10/2024
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)		
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. 48739 Based on observations, interviews, and record reviews, the facility failed to prepare food in accordance with professional standards for food service safety when the food preparation sink did not have an air gap (a vertical space between the end of a pipe and the top of a nearby sink that prevents the backflow of contaminated water). This failure had the potential for contaminated water to flow back into the sink and result in pathogenic (viruses, bacteria and other types of germs that can cause disease) microorganism (an organism that is so small it can only be viewed under a microscope) growth that could inadvertently (accidentally) be transferred to food and served to 93 residents in the facility, causing foodborne illness. Findings: During a concurrent observation and interview on 6/3/24 at 9:33 a.m. with Registered Dietician (RD) 1 and the Certified Dietary Manager (CDM) in the kitchen, there was no air gap (a physical separation between potentially contaminated water and the source of fresh water) underneath the food preparation sink. RD 1 stated there was not a drain under the sink to put an air gap. RD 1 stated the importance of having an air gap was so dirty water would not back flow into the sink. RD 1 stated if water back flowed into the sink, it could contaminate the food and get the residents sick. During a concurrent observation and interview on 6/4/24 at 9:05 a.m. with the [NAME] (CK) in the kitchen, the CK was cutting a roast for the lunch meal. The CK stated the pork roast was put in the refrigerator to thaw, but it was still frozen. The CK stated the roast was put in the sink under running water to complete the thawing process. During a review of the facility invoice titled, [Company Name], dated 6/3/24, the invoice indicated . DrainGap Multi-Port Drain Adapter . order date 6/3/24 at 5:41 p.m. During a review of the facility job description (JD) document titled, Certified Dietary Manager, dated 8/17/23, the JD indicated, . Ensure all local, state, and federal food handling, storage, and sanitation requirements are met or exceeded . During a review of the professional reference titled, FDA Food Code 2022, Chapter 5. Water, Plumbing, and Waste, section 5-203.14 indicated, . A PLUMBING SYSTEM shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the FOOD ESTABLISHMENT . backflow prevention is required by LAW, by: . providing an air gap as specified under S 5-202.13 . (continued on next page)		

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 06/10/2024
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of professional reference titled, FDA Food Code 2022 Annex 3. Public Health Reasons/Administrative Guidelines, section 5-202.13 indicated, . During periods of extraordinary demand, drinking water systems may develop negative pressure in portions of the system. If a connection exists between the system and a source of contaminated water during times of negative pressure, contaminated water may be drawn into and foul the entire system. Standing water in sinks, dipper wells, steam kettles, and other equipment may become contaminated with cleaning chemicals or food residue . Providing an air gap between the water supply outlet and the flood level rim of a plumbing fixture or equipment prevents contamination that may be caused by backflow .		

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 06/10/2024
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent infections for 5 of 14 sampled residents (Residents 77, 78, 79, 59, and 95) when: - Residents 77, 78 and 79's toilet including toilet seat commode in room [ROOM NUMBER] was soiled and splattered with feces (stool). This failure had the potential to result in cross contamination (bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) and transmission of infection between residents. - Two bags of dirty linens were found on the floor in a resident room. This failure had the potential to result in cross contamination which could lead to more serious health condition. - Licensed Vocational Nurses (LVN) 4 and 5 did not properly disinfect resident shared glucometer (device used to measure blood sugar) for Residents 59 and 95 after resident care. This deficient practice had the potential for the development and the spread of infection to all residents. Findings: - During a facility tour on 6/3/24, at 10:15 a.m. in A wing, room [ROOM NUMBER], feces was observed splattered in the toilet and toilet seat commode. During a concurrent observation and interview on 6/3/24 at 10:42 a.m. with the Medical Records Director (MRD), the MRD stated Resident 78 had told the staff he used the toilet after breakfast and made a mess in the toilet. The MRD stated the CNA should have tried cleaning the toilet and toilet seat commode then called housekeeping to sanitize toilet and toilet seat commode. MRD stated all three residents (Residents 77, 78, 79) in the room used the toilet and it was not ideal for the residents to use the dirty toilet. MRD stated it was an infection control issue because Resident 78 may have an infectious bacteria in his stool the facility staff did not know about and got transmitted to other residents. During a review of Resident 77's Admission Record (AR- a document with personal identifiable and medical information), dated 6/7/24, the AR indicated Resident 77 was admitted on [DATE] with diagnoses which included subdural hemorrhage (buildup of blood on the surface of the brain), anemia (lack of blood) and shortness of breath. During a review of Resident 78's AR, dated 6/7/24, the AR indicated Resident 78 was admitted on [DATE] with diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental function), and heart disease. During a review of Resident 79's AR, dated 6/7/24, the AR indicated Resident 79 was admitted on [DATE] with diagnoses which included fracture (bone break) of neck of left femur (thigh bone) and muscle weakness. (continued on next page)		

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 06/10/2024
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/24 at 12:10 p.m. with the Director of Staff Development (DSD), the DSD stated the facility practice was the Certified Nursing Assistants (CNAs) needed to clean the toilet as soon as resident reports an incident then call housekeeping to sanitize. DSD stated other residents in the room used the toilet and did not want residents using a dirty toilet. DSD stated the feces may have infectious bacteria which could be transmitted to the other residents. During an interview on 6/6/24 at 8:30 a.m. with the Infection Preventionist (IP), the IP stated CNAs were supposed to clean the toilet then call housekeeping to do a thorough cleaning and sanitizing of the toilet and toilet seat commode because it was an infection control issue. IP stated leaving the toilet dirty was not acceptable practice. During an interview on 6/6/24 at 12:48 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated cleaning toilets was a housekeeping job but when there was feces on the toilet and toilet seat, CNAs were supposed to clean first then call housekeeping to sanitize toilet and toilet seat. CNA 1 stated all three residents (Residents 77, 78 and 79) in room [ROOM NUMBER] used the toilet and did not want residents using a dirty toilet because it was an infection control issue. During an interview on 6/10/24 at 9:15 a.m. with the Director of Nursing (DON), DON stated her expectation was the CNA should have cleaned the toilet and toilet seat as soon as the resident reported the issue. DON stated all three residents in room [ROOM NUMBER] used the toilet and did not want residents to develop any infection because the staff did not clean the toilet and toilet seat commode. During a review of the facility's policy and procedure (P&P) titled Cleaning and Disinfection of Environmental Surfaces dated 8/19, the P&P indicated, . Environmental surfaces will be cleaned and disinfected according to CDC [Centers for Disease Control and Prevention- service organization that protects the public health] recommendations . OSHA [Occupational Safety and Health Administration] bloodborne pathogens . Environmental surfaces will be disinfected (or cleaned) on a regular basis . and when surfaces are visibly soiled . 2. During a concurrent observation and interview on 6/3/24 at 10:55 a.m. in A wing, room [ROOM NUMBER], two bags of dirty linens and a bag of garbage were found on the floor. CNA 5 was standing next to the bagged dirty linens and garbage and stated she just completed providing a bed bath to a resident and placed the dirty linens and garbage in a plastic bag and left it on the floor. CNA 5 stated she should not have placed the bagged dirty linens and garbage on the floor because it was an infection control issue. CNA 5 stated the practice was to place them on the corner top of the bed until they were placed in a hamper. During an interview on 6/5/24 at 11:49 a.m. with the DSD, the DSD stated dirty linens were placed in plastic bags and on the top corner of resident's bed and taken straight to the hamper. DSD stated dirty linens should not have been left on the floor, floors were more dirty than the bagged dirty linens. DSD stated it was an infection control issue and may cause cross contamination. During an interview on 6/6/24 at 8:22 a.m. with the IP, IP stated bagged dirty linens were not to be placed on the floor because the floor dirtier than the bagged dirty linens. IP stated bagged dirty linens should have been placed on the top corner of a resident bed. IP stated the DSD was responsible in conducting infection control training to staff. (continued on next page)		

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 06/10/2024
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/24 at 9:20 a.m. with the DON, she stated her expectation was for the staff to practice infection prevention and control. DON stated the staff knew not to leave bagged dirty linens on the floor because of the possibility of cross contamination. DON stated staff were given in-service training and was always given reminders on proper ways of handling dirty linens. During a review of facility's P&P titled, Laundry and Bedding, Soiled, dated 10/18, the P&P indicated, . Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control . All used laundry is handled as potentially contaminated . 41166 3. During a concurrent observation and interview on 6/3/24 at 11:07 a.m., with LVN 5 in the D wing, LVN 5 was observed cleaning and disinfecting a glucometer after using it for Resident 59's care. LVN 5 was observed wiping the front of the glucometer with the facility's bleach sanitizing wipe, the back of the glucometer with a new bleach sanitizing wipe and disinfecting by partially wrapping the glucometer with a new wipe, with the top and bottom of the glucometer exposed and not disinfected for the manufacturer contact time (time needed to kill any disease-causing organisms). LVN 5 acknowledged she did not appropriately disinfect the glucometer by not disinfecting the top and bottom of the glucometer. LVN 5 stated it was important to properly disinfect the glucometer in between patients for infection control to reduce germs. During a concurrent observation and interview on 6/3/24 at 11:29 a.m., with LVN 4 in the B wing, LVN 4 was observed cleaning and disinfecting a glucometer after using it for Resident 95's care. LVN 4 was observed cleaning the glucometer with the facility's bleach sanitizing wipe, then disinfecting by partially wrapping the glucometer with a new wipe, with the side of the glucometer exposed and not disinfected for the manufacturer contact time. LVN 4 acknowledged she did not appropriately disinfect the glucometer by not disinfecting the side of the glucometer. LVN 4 acknowledged the glucometer should be completely wrapped and wet for the manufacturer specified contact time in order to kill disease causing organisms. LVN 4 stated, using an improperly disinfected glucometer could potentially cause spread of infection to residents. During an interview on 6/3/24 at 2:47 p.m., with Director of Nursing (DON), DON stated the expectation was for nursing staff to wipe it throw it away, wipe it throw it away, wrap it with wipe like a burrito for time on wipe container. DON stated it was important to prevent the spread of infections. During a review on the manufacturer instructions for the facility glucometer, the manufacturer instructions indicated, To disinfect your meter, clean the meter surface with one of the approved disinfecting wipes. Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use. Wipe all external areas of the meter including both front and back surfaces until visibly wet.		

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 06/10/2024
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)		
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48430 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program for one of three sampled residents (Resident 85), when two cockroaches were found in the Resident 85's bathroom. This failure resulted in an ineffective pest control program with cockroaches found in Resident 85's bathroom. Findings: During a concurrent observation and interview on 6/3/24 at 3:34 p.m. with the Director of Nursing (DON), in Resident 85's bathroom, two, small brown, insects were observed. The DON stated, the insects were cockroaches. During an interview on 6/3/24 at 3:34 p.m. with the Administrator (ADM), in Resident 85's bathroom, the ADM stated, the pest control vendor that came to the facility was (Pest Control Company Name). During an interview on 6/3/24 at 3:34 p.m. with Resident 85, Resident 85 stated, he had seen cockroaches in the bathroom before. Resident 85 stated, I've stomped on them while I was on the [NAME]. During an interview on 6/4/24 at 9:17 a.m. with Housekeeper (HK) 1, HK 1 stated, she had seen cockroaches in the facility. HK 1 stated, there should not have been cockroaches in the facility, I would say no [cockroaches running around the facility], I don't like them. During an interview on 6/6/24 at 9:29 a.m. with the Infection Preventionist (IP), IP stated, there should not have been cockroaches in the facility. IP stated, . They're [cockroaches] not supposed to be there [anywhere in the facility]. The IP stated, pest control vendors came monthly or whenever necessary if the need arises. IP stated, if there were still pests in the facility, then the pest control program was not effective and needed to be re-evaluated. During an interview on 6/7/24 at 10:01 a.m. with the DON, the DON stated, there should not have been cockroaches in the facility. The DON stated, cockroaches could have spread diseases and illness to residents. The DON stated, she expected the pest control program to be effective, but if roaches were still in the facility, then the pest control program was not effective. During a review of the facility's maintenance logs (ML), the ML dated 6/23/23, indicated, Bwing Hall Roach Infestation. During a review of the facility's P&P titled, Pest Control, dated May 2008, the P&P indicated, This facility maintains an on-going pest control program to ensure that the building is kept free of insects . Pest control services are provided by [Pest Control Company Name].		