

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

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Form Approved OMB
No. 0938-0391

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 07/15/2026
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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility failed to ensure the physician was notified of an abnormal laboratory results for one of five sampled residents (Resident 1) when a sputum culture (a laboratory test performed on mucus coughed up from the lungs or airways to identified the type of infection) results showed heavy growth (a large of bacteria grew from the sputum) of extended-spectrum beta-lactamase (ESBL - producing <i>Klebsiella pneumoniae</i>, a type of bacteria that can cause infection and is resistant to many commonly used antibiotics) received on June 23, 2026. This failure placed Resident 1 at risk for delayed medical evaluation and treatment of a potentially serious respiratory infection (a severe infection affecting the lungs or airways that, if worsens or spreads, may lead to a serious complications.) Findings: During a review of Resident 1's admission Record (contains demographic and medical information), it indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included gastrostomy status (feeding tube placed through the abdominal wall into the stomach for nutrition and medications), chronic respiratory failure with hypoxia (a condition where the lungs cannot provide enough oxygen) and nontraumatic subdural hematoma (leading beneath the covering of the brain that can impair brain function). During a review of Resident 1's Sputum Culture report, dated June 23, 2026, the report indicated, the sputum specimen culture was collected on June 15, 2026, at 6:59 PM. The final, updated result was approved on June 23, 2026, at 10:29 AM. The report indicated, Critical SPUTUM CULTURE called to [name and title of the nurse who received the result] on June 23, 2026, at 10:53 AM. Final (Test). Extended spectrum beta-lactamase producing <i>klebsiella pneumoniae</i>. Growth. Heavy growth. During a telephone interview on July 27, 2026, at 4:30 PM, with the Operations Manager, (OM) the OM stated that when the facility staff receives a new critical infection-related laboratory result, the physician should be notified. The OM stated that the laboratory result and physician notification should be documented in the nursing progress notes. The infection preventionist should also be notified, and a change of condition (COC - a tool used by healthcare staff to quickly communicate a resident's change in condition to the provider) should be initiated when the results represent a new condition. The OM was unable to confirm what actions were taken regarding Resident 1's critical sputum culture result. During a review of the SBAR- Change of Condition Report (COC) dated June 25, 2026 5:30 AM, the COC indicated, 2. Situation concern (s) G-tube dislodged. (a feeding tube move out of the stomach.) C. Assessment. Patient was sent to hospital regarding G-tube dislodgement. Pt (patient) otherwise stable. The COC did not identify the June 23, 2026, critical sputum - culture result. During a review of Resident 1's Nursing Progress Notes, dated from June 8, 2026, through July 1, 2026, the Nursing Progress Notes, did not show documentation that the attending physician or pulmonologist was notified of the critical sputum culture result showing heavy growth of extended-spectrum (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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	beta-lactamase (ESBL) - producing klebsiella pneumoniae. There was no documented evidence in the Nursing Progress Notes that a follow - up instructions or treatment orders were obtained in response to the critical sputum result. During a concurrent telephone interview and record review on July 28, 2026, at 12:42 PM, with the Director of Nursing (DON), Resident 1's laboratory report for the Sputum Culture collected on June 15, 2026, and resulted on June 23, 2026, was reviewed. The laboratory test result indicated, ESBL - producing Klebsiella pneumoniae. The DON stated that, in this instance, the pulmonologist should have been notified, and a COC should have been completed. The DON further stated the facility's expectation was for critical laboratory findings to be reported to the physician immediately. During a concurrent telephone interview and record review on July 28, 2026, at 12:46, with the DON, Resident 1's SBAR - Change of Condition Report (COC) dated June 25, 2026, at 5:30 AM, was reviewed. The DON confirmed that the resident was transferred to the hospital on June 25, 2026 for G-tube dislodgment. The COC did not identify or address the June 23, 2026, sputum culture result indicating ESBL - producing Klebsiella pneumoniae. The DON stated that when the facility receives an abnormal or critical laboratory result, nursing staff are expected to assess the resident and to notify the physician and the pulmonologist. The DON stated that a COC addressing the sputum culture result should have been completed and reported to the physician immediately. During a concurrent record review and telephone interview on July 28, 2026, at 12:48 PM, the facility's policy and procedure titled Laboratory Testing Reviewed: January 16, 2026, was reviewed with the DON. The policy indicated, it is the policy of this facility to obtain laboratory services when ordered by a physician, PA, NP or clinical nurse specialist and to promptly notify the ordering entity of test results., Procedures.,2. Results of laboratory.,and diagnostic test outside the clinical reference ranges shall be reported to the resident's attending physician, PA, (physician assistant), NP (nurse practitioner) or clinical nurse specialist promptly or as specified in the order. 3. Notification of test results will be documented in the resident's clinical record. 4. Results of all diagnostic services shall be made a part of the resident's medical record. The DON stated, It doesn't look like we followed that policy.		