

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 05/01/2025
NAME OF PROVIDER OR SUPPLIER Cornerstone Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2550 9th Street Sanger, CA 93657	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity and respect for one of nine sampled residents (Resident 88) when Resident 88's urinary catheter (flexible tube inserted into the bladder to drain urine) bag was not covered and was visible to residents and visitors</p> <p>This failure violated Resident 88's right to dignity and privacy and had the potential to lead to psychological harm.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/27/25 at 12:24 p.m. in Resident 88's room, Resident 88 was sitting up in bed eating lunch. Resident 88's urinary catheter bag was hanging on the side of the bed uncovered. The urinary bag was visible when entering the room and the bag was filled with yellow urine. Resident 88 stated he had the foley catheter for a while but could not remember how long Resident 88 stated he did not know why staff had the catheter bag uncovered for everyone to see.</p> <p>During a review of Resident 88's, admission Record, (AR-a document with personal identification and medical information) dated 4/30/25, the AR indicated Resident 88 was re-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).</p> <p>During a review of Resident 88's Order Summary Report, [OSR] dated 4/30/25, the OSR indicated, . Indwelling Urinary Catheter Size . Order Date 4/19/25 .</p> <p>During a concurrent observation and interview with Certified Nurse Assistant (CNA) 2 on 4/27/25 at 2:06 p.m. outside of Resident 88's room, CNA 2 stated she taking care of Resident 88 for the day. CNA 2 stated Resident 88 has a foley catheter and it should be covered with a privacy bag. CNA 2 entered Resident 88's room and stated Resident 88's catheter bag was uncovered and exposed. CNA 2 grabbed a pair of gloves and placed Resident 88's catheter bag inside a privacy bag. CNA 2 stated the practice was to ensure catheter bag was placed in a privacy bag. CNA 2 stated it was Resident 88's right to have his privacy and dignity respected.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/29/25 at 9:40 a.m. with Infection Preventionist (IP-works to prevent germs from spreading within the facility), the IP reviewed list of residents on Enhanced Barrier Precaution (EBP-an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities) and stated Resident 88 is on EBP. The IP stated foley catheter bag should have been in a privacy bag. The IP stated the expectation was for all licensed nurses and CNAs to ensure foley catheter bags are covered with privacy bags because it was a resident right to have their privacy and dignity respected.</p> <p>During an interview on 5/1/25 at 1:21 p.m. with the Director of Nursing (DON), the DON stated the practice was to ensure foley catheter bags are always placed in a privacy bag. The DON stated it was the responsibility of nursing staff to ensure foley catheter bags are covered.</p> <p>The DON stated it was a dignity issue for Resident 88 to have his foley catheter bag exposed.</p> <p>During a review of the facility's policy and procedure titled Dignity, dated 2/2021, the P&P indicated, . 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 .</p> <p>During a review of the facility's policy and procedure (P&P) titled Resident Rights, dated 9/22/22, the P&P indicated .The resident has a right to be treated with respect and dignity, including: 1. The right to be free from any physical or chemical restraints . The resident has a right to personal privacy and confidentiality .</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Minimum Data Set (MDS-a computerized clinical assessment tool) Significant Change in Status Assessment (SCSA-a comprehensive assessment that must be completed when the resident meets the significant change guidelines for either major improvement or decline) within 14 days, for one of five sampled residents (Resident 83) when a significant changed had occurred.</p> <p>This failure had the potential to delay identification and implementation of necessary interventions to address Resident 83's care and support needs.</p> <p>Findings:</p> <p>During a review of Resident 83's admission Record, (AR-a document with personal identifiable and medical information) dated 4/30/25, the AR indicated Resident 83 was admitted to the facility on [DATE] with diagnoses which included multiple fractures of pelvis (break in multiple bones of hip bones), and surgical aftercare following surgery on the digestive system.</p> <p>During a review of Resident 83's Order Summary Report, dated 4/30/25, the OSR indicated, .Regular diet Regular texture, Regular (thin) consistency, for Double portion of protein . Order Date 01/21/2025 . Weight Bearing as Tolerated . Order Date 03/07/2025 .</p> <p>During a concurrent interview and record review on 4/30/25 at 2:03 p.m. with the Minimum Data Set Nurse (MDSN), Resident 83's MDS assessments were reviewed. The MDSN stated Resident 83 had a follow-up appointment with the orthopedist (medical doctor specializes in bones) and returned with a new order: Resident may have weight bearing as tolerated. The MDSN stated Resident 83's last MDS assessment was Medicare 5 (five) day assessment dated [DATE] and it was for the change of weight bearing status. The MDSN stated there was no significant change MDS assessment for Resident 83. The MDSN stated the significant change MDS assessment should have been completed within 14 days after the order was received for weight bearing.</p> <p>During an interview on 5/1/25 at 1:34 p.m. with the Administrator (ADM), the ADM stated his expectation was for MDSN to accurately complete MDS assessments timely. The ADM stated he expected the MDSN to review resident records and ensure assessments are opened and completed when due.</p> <p>During a review of the facility policy and procedure (P&P) titled, Conducting an Accurate Resident Assessment, dated 12/19/22, the P&P indicated, .The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment . The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status . Each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment .</p> <p>(continued on next page)</p>		

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<p>F 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of facility's document Job Description: MDS dated 6/30/23, the job description indicated, . Conduct and coordinate the development and completion of the resident assessment (MDS) in accordance with current rules, regulations, and guidelines that govern the resident assessment, including the implementation . Ensure that all assessments are completed and transmitted in a timely manner . Ensure that all members of the assessment team are aware of the importance of completeness and accuracy in their assessment functions .</p> <p>During a review of professional guideline titled, Long Term Care Facility Resident Assessment Instrument version 1.19.1 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 10/24, indicated, . 5-Day Assessment and Significant Change in Status Assessment . Comprehensive item set . Must be completed (item Z0500B) within 14 days after the determination that the criteria are met for a Significant Change in Status assessment . The MDS records for a nursing home resident are expected to occur in a specific order. For example, the first record for a resident is expected to be an Entry record with entry type (item A1700) indicating admission, and the next record is expected to be an admission assessment . 5-Day assessment, a Discharge assessment, or Death in Facility tracking record. iQIES will issue a warning when an unexpected record is submitted . Entry Date (item A1600) for entry records, and the discharge date (item A2000) for discharge or Death in facility records .Discharge Assessment-Return Not Anticipated (A0310F = 10) . Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days .</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet the required timelines for encoding and transmission of Minimum Data Set (MDS-evaluation of cognition, care needs and functional abilities) assessments for two of five sampled residents (Resident 44 and Resident 68) when the Minimum Data Set Nurse (MDSN) did not complete or transmit discharge MDS assessment for Resident 44 and Resident 68.</p> <p>This deficient practice resulted in the potential of resident's needs upon discharge going unmet.</p> <p>Findings:</p> <p>During a review of Resident 44's admission Record, (AR-a document with personal identifiable and medical information), dated 5/1/25, the AR indicated, Resident 44 was admitted to the facility on [DATE] with diagnoses which included asthma (difficulty breathing) hypertension (high blood pressure) and pain.</p> <p>During a review of Resident 68's admission Record, dated 5/1/25, the AR indicated Resident 68 was admitted to the facility on [DATE] with diagnoses which included muscle weakness, chronic obstructive pulmonary disease (COPD-chronic lung disease causing difficulty in breathing) and anemia (a condition where the body does not have enough healthy red blood cells).</p> <p>During a concurrent interview and record review on 5/1/25 at 8:05 a.m. with MDSN, Resident 44's clinical record was reviewed. MDSN stated Resident 44 was admitted to the facility on [DATE]. MDSN stated Resident 44's last MDS assessment was a quarterly assessment dated [DATE]. MDSN stated Resident 44 was sent out to general acute hospital (GACH) on 1/23/25. The MDSN stated Resident 44 did not return to the facility. The MDSN did not find a completed and transmitted MDS discharge assessment tracking for Resident 44 when Resident 44 was discharged to GACH on 1/23/25. The MDSN stated she did not do the discharge MDS assessment for Resident 44's discharge which was required to be completed within 14 days from his discharge</p> <p>During a concurrent interview and record review on 5/1/25 at 8:20 a.m. with MDSN, Resident 68's clinical record was reviewed. MDSN stated Resident 68 was admitted to the facility on [DATE]. MDSN stated Resident 68 left the facility against medical advice (AMA-patient leaving a facility against the advice of their doctor) on 2/26/25. MDSN stated Resident 68's last MDS assessment was Medicare five (5) assessment dated [DATE]. The MDSN did not find a completed and transmitted MDS discharge assessment tracking for Resident 68 when Resident 68 left the facility AMA on 2/26/25. The MDSN stated she did not open and complete the MDS assessment for Resident 68's discharge which was required to be completed within 30 days from discharge. The MDSN stated it was her responsibility to ensure assessments were opened, completed and transmitted in a timely manner.</p> <p>During an interview on 5/1/25 at 1:34 p.m. with the Administrator (ADM), the ADM stated his expectation was for the MDSN to complete assessments, and be done in a timely matter. The ADM stated MDSN was responsible in reviewing resident records and ensure required assessments are opened and completed when due.</p> <p>(continued on next page)</p>

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility policy and procedure (P&P) titled, Conducting an Accurate Resident Assessment, dated 12/19/22, the P&P indicated, .The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment . The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status . Each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment .</p> <p>During a review of facility's document Job Description: MDS dated 6/30/23, the job description indicated, . Conduct and coordinate the development and completion of the resident assessment (MDS) in accordance with current rules, regulations, and guidelines that govern the resident assessment, including the implementation . Ensure that all assessments are completed and transmitted in a timely manner . Ensure that all members of the assessment team are aware of the importance of completeness and accuracy in their assessment functions .</p> <p>During a review of professional guideline titled, Long Term Care Facility Resident Assessment Instrument version 1.19.1 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 10/24, indicated, . The MDS records for a nursing home resident are expected to occur in a specific order. For example, the first record for a resident is expected to be an Entry record with entry type (item A1700) indicating admission, and the next record is expected to be an admission assessment . 5-Day assessment, a Discharge assessment, or Death in Facility tracking record. iQIES will issue a warning when an unexpected record is submitted . Entry Date (item A1600) for entry records, and the discharge date (item A2000) for discharge or Death in facility records .Discharge Assessment-Return Not Anticipated (A0310F = 10) . Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days . For a resident discharged to a hospital or other setting (such as a respite resident) who comes in and out of the facility on a relatively frequent basis and reentry can be expected, the resident is discharged return anticipated unless it is known on discharge that they will not return within 30 days. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged . Must be completed (item Z0500B) within 14 days after the discharge date (item A2000) (i.e., discharge date (A2000) + 14 calendar days) .</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 for one of five sampled residents (Resident 57) when Resident 57's pressure ulcer (localized injury to the skin and underlying tissue caused by prolonged pressure) was inaccurately coded on the MDS assessment.</p> <p>This failure had the potential to result in Resident 57's care needs not being met and the potential for pressure ulcer to worsen</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/27/25 at 12:26 p.m. with Resident 57 in his room, Resident 57 was sitting up in bed eating lunch. Resident 57 observed with low air loss mattress (mattress designed to prevent and treat pressure ulcers) and denied any complaints or pain.</p> <p>During a review of Resident 57's admission Record, (AR- a document with personal identifiable and medical information), dated 4/30/25, the AR indicated Resident 57 was admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing), hemiplegia (muscle weakness or partial paralysis[complete or partial loss of muscle function]) and hemiparesis (one-sided muscle weakness), and shortness of breath.</p> <p>During a concurrent interview and record review on 4/30/25 at 11:06 a.m. with the Treatment Nurse (TXN), the TXN stated Resident 57 was admitted to the facility on [DATE] and the pressure ulcer to his right buttock was reported on 6/25/23. The TXN stated the ulcer was diagnosed as unstageable pressure injury (UTD-pressure injury where the base of the ulcer was obscured by slough [yellowish, pale dead tissue] and or eschar [dried, leathery layer of dead tissue covering the true depth of the wound]). The TXN stated Resident 57's UTD diagnosis was changed to Kennedy ulcer (skin ulcer that appears in the sacrum [triangular bone in the lower back] often a sign of impending death) on 7/17/24. The TXN stated she did not know why diagnosis was changed. TXN stated she continues to do the treatment on Resident 57's ulcer because it is still open.</p> <p>During a review of Resident 57's Order Summary Report, (OSR) dated 4/30/25, the OSR indicated, . cleanse Sacrum [NAME] terminal with appearance of stage 3 [three] area with normal saline, pat dry, apply .every shift . Order Date 4/23/25 .</p> <p>During a concurrent interview and record review on 4/30/25 at 2:15 p.m. with the Minimum Data Set Nurse (MDSN), the MDSN reviewed Resident 57's MDS quarterly assessment dated [DATE] section M (Skin Conditions), Resident 57's ulcer was not coded in the MDS assessment. The MDSN stated the assessment was not accurately coded. The MDSN stated, I should have coded him [Resident 57] having a stage 3 [three] pressure ulcer [full-thickness skin loss] or any ulcer but I did not, it was an error in coding, the assessment was not accurate. The MDSN stated the wound doctor assessed Resident 57's wound on 10/8/24 and changed the diagnosis to Kennedy ulcer with appearance of a stage 3.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/1/25 at 1:25 p.m. with the Director of Nursing (DON), the DON stated she did not check MDS assessments for accuracy. The DON stated the expectation was that each person completing assessment is responsible in ensuring the assessments are accurate. The DON stated there was an MDS consultant but not sure if the consultant checked the assessments for accuracy.</p> <p>During an interview on 5/1/25 at 1:35 p.m. with the Administrator (ADM), the ADM stated the expectation was for the MDSN to ensure assessments are accurate, complete and done timely.</p> <p>During a review of facility's policy and procedure (P&P) titled, Conducting an Accurate Resident Assessment, dated 12/19/22, the P&P indicated, . Qualified staff who are knowledgeable about the resident will conduct an accurate assessment . The appropriate, qualified professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident's strengths to maintain or improve medical status .</p> <p>During a review of professional reference titled, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.19.1 10/24, indicated. . Definitions . Surgical Wounds Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites . Steps for Assessment . Examine the resident and determine whether any ulcers, wounds, or skin problems are present .</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services in accordance with accepted professional standards of quality of care for one of three sampled residents (Resident 147) when Licensed Vocational Nurse (LVN) 5 signed Resident 147's electronic Treatment Administration Record (eTAR-digital version of treatment administered to a resident) indicating Resident 147 was wearing compression stockings on 4/29/25.</p> <p>This failure had the potential for Resident 147 to not receive prescribed care which could result in more serious health conditions.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/29/25 at 1:10p.m. in B wing hallway outside of Resident 147's room, Resident 147 was observed sitting up in wheelchair. Resident 147 was observed wearing non-skid socks and stated he did not remember wearing compression stockings since he was admitted in the facility.</p> <p>During a review of Resident 147's admission Record, (AR-a document with personal identifiable and medical information), dated 4/30/25, the AR indicated, Resident 147 was admitted to the facility on [DATE] with diagnoses which included encephalopathy (brain dysfunction- disruption in the way the brain functions), hypertension (high blood pressure) and muscle weakness.</p> <p>During a review of Resident 147's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 4/7/25, the MDS section C (Cognitive Patterns) indicated Resident 147 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 9 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview), which indicated Resident 147 was moderately impaired.</p> <p>During a review of Resident 147's Order Summary Report, dated 4/30/25, the OSR indicated, . Compression stockings-Apply in the morning and remove at bedtime . Order Date 04/25/2025, Start Date 04/25/2025 .</p> <p>During a review of Resident 147's Treatment Administration Record, (eTAR) dated 4/1/25-4/30/25, the eTAR indicated, Resident 147 wore his compression stockings on 4/26/25, 4/28/25, 4/29/25 and 4/30/25.</p> <p>During an interview on 4/29/25 at 1:11 p.m. with Certified Nursing Assistant (CNA)1, CNA 1 stated she was assigned to care for Resident 147. CNA 1 checked Resident 147 and stated Resident 147 was not wearing compression stocking, he was wearing non-skid socks. CNA 1 stated she did not put compression stockings on Resident 147 when she got him up in the morning. CNA 1 stated she did not know Resident 147 was supposed to wear compression stockings every day.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/29/25 at 1:18 p.m. with LVN 5, LVN 5 reviewed Resident 147's clinical record and stated compression stocking order for Resident 147 was ordered on 4/25/25 for swelling to his lower legs. LVN 5 stated he marked Resident 147's eTAR without checking if Resident 147 was wearing compression stockings. LVN 5 stated Resident 147 did not have compression stockings on, and he should have. LVN 5 stated it was licensed nurses and CNAs responsibility to ensure Resident 147 wore compression stockings every day. LVN 5 stated it was his responsibility to check Resident 147 if he was wearing compression stockings before he signed the eTAR. LVN 5 stated Resident 147's swelling could get worse if not wearing compression stockings as ordered.</p> <p>During an interview on 5/1/25 at 1:28 p.m. with the Director of Nursing (DON), the DON stated her expectation was for licensed nurses to check or assess before signing eTAR and or eMAR. The DON stated LVN 5 could have checked Resident 147 first to ensure Resident 17 was wearing compression stockings then signed the eTAR.</p> <p>During a review of Job Description: Licensed Vocational Nurse, dated 12/1/22, the job description indicated, . Position Summary The LVN is responsible for assisting with resident care under the medical direction and supervision of the residents' attending physician . Examine the resident and his/her records and charts . Perform administrative duties such as completing medical forms, reports . Provide assessment and diagnostic services to residents . Provide therapeutic services . Give direct physical and psychological nursing care .</p> <p>During a review of Job Description: Certified Nursing Assistant, dated 12/1/22, the job description indicated, . Promptly assist residents with Activities of Daily Living (ADL) and daily nursing care needs as directed in service plan . Complete all service plan tasks as scheduled and sign-off on each by end of shift . Encourage teamwork among all departments .</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for three of seven sampled residents (Resident 30, Resident 70 and Resident 294) when:</p> <p>1. Residents 30 and 294 did not receive appropriate monitoring for Vitamin D (a nutrient that the body needs for absorption of calcium).</p> <p>This failure had the potential risk for Resident 30 and Resident 294 to result in toxicity or ineffective dosing from a continued and unmonitored Vitamin D administration.</p> <p>2. Resident 294 was administered Torsemide (a medication used to help treat fluid retention and swelling) and did not have a diagnosis for fluid retention or swelling, and was administered Sevelamer Carbonate (a medication used to control high blood phosphate levels). Resident 294's record review indicated an active order for Sevelamer Hydrochloride (a medication used to control high blood phosphate levels) for hypocalcemia (low calcium blood levels) and did not have a diagnosis for hypocalcemia.</p> <p>These failures placed Resident 294 at risk for adverse effects from receiving medications without appropriate indications.</p> <p>3. Resident 294 and Resident 70 were administered amiodarone (a medication used to treat irregular heartbeat) and did not have appropriate monitoring for TSH levels (Thyroid-stimulating hormone, a blood test is an indicator of thyroid function).</p> <p>These failures had the potential risk of Resident 294 and Resident 70 experiencing adverse effects from inadequate and inappropriate monitoring of thyroid levels including fatigue, irritability, and weight gain.</p> <p>1a. During a record review of Resident 30's, admission Record, dated 4/29/25, the admission Record indicated, . Diagnosis information .Vitamin D deficiency (a condition where the body does not have enough vitamin D) .</p> <p>During a record review of Resident 30's Order Summary dated 4/29/25, the Order Summary indicated, Vitamin D3 capsule 1.25 MG [milligram- unit of measurement] (50000 units) one time a day every Monday, Wednesday, Friday for supplement.</p> <p>During an observation of medication cart for D Wing on 4/27/25 at 9:58 a.m. Resident 30 blister card containing 1 capsule vitamin D3 50,000 units capsule- take 1 capsule by mouth daily Monday, Wednesday, and Friday for supplement.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/28/25 at 9:31 a.m., with Licensed Vocational Nurse (LVN) 1 for D wing, Resident 30's laboratory orders and results were reviewed. LVN 1 acknowledged Resident 30 was currently being administered Vitamin D three times a week. LVN 1 was unable to provide documentation for monitoring Resident 30's vitamin D levels. LVN 1 acknowledged Vitamin D levels were not obtained for Resident 30 and stated it was important to make sure vitamin D level was within a healthy normal range.</p> <p>Durning an interview on 4/28/25 at 2:08 p.m. with the Director of Nursing (DON), DON acknowledged Resident 30 did not have Vitamin D lab orders and was being administered Vitamin D without accurate monitoring of Resident 30's blood level. DON stated monitoring was important to determine how the resident was responding to treatment and to administer the appropriate medication.</p> <p>During a telephone interview on 4/30/25 at 10:03 a.m. with the Pharmacy Consultant (PC), the PC stated it was important to obtain baseline labs and continue to periodically monitor to determine if medication was to be given.</p> <p>1b. During a record review of Resident 294's admission Record, dated 4/29/25, the admission Record indicated, .Diagnosis information .Atrial Fibrillation (an irregular, often rapid heartbeat), and End Stage Renal Disease (ESRD- a condition where the kidneys have permanently lost the ability to function).</p> <p>During a record review of Resident 294's Order Summary dated 4/29/25, the Order Summary indicated, Vitamin D capsule (Ergocalciferol) 50,000 units one time a day every Thursday for supplement. Order date: 4/19/25.</p> <p>During a concurrent interview and record review on 4/28/25 at 10:15 a.m., with LVN 3, Resident 294's Electronic Medical Records (EMR) was reviewed. LVN 3 was unable to provide documentation of Vitamin D monitoring for Resident 294. LVN 3 acknowledged Resident 294 was currently being administered Vitamin D 50,000 units every Thursday, and stated it was important to have labs to monitor the level of Vitamin D to determine its effect on Resident 294's health.</p> <p>During an interview on 4/28/25 at 2:08 p.m. with the DON, DON acknowledged Resident 249 did not have Vitamin D lab orders and was being administered Vitamin D without accurate monitoring of Resident 294's blood level. DON stated it was important to know the Resident's blood lab levels to administer appropriate medication and how the resident is responding to treatment.</p> <p>During a telephone interview on 4/230/25 at 10:03 a.m. with the PC, the PC stated there needed to be an order for baseline labs and continue to periodically monitor to determine if medication was to be given.</p> <p>2. During a record review of Resident 294's admission Record, dated 4/29/25, the admission Record indicated, .Diagnosis information .Atrial Fibrillation (an irregular, often rapid heartbeat), Heart Failure (a condition when the heart can't pump enough blood to meet the body's needs.) and End Stage Renal Disease (ESRD- a condition where the kidneys have permanently lost the ability to function).</p> <p>During a record review of Resident 294's Order Summary dated 4/29/25, the Order Summary indicated, Sevelamer HCl 800 MG, two tablets three times a day for hypocalcemia with meals Torsemide 20 MG tablet one-time a day for edema. Order date: 4/19/25.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 294's Medication Administration Record (MAR- a standardized record that organizes essential information about a resident and their prescribed medication and treatment, dated April 2025, the MAR indicated, Sevelamer HCl tablet 800 MG, two tablets by mouth three times a day for hypocalcemia with meals. Torsemide tablet 20 MG give one tablet by mouth one time a day for edema.</p> <p>During a record review on 4/28/25 at 9:19 a.m. of Resident 294's Lab Results Report, dated 4/25/25, Lab Results Report indicated Resident 294's Calcium level results 9.6 mg/dL (grams per deciliter). Range 8.4-10.6 mg/dL.</p> <p>During a record review on 4/28/25 at 9:19 a.m. of Resident 294's Lab Results Report, dated 4/25/25, Lab Results Report indicated Resident 294's Phosphatase level results 152 U/L (units per Liter). Range (30-120) mg/dL Flagged as high levels.</p> <p>During a concurrent interview and record review on 4/28/25 at 9:53 a.m., with LVN 3, Resident 294's admission Record, Order Summary Report, and MAR, dated April 2025 were reviewed. LVN 3 stated Resident 294's medical diagnoses did not include edema. LVN 3 acknowledged Resident 294 was not receiving torsemide for edema.</p> <p>During a concurrent interview and record review on 4/28/25 at 10:01 a.m., with LVN 3, Resident 294's MAR, Order summary Report and Lab Results Report, dated April 2025, were reviewed. LVN 3 stated the physician order was written for Sevelamer HCl for hypocalcemia. LVN 3 acknowledged Resident 294 was administered Sevelamer Carbonate, and stated The order and the blister pack look different. LVN 3 acknowledged Resident 294's lab results dated 4/25/25 for Phosphatase lab levels are indicated as being high level, the calcium lab level was normal. LVN 3 stated it was important to give the right medication because it's for specific diagnosis.</p> <p>During an interview on 4/28/25 at 2:05 p.m., with the DON, the DON acknowledged Resident 294 was receiving torsemide for edema but did not have a history of edema. The DON stated the indication of use for torsemide was incorrect. The DON stated she confirmed with the physician the appropriate indication for administration was for heart failure and not edema. The DON stated Sevelamer HCl is used for high phosphate levels and not calcium.</p> <p>During an interview on 4/30/25 at 10:03 a.m. with the PC, the PC stated the indication for administration of the medication in question for Resident 294 was not accurate, if the indication is wrong the facility needs to talk to the doctor to clarify the indication and diagnosis, before administering the medication. PC stated the wrong medication given could change the resident's condition.</p> <p>During a review of the manufacturer's instructions for Sevelamer Carbonate, the manufacturer instructions indicated, .for the control of serum phosphorus.</p> <p>3a. During a record review of Resident 70's admission Record, dated 4/29/25, the admission Record indicated, .Diagnosis information .Atrial Fibrillation (an irregular, often rapid heartbeat), hypertension (HTN-high blood pressure), and hypothyroidism (a condition where the thyroid gland doesn't produce enough thyroid hormone.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review of Resident 70's Order Summary dated 4/29/25, the Order Summary indicated, Amiodarone HCl oral tablet 100 MG . give one tablet by mouth one time a day for HTN hold if SBP&lt; [less than] 100 and DBP &lt; 60 pulse &lt; 60 Amiodarone HCl oral tablet 200 MG give one tablet by mouth in the evening for hypertension hold if less than 100, DSP 60 and HR 60. . Levothyroxine Sodium [medication to treat low thyroid levels] Oral Tablet 75 MCG [micrograms] give one tablet by mouth in the morning for hypothyroidism. Order date: 11/11/24.</p> <p>Durning a record review of Resident 70's Lab Results Report, dated 11/12/24, the Lab Results Report for TSH indicated TSH levels 5.15 U/mL, normal range (0.45-5.33 U/ml).</p> <p>Durning a review of Lab Results Report, dated 1/27/25, the Lab Results Report for TSH indicated high TSH levels 8.73 U/mL, normal range (0.45-5.33 U/ml).</p> <p>During a review of Resident 70's Progress Notes (PN), dated 1/28/25, the PN indicated, .abnormal TSH level. Plan; increase [brand name for levothyroxine] to 88 mcg QD [one time a day] .recheck TSH in 6weeks. Author facility Nurse Practitioner (NP).</p> <p>Durning an interview on 4/28/25 at 2:52 p.m., with Registered Nurse (RN) 1, RN 1 stated Resident 70 was receiving Amiodarone 100 mg in the morning, 200 mg in the evening and Levothyroxine 75 mcg once daily since admission. RN 1 acknowledged Resident 70's TSH lab levels as critical being a high lab. RN 1 stated the expectation was to contact the physician as soon as possible, to get new orders to change the medication according to labs. RN 1 acknowledged the PN dated 1/28/25 from the NP, giving instructions to recheck labs in six weeks and increase levothyroxine to 88 mcg daily. RN 1 was unable to provide documentation the NP's orders were implemented, and stated it was important to follow up on the lab orders and medication change because the lab value was critical.</p> <p>During an interview on 4/28/25 at 2:55 p.m., with the DON, the DON stated the expectation for nursing staff was to carry out the prescriber's order.</p> <p>During an interview on 4/30/25 at 10:03 a.m., with the PC, the PC stated Resident 70's levothyroxine was not increased to 88 mcg daily as ordered, and the expectation was to carry out the providers' orders. The PC stated this medication change was important to have better control over Resident 70's condition.</p> <p>During a review of the manufacturer's drug information for amiodarone, the manufacturer indicated, .can cause either hypothyroidism or hyperthyroidism .Monitor thyroid function prior to treatment and periodically thereafter, particularly in elderly patients .</p> <p>3b. During a record review of Resident 294's Order Summary dated 4/29/25, the Order Summary indicated, Amiodarone HCl oral tablet 200 MG give one tablet by mouth one time a day for abnormal heart rhythm.</p> <p>During a review of Resident 294's Lab Results Report for TSH, Resident 294's Lab Results Report, dated 4/25/25, indicated a TSH level of 0.00 uU/ml (micro-International Units per milliliter- unit of measurement).</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/28/25 at 10:16 a.m. with LVN 3, LVN 3 stated Resident 294 was admitted to the facility on [DATE] and the TSH lab was done on 4/19/25. LVN 3 stated the TSH levels was 0.00, indicating a critical lab value. LVN 3 stated the facility practice was to notify the provider right away and complete new orders.</p> <p>During an interview on 4/28/25 at 2:08 p.m., with the DON, the DON acknowledged Resident 294s TSH lab of 0.00 was a critical value. The DON stated there was no follow up and no TSH lab orders completed. The DON confirmed amiodarone was a medication known to have effects on thyroid levels.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Laboratory Services and Reporting dated 9/2/22, the P&P indicated, .The facility is responsible for the timeliness of the services. Promptly notify the ordering physician, . nurse practitioner .of laboratory results that fall outside the clinical reference range.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent when the facility's medication error rate was 15.38 percent. There were 27 opportunities for errors and four medication errors occurred for three of ten sampled residents (Resident 80, Resident 146, and Resident 294) when:</p> <ol style="list-style-type: none"> 1. Resident 80's blood glucose (simple sugar - the body's primary source of energy from food) was assessed after Resident 80 began eating lunch and not before meals, according to the prescriber order. 2. Resident 146's blood glucose was assessed after Resident 146 began eating lunch and not before meals, and medication Calphron (medication used to control phosphate levels to keep them from getting too high) was not administered with meals, according to the prescriber orders. 3. Resident 294 was administered medication not in accordance with the prescriber orders. <p>These failures in medication errors for Resident 80, Resident 146, and Resident 294, resulted in placing residents at risk for experiencing adverse side effects without adequate monitoring.</p> <p>Finding:</p> <ol style="list-style-type: none"> 1. During a medication pass observation on 4/27/25 at 12:12 p.m., Resident 80 was observed eating lunch in his room. Resident 80 stated he was eating chicken soup that was brought in by his wife. In Resident 80's room, Licensed Vocational Nurse (LVN) 2 was observed performing blood glucose check on Resident 80, with a resulting blood glucose reading of 289. (normal blood glucose is 70-130) LVN 2 informed Resident 80 Insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) coverage was needed based on Resident 80's blood glucose reading of 289. <p>During a review of Order Summary, dated 4/29/25, the Order Summary indicated, .May do Finger stick for Blood Glucose Levels before meals and at bedtime notify MD [Doctor of Medicine] if blood glucose is less than 70 or greater than 400. . Admelog Solo [NAME] Subcutaneous [under the skin] Solution (insulin Lispro) inject as per sliding scale: . 251-300 = 4 units; Order date: 4/25/25.</p> <p>During an interview on 4/27/25 at 2:25 p.m. with LVN 2, LVN 2 acknowledged Resident 80 had started eating his lunch before his blood glucose was assessed. LVN 2 stated the prescriber Insulin order instructed nursing staff to check blood glucose level before meals. LVN 2 stated blood glucose check done after eating would not be an accurate assessment of blood glucose per the order. LVN 2 stated it was important to check the blood glucose before meals, to know the resident's fasting blood levels and give the correct dose of insulin.</p> <p>During an interview on 4/28/25 at 1:59 p.m., with the Director of Nursing (DON), the DON stated it was important for nursing staff to follow orders with insulin checks before meals, so they don't give the wrong insulin dose.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Durning an interview on 4/30/25 at 10:26 a.m., with Pharmacy Consultant (PC), the PC stated the nursing staff should check insulin before meals to see how much insulin is needed for that resident. PC stated if insulin was given after meals, it could lower the residents' blood sugar too much.</p> <p>2. During a medication pass observation on 4/27/25 at 12:57 p.m., with LVN 2, LVN 2 was observed entering resident 146's room with the medication calcium acetate [brand name]. During this observation LVN 2 was observed assessing Resident146's blood glucose which resulted in reading of 353 mg/dL. LVN 2 stated she would administer insulin coverage based on the resident's blood glucose level. LVN 2 was observed administering resident 146's medication calcium acetate, including a subcutaneous injection of 10 units of insulin to Resident 146's upper abdomen.</p> <p>During an observation and interview on 4/27/25 at 1:03 p.m., with Resident 146, in Resident 146's room, Resident 146 was observed in bed with snacks at the bedside table, Resident 146 stated she had already had lunch at noon. Resident 146 stated she ate turkey steak with brown gravy, cauliflower, apple pie and a roll.</p> <p>During a record review of Resident 146's Order Summary, dated 4/29/25, the Order Summary indicated Monitor finger stick for Blood Glucose .before meals and at bedtime for diabetes. Order date: 3/22/25. . (Insulin Aspart) inject as per sliding scale: . 351-400= 10 units .subcutaneously before meals for Diabetes.</p> <p>During a concurrent interview and record review on 4/27/25 at 2:25 p.m., with LVN 2, LVN 2 acknowledged blood sugar check for Resident 146 was obtained after lunch. LVN 2 stated blood sugar check should be completed before meals, to know the residents fasting blood levels and give the correct dose of insulin. LVN 2 acknowledged medication calcium acetate [brand name] should have been given with meals, and was given after Resident 146 ate.</p> <p>During an interview on 4/28/25 at 1:59 p.m., with the DON), DON stated calcium acetate [brand name] will not work, the medication will not have the appropriate effect on the residents if given after meals. The DON stated it was also important for nursing staff to check the blood glucose level before meals to avoid administering the wrong insulin dose.</p> <p>During a review of the manufacturer's instruction for calcium acetate provided by the facility, revised 5/16, the manufacturer instructions indicated, [calcium acetate brand name] is a dietary supplement that binds dietary phosphate. By binding with dietary phosphate, oral supplementation with calcium can reduce the absorption of dietary phosphate.</p> <p>3. During medication pass observation on 4/28/25 at 7:38 a.m., in A-Wing with LVN 3, LVN 3 was observed preparing and administering two tablets of sevelamer carbonate (medication used to control high levels of phosphorous) 800 mg (milligrams- unit of measurement) to Resident 294.</p> <p>During a record review of Resident 294's Order Summary, dated 4/29/25, Resident 294's Order Summary indicated, Sevelamer HCl tablet 800 MG give two tablets by mouth three times a day for hypocalcemia [low calcium in the blood] with meals. Order date: 4/19/25.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 4/28/25 at 10:01 a.m., with LVN 3, Resident 294's Medication Administration Record (MAR), dated April 2025 was reviewed. Resident 294's MAR indicated, Sevelamar HCl 800 mg two tablets by mouth . LVN 3 acknowledged she administered Seveleamar Carbonate to Resident 294. LVN 3 stated the two medications were different. LVN 3 stated it was important for the right medication to be given to the residents because the medications are for specific diagnosis.</p> <p>During an interview on 4/28/25 at 1:59 p.m., with DON, the DON stated her expectation was for nursing staff to follow prescriber's orders as stated. DON stated it was considered a medication error</p> <p>During an interview with on 4/30/25 at 10:31 a.m., with the PC, the PC stated nursing staff should follow the prescribers order, if a medication was not administered as ordered, the resident's condition may not get treated appropriately.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled Medication Administration-General Guidelines, dated 1/22, the P&P indicated, .A triple check .5 Rights .in the process of preparation of medication for administration . Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 rights. .Medications are administered in accordance with written order of the prescriber .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper storage and disposal of medication and biologics in accordance with facility policy and procedures when:</p> <ol style="list-style-type: none"> 1. A partially used Lantus insulin pen (medication used to control high blood sugar) for Resident 17 was discarded in a container labeled, Medications to be destroyed in the medication room. <p>This failure had the potential for a medication error, and increased risk of injury and contamination, by not following facility policy.</p> <ol style="list-style-type: none"> 2. The red container, Medication to be destroyed, was observed to be overflowing with medication. <p>This failure had the potential for unauthorized access to medications.</p> <ol style="list-style-type: none"> 3. In the IV (intravenous fluid- fluids given directly into the blood stream) medication cart shared between A and B Wing, two 100 ml (unit of measurement- milliliters) 0.9% Normal Saline (NS- solution of salt dissolved in water, used for hydration) IV bags were observed partially open with manufacturer's overwrap with no date. <p>This failure had the potential of contamination and unsafe administration.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on 4/27/25 at 10:31 a.m., in the medication storage room, with Licensed Vocational Nurse (LVN) 3, a partially used 3 ml Lantus pen (long-acting insulin to decrease blood sugar) for Resident 17 was observed stored in a red plastic bin with a removable lid labeled, Meds to be destroyed. LVN 3 stated insulin pens are put in sharps container because of the insulin inside, and acknowledged Resident 17's Lantus pen was not properly discarded. <p>During a concurrent observation and interview on 4/27/25 at 10:31 a.m., with Director of Staff Development (DSD), the DSD stated insulin pens had to be wasted and put in the sharps container, the DSD stated, That cannot go in the red container labeled, 'Meds to be destroyed,' that bin is for pills only.</p> <p>During an interview on 4/28/25 at 1:52 p.m., with the Director of Nursing (DON), the DON stated the expectation of the nursing staff was to waste the remaining insulin and discard the pen in the sharps container, to prevent anyone from having access to the medication.</p> <p>During a review of the facility's Policy & Procedure (P&P) titled, Syringe and Needle Disposal, dated 1/18, the P&P indicated, .syringes and needles are placed into puncture resistant, one-way containers (sharps) specifically designed for that purpose .the disposal containers are fitted with a lid that prohibits reaching into the container .</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a concurrent observation and interview on 4/27/25 at 10:31 a.m., in the medication storage room, with LVN 3, the medication destruction bin labeled, Meds to be destroyed was observed to be overflowing with medication blister packs. Several blister packs (a form of packing where an individual pushed individually sealed tablets through the foil to take medication) were protruding above the rim of the container, preventing the lid from closing securely. Medications were visibly exposed and unsecured at the top of the bin. LVN 3 acknowledged the bin was overflowing and stated the bin should not be overflowing.</p> <p>During a concurrent observation and interview on 4/27/25 at 10:31 a.m., with the DSD in the medication storage room, the DSD stated the medication bin should not overflow.</p> <p>During an interview on 4/28/25 at 1:53 p.m., with the DON, the DON stated the facility should destroy the medication in the Meds to be destroyed bin before it overflowed. The DON stated it was important to keep it from overflowing because it gave easier access to the medications that needed to be destroyed.</p> <p>During an interview on 4/30/25 at 10:20 a.m., with the Consultant Pharmacist (CP), the CP stated the container containing discarded medication should be locked and should not be overflowing or preventing the lid from closing. The CP stated the overflowing medication container created easy accessibility to these medications.</p> <p>During a review of the facility's (P&P) titled, Storage of Medications, dated 1/18, the P&P indicated, . Medication storage areas are kept clean, well-lit, and free of clutter .</p> <p>3. During a concurrent observation and interview on 4/28/25 at 9:17 a.m., with the Assistant Director of Nursing (ADON) at the A-wing IV medication cart, two 100 ml 0.9% NS bags were observed in a partially opened manufacturer overwrap and undated. The ADON stated once opened, item needs to be dated.</p> <p>During an interview on 4/28/25 at 1:55 p.m., with the DON, the DON stated the facility expectation whenever a multi pack is opened, is that it must be dated with the open date, and the expired date. The DON stated this was an important practice so that nursing staff did not administer expired medications to a resident.</p> <p>During a review of the facility's (P&P) titled, Storage of Medications, dated 1/18, the P&P indicated, .Certain medications or package types, such as IV solutions .require an expiration date shorter than the manufacturer's expectation date to insure medication purity and potency.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the planned menus were followed when:</p> <ol style="list-style-type: none"> Two of 10 sampled residents (Resident 50 and Resident 83) received portion sizes that were different from what was prescribed by their Medical Doctor on 4/27/25. <p>This failure had the potential to result in Resident 50 and Resident 83 not meeting their physician's prescribed diet order and their nutritional needs not being met which can result in weight gain or weight loss.</p> <ol style="list-style-type: none"> Residents on a regular portion diet were served baked chicken portions during the lunch meal on 4/28/25 that were smaller than what was prescribed by their Medical Doctor. <p>This failure had the potential for all residents on a regular portion diet to receive inadequate amounts of protein, potentially leading to weight loss and malnutrition.</p> <p>Findings:</p> <ol style="list-style-type: none"> During a review of Resident 50's admission Record, (AR-a document with personal identifiable and medical information), dated 4/30/25, the AR indicated Resident 50 was admitted to the facility on [DATE] with diagnoses which included obesity (overweight, too much body fat), convulsions (involuntary, sudden, and often violent muscle contractions that can cause shaking or jerking movements of the body) and hypertension (high blood pressure). During a review of Resident 50's Order Summary Report (OSR) dated 4/30/25, the OSR indicated, .Regular diet Regular texture, Regular (thin) consistency, small portions for breakfast and lunch .Order Date 3/5/25 . During a review of Resident 83's admission Record, dated 4/30/25, the AR indicated Resident 83 was admitted to the facility on [DATE] with diagnoses which included multiple fractures of pelvis (break in multiple bones of hip bones), and surgical aftercare following surgery on the digestive system. During a review of Resident 83's Order Summary Report, dated 4/30/25, the OSR indicated, .Regular diet Regular texture, Regular (thin) consistency, for Double portion of protein . Order Date 01/21/2025 . <p>During a concurrent observation and interview on 4/27/25 at 11:55 a.m. in the dining room, Resident 50 was sitting up in his wheelchair and seated around a table with other residents. Resident 50 was eating lunch, his meal ticket indicated small portion. Resident 50's plate included a full portion of protein, bread, side dish and dessert. Resident 50 stated he did not have any problem with the food.</p> <p>(continued on next page)</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 4/27/25 at 12:05 p.m. in the dining room, Resident 83 was seated in the dining room with other residents eating lunch. Resident 83 was observed with regular sized food portions on his plate. Resident 83's meal ticket indicated resident 83 was to receive a double portion of protein. Resident 83 stated he only received one slice of meat.</p> <p>During a concurrent observation and interview on 4/27/25 at 12:10 p.m. with Certified Nursing Assistant (CNA) 5, she stated Resident 83 has one slice of meat on his plate. CNA 5 stated Resident 83 received the same amount of food as the rest of residents eating in the dining room. CNA 5 stated Resident 83 did not receive double portion of protein.</p> <p>During a concurrent observation and interview on 4/27/25 at 12:15 p.m. with Registered Dietitian (RD), the RD stated Resident 50 and Resident 83 did not receive their correct diet orders. The RD stated Resident 50 has an order for a small portion diet but the food served to him was not a small portion. The RD stated Resident 83 has an order for double portion of protein, but the food served was not a double portion of protein. The RD stated Resident 83 should have received a double portion of meat.</p> <p>During an interview on 4/29/25 at 10:50 a.m. with the Certified Dietary Manager (CDM), the CDM stated it was the responsibility of dietary cook and dietary aide to ensure residents received the correct diet. The CDM stated she was not sure if food trays were double checked before food carts were pushed out of the kitchen to distribute to residents. The CDM stated it was the responsibility of the nursing staff to check the plates to ensure each resident received their correct food based on their ordered diet. The CDM stated residents not receiving their correct diet could result in weight gain or weight loss.</p> <p>During an interview on 5/1/25 with the Director of Nursing (DON), the DON stated her expectation was for licensed nurses to check food trays and ensure food on the tray matched the meal ticket. The DON stated CNAs are supposed to check food on the tray and compare it with the meal ticket when they place the food in front of residents.</p> <p>During a review of facility's policy and procedure (P&P) titled, The Dining Experience: Objectives dated 2020, the P&P indicated, .Meals will be planned to meet nutritional adequacy and according to the resident's plan of care, while not limiting the residents right to make personal choices .</p> <p>During a review of facility's policy and procedure titled, The Dining Experience: Staff Roles, dated 2020, the P&P indicated, .Staff will guide residents in selecting meals of nutritional adequacy, but not limit the right to make informed personal choices. A resident who is assessed to not be capable of making informed choices will receive the meal as planned according to the menu spreadsheet and meal card .</p> <p>2. During a review of facility's Diet Spreadsheet for the lunch meal for April 28, 2025, showed the regular diet with regular portions to receive: 3 ounces (oz) Baked Chicken with Onion Gravy, #8 dip Herb Stuffing, 4 oz Vegetable Medley, 3X2-2 1/2 Apple Streusel Cake and 8 oz Beverage.</p> <p>During an observation of the lunch meal service on 4/28/25 starting at 11:40 a.m. in the kitchen, the steam table had the following foods: regular slices of chicken, regular herb stuffing, regular vegetable medley, mechanical chicken, mechanical vegetable medley, pureed chicken meat, pureed herb stuffing, pureed vegetables and gravy.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation of the lunch meal service on 4/28/25 starting at 11:41 a.m. in the kitchen, Dietary [NAME] (DC) 1 served one slice of baked chicken to residents on regular texture diet and dietary aide (DA) 1 used a yellow handled ladle to scoop gravy and pour on top of baked chicken meat.</p> <p>During a concurrent observation and interview on 4/28/25 at 12: 25 p.m. with DC 1, RD and DSM, DC 1 weighed several pieces of baked chicken, and the results ranged from 1.3 oz, 1.8 oz, 2 oz, 2 oz, 2.4 oz, 2.6 oz. DC 1 stated the chicken portion sizes served to residents on regular diet did not meet the ordered amount in the menu. DC 1 stated she felt bad because residents on regular diet did not receive the correct amount of chicken.</p> <p>During an interview on 4/29/25 at 10:59 a.m. with CDM, the CDM stated she ordered chicken from (name of company) and she made sure she picked the boneless four ounces. The CDM stated she was not sure why the portion sizes weights were less than 3 oz. The CDM stated residents on regular diet did not receive the correct portion sizes based on the diet spreadsheet and could result in weight loss.</p> <p>During an interview on 4/30/25 at 9:20 a.m. with the RD stated the menu on 4/28/25 was for 3 oz chicken pieces to be served to residents on regular diet. The RD stated residents on regular diet should have been served the correct portion size of chicken. The RD stated, It could result in weight loss if served under the recommended portion sizes.</p> <p>During a review of the facility's policy and procedure titled, Meal Identification, Resident Meal Card, dated 2020, the P&P indicated, . Resident meal cards will be used during meal service to ensure proper diets are served .</p> <p>During a review of the facility Job Description: Cook, dated 12/1/22, the job description indicated, . Adhere to all guidelines and approved menus and recipes when preparing meals, snacks, and all other food items . Be prepared and plan for all meals and snacks to ensure to ensure timely service for all meals .</p> <p>During a review of the facility Job Description: Culinary Director, dated 12/1/22, the job description indicated, . [NAME] and garnish meals with great taste and style . Create, plan and nurture culinary excellence . Ensure all foods being served and consistent with stated menu shared with residents and staff .</p> <p>During a review of the facility Job Description: Registered Dietitian, dated 12/1/22, the job description indicated, . Create a [NAME] culinary experience for our residents for every meal or snack every day . Ensure all local, state, and federal food handling, storage, and sanitation requirements are met or exceeded . Ensure all foods being served and consistent with stated menu .</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide food in accordance to resident preferences for one of six sampled resident (Resident 295) when Resident 295's preference to receive beverages other than milk was not followed.</p> <p>This failure caused resident 295 to be upset regarding the meal he had been provided and had the potential to cause Resident 295 to not receive the full nutritional benefit of his meal.</p> <p>Findings:</p> <p>During a review of Resident 295's, admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 5/1/25, the AR indicated Resident 295 was admitted to the facility on [DATE] with the following diagnoses: diabetes mellitus (A disease which results in too much sugar in the blood) and kidney failure (when the kidneys have been damaged over time resulting in decreased function).</p> <p>During a review of Resident 295's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive abilities), dated 4/4/25, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 295 had no cognitive impairment.</p> <p>During an observation on 4/27/25 at 11:09 a.m. in Resident 295's room, Resident 295 was served milk with his lunch tray. Resident 295 stated he had told staff he did not want to receive milk with his meals because he was tired of receiving it for breakfast lunch and dinner. Resident 295 stated it made him upset to receive milk for all the scheduled meals of the day because it felt like staff did not listen to his request.</p> <p>During an interview on 5/1/25 at 9:27 a.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated nursing staff were responsible for ensuring meal trays were accurate and followed resident preferences when they came out of the kitchen. LVN 6 stated ensuring residents received food which they preferred was important because it helped residents eat the meal in order to not experience weight loss.</p> <p>During a concurrent interview and record review on 5/1/25 at 9:48 a.m. with the Certified Dietary Manager (CDM), Resident 295's Meal ticket, dated 4/27/25, was reviewed. The Meal Ticket indicated .No milk, offer other beverages . the CDM stated Resident 295's preference for no milk should have been honored. The CDM stated kitchen staff should have ensured the meal had everything Resident 295 wanted as it was served on the tray. The CDM stated Resident 295 may have felt frustrated as a result of receiving milk if he didn't want it.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 5/1/25 at 10:37 a.m. with the Registered Dietician (RD), Resident 295's Progress Notes dated 4/7/25 was reviewed. The Progress Notes indicated . spoke to resident: allergy to fish and shellfish. Does not like hot cereal and cooked veggies. Would like to receive raw veggies only, and wants milk with his breakfast only . The RD stated Resident 295 made his preference clearly known and his preferences should have been honored. The RD stated if Resident 295's preference was not followed it put him at risk for malnutrition and following his meal preferences also provided a more homelike experience.</p> <p>During an interview on 5/1/25 at 11:52 a.m. with the Director of Nursing (DON), the DON stated all nursing and kitchen staff should have noticed Resident 295 was served milk. The DON stated Resident 295 should have received an alternative beverage as stated on the Meal Ticket and Progress Notes. The DON stated Resident 295 may have an uncomfortable reaction to drinking milk, so staff should have honored his preference.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Food preferences, dated 2020, the P&P indicated . 1. Following admission The Dining Services Manager, Registered Dietitian, or other designee will interview the resident to determine food preferences . A form such as a Food Preference Form may be used to document this information. Information should be appropriately logged in the meal card . 5. Resident food preferences are kept on file in the dining Services Department as a part of the meal card system and used to ensure each resident's needs and desires are met .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety when:</p> <ol style="list-style-type: none"> 1.The food preparation sink's 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) was not appropriate for use in a nursing facility. <p>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.</p> <ol style="list-style-type: none"> 2. Facility did not follow the thawing process for six packages of ground beef, stored in the refrigerator, with a prepared date of 4/16/25. 3. Two boxes of butter croissants stored in the walk-in pantry, instead of in the freezer <p>These failures had the potential for residents to develop gastrointestinal illness (illness that affects the digestive system [GI tract] which runs from mouth to anus) which could result in serious health conditions.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1.During a concurrent observation and interview on 4/27/25 at 9:45 a.m. in the kitchen with Certified Dietary Manager (CDM), the CDM stated the air gap under the preparation sink had a back flow preventer built in to prevent back flow of dirty water from happening. The CDM stated she did not know how the air gap under the food prep sink works because it is different from the air gap behind the ice machine. The CDM stated the Regional Maintenance Director (RMD) will be able to explain better how the air gap under the food prep sink works. <p>During an interview on 4/28/25 at 9:07 a.m. with the Maintenance Supervisor (MS), the MS stated the ice machine in the facility has an air gap. The MS stated air gap has to have a gap of 1.5-2 inches to allow water to drain and prevent backflow of dirty water.</p> <p>During an interview on 4/29/25 at 12:48 p.m. with the RMD, the RMD stated the air gap under the sink was a closed air gap and was installed last year. The RMD stated the air gap has a one-way valve to prevent the back flow of contaminated water back into the sink. The RMD stated he did not consult Department of Health Care Access and Information (HCAI-responsible for equitable access to health care for all Californians, ensuring safe and reliable healthcare facilities, and providing information to help improve care affordability and effectiveness) when he installed the air gap. The RMD stated he did not need to be certified to install air gap.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 4/30/25 at 9:05 a.m. with the Registered Dietitian (RD), the RD stated the air gap under a preparation sink was important to prevent back flow of dirty water and prevent contamination of food prepared in the sink. The RD stated the expectation was to ensure there was an air gap below the food prep sink to prevent residents from getting sick because of contaminated foods.</p> <p>During an interview on 5/1/25 at 1:45 p.m. with the Administrator (ADM), the ADM stated air gap was installed the previous year (2024).</p> <p>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 &sect; 5-202.13 .</p> <p>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 .</p> <p>2. During a concurrent observation and interview on 4/27/25 at 9:15 a.m. during an initial tour in the kitchen with the CDM, six packages of defrosted ground beef on the bottom shelf of the refrigerator. The CDM stated packages of ground beef were pulled out from the freezer on 4/16/25, use by date 4/29/25. The CDM stated the expectation was to pull out frozen foods to defrost up to three days before use. The DSM stated the packages of ground beef were pulled out from the freezer too soon.</p> <p>During a concurrent interview and record review on 4/29/25 at 11:10 a.m. with CDM, a photo of the ground beef taken on 4/27/25 was reviewed. The photo indicated prepared date 4/16/25, use by 4/29/25. The CDM stated she was not sure who pulled out the meat to thaw. The CDM stated the meat was sitting too long in the refrigerator to thaw and could grow bacteria. The CDM stated, We threw away the packages of meat, (they were) not safe to serve to residents.</p> <p>During an interview on 4/29/25 at 1:40 p.m. with Dietary [NAME] (DC) 1, DC 1 stated the practice was to pull out frozen meat to thaw three days before use. DC 1 stated ground beef should have been cooked and used on the third day. DC 1 stated packages of ground beef thawed were not safe to serve after three days, bacteria could have grown while it was sitting in the refrigerator.</p> <p>During an interview on 4/30/25 at 9:10 a.m. with the RD, the RD stated the practice was to pull out frozen meat to defrost in the refrigerator up to three days before the use date. The RD stated meat sitting out too long in the refrigerator can grow bacteria making it unsafe to serve to residents. The RD stated dietary staff did not want to serve unsafe foods to residents. The RD stated meat had to be used immediately or on the third day to prevent residents from getting sick.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3. During a concurrent observation and interview on 4/27/25 at 9:20 a.m. during an initial tour in the kitchen with CDM, observed two boxes of butter croissants in the pantry. The CDM stated the boxes of butter croissants indicated to keep frozen. The CDM stated the butter croissants were delivered Friday (4/25/25) and should have been left in the freezer. The CDM stated croissants, if not stored correctly, could cause foodborne illness (illness contracted from consuming contaminated food or beverage) if not thawed properly and served to residents.</p> <p>During an interview on 4/29/25 at 1:45 p.m. with DC 1, DC 1 stated butter croissants were delivered Friday and had to be stored in the freezer after delivery. DC 1 stated she was not sure if the croissants were pulled out to defrost and to be used but the menu spreadsheet does not call for use of croissants until Tuesday (4/29/25). DC 1 stated the box of butter croissants should have been left in the freezer to be safe to serve to residents.</p> <p>During an interview on 4/30/25 at 9:05 a.m. with RD, the RD stated she was not sure if staff were thawing butter croissants in the walk-in pantry. The RD stated butter croissants had to be stored properly to prevent bacteria from growing which could cause foodborne illness. The RD stated butter croissants could cause illness to residents if not thawed properly and served to residents.</p> <p>During a review of facility's policy and procedure (P&P) titled Food Storage (Dry, Refrigerated, and Frozen), dated 2020, the P&P indicated, .All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded . Follow and adhere to the guidelines regarding proper storage temperatures and maximum length of storage found in storage guidelines in the Sanitation section of the manual . Place frozen food deliveries in freezers immediately following their inspection. Never allow a frozen food to reach room temperature .During a review of the facility's policy and procedure titled Food Safety Requirements, dated 12/19/22, the P&P indicated, .Food safety practices shall be followed throughout the facility's entire food handling process . Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganism . Refrigerated storage - foods that require refrigeration shall be refrigerated immediately upon receipt or placed in freezer . Thawing - approved methods for thawing frozen foods including thawing in the refrigerator, submerging under cold water, thawing in a microwave oven, or as part of a continuous cooking process. Thawing at a room temperature is not acceptable .</p> <p>During a professional reference https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/big-thaw-safe-defrosting-methods. The reference indicated, . Raw or cooked meat, poultry or egg products, as any perishable foods, must be kept at a safe temperature during the big thaw. They are safe indefinitely while frozen. However, as soon as they begin to thaw and become warmer than 40 degrees Fahrenheit, bacteria that may have been present before freezing can begin to multiply. Perishable foods should never be thawed on the counter, or in hot water and must not be left at room temperature for more than two hours .</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation, interview, and record review, the facility failed to follow their policy and procedure, Garbage and Rubbish Disposal for three of three outside trash bins when the garbage was filled over the top of the bin not allowing the lids of the bins to be closed.</p> <p>This failure had the potential to attract animals, insects and pests which could lead to infestation (large number of pests), and the spread of disease.</p> <p>Findings:</p> <p>During an observation on 4/27/25 at 7:45 a.m., behind the facility, in the trash bin storage area, three of three trash bins were observed with the lids sitting on top of cardboard boxes,. plastic and other debris filled above the top of the trash bins.</p> <p>During an interview on 4/27/25 at 2:30 p.m. with the Certified Dietary Manager (CDM), the CDM stated the trash should not go over the top of the bin, the exposed trash could attract mice or other animals to the area and bring disease to the facility.</p> <p>During an interview on 4/27/25 at 2:42 p.m. with the Maintenance Supervisor (MS), the MS stated that the lids of the trash should not have been open and there should never be trash piled in over the rim so that the trash can closes correctly.</p> <p>During an interview on 5/1/25 at 11:40 a.m. with the Administrator (ADM), the ADM stated the trash bins should not be filled above the top of the bin, because trash could fall on the ground and encourage insects and animals to get into the trash and cause the spread of disease or infection.</p> <p>During a review of the facility's policy and procedure (PNP), titled, Garbage and Rubbish Disposal dated 2000, indicated, the PNP indicated, .Food Related Garbage and Refuse Disposal indicated . All garbage or rubbish is to be put into waste containers which are emptied as often as necessary to prevent over filling . all containers will be provided with tight-fitting lids or covers, and will be leak proof and water proof . as to be inaccessible to vermin .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. During a review of Resident 145's admission Record, dated 4/30/25, the AR indicated Resident 145 was admitted to the facility on [DATE] with diagnoses which included muscle weakness, difficulty in walking, and fusion of spine (surgical procedure that permanently joints two or more vertebrae in the spine, preventing movement between them).</p> <p>During a review of Resident 145's Order Entry undated, the order indicated, . Order Date 4/21/2025 . Enhanced Barrier Precaution .</p> <p>During a concurrent observation and interview on 4/27/25 at 11:10 a.m. in Resident 145's room, Resident 145 was lying in bed covered with bed sheets from chest down to his feet. Resident 145 stated he had been in the facility for at least two weeks. Resident 145 stated he was in the facility for therapy and receiving antibiotics (medications that fight bacterial infections) through the peripherally inserted central catheter (PICC- long, thin, flexible tube inserted into a vein in the arm and threaded up to a large vein above the heart) on his right arm.</p> <p>During an observation on 4/27/25 at 11:47 a.m. in Resident 145's room, Certified Nursing Assistant (CNA) 1 was observed providing care to Resident 145 without donning (wearing) proper personal protective equipment (PPE). Resident 145's room had a sign near his door that read, Enhanced Barrier Precautions, and next to his name there was sticker that read EBP. The sign indicated, Providers and staff must also: Wear gloves and gowns for the following high-contact resident care activities. Dressing, Changing briefs, or assisting with toileting . CNA 1 was observed wearing gloves but not a gown as CNA 1 provided personal hygiene and changed incontinent briefs of Resident 145.</p> <p>During an interview on 4/27/25 at 2:17 p.m. with CNA 1, CNA 1 stated she did not work with Resident 145 often and was not aware he was on EBP. CNA 1 stated she had only worn gloves when she provided care to Resident 145. CNA 1 stated she should have worn gown also when she provided personal care to Resident 145. CNA 1 stated it was important to wear proper PPEs when providing personal care to residents on EBP to prevent the spread of infections to other residents.</p> <p>During a review of Resident 88's admission Record (AR-a document with personal identifiable and medical information), dated 4/30/25, the AR indicated Resident 88 was admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with diagnoses which included hemiplegia 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).</p> <p>During a review of Resident 88's, Order Summary Report, dated 4/30/25, the order summary report indicated, .enhanced barrier precaution . Order Date 4/20/25 .</p> <p>During a concurrent observation and interview on 4/27/25 at 12:24 p.m. in Resident 88's room, Resident 88 was observed sitting up in bed eating. Observed on the side of the bed hanging on the bed rail was an uncovered urinary catheter bag filled with yellow urine. Resident 88 stated he had the urinary catheter but did not remember why.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/27/25 at 12:05 p.m. with the Treatment Nurse (TXN), the TXN stated the expectation was for staff to wear gowns and gloves when providing personal care to residents on EBP including changing incontinent briefs and handling of urinary catheter bags. TXN stated wearing proper PPE was important to prevent the spread of infection to other residents.</p> <p>During a concurrent observation and interview on 4/27/25 at 2:06 p.m. with CNA 2, CNA 2 entered Resident 88's room, removed Resident 88's urinary catheter bag from the rails and placed inside a privacy bag wearing gloves only. CNA 2 stated Resident 88 was on EBP because of the urinary catheter. CNA 2 stated she did not wear a gown when she touched Resident 88's urinary catheter bag and she should have. CNA 2 stated the facility practice was to wear proper PPE when providing personal care to residents on EBP to prevent spread of infections to other residents.</p> <p>During an interview on 4/29/25 at 9:40 a.m. with the Assistant Director of Nursing (ADON), the ADON stated she had been in the position for 10 days and assumed the position as the Infection Preventionist (IP) of the facility. The ADON stated currently the facility has a total of 32 residents on EBP. The ADON stated the Director of Staff Development (DSD) assisted in providing in-service training to nursing staff. The ADON stated the expectation was for all facility staff to wear the proper PPE when providing care to residents on EBP. The ADON stated licensed nurses and CNAs needed to wear gowns and gloves when providing personal care to residents on EBP to prevent the spread of infection and protect against the transmission of infections.</p> <p>During an interview on 5/1/25 at 1:21 p.m. with the DON, the DON stated her expectation was for staff to wear proper PPE when in contact with residents on EBP. The DON stated staff are expected to wear gowns and gloves when providing care to residents on EBP to protect residents from the spread of infections.</p> <p>During a review of facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 9/2/22, the P&P indicated, .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organism . High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheter, feeding tubes . Staff receive training on enhanced barrier precautions and are expected to comply with all designated precautions . Enhanced barrier precautions should be followed outside the resident's room when performing transfers and assisting during bathing . or any high-contact area .</p> <p>Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program to provide a safe and sanitary environment to help prevent infections for three of eight sampled residents (Resident 2, Resident 88 and Resident 145) when:</p> <ol style="list-style-type: none"> Licensed Vocational Nurses (LVN) 4 did not properly disinfect a glucometer (device used to measure blood sugar) used for multiple residents after providing care for Resident 2. <p>This failure had the potential for the development and the spread of infection to all residents who had their blood sugars checked with the glucometer.</p> <ol style="list-style-type: none"> Staff did not follow enhanced barrier precaution procedures prior to providing care to Resident 88 and Resident 145. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>This failures had the potential for the development and the spread of infection to all residents and/or staff in the facility.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/27/25 at 11:50 a.m., with LVN 4 in the C wing, LVN 4 was observed cleaning and disinfecting a glucometer after using it to obtain Resident 2's blood sugar level. LVN 4 was observed wrapping the glucometer without cleaning all the surfaces of the glucometer with a germicidal bleach wipe. LVN 4 acknowledged she did not appropriately disinfect the glucometer by not cleaning each side of surfaces of the glucometer with a new wipe and then wrapping the glucometer with a new wipe. LVN 4 stated it was important to properly disinfect the glucometer in between use on residents, for infection control and to reduce transmission of germs.</p> <p>During an interview on 4/28/25 at 1:47 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, and wrap it with wipe covering the glucometer, keeping it wet according to manufacturer wet time. DON stated it was important to prevent the spread of infections.</p> <p>During a review of the manufacturer's instructions for the germicidal bleach wipe, the manufacturer indicated, .product is for the exterior surfaces of the blood glucose meter .cleaning is to include vigorous wiping .for all surfaces.</p> <p>During a review of facility's policy and procedure (P&P) titled, Glucometer Disinfection, dated 9/2/22, the P&P indicated, .Using first wipe, clean .the surface of the glucometer .After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions .</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to provide a comfortable and homelike environment for two of 16 sampled residents (Residents 15 and 78), when:</p> <p>1.The wall in Resident 78's bedroom had deep scratches, exposing white chalky building material, and missing paint.</p> <p>This failure resulted in Resident 78 feeling unimportant, and not listened to.</p> <p>2.The wall in Resident 15's bathroom had an approximate one inch (unit of measure), by one inch hole in the wall.</p> <p>This failure had the potential to affect Resident 15's mental state as well as creating a portal for pests to enter the bathroom.</p> <p>Findings:</p> <p>1.During a concurrent observation and interview on 4/27/25 at 10:26 a.m. with Resident 78 in her room, the wall in her room near her bed had several areas of deep scratches with missing paint and areas of exposed white chalky building material. Resident 78 stated, . if I had more money the nursing home would have fixed the wall . I cannot afford to get a better room .</p> <p>During a review of Resident 78's, Record of Admission (RA), dated 5/1/25, the RA indicated Resident 78 was admitted from the hospital to the facility on 9/26/24, with diagnoses which included, borderline personality disorder (BPD - a mental health condition where a person experiences intense, unstable emotions, relationships, and self-image, often struggling with impulsivity and a fear of abandonment), muscle weakness, paroxysmal atrial fibrillation (a type of irregular heartbeat where the electrical signals in the heart's upper chambers [atria] become chaotic, causing a fast, irregular rhythm that comes and goes, usually resolving on its own or with treatment within a week), and hypertension (a condition where the force of blood pushing against your artery walls is consistently too high).</p> <p>During a concurrent observation and interview on 4/27/25 at 11:40 a.m. with Licensed Vocational Nurse (LVN) 1, in Resident 78's room, the scratches and missing paint were observed. LVN 1 stated, the wall in Resident 78's room was not a homelike environment. LVN 1stated she would not like to be in a room with walls like the walls in Resident 78's room.</p> <p>2.During an interview on 4/27/25 at 10:30 a.m. with Resident 15, Resident 15 stated there were holes and missing paint all over the building that have never been repaired.</p> <p>During a review of Resident 15's RA dated 4/30/25, the RA indicated Resident 15 had been admitted from the hospital to the facility on 2/25/25, with diagnoses which included, Diabetes Mellitus (DM - a condition where the body either doesn't produce enough insulin or can't effectively use the insulin it does produce, leading to high blood sugar levels), Depression (persistent sadness and a loss of interest or pleasure in activities), difficulty in walking, need for assistance with personal care, and muscle weakness.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 4/27/25 at 10:48 a.m. with Certified Nurse Assistant (CNA) 4, in Resident 15's bathroom, CNA 4 stated, she had not noticed the hole in the bathroom wall. CNA 4 stated the hole should have been placed on the maintenance log for it to be repaired. CNA 4 stated the hole could allow pests to enter the bathroom.</p> <p>During an interview on 4/28/25 at 11:08 a.m. with the Maintenance Director (MD), the MD stated the holes and scratches in the wall should have been placed on the Maintenance Log so they could have been repaired. The walls with scratches, missing paint, and the hole in the bathroom do not provide a home-like environment for the residents and holes in the wall provide a passageway for insects to enter the building.</p> <p>During a review of the facility's policy and procedure (P&P), titled Maintenance Inspection dated 12/19/22, indicated, . it's the policy of this facility to utilize a maintenance inspection checklist in order to assure a safe, functional, sanitary, and comfortable environment for residents .</p> <p>During a review of the facility's P&P titled Preventative Maintenance Program dated 12/19/22, indicated, . the MD is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings . are maintained .</p> <p>During a review of the facility's P&P titled Safe and Homelike Environment dated 12/19/22, indicated, . A homelike environment is one that de-emphasizes the institutional character of the setting to the extent possible . that is neat and well kept .</p>