

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055557	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Creekside Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to ensure adequate supervision was provided for one of three sampled residents (Resident 1) when Resident 1 fell out of bed during wound care treatment. This failure resulted in Resident 1 falling off the bed, placing his safety at risk. During a review of Resident 1's admission Records (general demographics information), the admission Records indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included quadriplegia (partial or total loss of sensory or motor function), respiratory failure (lungs cannot supply oxygen), type 2 diabetes mellitus (body has trouble controlling blood sugar) and pressure ulcer on the left hip (wound to hip). During a review of Resident 1's Minimum Data Set (MDS - clinical assessment tool used in nursing homes that serves as a comprehensive summary of a resident's functional capabilities, health conditions, and care needs.) Section GG Functional Abilities, dated March 25, 2026, the MDS Section GG Functional Abilities indicated, Code 2 (Impairment on both sides) . A. Upper Extremities (shoulder, elbow, wrist, hand) Code 2 given. B. Lower Extremities (hip, knee, ankle, foot) Code 2 given. During a review of Resident 1's Fall Risk Evaluation (clinical assessment tool used to evaluate an individual's likelihood of falling) from October 14, 2025, to June 6, 2026, the Fall Risk Evaluation indicated Resident 1 as High Risk for fall on June 06, 2026 , with 1-2 Falls in the past 3 months. During a review of Resident 1's Care plan (identifies the patient's physical, psychosocial and emotional needs to target goals and interventions), the Care plan indicated The resident [Resident 1] has little or no activity involvement related to physical limitations. The resident [Resident 1] has Activities of Daily Living (ADLS) (physical task of daily life) self-care performance deficit related to activity intolerance. resident [Resident 1] totally dependent on staff. Resident [Resident 1] is at risk for falls and injury related to impaired mobility. need for assistance with care and treatments, sudden involuntary movements (coughing episodes) requirement for bedside procedures. During a review of Resident 1's Situation Background Assessment Recommendation (SBAR - assessment tool to communicate with physician about patients) notes, dated June 06, 2026, at 2:19 PM, the SBAR indicated Resident [Resident 1] experienced a witnessed fall-related incident during wound care treatment. Resident [Resident 1] was positioned on her left side, facing patio door in the center of the bed when a sudden coughing episode caused an abrupt movement toward the edge of the bed. During the incident, resident [Resident 1] struck her head on the nightstand, sustaining an open area above the right eyebrow. Wound care [Txt nurse 1] nurse immediately intervened and assisted resident [Resident 1] to the floor. Resident [Resident 1] complained of pain following the incident. Upon assessment, resident [Resident 1] sustained an open area/laceration to the right side of the head with bleeding noted. Bleeding was controlled with pressure. Resident [Resident 1]'s gastrostomy tube (G-tube - feeding tube provided directly to stomach) was also noted to be dislodged. Resident [Resident 1] exhibited signs and symptoms of pain including moaning, facial grimacing, and muscle tension following the incident. the resident [Resident 1] was transferred to the Emergency Department for a higher level of care (Resident 1 required services provided at a hospital). During a review of Resident 1' emergency room Visit Notes dated June 06, 2026, at 3:33 PM, stated, Visit for (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055557	Facility ID: 055557 If continuation sheet Page 1 of 2

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fall, dislodged gastrostomy tube. No fractures. During an interview on June 24, 2026, at 12:32 PM, with Certified Nursing Assistant (can 1), CNA 1 stated, Resident 1 was total care (requires complete assistance with all activities) and was not able to assist with turning and repositioning. CNA 1 further stated, When wound treatment is done, the treatment nurse will call us to assist with the turning. During an interview on June 24, 2026, at 2:04 PM, with Certified Nursing Assistant (CNA 2), CNA 2 stated she helped Txt nurse 1 with Resident 1's treatment of the sacral wound. CNA 2 stated she asked Txt nurse 1 if she could perform wound care on Resident 1's foot by herself and she agreed. CNA 2 further stated she then stepped out of the room to attend to another resident, leaving Resident 1 lying on her side with Txt nurse 1 at bedside. CNA 2 stated when she went back into Resident 1's room, Resident 1 was on the floor, unable to hold the grab bar (a short rail attached to the bed for patients to grab and reposition or transfer). During an interview on June 24, 2026, at 12:43 PM, with License Vocational Nurse (LVN), LVN stated, Resident 1 required a two-person assist during care. LVN1 further stated, If the Treatment nurse did the wound treatments by themselves, it's not safe. This resident [Resident 1] is not able to assist while turning or providing care. LVN 1 stated, Regarding the fall, I think gravity took over due to her [Resident 1] knees, they are contracted. Her [Resident 1] knees will be over the bed on the other side, and it took her down. During an interview on June 24, 2026, at 12:56 PM, with Treatment Nurse (Txt nurse 2), the Txt nurse 2 stated, I do my wound treatments with the CNA. I was told this resident had a fall and the other wound treatment nurse [Txt nurse 1] was by himself doing the treatments when this happened. Txt nurse 2 stated Resident 1 was contracted to arms and lower extremities and it was safe to have 2 staff members present while providing wound care because Resident 1 also had an air mattress (inflates air to prevent and heal tissue damage and makes it easier for the residents to slide off), Resident 1 was not able to assist with the care. During an interview on June 24, 2026, at 1:26 PM, with the Director of Nursing (DON), the DON stated, Resident 1 was fully dependent and her knees are contracted. The nurse did state he had someone for the other wounds but not the ankle. She should not have fallen, and yes, she did have a fall. During a review of the facility's policy and procedure (P&P) titled, Fall Management, dated January 2026, the P&P indicated, This facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible, Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision, assistive devices and functional programs as appropriate to prevent accidents.		