

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/01/2025
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 12/06/2024
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 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. 50598 Based on observation, interview, record review, the facility failed to ensure one of five sampled residents (Resident 16) was treated with dignity and respect when Certified Nursing Assistant (CNA) 1 stood over Resident 16 while assisting with feeding. This failure had the potential to impact Resident 16's self-esteem and negatively affect dining experience. Findings: Resident 16 was admitted to the facility with diagnoses including Gastro Esophageal Reflux Disease (a condition where the stomach acid back flows towards the throat). Review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) indicated Resident 1 required partial to moderate assistance with feeding. During an observation on 12/4/24 at 12:44 PM, CNA 1 was observed standing on the right side of Resident 16 while feeding Resident 16 lunch. CNA 1 stood throughout the entire meal. During an interview on 12/4/24 at 12:58 PM, CNA1 stated standing was the only choice due to a chair not being available. During a concurrent interview and record review 12/6/24 at 10:05 AM, the Director of Staff Development (DSD) reviewed the facility document titled, CERTIFIED NURSING ASSISTANT SKILLS PERFORMANCE EVALUATION .Tray Pass .Resident ready for meal .sit down to feed resident . and stated the facility expected CNAs to sit with residents when assisting with meals. During an interview on 12/6/24 at 10:29 AM, the DSD stated staff standing while feeding residents placed the resident at risk for choking. The DSD also stated this practice decreased eye contact and could make the resident feel rushed. During an interview with Licensed Nurse (LN) 3, on 12/4/24 at 1:02 PM, LN 3 stated CNA 1 was standing while feeding a resident because of the decreased number of chairs for staff to sit down while feeding. (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	During an interview with the Director of Nursing (DON) on 12/6/24 at 10:47 AM, the DON stated staff was expected to sit down while feeding residents in order to preserve their dignity. A review of the facility provided document titled, Dignity dated February 2021, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Residents are treated with dignity and respect at all times.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49823 Based on interview and record review, the facility failed to provide services which met professional standards of quality for 2 of 16 sampled residents (Resident 60 and Resident 179) when, 1. The physician was not notified when vital signs were outside of ordered parameters for Resident 60; and, 2. The physician was not notified timely of abnormal lab results for Resident 179. These failures had the potential for unsafe medication use and risk of adverse effects for Resident 60, and the potential for a delay in treatment for Resident 179. Findings: 1. A review of Resident 60's Admission Record indicated Resident 60 was admitted to the facility in 2024 with diagnoses including end stage renal disease (failure of the kidneys to function normally), dependence on renal dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when your kidneys are unable to), and congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should, causing fluid to back up into the lungs). During a review of Resident 60's Care Plan, dated 7/26/24, the Care Plan, indicated, .Focus .Resident exhibits or is at risk for cardiovascular symptoms or complications related to diagnosis of heart failure . Interventions .Assess and monitor vital signs as ordered and report abnormalities to physician . During a review of Resident 60's Physician Order Summary, dated 7/26/24, the summary indicated, . Metoprolol Tartrate [medication given to treat high blood pressure, a condition in which the force of the blood pushing against the blood vessel walls is consistently too high. This causes the heart to work harder to pump blood] oral tablet 50 mg [unit of measure] give 1.5 tablet by mouth two times a day for hypertension [high blood pressure] . Notify MD [physician] if SBP [systolic blood pressure, maximum pressure in the body's vessels when the heart squeezes and pumps blood] < [less than] 100 or HR [heart rate] <60 . During a review of Resident 60's Medication Administration Record (or MAR, a list of medications and treatments provided to a resident) dated November 2024, the MAR indicated Resident 60's Metoprolol was held (not given) on 11/17/24 and 11/28/24 for heart rate outside of parameters ordered by the physician. During a review of Resident 60's Progress Notes, dated 11/17/24, there was no documentation the physician was notified of the heart rate outside of parameters. During a review of Resident 60's Progress Notes, dated 11/28/24, there was no documentation the physician was notified of the heart rate outside of parameters. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review of Resident 60's Electronic Medical Record (EMR) on 12/4/24 at 2:15 p.m. with Licensed Nurse (LN) 1 at the nurses' station, LN 1 stated if a medication was not given, the nurse documented NG on the MAR. LN 1 stated if the medication order directed the nurse to notify the physician with vital signs outside of the parameters, LNs documented the physician was notified in the resident's progress notes. LN 1 confirmed that on 11/17/24 and 11/28/24, Resident 60's Metoprolol dose was documented as not given on the MAR. LN 1 confirmed the progress notes did not indicate Resident 60's physician was notified that Resident 60's heart rate was outside of parameters on 11/17/24 and 11/28/24. During an interview on 12/4/24 at 3:55 p.m. with the Director of Nursing (DON), the DON stated her expectation was that the vital signs were taken and recorded prior to giving a medication with vital signs parameters. The DON stated that if the physician wrote orders to be notified when vital signs were outside of the ordered parameters, LNs would document physician notification in the resident's progress notes. The DON acknowledged the facility policy was not followed. During a review of a facility policy and procedure (P&P) titled, Administering Medications, revised April 2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescriber orders .If a dosage is believed to be inappropriate .the person preparing or administering the medication will contact the prescriber . During a review of an online document published by the National Library of Medicine, National Institutes of Health (NIH), titled, Stat Pearls Metoprolol, last review dated 2/29/24, indicated, .Common adverse effects . bradycardia [slow heart rate] .Monitoring .Metoprolol is a .medication that requires careful monitoring .The following parameters should be monitored .blood pressure and heart rate .Metoprolol can lower blood pressure and heart rate . 2. A review of Resident 179's Admission Record indicated Resident 179 was admitted to the facility in 2024 with diagnoses including cerebral infarction (a result of disrupted blood flow of the brain due to problems with blood vessels that supply it, also known as a stroke), anemia (a condition where the body doesn't have enough healthy red blood cells or hemoglobin [a protein in red blood cells that carries oxygen] to carry oxygen to the body's tissues), and hyponatremia (occurs when the level of sodium in the blood is too low). A review of Resident 179's Laboratory Results, dated 11/20/24, indicated the following abnormal results: . Reported Date: 11/20/24 20:13 [8:13 p.m.] .Red Blood Cells (RBC) 3.58 10⁶/ul (reference range [set of values that doctors use to interpret a patient's test results] 3.9-5.5 10⁶/ul) .Hemoglobin 8.3 g/dl [grams per deciliter-measurement used to report certain results] (reference range 11.0-18.0 g/dl) . Sodium 129 mEq/L [milliequivalent per liter-used to report certain results] (reference range 135-145 mEq/L) . Alkaline Phosphatase [an enzyme found in many tissues throughout the body] 1024 IU/L [international units per liter-used to report certain results](reference range 30-147 IU/L) . During a review of Resident 179's Progress Notes dated 11/20/24 through 11/23/24, there was no documentation the physician was notified regarding the abnormal lab results reported to the facility on [DATE]. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review of Resident 179's Electronic Medical Record (EMR) on 12/5/24 at 10:50 a.m. with Licensed Nurse (LN) 2 at the nurses' station, LN 2 stated that when LNs received abnormal lab results, the physician was called and notified. LN 2 stated the LNs either attached the progress note with physician notification to the abnormal lab results in the EMR, or the LNs opened a progress note and documented the physician was notified of the abnormal lab results in the Progress Notes section of the EMR. LN 2 stated that baseline labs (an initial measurement that is used for comparison over time) were ordered for residents admitted to the facility. LN 2 confirmed Resident 179's EMR did not indicate the physician was notified regarding the abnormal lab results reported to the facility on [DATE]. LN 2 stated resident safety was at risk, as staff needed to follow up with the physician on abnormal lab results. LN 2 stated that physician notification of abnormal lab results needed to be documented in the resident's EMR. During an interview and concurrent review of Resident 179's EMR on 12/5/24 at 1:10 p.m. with the Director of Nursing (DON), the DON stated the expectation was that the LNs checked the dashboard for lab results, assessed the resident for signs and symptoms related to the abnormal lab results, reported abnormal labs promptly to the resident's physician, and documented the lab result was reported in the resident's medical record. The DON stated not reporting the abnormal lab results promptly to the physician could result in decline of a resident's condition. The DON stated the physician was notified on 12/4/24 of the abnormal lab results for Resident 179 received on 11/20/24. The DON stated the physician should have been notified of the abnormal lab results sooner. DON acknowledged that the facility policy was not followed. During an interview by phone on 12/5/24 at 3:30 p.m. with Resident 179's physician (MDr), the MDr stated he expected to be notified right away of abnormal lab results. The MDr stated that if Resident 179's lab results were reported to him on 11/20/24, he would have sent orders for the abnormal results on the same day or the next day. A review of Resident 179's Physician Order Summary Report did not indicate any physician orders were written related to the abnormal lab results on 11/20/24 or on 11/21/24. During a review of a facility policy and procedure (P&P) titled, Lab and Diagnostic Test Results - Clinical, revised November 2018, the P&P indicated, .Protocol .Review by Nursing Staff .1. When test results are reported to the facility, a nurse will first review the results .3. A nurse will identify the urgency of communicating with the Attending Physician based on .the seriousness of any abnormality .If the resident has signs or symptoms of acute illness or condition change and he/she is not stable or improving, or there are no previous results for comparison, then the nurse will notify the physician promptly to discuss the situation, including a description of relevant clinical findings as well as the test results .Facility staff should document information about when, how, and to whom the information was provided and the response. This should be done in the Progress Notes section of the medical record . During a review of an online document published by Medline, National Institutes of Health (NIH), titled Complete Blood Count (CBC), last review dated 10/15/24, indicated, .abnormal levels of red blood cells, hemoglobin, or hematocrit may be a sign of .anemia . (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of an online document published by Medline, National Institutes of Health (NIH), titled Sodium Blood Test, last review dated 12/4/24, indicated, .A sodium blood test .may be used to help find and monitor conditions .without treatment, extremely low levels of sodium may also lead to a coma and become life-threatening . During a review of an online document published by Medline, National Institutes of Health (NIH), titled Alkaline Phosphatase, last review dated 11/5/24, indicated, .alkaline phosphatase test is often used to screen or to help diagnose diseases of the liver or bones .high alkaline phosphatase levels may be a sign of a liver problem or a bone disorder .		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41838 Based on observation, interview, and record review, the facility failed to puree (blend foods to smooth consistency) foods using methods that conserve nutritive value and flavor when excessive fluid was added, necessitating the addition of thickener. This failure had the potential of leading to poor intake, nutrient deficiencies, and weight loss for the 4 out of 62 residents eating facility prepared pureed meals. Findings: During a kitchen visit on 12/4/24 at 10:52 a.m., [NAME] (Ck) 1 was preparing the lunch meal. Ck 1 stated she had four residents on a pureed diet but would prepare five servings to add a buffer. Ck 1 placed five meatloaf servings in the food processor bowl and blended for approximately three seconds. She repeated blending for a few more seconds as the texture wasn't smooth enough. Ck 1 then added an unmeasured amount of broth and blended again for a few seconds, repeating this process several more times. After the fourth time of adding broth, Ck 1 found the meatloaf was runny and added a plastic spoonful of thickener, repeating four times before she was satisfied. Ck1 stated the goal was a consistency of baby food. During the same kitchen visit on 12/4/24 at 11:10 a.m., Ck 1 pureed the Au Gratin potatoes by scooping out five servings into the food processor bowl and blending for a total of approximately 6 seconds. Ck 1 added an unmeasured amount of milk to the bowl and blended. After blending, Ck 1 added thickener (1 plastic spoonful, twice) to correct the texture as the product was too runny. Review of [NAME] Dietitians, Guide to IDDSI [International Dysphagia Diet Standardization Initiative] Pureed at (www.rochedietitians.com) indicated, Individuals who are served . Pureed have a serious swallowing disorder called dysphagia [difficulty swallowing]. This means they cannot safely chew or swallow, so the food we serve must be smooth, moist, and prepared ready to swallow to minimize their risk of choking .Food texture characteristics include: -Smooth and free of lumps -Thick enough to hold shape on a plate or spoon -Falls off spoon in a single spoonful when tilted . -Cannot be poured, slow movement . During the plating of the meal on 12/4/24 starting at 12:15 p.m., the pureed meatloaf did not hold shape on the plate, instead forming a puddle. During a taste tray on 12/4/24 at 1:25 p.m., surveyors found the pureed meatloaf and pureed peas to be flavorless and gummy. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview with the Registered Dietitian (RD) on 12/5/24 at 1:05 p.m., the RD was asked about her expectation for pureeing food. The RD stated the process of adding liquids and thickener could change the taste of food. The RD concurred that excess liquids and thickener could affect the nutritional content of the foods. A review of Pureed Food: How To, Diet, and Uses Healthline website at www.healthline.com indicated, You can make almost any meal or snack into a puree by simply blending it with a little extra liquid, such as juice, water, or broth.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 41838 Based on observation, interview, and record review, the facility failed to provide alternative meal options of similar protein content to the meal entree when grilled cheese and peanut butter and jelly (PB&J) sandwiches were provided in place of the entree. This had the potential of leading to decreased protein intake for those choosing these alternatives. Findings: During the initial kitchen tour on 12/3/24 at 8:25 a.m., the alternative menu was observed hanging outside of the kitchen. This menu included Grilled Cheese and other sandwiches. During the lunch meal plating on 12/4/24 starting at 12:15 p.m., sandwiches such as grilled cheese and PB&J were provided on some meal trays due to resident request. These meals included the other side items from the lunch meal, but no additional source of protein. During an interview on 12/5/24 at 1:05 p.m. with the Registered Dietitian (RD), the RD concurred that some residents did receive sandwiches for their entree without an additional source of protein. Review of facility provided grilled cheese sandwich recipe indicated that it provided 15 grams of protein. Review of the facility provided PB&J recipe indicated that a sandwich would provide 18 grams of protein. The facility provided Meatloaf recipe did not include the nutrition breakdown. Review of website Nutritionvalue.org indicated that 3 ounces of beef meatloaf would provide 24 grams of protein.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41838 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety when: 1) Clean food service items were found put away wet (e.g. trays, steam table pans, scoops, and blender); 2) Can opener, food processor, and large saucepan were found dirty and/or rusted; 3) Raw chicken was prepared on a metal rack that had an uncovered container of dessert cups underneath; 4) Three bags in the freezer were open to the environment (sausage patties, biscuits, and mixed vegetables); 5) Staff were unable to demonstrate/explain the testing of sanitation concentration for the dish machine and red buckets/manual dish washing); and, 6) Resident refrigerator contained multiple food items with no name and/or date; and nursing staff were uncertain of how to label food brought in from outside, as well as where to reheat. These failures had the potential to lead to food borne illness for the 62 residents eating facility prepared meals. Findings: 1) During the initial kitchen tour on 12/3/24, beginning at 8:27 a.m. with the Dietary Director (DD), the blender was observed to be covered (indicating it was ready for use), but was found wet inside when the cover was removed. Two green scoops and one blue scoop were found in the scoop drawer stored wet. 17 out of 17 large steam table pans were found in the storage racks wet; and 7 out of 10 quarter sized steam table pans were stored wet. During a concurrent interview with the DD, she stated her expectation was that staff put away dishes after they were fully air dried. She went on to state that, wet nesting (placing wet items inside another item) could lead to contamination. Review of a facility provided policy titled, Ware washing (Healthcare Services Group, Inc., and its subsidiaries, revised 2/2023) stated in bullet 4, All dishware will be air dried and properly stored. Review of the United States (US) Food and Drug Administration (FDA) Food Code 2022, Section 4-901.11, indicated, items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2) During the initial kitchen tour/observation on 12/3/24, at 9:14 a.m. with the DD and the Regional Dietary Director (RDD) 1, the can opener, can opener sheath/base were found dirty with dark discoloration and rust. The food processor bowl, when opened, showed tan-colored crumbs inside. A large saucepan hanging in the ready to use area had food particles and rust inside. RDD 1 acknowledged the dirty and/or rusted items and moved them to the dish wash area for cleaning. During a concurrent interview with the DD, she stated her expectation was that staff properly wash cooking equipment and have it air dried after each use to avoid contamination. Review of a facility provided policy titled, Equipment (Healthcare Services Group, Inc., and its subsidiaries, Revised 9/2017) stated in bullet 3, All food contact equipment will be cleaned and sanitized after every use. In bullet 4 it further indicated, All non-food contact equipment will be clean and free of debris. A review of the US FDA 2022 Food Code, section 4-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, 1/18/23 version, indicated, .(C) Nonfood-Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 3) During the initial kitchen tour on 12/3/24 at 9:38 a.m., [NAME] (Ck) 1 was preparing raw chicken for the lunch meal by mixing it with seasonings in a large metal bowl. The bowl was placed on top of a metal cart where clean, uncovered dessert bowls were being stored. During an interview on 12/4/24 at 8:48 a.m., with the DD in the kitchen, Ck 1 was beginning to make meatloaf on this same metal cart. The DD stated that they had limited space in the kitchen and proceeded to move the dessert bowls to another area of the kitchen. A review of the US FDA Food Code 2022, 4-903.12 Prohibitions. Chapter 4. Titled, Equipment, Utensils, and Linens indicated that: (A) Except as specified in (B) of this section, cleaned and sanitized equipment . may not be stored: . 8) Under other sources of contamination. 4) During the initial kitchen tour on 12/3/24, at 9:54 a.m. with the DD and RDD 1, the walk-in freezer was observed. The freezer had three boxes (sausage patties, biscuits, and mixed vegetables) which contained plastic bags of these foods that had been left open to the environment. During a concurrent interview with RDD 1, he acknowledged the opened packages of frozen foods and stated they should be resealed and covered to prevent air exposure (potentially leading to cross contamination of the food) and freezer burn (which damages food). Review of a facility provided policy titled, Food Receiving and Storage-Refrigerated/Frozen Storage (Healthcare Services Group, Inc. and its subsidiaries, Revised 9/2017) indicated in bullet 1, All foods stored in the refrigerator or freezer are covered, labeled and dated. Review of the US FDA Food Code 2022 Annex 3. Public Health Reasons/Administrative Guidelines on section 3-302.11 Title Packaged and Unpackaged Food - Protection Separation, Packaging, and Segregation indicated, . Packaging must be appropriate for preventing the entry of microbes and other contaminants such as chemicals. These contaminants may be present on the outside of containers and may contaminate food if the packaging is inadequate or damaged, or when the packaging is opened. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5) During a concurrent observation and interview on 12/3/24 at 9:24 a.m., Dietary Aide (DA) 1 was washing the dishes from breakfast. She demonstrated how to check the sanitation concentration of the dish machine with a test strip into the rinse water via the initial dish machine drain. When asked to retest at the plate level, she was unable to get a reading which indicated the sanitation was effective. RDD 1 then attempted to test and noted sanitizer was not going through the tube to the machine. During a concurrent observation and interview on 12/3/24 at 4:02 p.m. DA 2 showed how he would check the dish machine sanitizer using a test strip. DA 2 placed the strip into the initial drain of the dishwashing machine instead of testing the plates that had been run through the machine to ensure that they were sanitized. The Department asked him to retest at the plate level which showed a concentration of 200 parts per million (ppm). When asked what the desired numbers were, DA 2 stated, any of the [four] levels would be OK. The DD corrected DA 2 and stated, the lightest color would not be concentrated enough, and the darkest color would be too concentrated. During this same kitchen visit on 12/3/24 at 4:11 p.m., DA 2 went on to show how he would wash dishes using the 3-compartment manual dishwashing process. He proceeded to show how to set up for washing, rinsing, and sanitizing but was unsure of the correct water temperature. He was shown the instructions posted over the sink but did not find the temperature on these instructions. RDD 1 stated he thought, it should be 110 F (Fahrenheit, a unit of measurement). DA 2 then demonstrated how he would test the sanitation concentration for the manual dish washing and red bucket sanitizing solution. The testing concentration showed 100 ppm which RDD 1 stated was OK even though it was the lowest of the 3 possible colors. A review of the test strip bottle on 12/3/24 at 4:17 p.m. did not show the desired concentration. RDD 1 was asked to provide instructions for the two sanitation strips (dish machine and red bucket/manual dish washing) the facility used. On 12/4/24 at 9:00 a.m., the DD was asked again to provide the dish machine and red bucket/manual dish washing instructions for test strips used in the facility. During a return visit to the kitchen on 12/4/24 at 9:12 a.m., DA 3 was asked to demonstrate sanitizing using the red buckets that are used to sanitize counters and fixed equipment. DA 3 stated they use the same sanitizer for the red buckets as they do to wash dishes by hand when the dishwasher is not working. DA 3 proceeded to describe the 3-compartment manual wash process. DA 3 was unable to state the temperature needed for effective cleaning and sanitizing. After checking with her supervisor, DA 3 stated, the temperature of the water in the sink should be 110 F. When asked about how long the dishes needed to remain in the sanitizer, she stated she would sanitize the dishes for 5-10seconds. Instructions over the sink stated to leave the dishes in the sanitizer for 10 minutes. During a demonstration of how to test the sanitizer solution the test strip concentration level result was 200 ppm. On 12/4/24 at 11:15 a.m., the DD brought the surveyors instructions for the red bucket/manual dish washing sanitizer solution, though nothing for the dishwashing machine. Review of given instructions showed that the red bucket instructions were not for the product that had been demonstrated (6 potential color options as opposed to the 3 on the bottle observed and had a 5 second wait time as opposed to 1 second on the bottle viewed). (continued on next page)		

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 12/06/2024
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a revisit to the kitchen on 12/4/24 at 11:46 a.m., the Department discussed with RDD 2 that these instructions were not same as the test strip bottle. RDD 2 concurred and said he would correct and get the instructions for dishwashing machine as well. No instructions were given prior to the end of survey. Review of the US FDA Food Code 2022, 4-501.116 titled, Warewashing Equipment, Determining Chemical Sanitizer Concentration indicated that Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. The Food Code also indicated in Annex 3-174 . a sanitizing solution that is too weak would be a violation of section 4- 501.114. A solution that is too strong would be a violation of section 7-204.11. Review of the US FDA Food Code 2022, Annex 3. Public Health Reasons/Administrative Guidelines. 7-204. 11 Titled, Sanitizers, Criteria indicated that Chemical sanitizers are included with poisonous or toxic materials because they may be toxic if not used in accordance with requirements listed in the Code of Federal Regulations (CFR). Large concentrations of sanitizer in excess of the CFR requirements can be harmful because residues of the materials remain . According to the US FDA Food Code 2022, Chapter 4, Equipment, Utensils, and Linens. 4-501.114 titled, Manual and Mechanical Ware washing Equipment, Chemical Sanitization - Temperature, pH (a measure of how acidic or basic a substance or solution is), Concentration, and Hardness indicated that A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under 4-703.11(C) shall meet the criteria specified under S7-204.11 . shall be used in accordance with the EPA-registered label use instructions, and shall be used as follows: (A) A chlorine solution shall have a minimum temperature based on the concentration and pH of the solution as listed in the following chart; as indicated . by the manufacturer's use directions included in the labeling. 6) During a visit to the resident dining room on 12/4/24 at 9:51 a.m. two refrigerators were observed in the area. Activities staff explained that the small refrigerator was used to stock snacks like sandwiches and pudding for residents who may want a snack after the kitchen closed. The second refrigerator contained resident food brought in from outside of the facility. When the large refrigerator was opened, it was filled with drinks and containers of food. Some items included names, room numbers, and dates. The refrigerator also contained the following items: -A fast food bag which listed an initial and last name, as well as a date of 11/3 (no year), but no room number, -A bag containing 5 string cheese with a room number, but no name or date, -A bottle of sports drink with a room number, but no name or date, -A package of noodle soup with a room number, but no name or date, and -A bag containing three plastic containers, which include a room number and date, but no name. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/5/24 at 9:55 a.m. Certified Nursing Assistant (CNA) 2 stated residents may receive food from outside sources. If the resident wanted it to be kept for later, the nurses would label it with the resident's name, room number and date by which it needed to be consumed. When asked how they would determine the date, she stated, it would depend, but was unable to give the criteria for figuring out the date. CNA 2 also stated that outside food would be heated for the resident in the microwaves in the employee break room. During an interview with CNA 3 on 12/5/24 at 10:13 a.m., she stated, the residents may bring store bought food or food prepared by family members to the facility. CNA 3 stated the food needs to be labelled with name or room number. When asked about the need for a date she was unsure. When prompted further about date labeling, she was unclear if the date would represent when the food was opened or brought in. CNA 3 further stated food would be discarded by common sense, such as it looks bad or is just sitting there or they can check the expiration date. CNA 3 went on to state that food would be reheated in the therapy microwave. During an interview on 12/5/24 at 10:25 a.m. the Rehabilitation Therapy Director (RTDr) stated the microwave in her department was only used for therapy purposes and it was not used for resident food heating. During an interview with the Director of Nursing (DON) on 12/5/24 at 1:40 p.m., the process for food brought from outside the facility was discussed. The DON was unfamiliar with the specifics of the policy but concurred that labeling with only a room number could lead to an inappropriate food being served to a resident. The DON further stated that the resident name is needed because sometimes residents are moved to another room. The DON went on to state, the staff knows where to reheat food and pointed to the staff breakroom. Review of facility provided policy titled, Safe Handling of Foods From Visitor dated 8/25/21 indicated in bullet 3 number 4, When food items are intended for later consumption, the responsible staff member will: a. Ensure that the food is stored separate or easily distinguishable from the facility food. b. Ensure that foods are in a sealed container to prevent cross contamination. c. Label foods with the resident's name and the current date and use by date (2 days from the date when the food was brought in) Example: day 1 is the date of food was brought in = 2/1/21. Use by date is = 2.2.21.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50598 Based on observation, interview, and record review, the facility failed to maintain infection prevention and control practices for a census of 67 residents when: 1. Urinals (a urine collection container) were not labeled and stored in a sanitary manner; 2. Two resident wash basins were stored on the floor in the bathroom, one was not labeled, and contained a soiled cloth; and, 3. Intramuscular Muscular Injection (an injection deep in the muscles) reconstitution (adding liquid to dry medication) was not properly handled; These failures increased the risk of infectious diseases for residents in the facility. Findings: 1. During a concurrent observation and interview with Certified Nursing Assistant (CNA) 1, on 12/3/24, at 9:32 AM, there were two urinals in a resident bathroom. One was not labeled with a name or room number and was upside down top of the toilet above the flushing handle. The other was placed on the assistive handrail next to the toilet. CNA 1 stated the urinal should be labeled and stated the location of both containers placed the residents at risk of an infection and cross contamination. During an interview on 12/6/24 at 9:05 AM, the Infection Preventionist (IP) stated the urinal, should have been properly labeled to ensure the residents did not use each other's items. The IP stated urinals should not be stored upside down on the toilet or hanging from handrails used by residents. 2. During a concurrent observation and interview on 12/3/24, at 9:05 AM, with Licensed Nurse (LN) 3, in a shared resident bathroom on station 2, there were two grey wash basins (buckets used to bath residents in bed) on the floor. One was not labeled, and the basins were stacked on top of each other, with a soiled dried washcloth hanging out between the basins. LN 3 stated the basins should not be kept on the floor and should be labeled, since this was a shared room and bathroom. LN 3 stated the cloth between the basins was soiled and should have been placed in the dirty linen after use. LN 3 stated this placed residents at risk for infection spreading. During an interview on 12/6/24 at 9:05 AM, the IP stated the basins should be properly labeled, sanitized after use, and placed in the residents' personal area. During an interview with the DON, on 12/6/24 at 11:15 AM, the DON stated the condition the urinals were found in did not meet the facility's expectations. The DON stated urinals should be labeled with name, room number, and date. The DON stated urinals should not be placed on the handrails, as this placed the residents at risk for falling. The DON stated the basins should have been labeled with name, room number and date, and placed with the residents' personal items, and the placement of the basins and presence of the soiled cloth placed the residents at risk for infection. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility document titled, Infection and Prevention Control Program dated 9/2024, indicated, Policy .The elements of the infection prevention control program consists of coordination/oversight policies/procedures, .prevention of infection .The infection prevention control committee .review will include . assessment of staff compliance with existing policies and regulations. A review of a facility document titled, Bedpan/urinal/offering and removing undated, indicated, After Assisting the Resident .Discard soiled towels, wash cloth, etc., in the soiled laundry container .clean, wash, and return to designated storage area. 40911 3. During an interview on 12/4/24, at 10 a.m. with Licensed Nurse (LN) 4, LN 4 stated Resident 130 would be receiving an IM (intramuscular) injection later in the morning and would be receiving an antibiotic that would require reconstitution. A review of Resident 130's medication label, dated 12/3/24, indicated to give ertapenem [an antibiotic]1 gm [gram-unit of measurement] vial, reconstitute vial with 3.2 ml [milliliter-unit of measurement] lidocaine [used to block pain]1% and inject 1.8 ml intramuscularly once a day for possible pneumonia for 2 days. During an observation on 12/4/24, at 11:46 a.m. on LN 4's medication cart, LN 4 took out two vials from her cart. One vial was the powdered antibiotic medication (ertapenem) and the other vial was the liquid solution (lidocaine) to mix with the powdered antibiotic. LN 4 took out a brand new 3 ml syringe with needle from her cart and drew up 3 ml lidocaine solution. LN 4 then placed the syringe with the lidocaine on top the cart leaving the needle exposed. LN 4 then injected the 3 ml lidocaine into the powdered medication. LN 4 then took the same syringe with needle and drew up the remaining 0.2 ml from the lidocaine solution and injected this into the powdered antibiotic medication. During an interview on 12/4/24, at 2:14 p.m, with LN 4, LN 4 confirmed she used the same syringe with the needle twice to draw up the lidocaine with 3 ml of lidocaine and then 0.2 ml. LN 4 stated that it was the correct technique when reconstituting medications. During an interview on 12/4/24, at 2:14 p.m. with the Director of Nursing (DON), the DON explained when reconstituting a medication, it was a best practice to not to inject the syringe with a needle twice into the same vial. The DON stated she expected the LN to have used multiple syringes with needles in reconstituting a medication and not to put the syringe with exposed needle on top of a contaminated surface. The DON further explained using the same needle to aspirate the lidocaine and exposing the needle to unclean surfaces could possibly lead to cross contamination that could result in an infected injection site. According to Center for Disease Control (CDC), The One and Only Campaign, a public health effort to eliminate unsafe medical injections, indicated, .Medication vials are entered with a new needle and a new syringe, even when obtaining additional doses for the same patient . www.cdc.gov/injection-safety/1anonly.html. (12/19/2024)		