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	07/18/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide evidence staff discussed with two of seven residents (Resident 7 and 54) whether the residents had an existing advance directive (a legal document that explains how an individual wants medical decisions to be made if the individual is incapable of making their own decisions) and were educated on their rights to establish a new advance directive if desired.This failure had the potential for Residents 7 and 54 to receive end of life care not in accordance with their wishes and for life sustaining measures to be rendered against what the residents (or their representatives) wanted.1. A review of Resident 7’s “admission Record” (contains medical and demographic information) indicated Resident 7 was admitted on [DATE], with diagnoses which included acute respiratory failure with hypoxia (a condition where the lungs cannot adequately oxygenate the blood, leading to dangerously low levels of oxygen in the body), cirrhosis of liver (a condition where scar tissue replaces healthy liver tissue due to long-term liver damage), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and a loss of interest) and tracheostomy status (medical condition of a person who has undergone a tracheostomy, a surgical procedure creating an opening in the trachea (windpipe) to facilitate breathing). During a review of Resident 7’s Electronic Health Record (EHR – electronic version of medical records), there was no documented evidence of whether or not Resident 7 had an existing advance directive and no documented evidence that Resident 7 had been informed about his right to formulate an advance directive. During a review of Resident 7’s undated “Physician’s Order for Life Sustaining Treatment” (POLST - written medical orders that addresses a limited number of critical medical decisions), it indicated under Section “D” (section regarding whether or not the resident had an existing advance directive or not) was left blank. During a concurrent interview and record review on July 18, 2025, at 11:51 AM, with the Corporate Medical Records Resource (CMRR), the CMRR stated she reviewed Resident 7’s medical records and was unable to find documented evidence to indicate whether or not Resident 7 or his representative had an advance directive or was provided information regarding the right to formulate an advance directive. The CMRR then reviewed Resident 7’s undated “POLST,” and acknowledged it was blank under section “D” regarding advance directives. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility’s policy and procedure titled, “Advance Directives,” dated January 25, 2025, the policy indicated, “The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy…1. If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives…b. Nursing staff will document in the medical record the offer to assist and the residents decision to accept or decline assistance…2. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff…” 2. During a review of Resident 54’s medical record, the “admission Record, it indicated Resident 54 was admitted to the facility on [DATE], with diagnoses which included traumatic hemorrhage of cerebrum (bleeding within the brain tissue itself, resulting from an injury to the head), and chronic respiratory failure with hypoxia (the lungs' inability to adequately oxygenate the blood over an extended period). During a concurrent interview and record review on July 17, 2025, at 1:14 PM, with the Interim Director of Nursing (IDON), the IDON reviewed Resident 54’s clinical record and stated there was no documentation of Resident 54 and/or the representative being offered assistance to accept or decline the establishing of an advanced directive. During a concurrent interview and record review on July 17, 2025, at 1:14 PM, with the IDON, the facility’s policy and procedure (P&P) titled, “Advance Directives,” dated January 25, 2025, was reviewed. The P&P indicated, “ .1. if the resident or representative indicates that he or she has not established advanced directives, the facility staff will offer assistance in the establishing advanced directives…1a. the resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision…1b. Nursing staff will document in the medical record the offer to assist and the residents decision to accept or decline assistance .”. The IDON stated the policy was not followed.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS- a computerized assessment instrument) Assessment was accurately completed to reflect the resident's status, care, and services for one of five sampled residents (Resident 2) reviewed for MDS, when Resident 2's schizophrenia diagnosis (a chronic and severe mental health disorder that affects how a person thinks, feels, and behaves) was not accurately coded on Resident 2's quarterly Minimum Data Set (a standardized, federally mandated evaluation of nursing home residents' health status, conducted every three months or more frequently if there's a significant change in condition) assessment. This failure had the potential to cause inaccuracy in identifying Resident 2's care and support needs.During a review of Resident 2's admission Record (contains demographic and medical information), it indicated Resident 2 was admitted to the facility on [DATE], with diagnoses of acute and chronic respiratory failure with hypoxia (when the lungs cannot adequately oxygenate the blood, leading to dangerously low levels of oxygen in the body), leukopenia (decrease white blood cell count), hypothyroidism (when your thyroid gland doesn't make and release enough hormone into your bloodstream), and schizophrenia. During a review of Resident 2's Quarterly MDS, dated [DATE], under the Section I (Active Diagnosis), it indicated Resident 2 did not have a schizophrenia diagnosis. During a review of Resident 2's Psychiatrist Assessment (a process of gathering information to diagnose and develop a treatment plan for a person experiencing mental health challenges), dated February 17, 2024, November 12, 2024, December 5, 2024, and June 20, 2025, it indicated Resident 2 had a diagnosis of schizophrenia, and was being evaluated and monitored for it. During a concurrent interview and record review on July 17, 2025, at 1:24 PM, with the Minimum Data Set Nurse (RN 2), RN 2 reviewed Resident 2's Quarterly MDS Assessment dated May 16, 2024, and stated Resident 2's active diagnosis for schizophrenia should have been coded.During a concurrent interview and record review on July 17, 2025, at 2:05 PM, with the Interim Director of Nursing (IDON), the facility's policy and procedure (P&P) titled, Accuracy of Assessment (MDS 3. 0), dated January 25, 2025, was reviewed. The P&P indicated, It is the policy of this facility to ensure that the assessment accurately reflects the resident's status . The IDON stated the policy was not followed. The IDON further stated it was important for the MDS to be accurately coded to make sure the care and support for the resident was accurate.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASARR - federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) was re-submitted for one of five sampled residents reviewed for PASARR Assessment (Resident 2).This failure had the potential to result in Resident 2 not being accurately assessed regarding supplemental treatment and services to better meet the needs of the resident.During a review of Resident 2's admission Record (contains medical and demographic information), it indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included schizophrenia, respiratory failure (when the lungs cannot adequately oxygenate the blood or remove carbon dioxide, leading to hypoxia (low oxygen) and/or hypercapnia (high carbon dioxide), and hypothyroidism (when the thyroid gland doesn't make and release enough hormone into your bloodstream). During a review of Resident 2's Psychiatrist Assessment, dated February 17, 2024, eight days after Resident 2's admission, the assessment indicated Resident 2 was diagnosed with schizophrenia. During a review of Resident 2's clinical record, there was no documented evidence to indicate Resident 2's PASARR was updated and re-submitted to reflect his diagnosis of schizophrenia. During a concurrent interview and record review on July 17, 2025, at 1:24 PM, with the Minimum Data Set Nurse (RN 2), RN 2 reviewed Resident 2 clinical records and stated it was her responsibility to update and re-submit the PASARR when there were any new diagnoses. RN 2 further stated she did not update and re-submit a new PASARR Assessment Level 1 for Resident 2 when she should have. During a review of the facility's policy and procedure (P&P) titled, PASRR Completion Policy, dated January 25, 2025, it indicated, The center will make sure that all admissions have the appropriate Patient Assessment and Resident Review (PASRR) completed.3. Administrator is accountable for monitoring the process of completing the necessary paperwork for the admission.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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 07/18/2025

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one resident (Resident 4) reviewed for pressure ulcers (a localized injury to the skin and/or underlying tissue resulting from pressure on the skin) received care for skin breakdown as specified in the resident's care plan (an individualized plan for the medical care of a resident) and physician's orders when there was no documented evidence to indicate Resident 4 received physician ordered wound care treatment for multiple days in May, June, and July 2025. This failure had the potential for Resident 4 to experience worsening pressure ulcer wounds and delayed wound healing.A review of Resident 4's admission Record (contains medical and demographic information), indicated Resident 4 was initially admitted on [DATE], with diagnoses which included cerebral palsy (a neurological disorder that affects movement, posture, and muscle tone), multiple sclerosis (a condition that affects your brain and spinal cord [central nervous system]), and epilepsy (seizure disorder).During a review of Resident 4's care plan, titled Sacrum [triangular bone at the base of the spine] stage 4 pressure injury [a pressure ulcer that has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints], dated May 20, 2025, it indicated, .goal - The resident's pressure ulcer will show signs of healing.interventions.administer treatments as ordered and monitor for effectiveness.During a review of Resident 4's care plan titled, Left malleolus [bony prominence on outside of the left ankle] stage 3 pressure injury [a pressure ulcer that extends through the skin tissues and into the fat layers], dated May 20, 2025, it indicated, .goal - The resident's pressure ulcer will show signs of healing.interventions.Administer treatments as ordered and monitor for effectiveness.During a review of Resident 4's care plan titled, Right lateral foot [outer aspect of right ankle] unstageable pressure injury/neuropathy [a pressure sore which has dead or non-viable tissue inside it which does not allow for pressure sore staging], dated July 8, 2025, the care plan indicated, .goal - The resident's pressure ulcer will show signs of healing.interventions.administer treatments as ordered and monitor for effectiveness.During a review of Resident 4's Treatment Administration Record (TAR - a document used by staff to record treatments administered to the resident) for the month of May 2025, it indicated the following:-For the resident's left malleolus pressure ulcer, there was a physician's order to .cleanse with NS [normal saline], pat dry, Therahoney [a honey based wound dressing], 4x4 foam dressing [a type of wound dressing] every day shift for 21 days. Upon further review of the TAR, there was no documented evidence indicating treatment had been provided to the resident on the days of May 4,11, and 20th, of 2025.-For the resident's sacrum pressure ulcer, there was a physician's order to .cleanse with NS, pat dry, Therahoney, 4x4 foam dressing every day shift for 21 days. Upon further review of the TAR, there was no documented evidence indicating treatment had been provided to the resident on the days of May 4,11, and 20, of 2025-A physician's order dated March 18, 2025, indicated, low air loss mattress [a specialized mattress which utilizes air to help prevent and treat pressure wounds] for tissue load management. Check placement, motor and setting every shift for preventive measures. Upon further review of the TAR, there was no documented evidence indicating the low air loss mattress was checked by staff on the day shift of May 4, and 11, 2025, and the evening shift of May 16, 19, 21, 22, 26, 27, and 28, of 2025. During a review of Resident 4's TAR for the month of June 2025, it indicated the following:-For the resident's sacrum pressure ulcer, there was a physician's order to .cleanse with NS, pat dry, Santyl [an ointment used to remove dead tissue from a wound], pack with packing strip [a type of gauze], 4x4 foam dressing every day shift for 21 days. Upon further review of the TAR, there was no documented evidence indicating treatment had been provided to the resident on the days of June 8, and 11, of 2025.- A physician's order dated March 18, 2025, indicated, low air loss mattress for tissue load management. Check placement, motor and setting every shift for preventive measures. Upon further review of the TAR, there was no documented evidence indicating the low air loss mattress was checked by staff on the evening shift of June 7, 10, 16, and 17, of 2025.During a review of Resident 4's TAR, dated July 2025, it indicated the following:- A physician's order dated March 18, 2025, indicated, low air loss mattress for tissue load management. Check placement, motor and setting every shift for preventive measures. Upon further review of the TAR, there was no documented evidence indicating the low air loss mattress was checked by staff on the evening shift of July 5, 6, 7, 10, 11, 15, and 16, of 2025.During a concurrent interview and record review on July 18, 2025, at 2:05 PM, with the Interim Director of Nursing (IDON), Resident 4's TARs for the months May, June, and July 2025, were reviewed. The IDON acknowledged there were multiple days in which there was no documentation Resident

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	07/18/2025

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Creekside Post Acute	35253 Avenue H Yucaipa, CA 92399

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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. (continued on next page)

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	055557	A. Building B. Wing	07/18/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two residents (Resident 43) reviewed for environment/accidents was free from accident hazards when Resident 43 fell from bed while receiving care from a Certified Nursing Assistant (CNA) on April 22, 2025.This failure may have contributed to Resident 43 to experience uncontrolled pain in the resident's coccyx area (often referred to as the tailbone, a small bone at the base of the spine) which resulted in the resident needing treatment and evaluation at a hospital.A review of Resident 43's admission Record (contains medical and demographic information), indicated Resident 43 was initially admitted on [DATE], with diagnoses which included osteomyelitis of vertebra (infection of the spine), dependence on respirator [ventilator] (ventilator- a machine which helps a person to breathe) status (refers to a patience reliance on a mechanical ventilator to breathe due to impaired lung function).During a review of Resident 43's Minimum Data Set Assessment (MDS assessment - a comprehensive assessment of a residents functioning status), dated April 4, 2025, the assessment indicated Resident 43 had impairment in both her upper and lower extremities (arm and leg) on one side of her body and was dependent upon staff when rolling left to right and right to left while in bed. During a review of Resident 43's Fall Risk Assessment (a scored assessment used to determine fall risk of a resident), dated March 28, 2025, the assessment indicated Resident 43 was, disoriented x 3 [disoriented to three of the following categories: person, place, time, situation] at all times and the resident was High Risk for falls.During a review of Resident 43's nursing progress note, dated April 22, 2025, the progress note indicated, CNA was in the process of changing Pt [patient] Pt was turned to her right, laying on her left. Pt turned further, and fell off the left side of the bed. Landed on her knees, then on to her coccyx.During a review of Resident 43's nursing progress note, dated April 22, 2025, the progress note indicated, N.O. [new order] received by NP [nurse practitioner] .transfer out to ER [emergency room] r/t [related to] uncontrolled back pain s/p [status post] fall.During a review of Resident 43's respiratory therapy progress note, dated April 22, 2025, the progress note indicated, Pt left with [name of ambulance company] .due to severe back pain after falling out of bed.During a review of Resident 43's Interdisciplinary Team note (IDT - a team of healthcare professionals from different disciplines working together to provide patient care), dated April 22, 2025, the IDT note indicated, Witnessed fall.root cause analysis, what was the root cause identified by IDT? CNA miscalculated pt's roll during her brief change.During a review of Resident 43's IDT note tilted, Post Fall Review, dated April 23, 2025, the review indicated, After investigation, it was concluded that while CNA was in the process of providing care to resident. CNA repositioned resident to have her laying on her left side of the bed and did not notice resident being too close to the edge of the bed at time of repositioning that resident rolled off the bed and landed on her knees and her coccyx.Interventions: .transfer out to hospital for unsubsided pain.staff in-service.During an interview on July 15, 2025, at 3:44 PM, Resident 43 stated she was sent to the hospital in April 2025 because she fell from her bed while a CNA was changing her brief. Resident 43 further stated there was one CNA present when she fell and she was sent to the hospital the next day because she had pain on her tailbone.During an interview on July 17, 2025, at 1:57 PM, with the Operation Manager (OP), the OP stated the facility investigation concluded that Resident 43's fall was the witness CNA's fault. The OP further stated when rolling residents in bed during cares, the resident was supposed to always be rolled towards the staff member, but the CNA stated she rolled the resident away from her instead, and that's when Resident 43 fell from the bed.During an interview on July 18, 2025, at 1:34 PM, with the Corporate Medical Records Resource (CMRR), the CMRR stated the facility did not have a policy and procedure regarding bed mobility or turning residents while in bed.During a review of the facility's policy and procedure titled, Safety and Supervision of Residents, dated January 25, 2025, the policy indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.

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	055557	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 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 observation, interview, and record review, the facility failed to maintain the acceptable parameters of nutritional status (factors that reflect that an individual's nutritional status is adequate, relative to his/her overall condition and prognosis, such as weight, food/fluid intake, and pertinent laboratory values), recognize, evaluate, and address the nutritional needs of one of three residents reviewed for nutrition (Resident 26) when: 1. Resident 26's tube feeding (method of providing nutrition directly into the stomach or small intestine when a person is unable to eat enough or at all by mouth) formula was administered as ordered by the physician on July 15, 2025, and July 16, 2025. Resident 26's had an order to receive 95 ml (milliliters, a unit of volume) per hour. On July 15, 2025, at 3:52pm Resident 26 only received 500 ml of formula for 9 hours, but should have received 855 ml (a difference of 355 ml). On July 16, 2025, at 3:32 PM, Resident 26 received 380 ml for 8 hours, of feeding but should have received 570 ml (a difference of 190 ml). 2. Residents 26's care plan (individualized treatment plan) interventions for pulling on his tube feeding and other life supporting medical equipment were not reevaluated since 2024. 3. Resident 26's intake and output (the measurement and recording of fluids consumed by a patient (intake) and fluids eliminated from the body (output)) was not accurately documented by the staff in accordance with the facility's policy. These failures had the potential to have contributed to Resident 26, a medically compromised patient, to lose 22 pounds in six months.Findings: 1. During a review of Resident 26's face sheet (contains demographic and medical information), it indicated Resident 26 was admitted to the facility on [DATE], with diagnosis of anoxic brain injury (brain damage from lack of oxygen), chronic respiratory failure (chronic lung disease that causes decreased oxygen) and hypertension (high blood pressure). During a review of Resident 26's physician orders, dated May 31, 2025, it indicated Resident 26 had an order to receive Enteral Feed Order, [Brand Name] 1.5 at 95 ml/hr (hour) x (for) 20 hours to provide 1900ml/ (or) 2850 kcal (a unit of energy measurement used in nutrition) due to weight loss. On at noon and off at 8:00 AM During a review of Resident 26's weight record, dated January 1, 2025, to June 25, 2025, it indicated Resident 26's weight on January 1, 2025, was 217 pounds, and 195 pounds on June 24, 2025 (22 pounds weigh lost). During a review of Resident 26's Progress Note, dated June 9, 2025, it indicated, .WT TREND (weight trends) -22# (a loss of 22 pounds) x(in) 6 months (10.1%) . During an observation on July 15, 2025, at 3:52 PM, with a Licensed Vocational Nurse (LVN 9), in Resident 26's room, Resident 26's was lying in bed, sleeping. Resident 26's tube feeding formula, which was hanging on a pole next to the resident, was inspected. Its label indicated the formula was initially hung on July 15, 2025, at 3:00 AM. It had approximately 1100 ml remaining, of a total volume of 1500 ml. (Resident 26 received 500 ml of formula for 9 hours, [Enteral Feed Order. on at noon and off at 8:00 AM] but should have received 855.) During another observation on July 16, 2025, at 3:32 PM, with LVN 9, in Resident 26's room, Resident 26 was lying in bed and appeared restless while pulling on the cord of his tube feeding. Resident 26's tube feeding formula, which was hanging on a pole next to the resident, was inspected. Its label indicated the formula was initially hung on July 16, 2025, hung at 4:00 AM. It had approximately 1400 ml remaining of a total volume of 1500 ml. (Resident 26 only received 380 ml of formula for 8 hours, [Enteral Feed Order. on at noon and off at 8:00 AM] but should have received 570 ml). During an interview on July 17, 2025, at 12:17 PM, with the Registered Dietitian (RD), the RD stated Resident 26 should have received 855 ml of the prescribed tube feeding for 9 hours but only received 500 ml. The RD further stated he did not receive 355 ml of the prescribed tube feeding for the day. The RD also stated that on July 16, 2025, Resident 26 should have received a total of 570 ml of the prescribed tube feeding for 6 hours, however only 190 ml were administered, leading for Resident 26 to miss 380 ml of the prescribed tube feeding. During a continued interview, RD stated Resident 26 should have received the correct amount ordered by the physician. The RD further stated she could not deny that missed feedings could contribute to weight loss. The RD stated Resident 26 was completely bed bound and was losing muscle mass, and the nursing staff should have documented the reason why the full tube feeding order was not provided. During a review of the facility's policy and procedure (P&P) titled, Nutrition Status Management, dated January 25, 2025, it indicated . ensure that all residents maintain acceptable parameters of nutritional status, such as body weight. During a review of the facility's P&P titled, Enteral Formula, Administration of Closed System, dated January 25, 2025, it indicated . This policy provides a means to safely administer a complete nutritional feeding to the resident. 2. During an observation and concurrent

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure their manual resuscitation (process of assisting or taking over a patient's breathing using a handheld device) policy was implemented for one of three residents (Resident 4) reviewed for respiratory care, when Resident 4 did not have an Artificial Manual Breathing Unit bag (AMBU bag - a hand-held medical device used to provide respiratory support to patients who are not breathing or are having difficulty breathing. Also known as a bag-valve-mask (BVM) or a manual resuscitator) at the bedside.This failure had the potential for Resident 4 to receive delayed emergency resuscitative measures during an emergency as a result of not having the required medical equipment immediately available.A review of Resident 4's admission Record (contains medical and demographic information) indicated Resident 4 was initially admitted on [DATE], with diagnoses which included acute respiratory failure with hypoxia (a condition where the lungs cannot adequately oxygenate the blood, leading to dangerously low levels of oxygen in the body), tracheostomy status (presence of a tracheostomy -surgically created opening in the neck that provides a direct pathway into the trachea for breathing), and dependence on respirator (ventilator- a machine which helps a person to breathe) status (refers to a patience reliance on a mechanical ventilator to breathe due to impaired lung function).During an observation on July 15, 2025, at 12:02 PM, Resident 4 was lying in her bed. Resident 4 had a tracheostomy which was connected to a ventilator. Resident 4 did not have an AMBU bag at her bedside or anywhere in the resident's immediate vicinity.During an interview on July 15, 2025, at 12:03 PM, with Respiratory Therapist 1 (RT 1), RT 1 stated every resident was supposed to have an AMBU bag at the head of their bed in case of an emergency.During a concurrent observation and interview on July 15, 2025, at 12:08 PM, with RT 1, in Resident 4's room,. RT 1 acknowledged Resident 4 did not have an AMBU bag available at the head of the bed or anywhere else in the resident's immediate vicinity. RT 1 looked for an AMBU bag in the resident's room but was unable to find an AMBU bag anywhere. RT 1 stated Resident 4 was supposed to have an AMBU bag available for her but did not. RT 1 further stated it is unacceptable.During an interview on July 18, 2025, at 1:36 PM, with the Respiratory Therapy Resource (RTR), the RTR stated the required equipment to be kept in the room for each resident included an AMBU bag and it was supposed to be at the resident's bedside. The RTR further stated it was important to keep an AMBU bag at the bedside in case they needed to perform manual ventilation of the resident (the process of assisting or taking over a patient's breathing using a handheld device, typically a bag-valve-mask (BVM) or AMBU bag, instead of a mechanical ventilator). During an interview on July 18, 2025, at 2:03 PM, with the Interim Director of Nursing (IDON), the IDON stated an AMBU bag was supposed to be at the bedside of all residents that had a tracheostomy and required the use of a ventilator.During a review of the facility's policy and procedure titled, Manual Resuscitation Device, dated April 17, 2025, it indicated, Policy: A manual resuscitator device will be placed at the bedside of each resident.Definition: A manual resuscitator device is a self-inflating bag-valve-mask device designed for the manual ventilation of a resident.

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	055557	A. Building B. Wing	07/18/2025

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used were labeled in accordance with professional standards, and storage of medications were properly secured for two of 11 medication carts (Med Cart - used to transport medication to resident's rooms) when: 1. Two bubble packs (small package enclosing goods in transparent dome-shaped plastic on a flat cardboard backing) containing Resident 18's Eliquis (a medication used for blood thinner) were found without expiration dates. This failure had the potential to cause the medication to lose its potential effects and be used for Resident 18. 2. Eight tubes of Santyl (a medication used for wounds) ointment were found without resident's identification labels. This failure had the potential to be accessed and administered in error. 3. Licensed Vocational Nurse (LVN 2) left Med Cart 4-1 unlocked and unattended for ten minutes. This failure had the potential to increase the risk of unauthorized access, misuse, and/or harm to a highly vulnerable population of 52 residents. 4. LVN 8 left Med Cart 3-1 unlocked and unattended for 5 minutes. This failure had the potential to increase the risk of unauthorized access, misuse, and/or harm to a highly vulnerable population of 52 residents.Findings: 1. During an inspection of medication cart 4-1 with a Licensed Vocational Nurse 1 (LVN1), on July 17, 2025, at 6:29 AM, two bubble packs containing Resident 18’s Eliquis 5 mg (milligram-a unit of measurement), which had missing expiration dates, were found inside a drawer. LVN 1 verified the finding. During an interview on July 17, 2025, at 6:40 AM, with LVN 1, confirmed the two bubble packs of Eliquis did not have an expiration date. LVN 1 further explained that Registered Nurses typically verify the expiration dates upon receipt of medications from the pharmacy and she does not know why these two bubble packs have no expiration dates on the labels. During an interview with the Operational Manager (OP) on July 17, 2025, at 10:55 AM, The OP acknowledged both bubble packs were to be removed from the medication cart, re-ordered, and the pharmacy was contacted to send new packets. 2. During an inspection of the treatment cart with LVN 3, on July 17, 2025, at 7:25 AM. Eight tubes of unlabeled Santyl medications were found inside the treatment cart. LVN 3 verified the finding. During the interview with the OP on July 17, 2025, at 10:55 AM, the OP stated that each Santyl ointment tube must have a pharmacy-issued label for safe identification of the resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the OP on July 18, 2025, at 10:44 AM, the Policy and Procedure (P&P) titled, “Labeling Requirements,” dated January 25, 2025, was reviewed. The P&P indicated, “All prescription drugs labels shall include the following information: (a) Brand or generic name of drug…(b) Strength of drug … (1) Quantity, (2) Expiration Date, (3) Resident’s name, (4) Direction of use, (5) Physician’s Name, (6) Date of dispensing, (7) Name, address and phone number of Pharmacy dispensing (8) Prescription number, (9) Any applicable Auxiliary Labels, (c) Improperly labeled containers will not be allowed for use and will be returned to the pharmacy as soon as possible, (d) Non-prescription/floor stock drugs must be kept in the original container … (e) Containers with soiled, damaged, incomplete, ineligible or makeshift labels are not to be used … (f) The nursing staff is not allowed to modify the Rx label in any way. Transferring content from one container to another is not allowed.” The OP acknowledged that the facility’s P&P were not followed. 3. During an observation on July 17, 2025, at 5:30 AM, LVN 2 was observed in hallway 4 preparing residents’ medications. LVN 2 entered room [ROOM NUMBER] to administer medications to residents in the room. LVN 2 was observed leaving the medication cart 4-1 unlocked, and unattended for 10 minutes. During an interview on July 17, 2025, at 5:40 AM, LVN 2 acknowledged the medication cart was unlocked and unattended. LVN 2 further stated the cart should have been locked when not in use. 4. During an observation on July 17, 2025, at 5:56 AM, a medication cart 3-1 was parked in hallway 3, outside of room [ROOM NUMBER], unlocked. LVN 8 was inside room [ROOM NUMBER], leaving the medication cart unlocked, and unattended for 5 minutes. During an interview on July 17, 2025, at 6:01AM, LVN 8 acknowledged the medication cart was unlocked and unattended. LVN 8 further stated the cart should have been locked when not in use. During a concurrent interview and record review, on July 17, 2025, at 7:15 AM, with the Interim Director of Nursing (IDON), the facility's policy and procedure (P&P) titled Security of Medication Cart, dated January 25, 2025, was reviewed. The P&P indicated, “…1. The nurse must secure the medication cart during the medication pass to prevent unauthorized entry…4. Medication carts must be securely locked at all times when out of the nurse’s view .” The IDON stated the P&P was not followed and further stated the medication carts should always be locked when unattended.

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	055557	A. Building B. Wing	07/18/2025

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Creekside Post Acute	35253 Avenue H Yucaipa, CA 92399

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to ensure staff who had appropriate competencies and skill set completed the resident's Quarterly Nutrition Assessment (a detailed evaluation of eating habits, weight and overall health related to food, done every 3 months). This failure had the potential to place 52 highly vulnerable residents' health at risk due to not receiving an adequate nutritional assessment.During a review of Residents 5, 8, 25 and 26's Quarterly Nutrition Assessments (comprehensive evaluation of an individual's nutritional status, aiming to identify any nutritional deficiencies or risks, and guide personalized interventions) between November 2024, through June 2025, it indicated the assessments were completed and signed by the Dietary Service Supervisor (DSS 1).During a review of Resident 8, 25 and 26's Quarterly Nutrition Assessments between November 2024, through June 2025, it indicated the assessments were completed and signed by DSS 2.During an interview on July 17, 2025, at 10:00 AM with DSS 1, DSS 1 verified that the completion of the quarterly nutrition assessment was being conducted and signed by DSS 1. During a telephone interview and concurrent record review, with the Registered Dietitian (RD), on July 17, 2025, at 12:17 PM, the RD reviewed Resident 26's Quarterly Nutrition Assessment, which indicated Resident 26 had an Ideal Body Weight Range (IBWR - a weight range associated with the lowest risk of mortality for a given height, age, sex, and sometimes frame size) was 208 pounds to 213 pounds. The RD stated she was not sure where DSS 1 got that weight range and further stated it was not a correct weight range for Resident 26. The RD stated the Dietary Supervisor was not qualified to do nutrition assessments.During an interview on July 18, 2025, at 2:24 PM, with the Interim Director of Nursing (IDON), the IDON stated the DSS does not have the scope of practice to conduct assessments. The IDON further stated the quarterly assessments were not verified by anyone else beyond the DSS.

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	055557	A. Building B. Wing	07/18/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 store resident food safely when:1. The resident refrigerator had multiple food items that were not labeled or dated. 2. The temperature of the refrigerator had not been monitored in June 2025 and July 2025. These failures had the potential for food borne illness (any illness resulting from eating contaminated/spoiled foods) in 25 medically compromised residents who were able to store food in this refrigerator.During a concurrent observation and interview on July 16, 2025, at 9:57 AM, with the Social Worker (SW), in the dining room, the resident refrigerator was found to have multiple food items that were not labeled or dated. Two thermometers were located outside of the fridge. The SW stated the food items stored in the refrigerator should be dated and labeled with the resident's name.During a concurrent interview and record review on July 16, 2025, at 11:00 AM, with the SW, the temperature logs for the resident refrigerator were reviewed. The SW stated there were no temperatures logged for the months of June 2025 and July 2025.During a concurrent interview and record review on July 18, 2025, at 10:43 AM, with the SW, the facility's policy and procedure (P&P) titled, Resident/Personal Food Storage, dated January 2025, was reviewed. The P&P indicated . 3. All refrigeration units will have internal thermometers to monitor for safe food storage temperatures. 5. Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's names, the item and the use by date. The SW stated the policy was not followed.

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	055557	A. Building B. Wing	07/18/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the documentation in the Electronic Health Record (EHR) was accurate for one of four residents (Resident 4) reviewed for advance directives (a legal document that outlines a person's healthcare wishes in the event that they become unable to make medical decisions for themselves due to illness, injury, or incapacity) when Resident 4's code status (refers to a patient's preferences regarding cardiopulmonary resuscitation [CPR] and other life-sustaining measures in the event of cardiac or respiratory arrest) contradictorily indicated Resident 4 was both Do Not Resuscitate (DNR - a medical order that instructs healthcare providers not to perform CPR if a patient's heart stops or breathing ceases) and Full-Code (indicates a patient's wish to receive all possible medical interventions, including CPR in the event the heart stops or breathing ceases).This failure had the potential for Resident 4 to receive end of life care not in accordance with their wishes and for life sustaining measures to be rendered against what the resident wanted.A review of Resident 4's admission Record (contains medical and demographic information), indicated Resident 4 was initially admitted on [DATE], with diagnoses which included acute respiratory failure with hypoxia (a condition where the lungs cannot adequately oxygenate the blood, leading to dangerously low levels of oxygen in the body), tracheostomy status (presence of a tracheostomy), and dependence on respirator (ventilator) status (refers to a patience reliance on a mechanical ventilator to breathe due to impaired lung function).During a review of Resident 4's EHR, the residents code status indicated .Do not resuscitate.full code.During an interview on [DATE], at 8:50 AM, with the Interim Director of Nursing (IDON), the IDON stated staff could find out the code status of a resident based off a document titled Physicians Orders for Life Sustaining Treatment, (POLST) or in the resident's electronic health record. The DON further stated the Code Status in the EHR was supposed to reflect the correct code status for each resident and that it was important to ensure the EHR accurately reflected the residents code status because it indicated what wishes the resident or the representative have for the resident.During a concurrent interview and record review on [DATE], at 8:52 AM, with the Interim Director of Nursing (IDON), Resident 4's EHR was reviewed. The IDON acknowledged Resident 4's code status indicated both DNR and Full Code. The IDON stated the EHR was incorrect and should only indicate the resident was DNR. The IDON further stated it was the licensed nurses' responsibility to ensure the code status for each resident was correct in the EHR.During a review of the facility's policy and procedure titled, Documentation Content of the Record Set, (undated), the policy indicated, .Federal regulation (F842) requires that the facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized.

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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. (continued on next page)

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	055557	A. Building B. Wing	07/18/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure facility staff follow the Infection Control Policies and Procedure 's standards for Transmission-Based Precautions (actions implemented in addition to standard precautions that are based upon the means of transmission in order to prevent or control infections) when a staff member was observed entering a Contact Precaution (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment) room without wearing the required Personal Protective Equipment (PPE- protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission.). This failure had the potential to place all residents, visitors, and staff at risk of being exposed to a contagious disease (illness caused by the spread of germs) that could compromise their health.Findings: During a review of the Resident 26's face sheet, it indicated Resident 26 was admitted to the facility on [DATE], with diagnoses which included chronic respiratory failure (a long-term condition where the respiratory system cannot adequately exchange oxygen and carbon dioxide), tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs) status, and gastrostomy (a surgically created opening in the stomach, typically accessed through the abdominal wall, that allows for the insertion of a feeding tube) status. During a review of Resident 26's physician's orders, dated July 2025, it indicated Resident 26 was placed on Contact Precautions due to being diagnosed with Candida Auris (a type of yeast that can cause severe illness and spreads easily among patients in healthcare facilities) as of July 20, 2024. During an observation and interview, on July 15, 2025, at 12:37 PM, a Certified Nurse Assistant 1 (CNA1) was outside Resident 26's room. CNA 1 performed hand hygiene using Hand Alcohol Rub ([NAME]), removed a lunch tray from the food cart, and entered Resident 26's room. Resident 26's room had a sign at the door which read Contact Precautions (measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment). CNA 1 entered the room without wearing PPE.During further observation, CNA 1 placed the tray on the over-the-bed table in front of Resident 26, returned to the door and removed a pair of gloves from the box located on the wall inside the room and don gloves. CNA1 returned to Resident 26's bedside, repositioned the resident in bed, placed a clothing protector, and opened the beverages from the lunch tray while wearing the same pair of gloves and no isolation gown. Upon exiting Resident 26's room, CNA 1 stated she usually wears a gown and gloves before entering a Contact Precaution room. CNA 1 could not explain why she had not done so on this occasion. During an interview with Licensed Vocational Nurse 7 (LVN 7), on July 15, 2025, at 12:37 PM, LVN 7 stated staff are required to perform hand hygiene and must wear a gown and gloves (PPE) before entering any Contact Precaution room. During an interview with the Infection Practitioner (IP) on July 16, 2025, at 11:12 AM, the IP stated all staff members are required to don (to put on) Personal Protective Equipment (PPE), including gowns and gloves, when entering such rooms. The IP further stated CNA1 should have performed hand hygiene, donned the appropriate PPE, requested another staff member to hand her the resident's lunch tray from the lunch cart, and then entered the room. The IP stated that CNA1 did not follow the facility's protocol when she entered the Contact Precaution room without wearing PPE. During a concurrent interview and record review with the Operational Manager (OP) on July 18, 2025, at 1:18 PM, the facility's Policies and Procedures (P&P) titled Isolation- Categories of Transmission-Based Precautions revised February 19, 2025, was reviewed. The P&P indicated, Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Policy interpretation and implementation: (1) standard precautions are used when caring for residents at all times regardless of their suspected or confirmed infection status, (2) Transmission-Based Precautions are additional measures that protect staff, visitors and other residents from becoming infected . The three types of Transmission-Based Precautions are contact, droplet and airborne . Contact precautions: (7) staff and visitors wear gloves when entering the room . (8) staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. The OP acknowledged that the facility's P&P were not followed and stated CNA1 should have don PPE before entering the Contact Precaution room.