STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555387	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center	9107 N. Davis Road Stockton, CA 95209

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. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure an environment free of accidents or hazards for two of four sampled residents (Resident 3 and Resident 4) when:Resident 3 did not have Wander Gard device (a wearable device that tracks movement and triggers automated security responses when a resident nears a restricted area) placement and functioning checks documented every shift daily per physician order after an elopement (when a resident leaves a healthcare facility against medical advice when doing so poses an imminent threat to the resident's health or safety) episode; andResident 4 did not have a Wander Gard device placed upon admission to the facility despite a recent history of elopement and according to facility policy.These failures put Resident 3 at increased risk of elopement and resulted in Resident 4 eloping (leaving the facility without staff knowledge) on 10/6/25, with the potential to lead to severe harm like falls, a serious injury, and/or deathFindings:1. A review of Resident 3's admission RECORD, indicated that Resident 3 was admitted to the facility with diagnoses which included Dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life).A review of Resident 3's Elopement Evaluation, dated 4/13/25, the evaluation indicated, .Does the resident have a history of elopement or an attempted elopement while at home: Yes.Does the resident have a history of attempting to leave the facility without informing staff: Yes. Has the resident expressed the desire to go home, packed belongings to go home or stayed near an exit door: Yes.Does the resident wander: Yes.During a review of Resident 3's SBAR [Situation, Background, Assessment and Recommendation, a healthcare communication tool] Communication Form and Progress Note, dated 4/13/25, the document indicated, .Summarize your observations and evaluation: .Resident [Resident 3] exited the main door of the building. Able to get redirected inside. No c/o [complaint of] pain or discomfort noted.Asked where she is going. Resident didn't say anything.Ensured all exits are secured with alarms. Whereabouts monitored.Primary Care Clinician Notified: Yes Date: 04/13/2025 Time: 11:00 AM. Recommendations of Primary Clinicians.Wander guard.During an interview on 10/24/25 at 3:30 p.m. with a Certified Nursing Assistant (CNA), the CNA stated that the Licensed Nurses checked the functioning of the Wander Guard devices, and the CNAs checked to make sure the devices were on the residents. During an interview on 10/24/25 at 3:30 p.m. with Licensed Nurse (LN) 2, LN 2 stated that the LNs checked the function of the Wander Gard devices every shift. LN 2 stated that the functioning of the Wander Guard devices was documented in the residents' EMR (Electronic Medical Record) either in the MAR (Medication Administration Record, a document listing medications and monitoring parameters) or the TAR (Treatment Administration Record, a list of prescribed treatments) each shift. During an observation and concurrent interview on 10/24/25 at 3:32 p.m. with Resident 3 in her room, Resident 3 sat in a wheelchair near her door with a Wander Guard device on her wrist. Resident 3 stated that she did not remember going outside of the facility in April of 2025. A review of Resident 3's TAR, dated 12/25, indicated that Resident 3's Wander Guard device placement and function was not checked every shift daily on 8/5/25, 8/27/25 and 8/30/25.A review of Resident 3's TAR, dated 9/25, indicated that Resident 3's Wander Guard device placement and function was not checked every shift daily on 9/1/25, 9/5/25, 9/11/25, 9/28/25, and 9/29/25.A review of Resident 3's TAR, dated 10/25, indicated that Resident 3's Wander Guard device placement and function was not checked every shift daily on 10/11/25. A review of Resident 3's Care Plan Report, indicated, .Focus.Wander gard [sp] Elopement Device Due to poor safety awareness.Date Initiated: 04/14/2025.Goal.The resident will remain safe from any harm.Target Date: 12/08/2025.Interventions.Check for proper fitting.The nurse will monitor resident's whereabouts.ensure wander gard [sp] is functioning properly. During a concurrent interview and record review of Resident 3's TARs, with the DON on 11/14/25 at 9:45 a.m., the DON stated that her expectation was that residents deemed at risk for wandering would have a Wander Guard device placed and would be monitored frequently. The DON stated that the staff checked the placement and function of the Wander Guard device every shift each day and documented the placement and function of the Wander Guard device in the residents' medical record. The DON confirmed that Resident 3 had a Wander Guard device. The DON stated that Resident 3 had a prior history of elopement in April of 2025. The DON confirmed that Resident 3 had a Wander Guard placed in April of 2025 after the elopement. The DON confirmed that Resident 3's Wander Guard placement and function were not documented in her TARs every day each shift on 8/5/25, 8/27/25, 8/30/25, 9/1/25, 9/5/25, 9/11/25, 9/28/25, 9/29/25 and 10/11/25. The DON stated that the risk was elopement. The DON confirmed that the facility policy was not followed.2. A review of

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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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and record review, the facility failed to ensure medical records were complete and accurate in accordance with professional standards for one of four sampled residents (Resident 4) when Resident 4's Visual Checks (a document detailing staff observations of Resident 4's activity in timed increments), dated 10/06/25 indicated that Resident 4 was in the facility during the time that he had eloped from the facility.This failure resulted in inaccurate documentation in Resident 4's medical record for twenty minutes, with staff documenting safety observations that they did not perform.Findings:A review of Resident 4's admission RECORD, indicated that Resident 4 was admitted to the facility in 2025 with diagnoses which included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life).A review of Resident 4's SBAR [Situation, Background, Assessment and Recommendation, a healthcare communication tool] Communication Form and Progress Note, dated 10/6/25 indicated, .the resident was noted with wandering behavior and had actual elopement incident.Code [NAME] (facility emergency response) was activated, room and facility ground physical check was done per protocol. At 1350H (hours), he was found walking in [sp] the sidewalk along the traffic light.he then came willingly with DON [Director of Nursing] and facility driver.During an interview on 10/24/25 at 1:04 p.m. with Licensed Nurse (LN) 1, LN 1 stated that she remembered Resident 4. LN 1 stated that she was not assigned to care for Resident 4 but was on duty the day of the incident. LN 1 stated that she saw the resident earlier in the day sitting in a wheelchair. LN 1 stated that later, a coworker told her that Resident 4 was missing. LN 1 stated that the staff looked for the resident but could not find him. LN 1 stated that she notified the Administrator (ADM) and the DON that the resident was missing. LN 1 stated that the staff announced the Code Green indicated that everyone was needed to find the resident as instructed by the ADM. LN 1 stated that staff looked both inside the facility and outside in the parking lot and surrounding areas but could not find the resident. LN 1 stated that the DON and another staff member got in the facility van and drove around to look for the resident. LN 1 stated that they found Resident 4 down the block at the stop light and brought him back to the facility. LN 1 stated that frequent visual checks were done on residents after elopement by the staff. LN 1 stated that the frequent visual checks on residents after elopement were documented on paper forms. A review of Resident 4's Visual Checks, form dated 10/6/25 indicated that Resident 4 was observed in location L2 which indicated Bedroom Awake every fifteen minutes from 1300 (1 PM) to 1345 (1:45 PM) on 10/6/25. During an interview and concurrent review of Resident 4's Visual Checks form and Electronic Medical Record [EMR], on 11/14/25 at 9:45 a.m. with the DON, the DON stated that her expectation was that staff documented accurately in the residents' medical records. The DON acknowledged that the entries on Resident 4's Visual Checks form dated 10/6/25 indicated that Resident 4 was in his room at 1:30 PM and at 1:45 PM on 10/6/25, and Resident 4's SBAR Communication Form and Progress Note, dated 10/6/25 indicated that Resident 4 was located down the street from the facility at a stop light at 1:50 PM on 10/6/25. The DON confirmed that the documentation on the Visual Checks form and the SBAR Communication Form and Progress Note were inconsistent, as staff noticed that Resident 4 was missing at 1:30 PM on 10/6/25. The DON stated that the documentation on Resident 4's Visual Checks form dated 10/6/25 should have been accurate. The DON acknowledged that the facility policy was not followed. A review of a facility policy and procedure (P&P) titled, Nursing Documentation, effective date 6/27/22, the P&P indicated, .Purpose.To communicate patient's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided.Policy.Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's/patient's (hereinafter patient) condition, situation, and complexity.Nursing documentation will follow.policy and procedure and federal and state regulations.Procedure.b. Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion.c. The patient's record specifies what nursing interventions were performed by whom, when, and where.d. All patient information will be documented, scanned, or entered in the appropriate section of the clinical record following established guidelines.