STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone at the Ranch	103 West Martial Ave Lafayette, LA 70506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure each resident's clinical record accurately reflected their advanced directives for 1 (#74) out of 1 (#74) residents reviewed for advanced directive. This deficient practice had the potential to affect the entire census of 73 residents. Findings:Review of Resident #74's electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, normal pressure hydrocephalus. Review of Resident #74's admission record revealed DNR (Do Not Resuscitate) status. Review of Resident #74's record revealed a Louisiana Physician Orders For Scope of Treatment (LaPOST) checked for:A. Do Not Attempt Resuscitation (DNR)B. Medical interventions: Person has pulse or is breathing-Selective Treatment C. Artificially Administered Fluids and Nutrition-No artificial nutrition by tube. D. Summary Discussed with-Personal Health Care Representative (PHCR), signed by physician on 10/26/2024 and signed by PHCR on 10/26/2024. A review of Resident #74's facility's document titled, Care Profile Report, Special Instructions revealed: Full Code. On 07/29/2024 at 2:06 p.m., a record review and interview was conducted with S2DON (Director of Nursing). S2DON confirmed the facility's document, Care Profile Report, Special Instructions read the resident is a full code. S2DON confirmed Resident #74's admission record read the resident is a DNR. S2DON confirmed Resident #74's record revealed the LaPOST form that indicated the resident had a DNR status and was signed on 10/26/2024. She stated the facility's document, Cornerstone at the Ranch Care Profile Report should have been updated to reflect the code status to DNR status and was not.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone at the Ranch	103 West Martial Ave Lafayette, LA 70506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interview, the facility failed ensure that a resident's drug regimen was free from unnecessary drugs by failing to ensure gradual dose reduction forms were reviewed by the physician for 2 (Resident #11 and Resident #46) out of 6 residents (#4, #7, #11, #36, #46, and #81) reviewed for unnecessary medications.Resident #11Resident #11 was admitted to the facility on [DATE]. His diagnoses include in part, but not limited to dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, depression;, restlessness and agitation.Review of Resident #11's annual MDS (Minimum Data Set) date 07/09/2025 revealed under Section N--Medications, the resident was taking an antipsychotic, antianxiety and antidepressant medications. Further review of the MDS revealed N0450, letter D, was marked with the number 1, indicating that a GDR had been documented by a physician as clinically contraindicated. Review of the facility's GDR binder revealed the following GDR forms dated 06/09/2025 for Resident #11 were not addressed by the physician: Psychotropic Diagnosis Request and Behavior for the use of Haldol (antipsychotic medication), Psychoactive Gradual Dose Reduction for the use of Haldol, Klonopin (antianxiety medication), Remeron and Zoloft (antidepressant medications) and, Antipsychotic Diagnosis Verification for use of Haldol. Resident #46Review of Resident #46's medical record revealed she was admitted to the facility on [DATE]. Her diagnosis included in part, but not limited to, depression, unspecified psychosis not due to a substance or known physiological condition, anxiety and senile degeneration of brain, not elsewhere classified. Further review revealed the resident was on hospice services.Review of Resident #46's quarterly MDS dated [DATE] revealed under Section N--Medications, the resident was taking an antipsychotic, antianxiety, and antidepressant medications. Further review of the MDS revealed N0450, letter D, was marked with the number 0, indicating that a GDR had not been documented by the physician as clinically contraindicated.Review of the facility's GDR binder revealed the following GDR form dated 06/09/2025 for Resident #46 was not addressed by the physician: Psychoactive Gradual Dose Reduction for the use of Quetiapine Fumarate (Seroquel) and Citalopram Hydrobromide (Celexa) (antidepressant medications) and Lorazepam (antianxiety medication). On 07/30/2025 at 5:00 P.M., S1ADM (Administrator). S1ADM stated that she was unable to provide documented evidence that Resident #11 and Resident #46's GDR(s) for June were addressed by the physician. She confirmed the GDRs should have been reviewed by now.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone at the Ranch	103 West Martial Ave Lafayette, LA 70506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's status for 1 (#76) of 46 sampled residents.Review of Resident #76's electronic health record (EHR) revealed an admission date of 04/15/2025 and a discharge date of 05/06/2025.Review of Resident #76's Discharge Return Not Anticipated MDS dated [DATE] revealed in Section A2105 a discharge status of short-term general hospital. Review of the facility's emergency transfer logs from March 2025 to July 2025 revealed Resident #76 was not listed as going to the hospital.Review of Resident #76's progress notes dated 05/06/2025, revealed an entry by S15LPN (Licensed Practical Nurse), resident left ama (against medical advice). Checked on post dc (discharge) by administrator and resident found in good condition in safe home.On 07/30/2025 at 11:56 a.m., an interview was conducted with S16SSD (Social Services Director). She stated that Resident #76 left the facility AMA to go home and was not sent to the hospital.On 07/30/2025 at 12:15 p.m., an interview was conducted with S1ADM (Administrator) and S2DON (Director of nursing). S1ADM stated Resident #76 left the facility AMA to go home. S2DON confirmed Resident #76 left AMA for her own home and stated that the MDS was incorrectly coded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone at the Ranch	103 West Martial Ave Lafayette, LA 70506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations and, interviews the facility failed to ensure the resident's care plan and physician's orders were followed for 5 (#8, #12, #36, #72, and #74) of 46 sampled residents. This was evidenced when staff failed to:1. document the severity of edema for Residents #8 and #72,2. document fluid intake with every meal for Resident #8,3. follow physician orders by not applying swath and sling to Resident #12's left arm,4. complete vital signs every shift for Resident #36,5. update Resident #74's care plan and physician's orders with the resident's code status and admission to hospice services Resident #12 Review of Resident #12's electronic clinical record revealed an admit date of 09/29/2020 with diagnoses that included Alzheimer’s Disease, Bilateral primary Osteoarthritis of knee, Osteoarthritis, and Mild protein calorie malnutrition. Review of Resident #12’s physician orders dated July 2025 revealed the following orders: Wear swath and sling to left arm when not icing or elevating it. Review of the resident's care plan dated 06/09/2025 read in part, wear swath and sling to left arm when not icing or elevating it as tolerated. Review of Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. On 07/28/2025 at 8:50 a.m., an observation was conducted in the resident’s room. Further observation did not reveal the resident was wearing swath and sling on her left arm. No icing or elevation of the left arm were observed. On 07/28/2025 at 11:50 a.m., an observation was conducted of Resident #12 during the lunch meal. Further observation revealed that Resident #12 left arm swath and sling had not been applied. On 07/29/2025 at 9:38 a.m., another observation was conducted inside Resident #12’s room. S13HCNA (Hospice Certified Nursing Assistant) had completed her bath, and was asked about the application of the swath and sling. S13HCNA stated she did not know anything about that. She stated that she had given the resident her bath for some time now, and had never seen nor applied a swath and sling to her left arm. On 07/29/2025 at 3:30 p.m., an interview was conducted with S14RN (Registered Nurse) who stated that the resident had a physician’s order for the swath and sling, and did not have an end date. The staff were supposed to be applying the swath and sling as per physician orders and per her care plan. Resident #72 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone at the Ranch	103 West Martial Ave Lafayette, LA 70506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #72’s electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, displaced fracture of base of neck of right femur, and aftercare following joint replacement surgery. Review of Resident 72’s July 2025 physician’s orders revealed an order dated 07/27/2025 for Monitor for edema q (every) shift. Chart severity. Chart 0=No edema noted, 1=+1 Edema, 2=+2 Edema, 3=+3 Edema, 4=+4 edema noted. Review of Resident #72’s July 2025 MAR (Medication Administration Record) revealed the following: Monitor for Edema Q-Shift. Chart severity. Chart 0=No edema noted, 1=+1 Edema, 2=+2 Edema, 3=+3 Edema, 4=+4 edema noted. There was no documentation that the charting of severity was done for the resident on the dates of 07/27/2025, 07/28/2025, 07/29/2025 and 07/30/2025. On 07/30/2025 at 5:20 p.m., an interview and record review was conducted with S3ADON (Assistant Director of Nursing). She reviewed Resident #72’s MAR and confirmed the resident’s severity of edema were not charted as ordered in July 2025. Resident #74 Review of Resident #74’s electronic medical record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, normal pressure hydrocephalus. Review of Resident #74’s hospice binder revealed that he was admitted to hospice services on 10/26/2024. Review of Resident #74's record revealed a Louisiana Physician Orders For Scope of Treatment (LaPOST) checked for: A. Do Not Attempt Resuscitation (DNR) B. Medical interventions: Person has pulse or is breathing-Selective Treatment C. Artificially Administered Fluids and Nutrition-No artificial nutrition by tube. D. Summary Discussed with-Personal Health Care Representative (PHCR), signed by physician on 10/26/2024 and signed by PHCR on 10/26/2024. Review of Resident #74’s July 2025 physician’s orders revealed no order for a DNR code status. Further review of Resident #74’s July 2025 physician’s order revealed no order for an admission to hospice services. Review of Resident #74’s care plan revealed no care plan had been developed for a code status. Further review of Resident #74’s care plan revealed no care plan had been developed for an admission to hospice services. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone at the Ranch	103 West Martial Ave Lafayette, LA 70506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/29/2025 at 2:06 p.m., an interview and record review was conducted with S2DON (Director of Nursing). S2DON confirmed that Resident #74’s July 2025 physician’s orders did not reveal an order for his code status or his admission to hospice services. S2DON confirmed that a physician’s order should have been documented for Resident #74’s code status and admission to hospice services and was not. S2DON also confirmed that Resident #74’s care plan did not include a care plan for his code status or his admission to hospice services. S2DON confirmed that a care plan should have been developed for Resident #74’s code status and admission to hospice and was not. Resident #36 Resident #36 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, hypertension, and dementia. Review of Resident #36’s electronic health record (EHR) revealed a physician’s order written on 06/17/2025, which read “Vitals Q shift every shift.” Further review of Resident #36’s EHR revealed in the vital signs documents for 07/2025 that vital signs were done only on the following dates: Blood pressure: 06/13/2025, 07/02/2025, 07/03/2025, 07/07/2025, and 07/22/2025; Temperature: 06/13/2025, 07/02/2025, 07/03/2025; Pulse: 06/13/2025, 07/02/2025, 07/03/2025, 07/07/2025, 07/22/2025; Respiration: 06/13/2025, 07/02/2025, 07/03/2025; and Oxygen Saturation: 06/13/2025, 07/02/2025, and 07/03/2025. Review of Resident #36’s medication and treatment administration records for 07/2025 revealed no vital signs recorded. On 07/30/2025 at 9:35 a.m. an interview and review of Resident #36’s EHR was conducted with S2DON (Director of Nursing) and S3ADON (Assistant Director of Nursing). They both confirmed the above vital signs were the only ones recorded for 07/2025. They also confirmed Resident #36 had an order for vital signs to be completed every shift and they should have been completed and recorded every shift and were not. Findings: Resident #8 Review of Resident #8’s EHR (Electronic Health Record) revealed she was admitted to the facility on [DATE] and had diagnoses including, but not limited to, end stage renal disease, essential hypertension, and chronic obstructive pulmonary disease, unspecified protein calorie malnutrition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone at the Ranch	103 West Martial Ave Lafayette, LA 70506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #8’s July 2025 physician’s orders revealed the following orders with start date of 4/25/2025: Monitor for Edema Q-Shift (every shift) Chart Severity. Chart 0= No edema noted; 1= +1 Edema; 2= 2+ Edema, 3= 3+ Edema, 4= 4+ Edema noted. Monitor fluid intake q (every) meal; 4=100%; 3=75%; 2=50%; 1=25%; 0=0% Review of Resident #8’s plan of care revealed the following in part: Potential for weight loss r/t (related to) Unspecified Protein-Calorie Malnutrition/Vitamin Deficiency - Interventions: Res (Resident) with 6% (6lb) wt (weight) loss in less than 30 days….Will continue to monitor intake and weigh weekly. I am at risk for complications related to dialysis for the diagnosis of: End Stage Renal Disease- Resident has right wall tunnel cath (catheter) - Interventions: Monitor fluid intake q (every) meal. Review of Resident #8’s EHR failed to reveal any evidence that the resident’s edema severity was documented every shift or that the resident’s fluid intake was monitored at every meal. On 07/29/2025 at 9:12 a.m., an interview was conducted with S6LPN (Licensed Practical Nurse). Resident #8’s physician’s orders were reviewed with S6LPN. S6LPN was asked if she had charted the severity of the resident’s edema as the physician order had stated. S6LPN was unable to provide evidence that the severity of the edema, if any, had been charted every shift. S6LPN was also asked if she monitored the resident's fluid intake and documented the percentage of fluid intake with each meal as stated in the physician’s orders. She stated that even though there was a physician’s order to monitor the resident’s fluid intake, the CNAs (Certified Nursing Assistants) were responsible for monitoring and documenting the resident’s fluid intake, and she had not documented the percentage of fluid intake with each meal. On 07/29/2025 at 9:40 a.m., an interview was conducted with S2DON (Director of Nursing). S2DON stated that because there had been a physician's order for monitoring the resident's fluid intake with each meal, it would have been the nurse's responsibility to monitor and document it. S2DON failed to provide evidence that Resident #8’s fluid intake had been documented with every meal. S2DON also confirmed there was no documented evidence that the nurses charted the severity of the resident’s edema each shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone at the Ranch	103 West Martial Ave Lafayette, LA 70506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone at the Ranch	103 West Martial Ave Lafayette, LA 70506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent new pressure ulcers from worsening. The facility failed to: 1. conduct weekly body audits;2. report new skin findings to the nurse practitioner/physician in addition to the treatment nurse; and3. administer standing wound care orders for newly identified stage I pressure ulcer for 1 (#44) of 3 (#2, #11, and #44) residents reviewed for pressure ulcers. This deficient practice resulted in actual harm for Resident #44 on 07/29/2025 when S11LPN assessed his sacral area and discovered a Stage II pressure ulcer that measured 1 cm (centimeter) x 0.5 cm to coccyx (area near base of spine). On 07/05/2025, S6LPN discovered redness to Resident #44's his sacral (area at base of spine) area and did not report it to the treatment nurse nor implement treatment as specified in the facility's wound care standing orders. S6LPN also noted redness to the same area on 07/12/2025 and again did not report to the treatment nurse nor implement the wound care standing orders. Review of Resident #44's July 2025 TAR (treatment administration record) failed to reveal that wound treatment per the facility's protocol had been provided since the identification of the redness. There was no evidence in the resident's record that a weekly body audit had been conducted after 07/12/2025. On 07/29/2025 at 9:54 a.m., Resident #44 reported to S11LPN that he had pain to his bottom. At this time, a skin observation of the resident's bottom was conducted by S11LPN in the presence of surveyor that revealed a stage II pressure ulcer to the resident's sacral area. S11LPN was unware of the resident's pressure prior to the observation.A review of Resident #44's clinical record revealed that he was admitted to the facility on [DATE] with diagnoses that included, but not limited to, type 2 diabetes mellitus, multiple sclerosis, and mild protein-calorie malnutrition. The resident also had a Stage II pressure ulcer to his sacrum upon admission that was resolved on 05/06/2025. Review of Resident #44's Minimum Data Set (MDS) dated [DATE] revealed his cognition was 15, indicating he was cognitively intact. The resident was independent with bed mobility and was occasionally incontinent of urine. Further review revealed he was at risk for developing pressure ulcers and had an unhealed pressure Stage II pressure ulcer upon admission. A review of Resident #44's Care Plan dated 04/25/2025 read, in part: Resident has potential for pressure ulcer/pressure injury development. Interventions read in part: Observe/document/report to physician as needed changes in skin status. On 07/05/2025, the resident had potential for impairment to skin integrity, skin tears, bruises related to age related changes to skin integrity. Interventions: middle of sacral area cleanse dry with normal saline, pat dry, apply zinc oxide or facility skin barrier and leave open to air daily. It further read in part: Resident has bladder incontinence at times. Interventions: brief use. Provide resident with briefs and incontinence aids as needed. Protective barrier cream as needed. Review of Resident #44's progress notes documented per S6LPN (Licensed Practical Nurses) dated 07/05/2025 read in part: Body Audit sacral redness in center surrounding skin is pink and margins intact. Further review of the progress notes revealed a body audit per S6LPN on 07/12/2025 read in part. sacral redness in center of surrounding skin is pink and margins intact. Resident #44's progress notes failed to reveal any additional body audits conducted after 07/12/2025. On 07/29/2025 10:15 a.m., an interview was conducted with S2DON (Director of Nursing) who stated that body audits on residents are to be done weekly. She reported that the facility had a wound care standing order protocol that required the nurses to notify the physician, treatment nurse, and initiate wound care when an area of concern was identified. Review of the facility document entitled Wound Care Standing Orders which read in part:2. Pressure Wounds: Notify physician/nurse practitioner, Responsible Party, and Treatment Nurse upon discovery. Stage I persistent reddened area that does not blanch - cleanse with normal saline, pat dry, apply zinc oxide or facility skin barrier.and leave open to air daily. Stage II - if serum filled blister - cleanse gently with normal saline and wound cleanser, gently apply skin barrier.or skin prep and leave open to air until healed. For abrasion or shallow crater: cleanse gently with normal saline or wound cleanser, apply skin barrier.mixed with collagen, cover with dry clean dressing daily and as needed until healed. On 07/30/2025 at 11:25 a.m., a phone interview was conducted with S6LPN. She stated she identified the red area on his sacral area on 07/05/2025 and 07/12/2025 but failed to notify the treatment nurse since the standing order treatment required the use of normal saline. She stated that the protocol was to identify the area; notify the nurse practitioner; initiate the treatment; and document the information into the communication log for shift to shift awareness. She confirmed that she had not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone at the Ranch	103 West Martial Ave Lafayette, LA 70506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, and interviews, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with current accepted professional principles by failing to discard expired medication in 2 medication rooms (Room A and Med Room B/C) of 2 (Med Room A and Med Room B/C) medication rooms sampled for medication storage. Findings:On [DATE], a review of the facility's policy titled, Storage of Medication dated [DATE], revealed in part. Policy Heading: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation:.4 .Discontinued, outdated, or deteriorated drugs or biologicals are destroyed.On [DATE] at 12:09 p.m., an observation was conducted of Med Room A with S3ADON (Assistant Director of Nursing) which revealed the following: 1. Sodium Chloride Tablets 1 gm (gram) bottle with an expiration date of 04/20252. (6) Acetaminophen Supp (suppository) 650 mg (milligram) with an expiration date of [DATE]. (8) Bisacodly Supp (suppository) 10 mg with an expiration date of [DATE]At that time, S3ADON confirmed the above medications were expired and should have been discarded and not in the medication room.On [DATE] 12:19 p.m., an observation was conducted of Med Room B/C with S3ADON which revealed the following: 1. Ferrous Sulfate Elixir bottle with an expiration date of 06/20252. Vitamin D-3 125 mcg (microgram) 5000 IU (international units) bottle with an expiration date of 06/2025 At that time, S3ADON confirmed the above medications were expired and should have been discarded and not in the medication room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone at the Ranch	103 West Martial Ave Lafayette, LA 70506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and interviews, the facility failed to dispose of garbage and refuse properly in the dietary garbage disposal area.On 07/30/2025, a review of the facility's undated policy and procedure titled Policy and Procedure for: Disposing of Garbage & Refuse Properly, read in part 1. Proper Garbage Containers.b. Waste must be properly contained and covered in dumpsters or compactors.2. Sanitary Garbage Storage: a. Garbage storage areas must be maintained in a sanitary condition.Conduct regular checks of garbage containers, transport routes, and storage areas to ensure compliance.On 07/28/2025 at 9:20 a.m., an observation was made of the dietary garbage disposal area with S4DM (Dietary Manager). Used gloves and other trash items were observed on the right immediately after stepping outside the building and entering the walkway leading to the garbage dumpster. There were two gloves on the ground close to a large yellow bucket. The garbage dumpster was open, and there were three used gloves on the ground in front of the dumpster. Further observation revealed a white garbage bag containing refuse outside and to the left of the dumpster. S4DM stated that the garbage dumpster was supposed to be kept closed and the surrounding areas clean at all times.On 07/29/2025 at 10:38 a.m., an interview was conducted with S1ADM (Administrator). She stated that the dumpster was used by the kitchen staff only. She stated that it was not supposed to be left like that and that the kitchen staff was responsible for maintaining the cleanliness of the area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195565	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cornerstone at the Ranch	103 West Martial Ave Lafayette, LA 70506

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review and interview, the facility failed to maintain an effective QAPI (Quality Assurance and Performance Improvement) program by failing to adequately monitor QAPI projects that were opened to determine if corrections or revisions were necessary. This had the potential to affect the 73 residents that resided at the facility. Findings: On 07/30/2025 at 5:30 p.m., review of the facility's QAPI program and current performance improvement projects and interview was conducted with S2DON (Director of Nursing). S2DON stated the facility had multiple nursing QA (Quality Assurance) projects that were opened prior to the survey. A review of the open QA projects was conducted with S2DON and revealed the following: -A QA project for GDRs (Gradual Dose Reductions) to be monitored and implemented was opened on 05/22/2025. Action steps were to meet with pharmacy consultant monthly and prn (as needed). There was no monitoring or audits conducted for the QA project. S2DON stated that she had not been monitoring or conducting audits for the GDRs QA project. -A second QA project for weekly body audits was reviewed with S2DON. The project was opened on 05/28/2025 and documented as ongoing on 05/30/2025. Action steps included placing a schedule for required daily body audits at each nurses' station, in-servicing staff, and monitoring. DON or designee was to complete 2 random observations throughout the facility at minimum 3 times per week for 4 weeks and will continue as deemed necessary. A nursing in-service conducted on 05/28/2025 revealed the following: We are required to do weekly skin inspections and general notes on our residents. This is the schedule. Also, please remind CNAs (Certified Nursing Assistants) to report all skin issues-redness, bruises, abrasions, etc). Monitoring began on 06/02/2025, with the last recorded monitoring conducted on 07/10/2025. S2DON stated that her treatment nurse had been out for the last two weeks, and the monitoring for this QA project had not been done from 07/10/2025 to 7/30/25. -A third QA project was reviewed with S2DON for expired medications that was opened on 05/30/2025. The QA monitoring for the medication room read: The DON/designee will complete a minimum of 5 random observations throughout the facility weekly for 4 weeks and will continue as deemed necessary. Monitoring began on 06/02/2025, and three observations were completed. Three observations were completed on 06/10/2025, and 06/18/2025. There was no other monitoring conducted from 6/18/2025 to 7/30/2025. At this time, S2DON confirmed that she was aware of deficient practice being cited on the current survey regarding GDRs, weekly body audits, and expired medications. She confirmed that adequate monitoring of opened QA projects had not been conducted prior to the survey.