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	12/21/2023

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45555 Based on observations, record reviews, interviews, and facility policy review, the facility failed to update comprehensive care plans to include bed rail recommendations for 2 (Resident #26 and Resident #31) of 3 sampled residents reviewed for bed rail usage. Findings included: A review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, with a revision date of March 2022, revealed, The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 1. A review of Resident #26's Admission Record revealed the facility admitted the resident on 04/22/2021 with diagnoses that included aphasia (a comprehension and communication disorder) following a cerebral infarction (stroke), chronic kidney disease, dementia, and schizophrenia. A review of Resident #26's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/05/2023, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. According to the MDS, Resident #26 required supervision or touching assistance when rolling left and right in bed and when moving from a sitting position to lying flat in the bed. The MDS revealed the resident required partial to moderate assistance when moving from lying flat in the bed to a sitting position, when standing from a sitting position, and when transferring to and from the bed to a chair or wheelchair. A review of a document titled, Bed Rail Evaluation, with an effective date of 11/05/2023, revealed Resident #26's bed rail recommendation was for one-quarter side rails for both the left and right upper sides of the bed as an enabler for turning side to side in bed, moving up and down in bed, pulling up into a sitting position from lying down, and during transfers in and out of bed. A review of Resident #26's care plan, last reviewed on 11/27/2023, revealed the care plan did not address the resident's bed rail recommendation. Observation on 12/18/2023 at 10:18 AM, revealed Resident #26 was lying in bed and had quarter bed rails up on both sides of the upper bed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident #31's Admission Record revealed the facility most recently admitted the resident on 09/09/2023. According to the Admission Record, Resident #31 had a medical history that included diagnoses of fusion of the cervical spine, osteoarthritis of the knee, polyneuropathy (damage to multiple peripheral nerves), protein-calorie malnutrition, muscle weakness, abnormal posture, unsteadiness on feet, and difficulty walking. A review of Resident #31's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/12/2023, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. According to the MDS, Resident #31 required limited assistance of one staff with bed mobility and transfers. A review of a document titled, Bed Rail Evaluation, with an effective date of 12/09/2023, revealed Resident #31's bed rail recommendation was for one-quarter side rails for both left and right upper sides of the bed as an enabler for turning side to side, pulling up into a sitting position from lying down, and during transfers. A review of Resident #31's care plan, last reviewed on 12/18/2023, revealed the care plan did not address the resident's bed rail recommendation. Observation on 12/19/2023 at 9:33 AM, revealed Resident #31 was in bed with quarter bed rails up on both upper sides of the bed. During an interview on 12/21/2023 at 9:02 AM, the Director of Rehabilitation (DOR) stated the use of bed rails should be care planned. During an interview on 12/21/2023 at 9:07 AM, Registered Nurse (RN) #7 stated the use of bed rails should be included on the resident's care plan. During an interview on 12/21/2023 at 9:15 AM, Licensed Vocational Nurse (LVN) #3 stated upon admission nursing assessed the residents for the use of bed rails, and if they determined that bed rails were appropriate then nursing would get an order, get consent, and then update the resident's care plan. LVN #3 stated the nurse who did the assessment should initiate or update the resident's care plan. During an interview on 12/21/2023 at 10:02 AM, LVN #2 stated if a resident was able to use bed rails for turning and repositioning, nursing would contact the physician to obtain an order, then update the resident's care plan. During an interview on 12/21/2023 at 10:14 AM, the Director of Nursing (DON) stated the nurse who conducted the bed rail assessment should have added the bed rail recommendations to the residents' care plans. The DON further stated nursing managers also updated care plans when they reviewed new admissions. During an interview on 12/21/2023 at 11:30 AM, LVN #8 stated the use of bed rails should be reflected on residents' care plans. During an interview on 12/21/2023 at 11:52 AM, the Administrator stated the use of bed rails should be reflected on residents' care plans.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 37047 Based on interviews, record review, and facility policy review, the facility failed to obtain a timely urine specimen for urinalysis for 1 (Resident #54) of 2 sampled residents reviewed for hospitalization . Findings included: Review of a facility policy titled, Lab and Diagnostic Test Results - Clinical Protocol, revised in November 2018, indicated, 1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. Review of Resident #54's Admission Record revealed the facility admitted the resident on 08/31/2023, with diagnoses that included unspecified cirrhosis of the liver and left clavicle fracture. Review of Resident #54's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2023, revealed Resident #54 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required substantial/maximal assistance with toileting hygiene and was always continent of bowel and bladder function. Review of Resident #54's care plan, initiated on 11/22/2023, revealed the resident required assistance with activities of daily living (ADLs). Review of an eINTERACT Change in Condition Evaluation - V 5.2, dated 11/01/2023, revealed Resident #54 was tired, weak, confused, or drowsy. The evaluation indicated the recommendation from the primary clinician was to obtain laboratory tests to include a urinalysis (UA). Review of Resident #54's Order Recap Report for the timeframe from 11/01/2023 to 12/31/2023, revealed a physician's order dated 11/01/2023, for urinalysis (UA) with culture and sensitivity (C&S) if indicated. Review of Resident #54's Follow-up Documentation, dated 11/02/2023 at 9:54 AM, revealed attempts were made to collect a urine specimen for urinalysis. Review of Resident #54's Follow-up Documentation, dated 11/03/2023 at 12:56 AM, revealed attempts were made to collect a urine specimen for urinalysis. Review of Resident #54's Follow-up Documentation, dated 11/03/2023 at 1:28 PM, revealed a specimen was collected for urinalysis from Resident #54. During an interview on 12/20/2023 at 9:20 AM, Licensed Vocational Nurse (LVN) #10 stated it took a few days to get Resident #54's urine specimen for urinalysis because Resident #54 urinated in an incontinence brief and was unable to use a urinal at that time. LVN #10 stated staff attempted to collect a urine sample on 11/02/2023, and staff obtained the urine specimen on 11/03/2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/21/2023 at 9:00 AM, Registered Nurse (RN) #7 stated that if a resident was incontinent and staff could not get a clean catch urine sample, staff would get a physician's order to obtain the sample by way of g straight catheterization (a soft, thin tube used to pass urine from the body). During an interview on 12/21/2023 at 9:49 AM, the Director of Nursing (DON) stated on 11/01/2023, staff unsuccessfully attempted to collect a urine specimen from Resident #54, and the unsuccessful attempt was reported to the next shift. The DON stated the urine specimen was collected on 11/03/2023. The DON stated she was unable to find documentation to indicate the doctor was made aware that staff had been unable to collect the urine sample for two days. The DON stated nursing staff should have contacted the doctor to ask if he wanted the nurse to collect a urine specimen by way of straight catheterization.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 45555 Based on observations, record reviews, interviews, and facility policy review, the facility failed to obtain consents and physician's orders for the use of bed rails for 2 (Resident #26 and Resident #31) of 3 sampled residents reviewed for bed rail usage. Findings included: A review of the facility policy titled, Bed Safety and Bed Rails, revised in August 2022, revealed, The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. Per the policy Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: a. The assessed medical needs that will be addressed with the use of bed rails; b. The resident's risks from the use of bed rails and how these will be mitigated; c. The alternatives that were attempted but failed to meet the resident's needs; and d. The alternatives that were considered but not attempted and the reasons. 1. A review of Resident #26's Admission Record revealed the facility admitted the resident on 04/22/2021 with diagnoses that included aphasia (a comprehension and communication disorder) following a cerebral infarction (stroke), chronic kidney disease, dementia, and schizophrenia. A review of Resident #26's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/05/2023, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. According to the MDS, Resident #26 required supervision or touching assistance when rolling left and right in bed and when moving from a sitting position to lying flat in the bed. The MDS revealed the resident required partial to moderate assistance when moving from lying flat in the bed to a sitting position, when standing from a sitting position, and when transferring to and from the bed to a chair or wheelchair. A review of a document titled, Bed Rail Evaluation, with an effective date of 11/05/2023, revealed Resident #26's bed rail recommendation was for one-quarter side rails for both the left and right upper sides of the bed as an enabler for turning side to side in bed, moving up and down in bed, pulling up into a sitting position from lying down, and during transfers in and out of bed. Per the evaluation, the final actions needed for bed rail use were to obtain consent and a physician's order. A review of Resident #26's electronic health record (EHR) revealed no evidence informed consent was obtained for the use of bed rails for the resident. A review of Resident #26's Order Summary Report, listing active orders as of 12/20/2023, revealed no order for the use of bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/18/2023 at 10:18 AM, revealed Resident #26 was lying in bed and had quarter bed rails up on both sides of the upper bed. 2. A review of Resident #31's Admission Record revealed the facility most recently admitted the resident on 09/09/2023. According to the Admission Record, Resident #31 had a medical history that included diagnoses of fusion of the cervical spine, osteoarthritis of the knee, polyneuropathy (damage to multiple peripheral nerves), protein-calorie malnutrition, muscle weakness, abnormal posture, unsteadiness on feet, and difficulty walking. A review of Resident #31's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/12/2023, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. According to the MDS, Resident #31 required limited assistance of one staff with bed mobility and transfers. A review of a document titled, Bed Rail Evaluation, with an effective date of 12/09/2023, revealed Resident #31's bed rail recommendation was for one-quarter side rails for both left and right upper sides of the bed as an enabler for turning side to side, pulling up into a sitting position from lying down, and during transfers. The evaluation indicated final actions needed for bed rail use were to obtain consent and to obtain a physician's order. A review of Resident #31's electronic health record (EHR) revealed no evidence informed consent was obtained for the use of bed rails for the resident. A review of Resident #31's Order Summary Report, listing active orders as of 12/19/2023, revealed no order for the use of bed rails. Observation on 12/19/2023 at 9:33 AM, revealed Resident #31 was in bed with quarter bed rails up on both upper sides of the bed. During an interview on 12/19/2023 at 12:43 PM, the Director of Nursing (DON) stated the facility did not have consents for the use of bed rails for Resident #26 or Resident #31. During an interview on 12/21/2023 at 9:02 AM, the Director of Rehabilitation (DOR) stated nursing staff did the initial assessment for bed rails, and then they referred the resident to the therapy department to determine what type of rails to use. The DOR stated therapy then relayed information back to the DON to get consent from the resident or resident representative. The DOR stated as far as she knew, a physician's order was needed for the use of bed rails. During an interview on 12/21/2023 at 9:07 AM, Registered Nurse (RN) #7 stated residents were assessed upon admission for the use of bed rails, and the staff got consent for the use of bed rails at that time. RN #7 stated that to know if a resident needed bed rails, she would have to look in the EHR at the resident's physician orders to verify and then make sure that an informed consent was in place. During an interview on 12/21/2023 at 9:15 AM, Licensed Vocational Nurse (LVN) #3 stated upon admission, nursing staff assessed residents for the use of bed rails, and if they determined that bed rails were appropriate, nursing staff should obtain a physician's order and consent for the bedrails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/21/2023 at 10:02 AM, LVN #2 stated upon admission, residents were assessed to determine whether they were able to move around in the bed, and if they could not, the resident would not be appropriate for the use of bed rails. LVN #2 stated if the resident was able to use the rails for turning and repositioning, nursing staff would obtain a physician's order and get informed consent. In a follow-up interview on 12/21/2023 at 10:14 AM, the DON stated if a resident required the use of bed rails, a physician's order, and consent from either the resident or the resident representative was obtained. During an interview on 12/21/2023 at 11:52 AM, the Administrator stated he was unsure about the need for bed rail consents.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 37047 Based on interviews, record review, and facility document and policy review, the facility failed to provide a pneumococcal vaccination for 1 (Resident #37) of 5 sampled residents reviewed for immunizations. Findings included: Review of a facility policy titled, Pneumococcal Vaccine, revised in October 2019, revealed, All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The policy specified, Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol. Review of Resident #37's Admission Record revealed the facility most recently admitted the resident on 05/12/2022, with diagnoses that included unspecified dementia. Review of Resident #37's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/09/2023, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. Review of a Pneumococcal Vaccine Informed Consent revealed Resident #37's responsible party (RP) gave verbal consent on 09/15/2023, for the facility to administer the pneumococcal vaccine to the resident. Review of Resident #37's Immunization Record, revealed Resident #37 did not receive the pneumococcal vaccine. During an interview on 12/20/2023 at 9:45 AM, the Infection Preventionist (IP) stated Resident #37 did not receive the pneumococcal vaccine. The IP stated Resident #37 had not received the vaccination because she had not gotten to it yet. During an interview on 12/21/2023 at 9:33 AM, the Director of Nursing (DON) stated the IP was responsible for obtaining consents and physician's orders for vaccines. The DON stated this was done upon admission and seasonally. The DON stated that once there was a completed consent form, the vaccine should be given as soon as there was a physician's order. The DON stated that it might take a few days between the consent being signed and when residents were given the vaccine. The DON stated if Resident #37's RP consented to the vaccine, the vaccine should have been given. During an interview on 12/21/2023 at 10:54 AM, the Administrator stated after a resident was provided education on the risks and benefits of a vaccine, the vaccine should be administered.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37047 Based on interviews, record reviews, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guidance titled Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States, the facility failed to provide a COVID-19 vaccination for 2 (Resident #37 and Resident #16) of 5 sampled residents reviewed for immunizations. Findings included: Review of a facility policy titled, Coronavirus Disease (COVID-19)- Vaccination of Residents, revised in June 2022, revealed, Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident has already been immunized. The policy specified, 15. Booster vaccine doses are provided in accordance with current CDC guidance and 19. If a resident requests vaccination, but missed earlier opportunities for any reason, the vaccine will be offered to that resident as soon as possible. Efforts to help the resident obtain vaccination are documented. Review of CDC guidance titled, Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States, last updated on 11/03/2023, revealed the section titled, COVID-19 vaccination guidance for people who are moderately or severely immunocompromised, Ages [AGE] years and older, indicated that individuals who received two doses of any Moderna COVID-19 vaccine prior to the updated 2023-2024 Formula should receive one dose of the updated 2023-2024 formula at least four weeks after their last dose. The guidance specified that an individual who received three or more doses of any mRNA (messenger ribonucleic acid) vaccine prior to the updated 2023-2024 formula should receive one dose of the updated 2023-2024 formula at least eight weeks after their last dose. 1. Review of Resident #37's Admission Record revealed the facility most recently admitted the resident on 05/12/2022, with diagnoses that included unspecified dementia. Review of Resident #37's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/09/2023, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. Review of Resident #37's care plan, initiated 05/13/2022, revealed the resident was at risk for COVID-19 exposure. Review of a COVID-19 Vaccine Consent Form, revealed Resident #37's responsible party (RP) provided Resident #37's prior COVID-19 vaccination history and gave verbal consent on 09/15/2023, for the facility to administer the COVID-19 vaccine to the resident. According to the COVID-19 Vaccine Consent Form, Resident #37 received their first dose of the Moderna COVID-19 vaccination series on 04/13/2021 and their second dose on 05/12/2021, as well as boosters on 03/11/2022 and 08/26/2022. Review of Resident #37's Immunization Record, revealed the resident had not received another dose of the COVID-19 vaccine after the facility received consent on 09/15/2023. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/2023 at 9:45 AM, the Infection Preventionist (IP) stated Resident #37's RP consented for the resident to receive the COVID-19 vaccine. The IP stated she attempted to administer the vaccine, but Resident #37 refused two times, although these attempts were not documented. The IP stated the staff needed to catch Resident #37 when the resident was in a better mood. 2. Review of Resident #16's Admission Record revealed the facility admitted the resident on 05/06/2021, with diagnoses that included chronic kidney disease with heart failure. Review of Resident #16's annual Minimum Data Set, with an Assessment Reference Date (ARD) of 10/06/2023, revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. Review of Resident #16's care plan, initiated 05/07/2021, revealed the resident was at risk for COVID-19 exposure. Review of a COVID-19 Vaccine Consent Form, revealed Resident #16's conservator gave consent on 09/18/2023, for the facility to administer the COVID-19 vaccine to the resident. According to the COVID-19 Vaccine Consent Form, Resident #16 received their first dose of the Pfizer COVID-19 vaccination series on 04/15/2021 and their second dose on 05/06/2021, as well as boosters on 02/25/2022 and 08/26/2022. Review of Resident #16's Immunization Record, revealed the resident had not received another dose of the COVID-19 vaccine after the facility received consent on 09/18/2023. During an interview on 12/20/2023 at 9:50 AM, the Infection Preventionist (IP) stated the facility had the consent for Resident #16 to receive the COVID-19 vaccination, but it had not been administered. The IP stated there was not a reason that it was not given. During an interview on 12/21/2023 at 9:33 AM, the Director of Nursing (DON) stated the IP was responsible for obtaining consents and physician's orders for vaccines. The DON stated this was done upon admission and seasonally. The DON stated once there was a completed consent form, the vaccine should be given as soon as there was a physician's order. The DON said this should take no more than a few days. The DON stated if the facility had received consents to administer Resident #37's and Resident #16's vaccines, the vaccines should have been given. During an interview on 12/21/2023 at 10:54 AM, the Administrator stated after a resident was provided education on the risks and benefits of a vaccine, the vaccine should be administered.