

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: 555387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Creekside Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review, the facility failed to complete an accurate assessment in a timely manner for one of two sampled residents (Resident 1) when Resident 1's stage 2 pressure ulcers (localized skin and tissue injuries caused by prolonged pressure, friction, or shear, primarily develop over bony prominences like the tailbone, heels, and hips, stage 2 is a partial-thickness skin loss) at right buttocks and left buttocks merged and worsened to stage 3 pressure ulcer (a severe wound featuring full-thickness skin loss where subcutaneous fat is visible, but muscle, tendon) at coccyx and a Significant Change in Status Assessment (SCSA- an assessment which captures a major decline or improvement in a resident's condition) was not completed. This failure placed Resident 1 at risk for not receiving the necessary services indicated for Resident 1's current condition upon change in status and had the potential to worsen Resident 1's wound and health condition. Findings: During a concurrent interview and record review with the MDSC (A Minimum Data Set Coordinator is a specialized nurse in nursing facilities who oversee the standardized resident assessment process required for federal funding, tracking patient health status, compliance, and care planning) on 5/7/26, at 3:12 PM, The MDSC stated they would complete a SCSA if a resident had a decline, or started on new therapy. During a concurrent interview and record review with the MDSC, on 5/8/26, at 1:31 PM, Resident 1's MDS (a standardized, federally mandated clinical assessment tool used in nursing homes to evaluate a resident's overall health, functional capabilities, and care needs) assessments were reviewed. The MDSC stated he was not sure if stage 2 pressure ulcer would prompt a SCSA assessment. The MDSC stated stage 3 or stage 4 pressure ulcer development would prompt to complete a SCSA. The MDSC stated they checked residents' change of condition notes, wound notes, progress notes to assess for any significant changes. The MDSC added they also reviewed the evaluations and new doctor's orders. The MDSC stated that if a resident's pressure ulcer went from stage 2 to stage 3, then there should be an SCSA conducted by the following business day. The MDSC stated that without proper assessment, a resident would be at risk for wound development and/or worsening of wounds and sepsis (the body's extreme, life-threatening response to an infection). The MDSC further stated that resident's plan of care could differ if not accurately assessed. During a concurrent interview and record review with the DON, on 6/4/26, at 3:53 PM, Resident 1's wound progress notes dated 6/6/24 and 6/20/24 were reviewed. The DON confirmed Resident 1's stage 2 pressure ulcer on the left and right buttocks merged and became stage 3 pressure ulcer at coccyx on 6/20/24. The DON stated Resident 1's stage 2 pressure ulcer worsened to stage 3 pressure ulcer. The DON stated worsening of the wound from stage 2 to stage 3 was a very significant change of condition (COC) and there should have been an MDS assessment. The DON confirmed that an SCSA was not conducted when Resident 1's stage 2 pressure ulcer worsened to stage 3 on 6/20/24. The DON stated the purpose of MDS assessment was to conduct accurate assessment, that would trigger the interventions, and if not done, then there would not be accurate interventions and the wound could worsen. A review of the Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.18.11, dated October 2023, indicated in Chapter 2: Assessments, An SCSA is appropriate when: -There is a determination that a significant change (either improvement or decline) in a resident's condition from their baseline has occurred as (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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and - The resident's condition is not expected to return to baseline within two weeks . emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status.Must be completed .within 14 days after the determination that the criteria are met for a Significant Change in Status assessment . SECTION M: SKIN CONDITIONS.A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program.		

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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 assessments were completed accurately for one of two sampled residents (Resident 1) when:1. Resident 1's admission Minimum Data Set (MDS- a standardized, federally mandated clinical assessment tool used in nursing homes to evaluate a resident's overall health, functional capabilities, and care needs) assessment inaccurately reflected Resident 1 without pressure ulcer (localized skin and tissue injuries caused by prolonged pressure, friction, or shear, primarily develop over bony prominences like the tailbone, heels, and hips) upon admission to the facility,2. Resident 1's admission nursing assessment did not accurately reflect Resident 1's skin integrity, and3. Resident 1's weekly nursing assessments did not reflect Resident 1's skin condition accurately.These failures resulted in delayed wound care treatment and worsening of Resident 1's pressure ulcers.Findings:1. Review of Resident 1's MDS assessment dated [DATE], Section I - Active Diagnoses, indicated Resident 1 had multiple diagnoses including but not limited to generalized muscle weakness, type 2 diabetes mellitus (a medical condition that causes high blood sugar levels), and cerebrovascular accident (CVA or stroke).During a concurrent interview and record review with the Director of Nursing (DON) on 5/8/26, at 8:19 AM, the DON confirmed that Resident 1's Care Plan dated 5/26/24 indicated, .Resident at risk for skin breakdown related to: admitted with Scattered Discoloration to L [left] and R [right] upper extremities [NAME] [in hospital acquired]: Stage 2 to R/L [right and left] buttock.During a concurrent interview and record review with the MDSC, on 5/8/26, at 1:31 PM, the MDSC stated they checked hospital records to make sure all orders were correct and captured. The MDSC confirmed Resident 1's hospital record titled, PROBLEM LIST & PLAN, dated 5/16/24, indicated Resident 1 had back wound and was seen by wound care, discharge planning included anticipate discharge within 3 days and wound care was ordered. The MDSC confirmed Resident 1's care plan dated 5/26/24, indicated, .Resident [Resident 1] at risk for skin breakdown related to: admitted with Scattered Discoloration to L [left] and R [right] upper extremities [NAME] [in hospital acquired]: Stage 2 to R/L [right and left] buttock. The MDSC confirmed Resident 1's admission MDS assessment dated [DATE], in Section M did not reflect Resident 1's stage 2 pressure ulcers upon admission. The MDSC stated they should have accurate assessment for resident care to contribute to accurate interventions for the resident.During an interview with the DON on 5/8/26, at 4:40 PM, the DON stated that an accurate treatment would always be based on an accurate assessment. The DON stated there was a note in the referral from the hospital that Resident 1 had wound care. The DON stated care plan dated 5/26/24 specified that Resident 1's stage 2 pressure ulcers at right and left buttock were hospital acquired. The DON stated there was contradicting MDS assessment. The DON stated that the purpose of accurate assessment was to address the resident's medical problems accurately, and to provide proper interventions. The DON further stated that if the interventions were not accurate then it would not address the problem and it would affect resident's goal of care. 2. During a concurrent interview and record review with the Director of Nursing (DON), on 6/4/26, at 3:17 PM, the DON stated that during a resident's admission at the facility, the nurses must do a head-to-toe assessment and document the skin assessment in the admission nursing evaluation. The DON stated if a resident had skin issues, the nurses should describe the wound condition, notify the doctor immediately, get treatment orders and get a wound consult. The DON stated Resident 1's care plan dated 5/26/24, indicated Resident 1 was admitted with scattered discoloration to left and right upper extremities and hospital acquired stage 2 pressure ulcer at left and right buttock. The DON confirmed Resident 1's admission nursing assessment titled Nursing Documentation Evaluation dated 5/25/24, indicated Resident 1 had no skin issues. The DON stated it was an inaccurate assessment. The DON stated nurse should have completed an accurate assessment. The DON confirmed a there were no treatment orders for Resident 1's stage 2 pressure ulcers until 6/5/24. The DON confirmed Resident 1's wound progress (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notes dated 6/6/24 and 6/20/24 indicated Resident 1's right and left buttock stage 2 (a partial-thickness skin loss) pressure ulcers merged into stage 3 (a severe wound featuring full-thickness skin loss where subcutaneous fat is visible) pressure ulcer at coccyx on 6/20/24. The DON stated Resident 1's pressure ulcers got worsened from stage 2 to stage 3.3. During a concurrent interview and record review with the DON, on 6/4/26, at 4:18 PM, the DON stated Resident 1's care plan dated 5/26/24, indicated Resident 1 was admitted with scattered discoloration to left and right upper extremities and hospital acquired stage 2 pressure ulcer at left and right buttock. The DON confirmed Resident 1's weekly summaries dates 5/30/24 and 6/2/24, indicated Resident 1 had no skin issues. The DON confirmed Resident 1's nurses note titled Daily Documentation dated 6/5/24, indicated that Resident 1 had no skin issues. The DON stated nursing assessments dated 5/30/24, 6/2/24 and 6/5/24 were not accurate. The DON stated that the purpose of skin assessment was to address the skin issue, and if they missed seeing or documenting it, they could not provide an accurate treatment. The DON further stated that if the wounds were not treated, it might get worse and the resident could get an infection. The DON stated the nursing assessments should be accurate and the nurses should develop a care plan right away. The DON stated that the care plan should be updated every time there was a change in condition. Review of the facility's policy and procedure titled, Comprehensive Assessments and the Care Delivery Process, revised December 2016, indicated, .Comprehensive assessments will be conducted to assist in developing person-centered care plans. Assessment and information collection includes (WHAT, WHERE and WHEN?). The objective of the information collection (assessment) phase is to obtain, organize, and subsequently analyze information about a patient. Assess the individual. Observation. Physical Assessment. Complete the Minimum Data Set within 14 days after admission, within 14 days after it is determined that the resident has had a significant change in physical or mental condition, and annually. Review of the facility's policy and procedure titled, Skin Integrity Management, dated 5/26/21, indicated, .PURPOSE To provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment and promote healing of all wounds. Staff continually observes and monitors patients for changes and implements revision to the plan of care as needed. Complete comprehensive evaluation of the patient upon admission/re-admission to the Center. Identify patient's skin integrity status and need for prevention intervention or treatment modalities through review of all appropriate assessment information.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide necessary care and services to prevent and/or heal pressure injuries (areas of damaged skin caused by staying in one position for too long) for one of two sampled residents (Resident 1) when: 1a. Resident 1 did not have any treatment orders for his stage 2 pressure ulcers on his left and right buttock for 10 days from 5/25/24 to 6/4/24, b. Low air loss (or LAL, a mattress designed to prevent and treat pressure wounds that uses a continuous, gentle flow of air through a surface of tiny holes to reduce pressure helping to prevent and treat skin breakdown and pressure wounds) mattress was not ordered timely for Resident 1, c. Resident 1's care plan interventions of turning and repositioning and wound care treatments for pressure ulcer healing were not implemented consistently, d. Resident 1 was not seen by a wound specialist for 13 days from 6/6/24 till 6/20/24, e. IDT meetings (Interdisciplinary Team meeting: a collaborative gathering of professionals from different specialties such as doctors, nurses, social workers, and therapists who meet to coordinate holistic, personalized care plans for a patient) regarding Resident 1's pressure ulcers were not done for 5 months from 5/25/24 till 10/3/24 and care plans were not updated consistently, and 2. Resident 2 was not repositioned every 2 hours as ordered. These failures resulted in worsening and delayed healing of Resident 1's pressure ulcers and had potential of developing new pressure ulcers for Resident 1 and Resident 2 and risk of reopening old pressure ulcers for Resident 2. Findings: 1a. Review of Resident 1's Hospital Discharge summary dated [DATE] indicated Resident 1 had multiple diagnoses including but not limited to upper GI bleed (blood loss from the esophagus, stomach, or upper small intestine), scattered acute to subacute infarctions (small, patchy areas of tissue death in the brain that happened at slightly different times suggesting an ongoing process rather than single large stroke), ventilator acquired pneumonia (a severe lung infection that develops in a person on mechanical ventilation), dysphagia (difficulty swallowing), anemia (lack of red blood cells), ESRD (End-Stage Renal Disease - the final, permanent stage of chronic kidney disease, where the kidneys can no longer filter waste and excess fluids from the body). Further review of the discharge summary indicated Resident 1 had back wound, was seen by the wound care and to apply triple antibiotic wound cream to open areas. During a concurrent interview and record review with the DON, on 5/8/26, at 8:19 AM, Resident 1's Care plan dated 5/26/24 was reviewed with the DON. The DON confirmed the care plan indicated Resident 1 was admitted with stage 2 pressure ulcer (a partial-thickness skin loss) on right and left buttocks and interventions included to provide wound treatment as ordered. The DON confirmed that Resident 1's order summary report from May 2024 to October 2024 indicated there were no treatment orders for Resident 1's pressure ulcers upon admission for 10 days from 5/25/24 to 6/4/24. During a concurrent interview and record review with the Infection Preventionist (IP), on 5/8/26, at 2:15 PM, Resident 1's physician orders dated 6/4/24 were reviewed with the IP. The IP confirmed that the first wound treatment order for Resident 1, .Open areas to bilateral Medi honey [a medical-grade, sterilized honey used to treat wounds, burns, and ulcer] for bilateral inner buttocks. was ordered on 6/4/26, 10 days after Resident 1 was admitted to the facility. The IP stated that a delay in wound treatment could contribute to worsening or developing more wounds. The IP further stated that if a resident was not properly assessed, it could affect the interventions. 1b. During a concurrent interview and record review with the Infection Preventionist (IP) on 5/8/26, at 2:15 PM, Resident 1's order summary report was reviewed. The IP stated that the LAL mattress was part of their wound prevention, and treatment if a resident had pressure ulcers. The IP confirmed that Resident 1 was diagnosed with Stage 2 pressure ulcer on left and right buttocks on 6/6/26. The IP confirmed the LAL mattress for Resident 1 was not ordered until 6/12/24. The IP stated she did not know why the order was delayed. The IP stated that the LAL mattress should have been ordered at the same day they found Resident 1's pressure ulcers to prevent it from getting worse. The IP stated that the risk of the delayed (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention would be worsening of the wounds. During a concurrent interview and record review with the DON, on 5/8/26, at 8:19 AM, Resident 1's initial wound evaluation & management summary report dated 6/6/24 was reviewed. The DON confirmed the report indicated Resident 1 had stage 2 pressure ulcer of the right and left buttock with recommendations of using a moisture barrier cream three times daily for 30 days, off load (keeping pressure off) wound, and reposition. Resident 1's wound evaluation & management summary report dated 6/27/24 was reviewed with the DON. The DON confirmed the report indicated Resident 1 had stage 3 pressure wound on coccyx (tailbone) exacerbated due to generalized decline of Resident 1. The DON stated Resident 1 was hospitalized on [DATE] and was readmitted to the facility on [DATE] with admitting diagnosis of cellulitis (bacterial skin infection), sepsis (life-threatening reaction to an infection that causes immune system to harm healthy tissues and organs)/decubitus ulcer (pressure sore or bedsore) of coccyx and sacrum. During an interview with the DON, on 5/8/26, at 5:17 PM, the DON stated she expected LAL mattress to be ordered at the same time when a resident was diagnosed with a pressure ulcer. The DON stated that the purpose of LAL mattress was to maintain the skin intact, to distribute the weight and help with preventing or worsening of wound. The DON stated that she expected the nurses to notify the doctor to obtain a LAL mattress order when Resident 1 was diagnosed with pressure ulcer. The DON stated that ideally the LAL mattress should be ordered together with the other wound treatments. The DON stated that the nurses were responsible to implement the LAL mattress nursing intervention in collaboration with the maintenance staff. During concurrent interview and record review with the DON on 6/4/24 at 3:39 PM, the DON confirmed Resident 1's wound report dated 6/6/24 indicated the physician recommendations included offload wound and reposition. The DON stated offload wound meant to keep pressure off of the wound which was implemented by turning, repositioning the resident to their sides and using LAL mattress. The DON confirmed their policy indicated to determine the need for offloading devices to implement the pressure ulcer prevention interventions. The DON stated offloading devices meant LAL mattress. The DON stated they had LAL mattress available in the facility and were used for residents who were at risk of developing pressure ulcers or had pressure ulcers. The DON stated LAL mattress should have used for Resident 1 the day he was noted with the wound on 6/4/24 and as doctor recommended offloading on 6/6/24. The DON stated if LAL mattress was not used timely then pressure ulcer would not be offloaded, which could worsen the pressure ulcer and increased the risk of infection and decline in resident health condition. 1c. During a concurrent interview and record review with the DON, on 5/8/26, at 8:19 AM, Resident 1's Care plan dated 5/26/24 was reviewed with the DON, indicated, [Resident 1 was] at risk for skin breakdown related to: admitted with Scattered Discoloration to L [left] and R [right] upper extremities [NAME] [in hospital acquired]: Stage 2 to R/L [right and left] buttock. Interventions. LAL mattress Supplements as ordered Date Initiated: 06/12/2024. Provide wound treatment as ordered Date Initiated: 05/26/2024. During a concurrent interview and record review with the Infection Preventionist (IP), on 5/8/26, at 2:15 PM, the IP stated that the interventions on the care plan should be implemented by any health care staff caring for the resident. During a concurrent interview and record review with the DON, on 5/8/26, at 4:40 PM, Resident 1's Treatment Administration Record (TAR) from June 2024 to October 2024 was reviewed. The DON verified that TAR indicated Resident 1 did not receive wound treatment for his right buttock pressure ulcer on 6/16/24, coccyx pressure ulcer on 8/22/24, and 9/27/24. The DON confirmed TAR dated October 2024 indicated a LAL mattress setting and function check every shift were not done on the day shift of October 9, 10 and 14. The DON stated she expected the nursing staff to document all nursing interventions that were done for Resident 1. The DON stated that the purpose of turning and repositioning a resident was to prevent skin breakdown and enhance resident mobility. The DON stated that the purpose of wound treatments was to resolve and treat any wound concerns and skin alterations. The DON stated if the wound treatments or interventions were not done consistently, the resident would be at high risk for skin alterations, and it would be a cycle, and the wound could possibly not heal. Resident 1's turning (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and repositioning record for May 2024 to October 2024 was reviewed with the DON. The DON confirmed the record indicated to turn and reposition Resident 1 every 2 hours every shift. The DON confirmed that there was no record that Resident 1 was turned and repositioned on the day shift on 6/14/24, 6/16/24, 6/19/24, 7/15/24, 7/16/24, 7/19/24, 7/23/24, 8/23/24, on the evening shift on 5/26/24, 6/10/24, 10/10/24, 10/21/24, and on the night shift on 5/31/24, 6/22/24, 6/30/24, 8/31/24, , 918/24, 9/27/24, 9/30/24, 10/6/24, 10/9/24, 10/10/24, 10/16/24, 10/17/24. The DON stated when it was not documented she could not say if Resident 1 was turned and repositioned on those days. The DON stated that the purpose of turning and repositioning was to prevent skin breakdown and enhance resident mobility. The DON further stated that the risk if turning and repositioning was not done would be skin alterations, risk of wound reopening.1d. During a concurrent interview and record review with the DON, on 6/4/26, at 3:39 PM, the DON stated a resident with pressure ulcer should be seen every week by a wound doctor. The DON confirmed Resident 1's Wound Progress Note dated 6/13/24, indicated, .Patient [Resident 1] not seen due to a non-wound-related hospitalization. Resident 1's Census List (Resident's history of admission, readmission, bed change and transfer to hospital) was reviewed with the DON. The DON confirmed Resident 1 was in the facility and was not at the hospital on 6/13/24. The DON confirmed Resident 1's progress notes dated 6/12/24, indicated Resident 1 was moved to another room on 6/12/24. The DON confirmed Resident 1's wound progress note dated 6/6/24, indicated, .FOLLOW-UP Evaluation by wound care specialist within 7 Day(s) with further intervention . The DON confirmed that Resident 1 was not seen by the wound doctor for 13 days from 6/6/24 till 6/20/24. The DON stated besides wound nurse, a resident should be seen by a medical professional, wound doctor every week to evaluate resident's wounds because it was a higher level of profession, they would be able to further the treatment. The DON stated that when Resident 1 was not seen by the wound specialist for 13 days, there was a risk for infection, the wounds could worsen if not seen by a wound specialist/professional.During a concurrent interview and record review with the DON, on 6/4/26, at 3:53 PM, Resident 1's wound progress notes dated 6/20/24 was reviewed. The DON stated the wound report indicated Resident 1's left and right buttocks stage 2 pressure ulcers merged and became one pressure ulcer - stage 3 (a severe wound featuring full-thickness skin loss where subcutaneous fat is visible) at coccyx. The DON stated that Resident 1's pressure ulcer got worsened.1e. During a concurrent interview and record review with the DON, on 6/4/26, at 3:53 PM, the DON stated a wound meeting should be done weekly with IDT, including Registered Dietician for resident's nutritional supplements for wound healing, Infection Preventionist for any wound related infections, MDS coordinator for proper coding, Activity Director for bedbound resident to encourage turning and repositioning, Physical Therapist for the mobility of residents with wounds. The DON confirmed the care plan dated 5/26/24, indicated Resident 1 was admitted with stage 2 pressure ulcer on right and left buttocks. The DON confirmed Resident 1's wound report dated 6/20/24, indicated Resident 1's stage 2 pressure ulcers on right and left buttocks were merged and became stage 3 coccyx pressure ulcer on 6/20/24. The DON confirmed there were no IDT meetings held until 10/3/24 when Resident 1's wound had progressed to stage 4 (the most severe form of pressure injury, involving full-thickness tissue loss with exposed fascia, muscle, tendon, or bone). The DON stated there was risk of worsened wound and infection when weekly wound IDT meetings were not conducted. The DON stated resident's pressure ulcer care plan should be updated to reflect the wound condition, stage, size, site, treatment and interventions. The DON stated the care plan should be updated on the same day there was a change in wound condition, size, treatment. Resident 1's care plans were reviewed with the DON. The DON confirmed Resident 1's care plan was not updated to reflect Resident 1's pressure ulcer and treatment changes on 6/20/24. The DON stated the care plan should have been updated because it was a change in condition (COC). The DON stated care plan was their guide in caring for the residents, addressing the health concerns of the residents, addressing the wound. The DON stated when care plan was not updated, then there was a risk not to implement the expected interventions, treatment, worsened (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound and Resident 1's condition could have deteriorated. 2. Review of Resident 2's admission RECORD, indicated Resident 2 had a diagnosis of dislocation of internal right hip prosthesis, periprosthetic fracture around prosthetic right hip joint, presence of right artificial hip joint, and generalized muscle weakness. Review of Resident 2's Care Plan, dated 1/21/26, indicated Resident 2 was at risk for impaired skin integrity related to urinary and bowel incontinence, fragile skin, limited mobility, and history of pressure injuries. Care Plan Interventions included reposition at least every 2 hours and utilize pressure-relieving devices as ordered. During a concurrent observation and interview with certified nursing assistant (CNA) 1, on 5/7/26, at 3:03 PM, Resident 2 was observed sleeping on his bed while lying on his back. CNA 1 stated she usually turned and repositioned Resident 2 every 2 hours. CNA 1 stated that not all residents were scheduled to be turned every 2 hours, but they would reposition all of them as much as possible. CNA 1 stated they documented the turning and repositioning in the electronic health record (EHR). CNA 1 stated the nurses would tell them which resident needed to be turned and repositioned. CNA 1 stated that sometimes they would know which residents needed to be turned and repositioned such as if they had surgery, in pain or had wounds. During a concurrent interview and record review with the Director of Nursing (DON), on 5/7/26, at 4:07 PM, Resident 2's turning and repositioning record from February 2026 -April 2026 was reviewed. The DON confirmed that there was no documentation of turning and repositioning on the day shift of 4/10/26, 5/5/26, evening shift of 2/14/26, 4/4/26, night shift of 2/26/26 and 2/28/26, 3/28/26, 3/31/26 and 4/30/26. During a concurrent observation and interview on 6/4/26, at 1:47 PM, Resident 2 was observed lying in bed in a supine position (lying flat on the back with face and torso facing upward). Resident 2 stated he was not sure if he could turn by himself. Resident 2 was then observed trying to turn himself but could not do it all the way. Resident 2 stated he no longer had wounds on his back. Resident 2 stated that staff did not tell him that he needed to reposition himself. During an observation on 6/4/26, at 2:58 PM, Resident 2 was observed lying flat on his back. During a concurrent observation and interview with CNA 2, on 6/4/26, at 3:59 PM, Resident 2 was lying on his back. CNA 2 stated that Resident 2 could not turn by himself. CNA 2 further stated that Resident 2 needed extensive assistance to turn in his bed. CNA 2 confirmed that Resident 2 could not push himself to turn to his side. During a concurrent observation and interview with CNA 2, on 6/4/26, at 5:08 PM, Resident 2 was observed in a semi-Fowler's position (a posture where a person lies on their back with the head and upper body elevated at a 30 to 45-degree angle). CNA 2 stated they were supposed to turn and reposition Resident 2 every 2 hours. CNA 2 stated Resident 2 was forgetful and could not remember that he was supposed to reposition every 2 hours. CNA 2 stated they needed to remind him and assist him with repositioning. CNA 2 stated it was part of their job to turn and reposition residents and document it in their record. CNA 2 stated her shift started at 2:30 PM but she didn't start working on the floor until around 4pm and repositioned him around 4pm. CNA 2 stated she did not know when the last time Resident 2 was repositioned. CNA 2 stated she did not get the report from the previous shift about Resident 2's repositioning. CNA 2 stated she usually checked residents' vital signs (clinical measurements that indicate the state of a body's essential functions such as body temperature, heart rate (pulse), respiratory rate, and blood pressure) in the beginning of her shift and then repositioned the resident or tell them to reposition. During an interview on 6/4/26, at 5:19 PM, with Licensed Nurse (LN) 2, LN 2 stated Resident 2 was at risk for skin breakdown. LN 2 stated residents should be repositioned every 2 hours. LN 2 stated that Resident 2 could not remember that he needed to reposition and staff needed to remind him. LN 2 stated turning and repositioning was important to offload the pressure, to prevent skin breakdown. LN 2 stated that repositioning meant offloading one side, lying on a side. LN 2 stated changing a resident's position from supine to semi-Fowlers would not be considered repositioning since pressure would remain on resident's back, bony prominences buttocks, sacrum and coccyx. During an interview with the DON, on 5/8/26, at 4:40 PM, the DON stated if a care was not documented then could not say it was not done. The DON stated she expected the nurses and CNAs to document all the nursing interventions those (continued on next page)		

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Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Creekside Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was done for the resident. The DON stated that the purpose of turning and repositioning was to prevent skin breakdown and enhance resident mobility. The DON further stated that the risk if turning and repositioning was not done would be skin alterations, risk of wound reopening. A review of the facility's policy and procedure titled, Wound Care, dated 2001, indicated, .The purpose of this procedure is to provide guidelines for the care of wounds to promote healing .Apply treatments as indicated .Use supportive devices as instructed .Documentation. The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data. 9. If the resident refused the treatment and the reason(s) why. A review of the facility's policy and procedure titled, Skin Integrity Management, dated 5/26/21, indicated, .PURPOSE To provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment and promote healing of all wounds. Staff continually observes and monitors patients for changes and implements revision to the plan of care as needed. Complete comprehensive evaluation of the patient upon admission/re-admission to the Center. Identify patient's skin integrity status and need for prevention intervention or treatment modalities through review of all appropriate assessment information. Document on Treatment Administration Record (TAR) or in [Electronic Health Record]. Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated. Implement pressure ulcer prevention for identified risk factors. Determine the need for support surface for bed and chair. Determine the need for offloading devices .Turning and repositioning based on resident care needs. A review of the facility's policy and procedure titled, CARE PLAN COMPREHENSIVE dated 8/25/21, indicated, .PURPOSE An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident. Each resident's comprehensive care plan is designed to. Aid in preventing or reducing declines in the resident's functional status and/or functional levels. A review of the facility's undated policy and procedure titled, Activities of Daily Living (ADLs), Supporting indicated, Residents will provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable. b. Unavoidable decline may occur if he or she: Refuses care and treatment to restore or maintain functional abilities and the refusal and information are documented in the resident's clinical records.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on interview, and record review, the facility failed to provide appropriate care and services for G-tube feeding (method of providing nutrients via a tube directly into the stomach or intestine when a person is unable to eat by mouth) for one of two sampled residents (Resident 1) when Resident 1's G-tube (gastrostomy tube - a medical device inserted directly through the abdomen into the stomach) dressing was not changed for more than a month. This failure had the potential for Resident 1's G-tube site to develop an infection and/or sepsis (life-threatening reaction to an infection that causes immune system to harm healthy tissues and organs). Findings: A review of Resident 1's admission RECORD, indicated Resident 1 had multiple diagnoses including but not limited to, gastrostomy status (presence of a surgical opening in the abdomen that leads directly into the stomach). During a concurrent interview and record review, on 5/8/26, at 8:19 AM, Resident 1's progress note dated 10/28/24 was reviewed with the Director of Nursing (DON). The progress note indicated Resident 1 had large amount of blood coming from wound and the doctor was notified and sent Resident 1 to the emergency department. On a separate progress notes dated 10/28/24, indicated, . CALLED [hospital name] ED [emergency department] FOR F/U [follow up], NURSE STATED PT [patient/Resident 1] admitted for SEPSIS/ GT [G-tube] WOUND INFECTION. Treatment Administration Record (TAR) was reviewed from September 2024- October 2024 with the DON. The DON confirmed that there was no TAR or order for G-Tube site cleaning and dressing when Resident 1 was readmitted in September 2024. During a concurrent interview and record review with the Infection Preventionist (IP), on 5/8/26, at 2:15 PM, the IP stated she expected the nurses caring for residents with G-tube to clean the G-tube site daily with normal saline and change the dressing daily and as needed. The IP confirmed that the order for G-tube cleaning and dressing change was never placed back or reordered when Resident 1 was readmitted in September 2024 to the facility. The IP stated that it was important to clean and change the G-tube dressing because it would be a risk for infection, the site could get infected, and it could lead to sepsis. The IP stated she would know that the dressing had been change if the dressing had a date or the TAR had been signed, unless there was no order. The IP stated that the only way to know if it was done was to check the actual dressing and the TAR. The IP stated that physician's order was important to guide the nurses for the proper care of the residents. The IP confirmed that Resident 1 had not had G-tube dressing change for 41 days from 9/17/24 to 10/28/24. The IP stated that the incident was preventable if the nurses were doing the dressing change. During an interview with Licensed Nurse (LN) 1, on 4/8/26, at 4:22 PM, LN 1 stated she would know if a resident's G-tube dressing was changed if there was a date on the dressing and it should also be documented in the TAR. LN 1 stated if there was no order for the G-tube cleaning and dressing change, she would call the doctor. During an interview with the DON, on 5/8/26, at 4:40 PM, the DON confirmed that there was no G-tube dressing change and cleaning order for Resident 1 for 41 days from 9/17/24 to 10/28/24. The DON stated she expected the nurses to assess Resident 1's G-tube site, check patency, check the dressing, check for signs and symptoms of infection and do the dressing daily and as needed. The DON stated that if there was no order for G-tube dressing change and cleaning, the nurses should have followed up with the doctor to obtain a treatment order for dressing change. The DON further stated that the bedside nurse had the responsibility to obtain the order and implement it. A review of the facility's policy and procedure titled, Enteral Nutrition dated November 2018, indicated, .Staff caring for residents with feeding tubes are trained on how to recognize and report complications associated with the insertion and/or use of feeding tube, such as. Skin breakdown around insertion site.		