STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055557	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Post Acute	35253 Avenue H Yucaipa, CA 92399

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their Medication Administration policy and procedure for one (1) of three (3) sampled residents (Resident 1) when Resident 1's scheduled dose for 8:00 PM to 10:00 PM medications were not recorded as administered on Resident 1's Medical Administration Record (MAR) on December 31, 2025. This failure has the potential for Resident 1 to be at risk of overdose or missed doses.Findings: A review of Resident 1's face sheet (contains demographic and medical information) indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included Idiopathic Pulmonary Fibrosis (IPF- a serious lung disease where the lungs scar and stiffen, making it hard to breathe), and chronic respiratory failure with hypoxia (lungs aren't doing their job well enough to keep your body supplied with oxygen and clear out waster (Carbon dioxide)). A review of Resident 1's MAR for the month of December 2025 indicated multiple scheduled medications between 8:00 PM and 10:00 PM had no nursing signature or documentation to indicate that it was administered. The medications that had missing signatures were as follows: 1. Losartan Potassium Oral Tablet 50 mg (milligram - unit of measurement) - Give 1 tablet by mouth every 12 hours for hypertension (high blood pressure). (Scheduled to be administered at 8:00 PM.)2. Atorvastatin Calcium Oral Tablet 80 mg - Give 1 tablet by mouth at bedtime for hyperlipidemia (high levels of fat in the blood). (Scheduled to be administered at 9:00 PM.)3. Ezetimibe Oral Tablet 10 mg - Give 1 tablet by mouth at bedtime for hyperlipidemia. (Scheduled to be administered at 9:00 PM.)4. Amlodipine Besylate Oral Tablet 5 mg - Give 1 tablet by mouth every 12 hours for hypertension. (Scheduled to be administered at 9:00 PM.) 5. Carvedilol Oral Tablet 25 mg - Give 1 tablet by mouth every 12 hours for hypertension. (Scheduled to be administered at 9:00 PM.) 6. Pro-Stat Oral Liquid - Give 30 mL (milliliter - unit of measurement) by mouth every 12 hours for supplementation. (Scheduled to be administered at 9:00 PM.) 7. Ticagrelor Oral Tablet 90 mg - Give 1 tablet by mouth every 12 hours for DVT (Deep Vein Thrombosis - formation of blood cloth) prophylaxis (prevention). (Scheduled to be administered at 9:00 PM.) 8. Gabapentin Capsule 100 mg - Give 1 capsule by mouth every 8 hours for neuropathic pain (chronic condition caused by damage or disease affecting the somatosensory nervous system, resulting in abnormal sensations). (Scheduled to be administered at 9:00 PM.) 9. Pirfenidone Oral Tablet 801 mg, to be administered one tablet by mouth every 8 hours for respiratory failure, at 6:00 AM, 2:00 PM, 10:00 PM. (Scheduled to be administered at 10:00 PM.) During a concurrent telephone interview and record review with the Director of Nursing (DON), on January 20, 2026, at 12:16 PM, the DON reviewed Resident 1's MAR for the month of December 2025 and confirmed there was no documentation that Resident 1 received his scheduled dose for 8:00 PM to 10:00 PM medications on December 31, 2025. During a telephone interview on January 20, 2026, at 1:29 PM, with the License Vocational Nurse (LVN 1), LVN 1 stated he administered all of Resident 1's scheduled 8:00 PM to 10:00 PM medications on December 31, 2025, but he forgot to document it on Resident 1's MAR. He (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged that he should have signed the MAR immediately after administering the medication rather than waiting until the end of his shift. A review of the facility's undated policy and procedure titled, VIII. Specific Medication Administration Procedure, indicated, After administration, return to cart and document administration in Medication Administration Record (MAR) or Treatment Administration Record (TAR). A review of the facility's policy and procedure titled, Medication Administration, revised on January 16, 2026, indicated, .7. The Licensed nurse administering the medication must record such administration of medication in the medication administration record. (EMAR).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medication was administered in accordance with the facility's policies and procedures (P&P) for one (1) of three (3) sampled residents (Resident 1) when Resident 1 did not receive his medication, Pirfenidone (a medication for Idiopathic Pulmonary Fibrosis (IPF- a serious lung disease where the lungs scar and stiffen, making it hard to breathe), on three occasions, December 26, 2025 at 2:00 PM, December 27, 2025, at 2:00 PM, and December 28, 2025, at 10:00 PM. This failure had the potential to place Resident 1 at risk for adverse effect such as a return or worsening of idiopathic pulmonary fibrosis (IPF) symptoms, which includes shortness of breath, extreme tiredness, and dry hacking cough.Findings: A review of Resident 1's face sheet (contains demographic and medical information) indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included IPF, and chronic respiratory failure (long-term condition where the lungs gradually become unable to get enough oxygen into the blood or remove enough carbon dioxide) with hypoxia (low levels of oxygen in the body). A review of Resident 1's physician's order, dated December 21, 2025, indicated Resident 1 had an order to receive Pirfenidone Oral Tablet 801 mg (milligram-unit of measurement) one tablet by mouth every 8 hours, 6:00 AM, 2:00 PM, and 10:00 PM. A review of Resident 1's Medication Administration Record (MAR) for the month of December 2025, indicated Resident 1 did not receive his medication, Pirfenidone, on three occasions, December 26, at 2:00 PM, December 27, at 2:00 PM, and December 28, at 10:00 PM. During a concurrent interview and record review on January 15, 2026, at 2:24 PM, with License Vocational Nurse (LVN 1), LVN 1 reviewed Resident 1's MAR for the month of December 2025 and stated he did not administer Resident 1's Pirfenidone on two occasions, December 26, 2025, at 2 PM, and December 27, 2025, at 2 PM. He further stated he did not find the medication in the cart, and he did not check with the previous nurse to see if the medication was available. During an interview on January 15, 2026, at 2:52 PM, with the Director of Nursing (DON), the DON stated her expectation was for communication between nurses to take place during shift changes, which unfortunately did not occur, leading to Resident 1 not receiving his medication as prescribed, an outcome that is deemed unacceptable. She acknowledged that it was the facility's duty to guarantee that medications were administered according to the prescribed orders. During a telephone interview on January 16, 2026, at 5:36 PM, with LVN 2, LVN 2 stated she did not administer Resident 1's Pirfenidone on December 28, 2025, at 10:00 PM because she was unable to locate the medication in the cart. A review of facility Policy and Procedures (P&P) titled, Medication Administration, reviewed January 16, 2026, indicated, .Medications must be administered in accordance with the written orders of the attending physician.