

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Stanford Court Skilled Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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 interview and record review, the facility failed to ensure written information related to advance directive was provided to 6 of 10 sampled residents (1,12,45, 85, 130, and 144). This failure may affect Resident 1,12, 45, 85, 130, and 144's decision to formulate an advance directive due to lack of knowledge and information. FindingsOn 12/3/25 a review of Resident 1's clinical record was conducted. Resident 1 was admitted to the facility on [DATE] per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 10/16/25, indicated, [] I have received the brochure on Advance Directives was left blank. There was no documentation that the facility provided Resident 1 with Advance Directive information.On 12/3/25 a review of Resident 12's clinical record was conducted. Resident 12 was admitted to the facility on [DATE] per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 1/4/25, indicated, [] I have received the brochure on Advance Directives was left blank. There was no documentation that the facility provided Resident 12 with Advance Directive information.On 12/3/25 a review of Resident 45's clinical record was conducted. Resident 45 was admitted to the facility on [DATE] per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 11/13/25 indicated, [] I have received the brochure on Advance Directives was left blank. There was no documentation that the facility provided Resident 45 with Advance Directive information.On 12/3/25 a review of Resident 85's clinical record was conducted. Resident 85 was admitted to the facility on [DATE] per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 11/17/25 indicated, [] I have received the brochure on Advance Directives was left blank. There was no documentation that the facility provided Resident 85 with Advance Directive information.On 12/3/25 a review of Resident 130's clinical record was conducted. Resident 130 was admitted to the facility on [DATE] per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 11/23/25 indicated, [] I have received the brochure on Advance Directives was left blank. There was no documentation that the facility provided Resident130 with Advance Directive information.On 12/3/25 a review of Resident 144's clinical record was conducted. Resident 144 was admitted to the facility on [DATE] per the facility's admission Record. The facility's document titled Advance Directive Acknowledgement dated 11/28/25 indicated, [] I have received the brochure on Advance Directives was left blank. There was no documentation that the facility provided Resident 144 with Advance Directive information.On 12/04/2025 at 3:28 P.M. an interview was conducted with the DON. The DON stated that written documentation was not provided to Residents 1,12, 45, 85, 130, and 144. The DON stated her expectation was that there should have been documentation in the medical record that an Advance Directive brochure was given or refused by the resident, the resident's family, and/or representative. A review of the facility's policy titled Advance Directive dated September 2022 indicated, .Policy Statement. Advance directives are honored in accordance with state law and facility policy.Determining Existence of Advance Directive .The resident or representative is provided with written information .to formulate an advance directive .		

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the water temperature in nine residents' rooms (Resident 134, 135, 140, 123, 128, 132, 113, 53, and 147) and the shower room located by the 500 rooms was below 120 degrees Fahrenheit (F).As a result of this deficient practice, there was the potential for residents using the water to get scalded. Findings:A review of Resident 134's admission Record indicated the resident was admitted to the facility on [DATE].A review of Resident 135's admission Record indicated the resident was admitted to the facility on [DATE].A review of Resident 140's admission Record indicated the resident was admitted to the facility on [DATE].A review of Resident 123's admission Record indicated the resident was admitted to the facility on [DATE].A review of Resident 128's admission Record indicated the resident was admitted to the facility on [DATE].A review of Resident 132's admission Record indicated the resident was admitted to the facility on [DATE].A review of Resident 113's admission Record indicated the resident was admitted to the facility on [DATE].A review of Resident 53's admission Record indicated the resident was admitted to the facility on [DATE].A review of Resident 147's admission Record indicated the resident was admitted to the facility on [DATE].On 12/1/25 at 2:33 P.M., an observation was conducted inside Resident 134's room. Resident 134's sink had a faucet with one handle for hot and cold water. When twisted to the left, hot water came out that was steamy and painful to the touch in one second. On 12/1/25 at 2:38 P.M., a joint observation of Resident 134's sink was conducted with the environmental services director (ESD). The ESD used the facility's thermometer to test the water temperature in Resident 134's sink. The water was 143 F. The ESD stated, It's too hot. Should be less than 120 F. On 12/1/25 at 2:40 P.M., a joint observation of Resident 140's sink was conducted with the ESD. The ESD tested the resident's sinks' water temperature. It was 140 F. On 12/1/25 at 2:44 P.M., a joint observation of Resident 123, 128, 132, and 113's sink was conducted with the ESD. The ESD tested the resident's sinks' water temperature. It was 152 F. The ESD stated the water was, dangerously hot and could hurt a resident.On 12/1/25 at 2:46 P.M., a joint observation of the water in the shower room located near the 500 rooms was conducted with the ESD. The ESD tested the water temperature coming out of the shower head. It was 125 F. On 12/1/25 at 2:48 P.M., a joint observation of Resident 53 and 147's sink was conducted with the ESD. The ESD tested the resident's sinks' water temperature. It was 122 F. On 12/1/25 at 2:49 P.M., a joint interview and record review was conducted with the ESD. The Environmental Daily Logs were reviewed with the ESD. The logs indicated on 12/1/25, .Resident Bathroom Random hot water temperature on station 1 [Resident 134's room] 110 F [and] Resident Bathroom Random hot water temperature on station 2 [400's room number] 110 F. The ESD stated he took the temperatures that morning. The ESD stated the log only had temperatures taken for two water heaters. The ESD stated there were four water heaters that supplied water to resident rooms. The ESD stated the log needed to be revised to include a water temperature check of a resident room that received water from each water heater. The ESD stated he was unsure which water heater was sending water to Resident 134, 135, 140, 123, 128, 132, 113, 53, and 147's rooms and the shower room located by the 500 rooms. On 12/1/25 at 3 P.M., an observation of the water heater located in the activity director's office was conducted with the ESD. Another ESD from another building was also present. The water heater's thermostat was set at 117 F. There was a thermometer installed to test the outgoing water from the water heater. The ESD stated the thermometer was broken. The ESD stated the thermometer should have been in working order to ensure the outflowing water was in sync with the thermostat.On 12/1/25 at 3:30 P.M., an interview was conducted with Resident 140 while inside the resident's room. Resident 140 stated, The water's always hot in the sink. Resident 140 stated it had been hot since she was admitted to the facility. Resident 140 stated she knew not to turn the faucet (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	handle all the way to the left. On 12/1/25 at 3:40 P.M., an interview was conducted with the administrator (ADM). The ADM stated residents' water temperature above 120 F was a safety concern. A review of the State Operations Manual (SOM) Appendix PP revised 7/23/25, indicated a third-degree burn (burns that penetrate the entire thickness of the skin and permanently destroy tissue) could occur within five seconds at 140 F, within two seconds at 148 F, and one second at 155 F. A safe bathing temperature was 100 F. A review of the facility's undated policy titled Water Temperatures, Safety of, indicated, .Water heaters that service resident rooms, bathrooms, common areas. shall be set to temperatures of no more than 120 F.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide proper pharmaceutical services for three of three residents (Residents 45, 134, 146) when: 1. The administration of busPIRONE (anti-anxiety medication that is primarily used to treat general anxiety disorder) was 3 hours and 55 minutes late for one resident (Resident 45).2. There were delays in the MAR documentation after controlled medications were removed from the locked storage for two of two randomly selected residents (Resident 134 and 146).As a result, it could not be determined what time the medications were administered to Residents 45, 134, and 146. Findings: 1. A review of Resident 45's admission Record indicated the resident was admitted to the facility on [DATE].A review of Resident 45's physician's order dated 11/19/25 indicated: - busPIRONE oral tablet 5 mg (milligram) give one tablet by mouth two times a day for anxiety (scheduled at 9 A.M. and 6 P.M.).On 12/2/25 at 2:47 P.M., a concurrent interview and record review of Resident 45's physician order and MAR for November 2025 for buspirone was conducted with Licensed Nurse (LN) 11. LN 11 reviewed and stated that Resident 45's physician ordered administration time for busPIRONE was at 9 A.M. on 11/27/25, but the administration time entered in the MAR was at 1:55 P.M. LN 11 then reviewed Resident 45's clinical record. LN 11 stated there was no documentation to explain the delay of the resident's busPIRONE administration. LN 11 stated medication administration time window was one hour before and after the scheduled time. LN 11 stated there should have been documentation of the administration delay. 2. A review of Resident 134's admission Record indicated the resident was admitted to the facility on [DATE].A review of Resident 134's physician's order dated 11/25/25, indicated: - Lyrica Capsule 75 mg give one capsule by mouth one time a day for pain. A record review of Resident 134's CDR and MAR for November 2025 documentation for Lyrica was conducted. The CDR indicated on 11/30/25, Resident 134's Lyrica was removed from the locked storage at 9 A.M. and the MAR indicated that the resident was administered the medication at 11:25 A.M.A review of Resident 146's admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis including epilepsy (a brain condition causing repeated seizures).A review of Resident 146's physician's order dated 11/23/25, indicated: - Lacosamide oral tablet 200 mg give one tablet by mouth two times a day for epilepsy (scheduled for 9 A.M. and 9 P.M.). On 12/3/25 at 2:58 P.M. a concurrent interview and record review of Resident 146's lacosamide documentation for the CDR and MAR for December 2025 was conducted with LN 11. LN 11 stated that the resident's CDR documentation on 12/3/25 indicated the medication was removed from the locked storage at 8:03 A.M., while the administration of the medication was documented in the MAR at 9:59 A.M. LN 11 stated it was her documentation. LN 11 stated she documented the resident's lacosamide late on the MAR. LN 11 stated she gave the lacosamide with the rest of the resident's morning medications scheduled at 9 A.M. but forgot to document it until 9:59 A.M. LN 11 stated she should have documented the lacosamide administration immediately after it was administered to the resident.On 12/4/25 at 2:25 P.M., a joint interview and record review was conducted with the Director of Nursing (DON). The DON reviewed Resident 45's busPIRONE MAR for November 2025. The DON reviewed the resident's clinical record and stated there was no documentation that explained the late administration of busPIRONE on 11/27/25. The DON stated her expectation was for the nurses to document in the MAR immediately after the medications were administered. The DON stated she expected the nurses to notify the provider if a medication was not given at a scheduled time and to document the notification and the reason for the delay in the resident's clinical record. The DON reviewed Resident 134's discrepancies on the CDR and November 2025 MAR for the 9A.M. dose of Lyrica on 11/30/25. The DON reviewed Resident 146's discrepancies on the CDR and December 2025 MAR for the 9 A.M. dose of lacosamide on 12/3/25. The DON reviewed both resident's clinical records (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and stated that there was no documentation that explained the delay in the MAR entries. The DON stated nurses should not delay controlled medication administration for even 10 minutes after the medication was removed from the locked storage. The DON stated controlled medications must be administered immediately after their removal from the locked storage and their administration times must be documented on the resident's MAR in a timely manner. A review of the facility's policy titled Administering Medications revised April 2019, indicated, .4. Medications are administered in accordance with prescriber orders, including any required time frame.7. Medications are administered within one (1) hour of their prescribed time .21. If a drug is given at a time other than the scheduled time, the individual administering the medication shall document.22. The individual administering the medication documents the resident's MAR .after giving each medication and before administering the next ones.A review of the facility's undated policy titled Medication Administration Orals, indicated, .14. Chart medication administration on Medication Administration Record immediately following each resident's medication administration.A review of the facility's undated policy titled Medication Administration Controlled Substances, indicated, .4. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage: . a. Date and time of administration.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of five residents (Resident 133) was free from unnecessary medications when licensed nurses (LN) did not follow the physician orders while administering laxatives (medication that promotes bowel movements) nine times. As a result of this deficient practice, Resident 133 experienced several episodes of diarrhea. Cross Reference: F726Findings: A review of Resident 133's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of surgical aftercare following surgery on the nervous system. On 12/2/2025 at 8:50 A.M., an observation and interview was conducted with Resident 133 while inside his room. Resident 133 was observed with a nasal gastric tube (NG-tube a thin, soft tube that goes in through the nose, into the stomach, used to give food and medications). The resident stated he had diarrhea every day since he was admitted into the facility. Resident 133 stated he was not sure if he was receiving any stool softeners or laxatives. A review of Resident 133's physician's order dated 11/21/25 indicated, polyethylene glycol 3350 Powder, give 17 grams via NG-Tube one time a day for constipation prevention mix powder in 8 oz water (hold for loose stool) start date 11/22/25. A review of Resident 133's physician's order dated 11/21/25, docusate sodium oral liquid 50 milligrams (mg)/5 milliliters (ml), give 10 ml via NG-tube two times a day for constipation prevention (hold for loose stool) start date 11/22/25. A review of Resident 133's physician's order dated 11/21/25, psyllium husk powder give one tablespoon via NG- tube three times a day for constipation prevention mix with eight ounces of water (hold for loose stool) start date of 11/22/25. A review of Resident 133's care plan dated 11/21/25, titled LTCP (long term care plan): At risk for constipation related to decreased mobility, potential side effects of medications. Goal: Will report continuous satisfactory bowel movements every two to three days as evidenced by soft, formed stools, and does not strain in passing stools. Approaches: .Administer medications for constipation prevention as ordered by the Physician. On 12/3/25 at 3:35 P.M., an interview and record review was conducted with Licensed Nurse (11). LN 11 reviewed Resident 133's Bowel Elimination Record ([NAME]) and MAR (Medication Administration Record) for the month of November and December 2025. A review of Resident 133's [NAME] and MAR record indicated: The [NAME] indicated the resident had a loose stool on 11/24/25 at 10:29 A.M. The MAR indicated on 11/24/25 at 9 A.M., Resident 133 was administered polyethylene glycol 3350 powder, docusate sodium oral and psyllium husk powder. The MAR indicated on 11/24/25 at 1 P.M., Resident 133 was administered psyllium husk powder. The [NAME] indicated the resident had a watery stool on 11/25/25 at 2:59 P.M. The MAR indicated on 11/25/25 at 5 P.M., Resident 133 was administered psyllium husk powder. The [NAME] indicated the resident had loose stools on 11/26/25 at 6:51 A.M., 10:27 A.M, and at 7:47 P.M. The MAR indicated on 11/26/25 at 9 P.M., Resident 133 was administered docusate sodium oral. The [NAME] indicated resident had a watery stool on 11/28/25 at 9 A.M. The MAR indicated on 11/28/25 at 9 P.M., Resident 133 was administered docusate sodium oral. The [NAME] indicated the resident had a watery stool on 11/29/25 at 9 A.M., and loose stool at 8:15 P.M. The MAR indicated on 11/29/25 at 9 A.M., Resident 133 was administered polyethylene glycol 3350 powder and docusate sodium oral. The [NAME] indicated the resident had a watery stool on 11/30/25 at 5:40 A.M. and putty-like stools at 2:22 P.M. and at 9:05 P.M. The MAR indicated on 11/30/25 at 9 P.M., Resident 133 was administered docusate sodium oral. The [NAME] indicated the resident had a putty-like stool on 12/1/25 at 2:59 P.M. and loose stool at 9:24 P.M. The MAR indicated on 12/1/25 at 9 P.M., Resident 133 was administered docusate sodium oral. The [NAME] indicated the resident had watery stools on 12/2/25 at 9 A.M. and 2:26 P.M. The MAR indicated on 12/2/25 at 5 P.M., Resident 133 was administered psyllium husk powder. LN 11 stated she would ask the resident about their bowel movements, if they are not alert enough to know, she would check the medical records of their last bowel movements to see if they had a bowel movement. LN 11 stated Resident 133 was having loose stools, and she still (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gave the resident laxative medications. LN 11 stated she should have held the laxative medications for Resident 133. LN 11 stated complications from loose stool could have caused dehydration and weight loss. On 12/4/2025 at 11:23 A.M., an interview was conducted with the Director of Nursing. The DON stated licensed nurses should have asked the resident about their bowels movements, checked the PCC (point click care) dashboard that would track a resident's bowel movements, and they should have asked the CNA about the bowel movement. The DON stated the licensed nurses should have assessed first and then followed the physician's orders to properly medicate Resident 133. A review of the facility's policy titled Administering Medications revised April 2019, indicated, .4. Medications are administered in accordance with prescriber orders. The policy did not provide guidance related to unnecessary medications.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure practices that mitigated the risk of resident food contamination were followed when:1. The dietary manager (DM) did not wear a beard guard while in the kitchen and overseeing the breakfast tray line.2. [NAME] 1 used a broken thermometer to take final food temperatures prior to serving. In addition, staff did not take final food temperatures consistently before the food was placed on the tray line and then served to residents. These deficient practices had the potential to cause foodborne illnesses. Findings:1. On 12/1/25 at 7:42 A.M., an observation was conducted in the kitchen. The DM was observed standing behind the tray line where kitchen staff were actively serving breakfast. The DM wore a surgical mask. The DM had facial hair approximately a half inch long exposed on both cheeks. On 12/1/25 at 8:05 A.M., an interview was conducted with the DM. The DM stated he should have worn a beard guard over the surgical mask to cover all of his facial hair. The DM stated beard guards had to be worn over facial hair to prevent hair from getting into the food. A review of the facility's undated form titled Competencies for Food and Nutrition Services Employees, indicated, .Infection Control Practices/Employee Hygiene. Uses hair restraints and beard guards properly. A review of the facility's policy titled Policy & Procedure Manual Food Safety and Sanitation, dated 2023, indicated, .2. Employees. Beard nets are required when facial hair is visible. 2. On 12/3/25 at 10:46 A.M., an observation was conducted in the kitchen. [NAME] 1 was observed calibrating the facility's digital thermometer (orange in color) that would be used to take food temperatures. [NAME] 1 placed the thermometer into a full cup of ice water. The thermometer shut off at 33 degrees Fahrenheit (F) and did not reach 32 F. The thermometer was turned back on, and it then read 34 F and continued to increase in temperature. [NAME] 1 stated the thermometer did not calibrate. The DM provided another digital thermometer (black in color) to [NAME] 1. The second thermometer reached 32 F and calibrated with no issues. On 12/3/25 at 10:50 A.M., [NAME] 1 began to take the temperatures of the food as it was placed on the steam table using the orange digital thermometer. [NAME] 1 was asked why she was using the thermometer that did not calibrate. [NAME] 1 stated the black one was for taking the temperature of cold food. [NAME] 1 stated she always used the orange thermometer to take the temperature of hot food. The DM stated the orange thermometer was broken and should not have been used to take food temperatures. The DM instructed [NAME] 1 to use the black thermometer to take final food temperatures. On 12/3/25 at 11:25 A.M., [NAME] 1 was observed serving food. [NAME] 1 was not observed taking the final temperature of the chopped lasagna. [NAME] 1 was asked what the final temperature of the chopped lasagna was. The food temperature log was reviewed with [NAME] 1. [NAME] 1 stated she did not write down the final temperature of the chopped lasagna because there was no space to write it on the form. [NAME] 1 then stated she should have taken the temperature of the chopped lasagna before serving it. On 12/3/25 at 11:35 A.M., [NAME] Assistant (CA) was observed bringing another lasagna out from the cooking area and placing it on the steam table. CA was not observed taking the final temperature of the lasagna. On 12/3/25 at 11:45 A.M., an interview was conducted with the CA. CA 1 was asked what the final temperature of the lasagna brought out at 11:35 A.M., was. Half the lasagna had already been served. CA stated she did not write the final temperature down. CA was asked if she took the final temperature of the lasagna. CA stated, No. On 12/4/25 at 9:55 A.M., an interview was conducted with the DM and the registered dietitian (RD). The DM and RD both stated it was their expectation for final food temperatures to be taken on all food items prior to being served. The DM and RD both stated this had to be done to ensure the food was safe to serve to the residents. A review of [NAME] 1 and CA's Competencies for Food and Nutrition Services Employees dated 3/12/25 and 3/13/25, indicated, .Food safety Requirements. Uses thermometers correctly to check food temperatures. Checks and records temperatures prior to service. A review of the facility's policy titled Policy & Procedure (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resource: Taking Accurate Temperatures dated 2023, indicated, Choosing a Thermometer [:] Start with an accurately calibrated thermometer that is in good working condition. The policy did not provide guidance related to when to take a final food temperature.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 observation, interviews, and record reviews, the facility failed to implement interventions for one of seven residents (Resident 16) written care plan (detailed plan with information about a resident's treatment, goal, and interventions) for activities of daily living related to nail care. This failure had the potential for the resident to not receive care and services specific to the residents' needs. Findings A review of Resident 16's admission record indicated the resident was admitted on [DATE] with diagnoses which included unspecified fracture of the fifth lumbar vertebra, need for assistance with personal care, and abnormalities of gait and mobility. On 12/1/25 at 8:35 A.M., an observation and interview was conducted with Resident 16 in Resident 16's room. Resident 16 was lying in bed, watching tv. The resident's fingernails were observed to be long, approx. 1/2 in length, yellow and discolored. Resident 16 stated she preferred to have long fingernails, but they were too long now and that she needed them cut. Resident 16 stated she had told the staff many times she wanted her fingernails cut and filed shorter. Resident 16 stated her fingernails had only been cut once since she had been at this facility. A review of Resident 16's care plan problem titled resident's activities of daily living routine and/or preferences indicated the resident prefers to keep her fingernails long. Interventions include offer to file resident's nails. On 12/1/25 at 9:23 A.M., an interview was conducted with Licensed Nurse (LN) 16. LN 16 stated when Resident 16 requested her nails to be cut and filed, the CNA should have cut and file the resident's fingernails. On 12/1/25 3 P.M., an observation and interview was conducted with Certified Nursing Assistant (CNA) 17 in Resident 16's room. CNA 17 observed Resident 16's fingernails and stated that Resident 16 had very long fingernails. CNA 17 stated she should have filed or cut Resident 16's nails to prevent scratching, for hygiene, and to prevent infection. On 12/1/25 at 3:17 P.M., an observation and interview was conducted with Licensed Nurse (LN) 18 in Resident 16's room. LN 18 stated the resident's fingernails were long and yellowing and she should have offered to cut her fingernails for hygiene purposes. LN 18 stated Resident 16 would have had pride in her appearance if her fingernails were cut shorter. On 2/4/25 at 3:28 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that Resident 16's nail care should have been provided. The DON further stated the Resident's 16 ADL care plan related to nail care was not implemented. The facility policy and procedure titled CARE PLAN, COMPREHENSIVE PERSON-CENTERED revised March 2022 indicated, .Policy Statement A comprehensive, person-centered care plan . is developed and implemented for each resident. 7b. describe the services that are to be furnished .		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide the necessary nail care to maintain good grooming and personal hygiene for one of seven residents (Resident 16). This failure resulted in Resident 16 having long, yellowing, discolored fingernails. Findings: A review of Resident 16's admission Record indicated Resident 16 was admitted on [DATE] with diagnoses which included unspecified fracture of the fifth lumbar vertebra, need for assistance with personal care, and abnormalities of gait and mobility. On 12/1/25 at 8:35 A.M., an observation and interview was conducted with Resident 16 in Resident 16's room. Resident 16 was lying in bed, watching tv. The resident's fingernails were observed to be long, approx. 1/2 in length, yellow and discolored. Resident 16 stated she preferred to have long fingernails, but they were too long now and that she needed them cut. Resident 16 stated she had told the staff many times she wanted her fingernails cut and filed shorter. Resident 16 stated her fingernails had only been cut once since she had been at this facility. A review of Resident 16's care plan problem titled resident's activities of daily living routine and/or preferences indicated the resident prefers to keep her fingernails long. Interventions include offer to file resident's nails. On 12/1/25 at 9:23 A.M., an interview was conducted with Licensed Nurse (LN) 16. LN 16 stated when Resident 16 requested her nails to be cut and filed, she would have expected the CNA to cut and file the resident's fingernails. On 12/1/25 3 P.M., an observation and interview was conducted with Certified Nursing Assistant (CNA) 17 in Resident 16's room. CNA 17 observed Resident 16's fingernails and stated that Resident 16 had very long fingernails. CNA 17 stated she should have filed or cut Resident 16's nails to prevent scratching, for hygiene, and to prevent infection. On 12/1/25 at 3:17 P.M., an observation and interview was conducted with Licensed Nurse (LN) 18 in Resident 16's room. LN 18 stated the resident's fingernails were long and yellowing and she should have offered to cut her fingernails for hygiene purposes. LN 18 stated Resident 16 would have had pride in her appearance if her fingernails were cut shorter. On 2/4/25 at 3:28 P.M., an interview with the Director of Nursing (DON) was conducted. The DON stated that Resident 16's nail care should have been provided. The facility policy and procedure titled FINGERNAILS/TOENAILS, CARE OF revised, February 2018 indicated, .The purpose of this procedure are to clean the nail bed, to keep nails trimmed and to prevent infections .General Guidelines 1. Nail care includes daily cleaning and regular trimming .The facility policy and procedure titled ACTIVITIES OF DAILY LIVING (ADL), SUPPORTING revised March 2018 indicated, .Policy Statement. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure six of six licensed nurses (LN 11, LN 21, LN 22, LN 23, LN 24 and LN 25) staff were competent when assessing bowel eliminations and administering laxatives.As a result, there was the potential for residents to be given unnecessary laxatives (promotes bowel movements) which may lead to diarrhea, weight loss, skin breakdown and dehydration.Findings:A review of Resident 133's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of surgical aftercare following surgery on the nervous system.On 12/2/2025 at 8:50 A.M., an observation and interview was conducted with Resident 133 while inside his room. Resident 133 was observed with a nasal gastric tube (NG-tube a thin, soft tube that goes in through the nose, into the stomach, used to give food and medications). The resident stated he had diarrhea every day since he was admitted into the facility. Resident 133 stated he was not sure if he was receiving any stool softeners or laxatives. A review of Resident 133's physician's order dated 11/21/25 indicated, polyethylene glycol 3350 Powder, give 17 grams via NG-Tube one time a day for constipation prevention mix powder in 8 oz water (hold for loose stool) start date 11/22/25. A review of Resident 133's physician's order dated 11/21/25, docusate sodium oral liquid 50 milligrams (mg)/5 milliliters (ml), give 10 ml via NG-tube two times a day for constipation prevention (hold for loose stool) start date 11/22/25. A review of Resident 133's physician's order dated 11/21/25, psyllium husk powder give one tablespoon via NG- tube three times a day for constipation prevention mix with eight ounces of water (hold for loose stool) start date of 11/22/25.A review of Resident 133's care plan dated 11/21/25, titled LTCP (long term care plan): At risk for constipation related to decreased mobility, potential side effects of medications. Goal: Will report continuous satisfactory bowel movements every two to three days as evidenced by soft, formed stools, and does not strain in passing stools. Approaches: .Administer medications for constipation prevention as ordered by the Physician.On 12/3/25 at 3:35 P.M., an interview and record review was conducted with Licensed Nurse (11). LN 11 reviewed Resident 133's Bowel Elimination Record ([NAME]) and MAR (Medication Administration Record) for the month of November and December 2025.A review of Resident 133's [NAME] and MAR record indicated:The [NAME] indicated the resident had a loose stool on 11/24/25 at 10:29 A.M.The MAR indicated on 11/24/25 at 9 A.M., Resident 133 was administered polyethylene glycol 3350 powder, docusate sodium oral and psyllium husk powder.The MAR indicated on 11/24/25 at 1 P.M., Resident 133 was administered psyllium husk powder.The [NAME] indicated the resident had a watery stool on 11/25/25 at 2:59 P.M. The MAR indicated on 11/25/25 at 5 P.M., Resident 133 was administered psyllium husk powder.The [NAME] indicated the resident had loose stools on 11/26/25 at 6:51 A.M.,10:27 A.M, and at 7:47 P.M.The MAR indicated on 11/26/25 at 9 P.M., Resident 133 was administered docusate sodium oral.The [NAME] indicated resident had a watery stool on 11/28/25 at 9 A.M.The MAR indicated on 11/28/25 at 9 P.M., Resident 133 was administered docusate sodium oral.The [NAME] indicated the resident had a watery stool on 11/29/25 at 9 A.M., and loose stool at 8:15 P.M.The MAR indicated on 11/29/25 at 9 A.M., Resident 133 was administered polyethylene glycol 3350 powder and docusate sodium oral.The [NAME] indicated the resident had a watery stool on 11/30/25 at 5:40 A.M. and putty-like stools at 2:22 P.M. and at 9:05 P.M.The MAR indicated on 11/30/25 at 9 P.M., Resident 133 was administered docusate sodium oral.The [NAME] indicated the resident had a putty-like stool on 12/1/25 at 2:59 P.M. and loose stool at 9:24 P.M.The MAR indicated on 12/1/25 at 9 P.M., Resident 133 was administered docusate sodium oral.The [NAME] indicated the resident had watery stools on 12/2/25 at 9 A.M. and 2:26 P.M.The MAR indicated on 12/2/25 at 5 P.M., Resident 133 was administered psyllium husk powder.LN 11 stated she would ask the resident about their bowel movements, if they are not alert enough to know, she would check the medical records of their last bowel movements to (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	see if they had a bowel movement. LN 11 stated Resident 133 was having loose stools, and she still gave the resident laxative medications. LN 11 stated she should have held the laxative medications for Resident 133. LN 11 stated complications from loose stool could have caused dehydration and weight loss. A review of Resident 133's MAR for November and December 2025, indicated on 11/24/25 at 9 A.M. and 1 P.M., laxatives were administered by LN 21. The MAR indicated on 11/25/25 at 5 P.M., the laxative was administered by LN 22. The MAR indicated on 11/25/25 at 5 P.M., the laxative was administered by LN 11. The MAR indicated on 11/26/25 at 9 P.M., the laxative was administered by LN 22. The MAR indicated on 11/28/25 at 9 P.M., the laxative was administered by LN 22. The MAR indicated on 11/29/25 at 9 A.M., the laxative was administered by LN 24. The MAR indicated on 11/30/25 at 9 P.M., the laxative was administered by LN 23. The MAR indicated on 12/1/25 at 9 P.M., the laxative was administered by LN 25. The MAR indicated on 12/2/25 at 5 P.M., the laxative was administered by LN 22. A review of LN in-service titled In-service Compliance Training Record dated 7/17/25 for Bristol Stool Chart and Bowel Assessment, instructed by the DON, indicated, .B. Interpretation & Clinical Significance, discuss what stool types can indicate. Diarrhea (5-7) Medication side effects (antibiotics, laxatives) . LN 22 and LN 24 were not listed on the sign in sheet as having attended in-service. LN 11, LN 21, LN 23, LN 25 attended the in-service. On 12/4/2025 at 11:23 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated licensed nurses should have asked the resident about their bowels movements, checked the PCC (point click care) dashboard that would track a resident's bowel movements, and they should have asked the CNA about the bowel movement. The DON stated the licensed nurses should have assessed first before the laxatives were administered to Resident 133. The DON stated she gave an in-service on bowel assessment and laxatives on 7/17/25 and she did not require a written posttest. A review of facility policy titled Bowel (Lower Gastrointestinal Tract) Disorders-Clinical Protocol, revised date September 2017, indicated, . Assessment and Recognition 3. In addition, the nurse shall assess and document/report the following: F. Abdominal assessment. Monitoring and Follow-up 1. The Staff and physician will monitor the individual's response to interventions and overall progress.		

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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. Based on observation, interview, and record review, the facility failed to ensure one medication cart was locked when unattended. This failure had the potential for residents and unauthorized staff to have access to the medications in the medication cart. Findings: On 12/1/25 at 2:45 P.M., an observation was conducted in the hallway by the 500 series resident rooms. A medication cart was observed unattended and unlocked. Licensed nurse (LN) 1 left a resident's room and was walking down the hall. LN 1 stated the unlocked medication cart was not assigned to her. LN 1 stated the medication cart should not have been left unsecured in the hallway. On 12/3/25 at 3:33 P.M., an interview was conducted with LN 2. LN 2 stated the unlocked medication cart that was observed on 12/1/25, was her assigned medication cart. LN 2 stated she forgot to lock the medication cart. LN 2 stated residents and unauthorized staff could have gained access to the medications that were inside the cart. LN 2 stated it was her responsibility as the assigned nurse to ensure the medication cart was locked when not in use. On 12/4/25 at 3:05 P.M., an interview was conducted with the director of nursing (DON). The administrator and regional administrator were also present. The DON stated medication carts should be locked when the assigned nurse is not present. A review of the facility's undated policy titled Medication Labeling and Storage indicated, .4. Compartments (.drawers, cabinets, rooms, refrigerators, carts.) containing medications and biologicals are locked when not in use. carts used to transport such items are not left unattended if open or otherwise potentially available to others.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure two kitchen staff (Cook 1 and cook assistant [CA]) were competent in taking final food temperatures and proper use of the thermometer. As a result of these deficient practices, there was the potential for residents' food to have been contaminated and unsafe to consume. Findings: On 12/3/25 at 10:46 A.M., an observation was conducted in the kitchen. [NAME] 1 was observed calibrating the facility's digital thermometer (orange in color) that would be used to take food temperatures. [NAME] 1 placed the thermometer into a full cup of ice water. The thermometer shut off at 33 degrees Fahrenheit (F) and did not reach 32 F. The thermometer was turned back on, and it then read 34 F and continued to increase in temperature. [NAME] 1 stated the thermometer did not calibrate. The DM provided another digital thermometer (black in color) to [NAME] 1. The second thermometer reached 32 F and calibrated with no issues. On 12/3/25 at 10:50 A.M., [NAME] 1 began to take the temperatures of the food as it was placed on the steam table using the orange digital thermometer. [NAME] 1 was asked why she was using the thermometer that did not calibrate. [NAME] 1 stated the black one was for taking the temperature of cold food. [NAME] 1 stated she always used the orange thermometer to take the temperature of hot food. The DM stated the orange thermometer was broken and should not have been used to take food temperatures. The DM instructed [NAME] 1 to use the black thermometer to take final food temperatures. On 12/3/25 at 11:25 A.M., [NAME] 1 was observed serving food. [NAME] 1 was not observed taking the final temperature of the chopped lasagna. [NAME] 1 was asked what the final temperature of the chopped lasagna was. The food temperature log was reviewed with [NAME] 1. [NAME] 1 stated she did not write down the final temperature of the chopped lasagna because there was no space to write it on the form. [NAME] 1 then stated she should have taken the temperature of the chopped lasagna before serving it. On 12/3/25 at 11:35 A.M., [NAME] Assistant (CA) was observed bringing another lasagna out from the cooking area and placing it on the steam table. CA was not observed taking the final temperature of the lasagna. On 12/3/25 at 11:45 A.M., an interview was conducted with the CA. CA 1 was asked what the final temperature of the lasagna brought out at 11:35 A.M., was. Half the lasagna had already been served. CA stated she did not write the final temperature down. CA was asked if she took the final temperature of the lasagna. CA stated, No. A review of [NAME] 1 and CA's Competencies for Food and Nutrition Services Employees (competency checklist) dated 3/12/25 and 3/13/25, indicated, .Food safety Requirements. Uses thermometers correctly to check food temperatures. Checks and records temperatures prior to service. On 12/4/25 at 9:55 A.M., an interview and record review was conducted with the DM and the registered dietitian (RD). The DM reviewed [NAME] 1 and the CA's Competencies for Food and Nutrition Services Employees. The DM stated there was no section related to thermometer calibration on the competency checklist. The RD stated there should have been a section on the Competencies for Food and Nutrition Services Employees that addressed calibrating the thermometer and what to do if the thermometer did not calibrate. The DM and RD both stated [NAME] 1 had not been competent. The DM and RD stated [NAME] 1 should have known not to use a malfunctioning thermometer that did not calibrate. The DM and RD both stated it was their expectation for final food temperatures to be taken on all food items prior to being served. The DM and RD both stated this had to be done to ensure the food was safe to serve to the residents. The DM and RD both acknowledged taking food temperatures were on both [NAME] 1 and the CA's Competencies for Food and Nutrition Services Employees. A review of the facility's policy titled Policy & Procedure Manual Personnel-General dated 2023, indicated, Policy: The food and nutrition services department will be staffed to assure that sufficient, competent, supportive personnel carry out the functions of the department.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to follow the menu during lunch service. This deficient practice had the potential for residents to not be satisfied with the food which may lead to weight loss. Findings: A review of the facility's census dated 12/1/25 indicated there were 102 residents in the facility. On 12/2/25 at 10:04 A.M., a confidential group interview was conducted with eight residents. The facility's food was discussed. The confidential group residents stated sometimes they received food that was not on the menu. The confidential group residents stated they wanted the menu to be followed. A review of the facility's lunch menu for 12/3/25 indicated, Meat lasagna, marinara sauce, garlic bread, mixed vegetables, sorbet, and 2% milk. On 12/3/25 at 11:15 A.M., an observation in the kitchen was conducted during lunch tray line. Several residents' meals were observed plated and placed in the meal cart. The plated food was observed without mixed vegetables. [NAME] 1 stated the mixed vegetables were not on the menu. [NAME] 1 stated garden salad was to be served today. The dietary manager (DM) stated [NAME] 1 was incorrect and that mixed vegetables was on the menu and should have been served. The DM stated they would start making the mixed vegetables to be served for lunch. On 12/4/25 at 9:55 A.M., an interview was conducted with the DM and the registered dietitian (RD). The DM and the RD both stated it was their expectation that the menu be followed. The DM and RD both stated residents should have been served what they expected on the menu. A review of the facility's policy titled Policy & Procedure Manual Menu Planning dated 2023, did not provide guidance related to following the menu.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow appropriate infection prevention and control practices when a nurse did not clean the blood pressure cuff in between resident uses for three of three residents (Resident 20, 85, and 132). In addition, the facility failed to properly clean and disinfect a Purewick device (an external urinary catheter) according to the manufacturer's guidelines for one resident (Resident 124). As a result of these deficient practices, the residents were placed at risk for contracting infections. Findings: 1. A review of Resident 20's admission record indicated the resident was admitted on [DATE] with diagnosis including hypertensive heart disease (a collection of heart problems that develop over time because of long-term, untreated high blood pressure) and heart failure (the heart muscle doesn't pump blood as well as it should to meet the body's needs). A review of Resident 85's admission record indicated the resident was admitted on [DATE] with diagnosis including hypertensive heart disease. A review of Resident 132's admission record indicated the resident was admitted on [DATE] with diagnosis including hypertension (high blood pressure). On 12/3/25 at 7:56 A.M., an observation of medication administration was conducted with Licensed Nurse (LN) 12. LN 12 was observed using a manual blood pressure cuff to check the blood pressure on Resident 132's arm in his room. When finished, LN 12 returned to her medication cart parked at the room entrance and placed the blood pressure cuff in the bottom left drawer of the cart without disinfecting it. On 12/3/25 at 8:12 A.M. and at 8:33 A.M., an observation of medication administration was conducted with LN 12. LN 12 continued using the same undisinfected blood pressure cuff on Resident 20 and then Resident 85. Each time LN 12 used the blood pressure cuff on a resident, she returned it to the bottom left drawer of the medication cart without disinfecting it. On 12/3/25 at 9:25 A.M., an interview with LN 11 was conducted. LN 11 stated the blood pressure cuffs should be disinfected after every use with a disinfecting cloth. On 12/3/25 at 2:52 P.M., a follow up interview was conducted with LN 12 regarding disinfection of blood pressure cuff between resident uses. LN 12 stated she should have cleaned the blood pressure cuff with the disinfecting wipes after each resident use to prevent infections. On 12/4/25 at 2:25 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that she expected her nursing staff to disinfect blood pressure cuffs after each use. The DON stated it was important for infection prevention control. A record review of the facility's policy titled Cleaning and Disinfection of Resident &ndash; Care Items and Equipment revised September 2022, indicated, .5. Reusable items are cleaned and disinfected or sterilized between residents. 2. A review of Resident 124's admission record indicated Resident 124 was admitted on [DATE] with diagnoses which included urinary tract infection and need for assistance with personal care. (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An undated Care Plan for PureWick indicated at risk for chronic urinary tract infection, urethra trauma and skin irritation related to catheter tubing use. Interventions included change PureWick nightly and apply every night before bedtime, and empty catheter cannister. A treatment order dated 11/25/25 indicated change PureWick nightly and apply every night before bedtime. A treatment order dated 11/25/25 indicated remove PureWick after breakfast. On 12/1/25 at 9:31 A.M., an interview and observation was conducted with Resident 124 in the resident's room. A clear plastic tubing was seen coming from under Resident 124's blankets draining clear yellow fluid into a cannister located at Resident 124's right side of the bed. Resident 124 stated that the device was her own PureWick that she had brought from home. Resident 124 stated she was unsure when the last time the tubing was changed. Resident 124 stated she did not know if the staff cleaned the container. On 12/3/25 at 10:52 A.M., an interview was conducted with Licensed Nurse (LN) 20. LN 20 stated Resident 124 used her own PureWick and that her family brought supplies in for her to use. LN 20 stated she was not sure when the cannister and collection tubing was cleaned and disinfected. LN 20 stated the PureWick cannister and collection tubing should have been cleaned and disinfected daily, and collection tubing should be labeled. LN 20 stated cleaning and disinfecting the PureWick cannister and collection tubing should have been done to prevent infection. On 12/3/25 at 3:35 P.M., an interview was conducted with the Infection Preventionist (IP). The IP stated the facility did not have a policy on the PureWick device. The IP stated her expectation was that the PureWick catheter collection tubing and cannister would have been cleaned and changed according to physician order. The IP stated her expectation was that the collection tubing would have been labeled in order to know when the tubing needed to be changed. A review of the Manufacturer directions of (Brand name) PureWick Female External Catheter dated 2024, indicated the collection canister, canister lid, collector tubing, and pump tubing should be cleaned and disinfected after each use. It is recommended to replace the collection canister and tubing at least every 60 days (about 2 months). Retrieved from https://PureWickathome.ca On 12/4/25 at 10:14 A.M. an interview was conducted with the IP. The IP stated that she had reviewed the PureWick manufacturers recommendations and that we needed to do better job at cleaning and disinfecting tubing and cannisters. The IP stated she found a PureWick policy, but it did not address cleaning and disinfecting. The IP stated her expectation was that the PureWick collection canister, canister lid, collector tubing, and pump tubing would be cleaned and disinfected on a daily basis according to the manufacturer's guidelines. On 12/4/25 at 3:28 P.M. an interview was conducted with the Director of Nursing (DON). The DON stated that her expectation was that the Manufacturers guidelines for PureWick Female External Catheter cleaning and disinfecting for collection canister, canister lid, collector tubing, and pump tubing would be followed. The facility policy and procedure titled PUREWICK FEMALE EXTERNAL CATHETER effective date July 1, 2022, did not address collection canister, canister lid, collector tubing, and pump tubing cleaning and disinfecting.		