STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056090	A. Building B. Wing	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Rehabilitation & Behavioral Health	850 Sonoma Ave Santa Rosa, CA 95404

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and record reviews, the facility failed to honor the right to self-determination (making own decisions) nor ensured one out of three sampled residents (Resident 1) was treated with respect and dignity, when Licensed Nurse (LN) B touched Resident 1 without consent.This failure resulted in Resident 1 feeling she was not treated with respect and dignity and that her rights were violated.Findings:A review of Resident 1s face sheet (front page of the chart that contains a summary of basic information about the resident) indicated she was admitted to the facility in April of 2025 and was self-responsible (taking ownership of one's actions and decisions).During an interview on 7/22/25 at 3:00 p.m., Resident 1 stated there was an incident when LN B had dragged her from the floor in the hallway back to her bed. Resident 1 stated at the time of incident, she was in a lot of pain and had laid down on a blanket in the hallway, as she believed it would help relieve her pain. Resident 1 stated LN B had grabbed her on the side by her armpits and dropped her onto her bed. Resident 1 stated while LN B was grabbing her off the floor she was repeatedly yelling, do not touch me! I do not give you permission to touch me! Let go of me! Resident 1 stated she also told LN B to call the police, to which LN B did not comply. Resident 1 stated LN B had completely disregarded her rights not to be touched without her consent and had not treated her with dignity and respect.During an interview on 7/22/25 at 3:23 p.m., LN B stated he recalled an incident, around the time he was giving Resident 1 pain medication, where Resident 1 had laid down on a blanket on the floor in the hallway. LN B stated Resident 1 would not get up from the floor when he asked and verified he had lifted Resident 1 up from the floor and took her to her bed. LN B confirmed Resident 1 had told him not to touch her and had repeated that she did not consent for him to touching her throughout the incident. LN B acknowledged Resident 1 also told him to call the police but he had not. LN B stated that in hindsight, he could have handled the situation better and should not have touched Resident 1 without her consent.During an interview on 7/22/25 at 3:44 p.m., the Director of Nursing (DON) stated she was aware Resident 1 alleged LN B had been physically abusive towards her during an incident when Resident 1 was lying on the floor in the hallway and LN B had taken to her bed. The DON stated she was not aware that Resident 1 had asked LN B not to touch her. The DON verified, when Resident 1 asked LN B not to touch her, LN B should have complied in respect to Resident 1's rights. The DON added, there were other ways to transfer Resident 1 from the floor to the bed.During an interview on 7/22/25 at 3:50 p.m., Unlicensed Staff D stated if a resident told a staff not to touch them, staff should not touch the resident. Unlicensed Staff D added, touching a resident without their consent was a violation of their rights.During an interview on 7/22/25 at 3:53 p.m., LN C stated if a resident said they did not give you consent to touch them, then you should not touch them. LN B stated if you touch a resident without their consent, they could feel their rights were not respected and they were violated.During an interview on 7/22/25 at 3:56 p.m., LN E stated if a resident did not give you permission to touch them and told you not to touch them, regardless of the situation, the staff should not touch the resident. LN E stated staff should respect residents' choices.A review of the facility's policy and procedure (P&P) titled Residents Rights, revised 12/2016, the P&P indicated, . Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include.the residents right to be treated with respect, kindness and dignity.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure an abuse allegation was reported timely, not later than two hours, for one out of three sampled residents (Resident 1), when an allegation of abuse was made on 7/7/25 but wasn't reported to the local police department until 7/8/25.This failure could result in continued harm and further abuse.Findings:A review of the report of suspected dependent adult/elder abuse, dated 7/7/25, indicated Resident 1 reported an allegation of physical abuse against Licensed Nurse (LN) B.A review of the Interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of the residents) note, dated 7/14/25, indicated Resident 1 reported the physical abuse allegation on 7/7/25 at 3:10 p.m.During an interview on 7/22/25 at 2:35 p.m., the Director of Nursing (DON) stated abuse allegations should be reported to California Department of Public Health (CDPH, state licensing), the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) and the police immediately within two hours.During an interview on 7/22/25 at 3:53 p.m., Licensed Nurse (LN) C stated all abuse allegations should be reported to the police, the ombudsman and the state within two hours. LN C stated abuse allegation should be reported timely to ensure residents' safety.During an interview on 7/22/25 at 4:20 p.m., the Director of Staff Development (DSD) stated all abuse allegations should be reported to the Ombudsman, the police and the state within 2 hours.During a concurrent telephone interview and record review on 7/24/25 at 11:09 a.m. with the DON, Resident 1's Social Services (SS) progress note, dated 7/8/25, and the facility's fax confirmation sheet, dated 7/8/25, was reviewed. The DON verified the documentation indicated that SS hadn't reported the allegation of physical abuse to the Santa [NAME] police department until 7/8/25 which was later than the two hour reporting expectation.A review of the facility's policy and procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 11/2023, indicated, . the administrator or the individual making the allegation immediately reports his or her suspicion to the following person or agencies: state licensing/certification agency responsible for surveying/licensing the facility, local state ombudsman, law enforcement official.immediately is defined as within 2 hours of any allegations involving any form of abuse.A review of the All Facilities Letter (AFL, information contained may include changes in requirements in healthcare, enforcement, new technologies, scope of practice, or general information that affects the health facility) 21-26, dated 7/26/21, indicated, . Pursuant to Title 42 CFR section 483.12(c)(1) . facilities must report any instance of suspected or alleged abuse, neglect, exploitation, and/or mistreatment of elders or dependent adults to their local law enforcement agency, LTC ombudsman, and [CDPH]. When to Report . for incidents that involve abuse or result in serious bodily injury, facilities must: Call local law enforcement immediately, but no later than two hours after the allegation is made. File a written or electronic report to the LTC ombudsman, local law enforcement, and [CDPH] within two hours .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interviews and record review, the facility failed to ensure medications were secured and inaccessible to unauthorized staff and residents when one medication cart was left unlocked and unattended.This failure had the potential to put all 95 facility residents at risk for unauthorized access to and ingestion of unsecured medications.Findings:During an observation on 7/22/25 at 2:26 p.m., one medication cart was not locked while unattended. There was no nurse in sight. During a concurrent observation and interview on 7/22/25 at 2:29 p.m., a nurse came and locked the medication cart. Licensed Nurse (LN) A verified she left station 1B medication cart unlocked to go with the Director of Nursing (DON) inside the medication room. LN A stated medication cart should be kept locked at all times when unattended to ensure there was no unauthorized access to the medications inside the cart. LN A stated keeping the medication cart locked when unattended was for resident and staff safety. During an interview on 7/22/25 at 2:50 p.m., the DON stated she knew about one of the nurses not locking the medication cart. The DON stated it was important medication cart was locked when unattended for everyone's security. During an interview on 7/22/25 at 3:32 p.m., LN B stated medication cart should be locked at all times when unattended to ensure patients' safety. A review of the facility's policy and procedure (P&P) titled Storage of Medications, revised April 2007, the P&P indicated, . compartments (including but not limited to drawers, cabinets, rooms, refrigerators, carts, boxes) containing drugs and biologicals shall be locked when not in use.