STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555290	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanford Court Skilled Nursing & Rehab Center	8778 Cuyamaca Street Santee, CA 92071

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide necessary wound treatment and services in accordance with professional standards of practice by failing to obtain, implement, and provide evidence of physician ordered surgical wound care treatment for one of three residents (Resident 1).These deficient practices placed Resident 1 at risk for worsening of the surgical wound, infection, pain, delayed healing, and further health complications that could result in negative health outcomes.Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included history of diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and osteomyelitis (inflammation of bone or bone marrow, usually due to infection). A record review of Resident 1's minimum data set (MDS - a federally mandated resident assessment tool) dated 4/22/26 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 13 points out of 15 possible points which indicated Resident 1 was cognitively (pertaining to memory, judgement and reasoning ability) intact (alert to person, place, situation, and time). On 5/7/26 at 1:08 P.M., an interview and record review was conducted with the Social Service Director (SSD). The SSD stated Resident 1 was admitted to the facility on [DATE] and discharged home on 5/6/26. The SSD stated Resident 1 underwent a surgical procedure for the left foot (4/14/26) at [Hospital Name]. The SSD stated Resident 1 was at the facility for skilled (24-hour medical care provided in a nursing home or facility by licensed professionals e.g. nurses, physicians and therapists) services for surgical wound management of the left foot. The SSD stated nursing was providing medication management with antibiotics (medications for infection) and wound treatments. The SSD stated the physician's orders to the left lower extremity (LLE-leg, foot), included monitoring for signs and symptoms of infection. The SSD stated Resident 1 had a LLE post op [after surgery] shoe and was non-weight bearing (NWB) during Resident 1's stay at the facility. On 5/7/26 at 2 PM an interview and record review was conducted with the Director of Nursing (DON). The DON stated Resident 1 had a left second toe amputation (surgical removal) related to the surgical left foot wound. The DON stated Resident 1 was admitted to the facility with the left foot wrapped (surgical wound) and had physician orders to monitor the LLE for signs and symptoms of infection; however, there were no physician treatment orders in place for the surgical (LLE) wound management during Resident 1's stay at the facility. The DON stated the facility should have implemented surgical wound treatment orders and routinely removed and assessed Resident 1's dressing to monitor for signs and symptoms of infection and other complications. The DON further stated Resident 1 attended follow-up orthopedic and podiatry appointments on 4/21/26; however, Resident 1's record did not contain updated wound care treatment orders following appointments. On 5/7/26 at 2:11 P.M., an interview and record review was conducted with the wound nurse (WN). The WN stated we [wound care nurses] were doing the betadine [used on the skin to treat or prevent skin infection in minor cuts, scrapes, or burns] dressing with sutures [surgical thread to sew skin together] then wrapped it with Kerlix [type of fluffy, stretchy medical bandage used to wrap, secure, and protect wounds] and ace wrap [a stretchy, elastic bandage] during Resident 1's stay at the facility; however, there were no (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician orders entered for the left surgical foot wound treatments and the treatments were not documented in the medical record. The WN stated Resident 1's left surgical foot wound did not have actual treatment orders as provided by the WN. The WN stated the facility [licensed nurses] should have clarified and obtained physician orders for ongoing surgical wound care management, including routine dressing changes, wound assessments, and monitoring for signs and symptoms of infection. The WN further stated the lack of treatment orders and wound monitoring placed Resident 1 at risk for infection, increased pain, worsening of the surgical wound, and delayed healing. On 5/7/26 at 3 P.M., an interview with the DON was conducted. The DON stated the facility's expectation upon admission was for the WN to complete a comprehensive wound assessment and for the WN to reassess the wound the following day to ensure appropriate physician treatment orders were obtained and implemented based on the type and condition of the wound. The DON stated Resident 1 had diagnosis that included DM and post-surgical LLE wound related to osteomyelitis and required ongoing wound care management and monitoring. The DON further stated the absence of physician ordered treatment for the left surgical wound placed Resident 1 at risk for deterioration of the wound, re-infection, increased pain, delayed healing and worsening complications related to osteomyelitis. A review of the facility's policy and procedure titled, Wound Care dated October 2010, indicated .Verify that there is a physician's order for this procedure The following information should be recorded in the resident's medical record.The type of wound care given. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound.The signature and title of the person recording the data.