STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055099	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Healthcare Center	1900 Church Lane San Pablo, CA 94806

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. (continued on next page)

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

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure three of four sampled residents (Resident 3, Resident 18, and Resident 45) Preadmission Screening and Resident Review (PASRR) were screened and referred to the appropriate state mental authority for Level II PASRR evaluation and determination.(PASRR is a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are appropriately placed in nursing homes for long term care). This failure had the potential to prevent residents from receiving appropriate required mental health services. During a review of Resident 3's Minimum Data Set (MDS-an assessment screening tool used to guide care), dated 6/19/25 the MDS indicated Resident 3 was admitted to the facility on [DATE] with diagnosis that included post-traumatic stress disorder (PTSD a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and depression. During a concurrent interview and record review on 8/7/25 at 9:32 a.m. with Director of Nursing (DON), Resident 3's PASRR Level I screen dated 6/13/25 was reviewed. PASRR Level I indicated Resident 3 did not had a diagnosis of serious mental illness. DON stated Resident 3's Level I PASRR was initiated from hospital before admission to facility. DON stated facility's process was for the Interdisciplinary Team (IDT) to review residents PASRR upon admission from the hospital and determine if there is required follow up. DON stated Resident 3's PASRR Level I was not accurately screened or referred to the appropriate state mental authority for Level II PASRR evaluation and determination.(IDT-an interdisciplinary team is a group of professionals from different fields who collaborate to address complex needs, often in healthcare or other specialized settings). During a review of Resident 18's Minimum Data Set (MDS-an assessment screening tool used to guide care), dated 5/26/25 the MDS indicated Resident 18 was admitted to the facility on [DATE] with diagnosis that included psychotic disorder (a mental disorder characterized by a disconnection from reality) and anxiety a mental health disorder characterized by feeling of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and depression. During a concurrent interview and record review on 8/6/25 at 8:43 a.m. with DON, Resident 18's PASRR Level I screen dated 9/16/24 was reviewed. PASRR Level I indicated Resident 18 did not have a serious mental illness or a diagnosis of serious mental illness. DON stated Resident 18's Level I PASRR was not accurately screened. DON stated it was important to make sure PASRRs accurately reflect residents' mental health conditions in order for Resident 18 to receive necessary supporting care.During a review of Resident 45's MDS, dated [DATE], the MDS indicated Resident 45 was admitted to the facility on [DATE] with diagnosis that included depression and schizophrenia (a mental disorder that affects a person's ability to think, feel, and behave clearly). During a concurrent interview and record review on 8/7/25 at 9:49 a. m. with DON, Resident 45's PASRR Level I screen dated 8/16/21 was reviewed. PASRR Level I indicated Resident 45 required a Level II mental health evaluation and referral. DON stated Resident 45 was not rescreened and referred to the appropriate state mental authority for Level II PASRR evaluation and determination.During a review of the facility's policy and procedure (P&P) titled, PASSR, undated, the P&P indicated, The facility's designated staff will review the PASSR from the acute hospital and determine if there is a required follow-up i.e., Level II referral, etc.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to provide routine medications to meet the needs of one of two sampled residents (Resident 62) and ensured controlled medications (those with high potential for abuse and addiction) were accurately reconciled for two of three sampled residents (Resident 3 and 39) when:1.Resident 62's basaglar insulin (medication used to help manage blood sugar levels) and epogen (medication used to treat anemia, a condition where the blood doesn't carry enough oxygen to the rest of the body) were not available for administration. These failures resulted in Resident 62 to not receive medications as ordered by the physician.2.Resident 3 and 39's controlled drug records were documented illegibly. These failures resulted in inaccurate accountability of controlled medications and potential for misuse or diversion (illegal distribution or abuse of prescription drugs or their use for purpose not intended by the prescriber) of controlled medications.1. During a review of Resident 62's Face Sheet, printed on 8/6/25, the Face Sheet indicated Resident 62 was admitted in the facility on 12/6/24 with a diagnosis of diabetes mellitus (a condition where blood sugar levels are too high) and anemia (a condition where the blood doesn't carry enough oxygen to the rest of the body).During a concurrent medication administration observation and interview on 8/5/25 at 9:00 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 was observed preparing and administering 12 out of 14 scheduled medications for Resident 62. LVN 1 stated Resident 62's basaglar insulin and epogen medications were not available. LVN 1 stated basaglar insulin and epogen medications were usually stored in the medication room refrigerator.During a concurrent observation and interview on 8/5/25 at 9:30 a.m. with LVN 1 in the medication room, LVN 1 unlocked the medication room refrigerator and searched for Resident 62's basaglar insulin and epogen medication. LVN 1 stated Resident 62's basaglar insulin and epogen were not in the refrigerator.During a review of Resident 62's Physician Order Report, dated 8/4/25, the Physician Order Report indicated Resident 62 had an order to receive seven units of basaglar insulin once a day at 9:00 a.m. for diabetes mellitus.During a review of Resident 62's Medication Administration History dated 8/5/25, the Medication Administration History indicated, Resident 62's basaglar insulin was not available and not administered.During a concurrent interview and record review on 8/6/25 at 11:48 a.m. with Registered Nurse (RN) 1, Resident 62's Progress Notes, dated 8/5/25 was reviewed. The Progress Notes indicated, Resident 62's epogen medication was denied by the insurance and RN 1 requested for a STAT delivery (medication to be delivered within a specific timeframe) from the pharmacy at 11:26 a.m. RN 1 stated STAT medication delivery were expected to be delivered within four hours from the time it was requested.During a review of Resident 62's Progress Notes, dated 8/5/25, the Progress Notes indicated, Resident 62's epogen medication delivery was followed up by RN 1 from the pharmacy at 5:51 p.m.During a review of Resident 62's Medication Administration History dated 7/8/25, 7/10/25, 7/12/15, 7/17/25, 7/19/25, 7/24/25, 7/26/25, 7/31/25, the Medication Administration History indicated, Resident 62's epogen medication were scheduled to be administered at 9:00 a.m. but were not available and were not administered.During a review of the facility's policy and procedure (P&P) titled, Medication Pass Guidelines, undated, the P&P indicated, To assure the most complete and accurate implementation of physicians' medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate, safe, timely manner . Medications are administered in accordance with written orders of the attending physician . 6. Administer medications within 60 minutes of the scheduled time. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the company.2a. During a review of Resident 3's Face Sheet, printed on 8/6/25, the Face Sheet indicated Resident 3 was admitted in the facility on 6/13/25 with a diagnosis of chronic pain syndrome (pain that lasts for over three months). During a concurrent interview and record review on 8/6/25 at 10:43 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 3's undated Norco (controlled medication to relieve pain) Controlled Drug Record (an inventory sheet that keeps record of the usage of controlled medications) was reviewed. The Controlled Drug Record indicated, the documented date, time and signature of the 12th dose of Norco had multiple black lines across the numbers and letters. LVN 2 stated one line across the date, time and signature should have been made for documentation error. LVN 2 stated the nurse who made the documentation error should have written their initials next to the line.2b. During a review of Resident 39's Face Sheet, printed on 8/6/25, the Face Sheet indicated Resident 39 was admitted in the facility on 7/11/25 with a diagnosis of diverticulitis (condition where pouches in the lining of the colon become inflamed or infected) of large intestine During a

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to ensure infection control practices were observed by one of one sampled laundry staff (LS) when the LS was not wearing a gown while moving soiled linen from the soiled linen hamper in to the washer.This failure had the potential for cross contamination and spread of infections among 72 residents at the facility.During a concurrent observation and interview on 8/7/25 at 10:09 a.m. with the LS and Certified Nursing Assistant (CNA) 1 in the laundry room, the LS was observed grasping soiled linen from the hamper in to the washer only with gloved hands. The LS stated she had never used a gown or was told to use a gown when putting the dirty linen in to the machine. The LS stated wearing the gown could protect staff and other residents from the spread of infection. During a concurrent observation and interview on 8/7/25 at 10:15 a.m. with the Laundry Staff Supervisor (LSS) in the laundry room, the LS continued to move the soiled linen from the hamper in to the washer with only gloved hands. The LSS stated gown should be worn all the time when picking dirty linen from the hamper. The LSS stated some laundry staff would wear a gown and some would not. The LSS stated wearing a gown made other laundry staff feeling hot. During a review of facility's policy and procedure (P&P) titled, Soiled Linen Collection and Transfer, undated, the P&P indicated, Soiled linen should not be carried against clothing when transporting . Put on personal protective equipment (PPE - refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission) before handling soiled linen or clothing.