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	03/20/2026

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 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. Based on observation, interview, and record review the facility failed to provide food storage and preparation, as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food safety for the 73 residents who ate facility prepared meals when: 1. Dishware not kept according to standard; 2. Food preparation equipment not kept clean per food safety standards; 3. Food items not properly labeled and/or stored and; 4. Staff unfamiliar with correct sanitizing process. These failures had the potential to put residents at risk for foodborne illnesses. Findings: 1. During a concurrent observation and interview on 3/17/26, during the initial kitchen tour at 8:20 a.m., with the CDM (Certified Dietary Manager) in the kitchen, four (4) out of twelve (12) coffee mugs were found scratched on the inside surface. The CDM confirmed this finding and stated the mugs should have been replaced. During a concurrent observation and interview on 3/17/26, during the initial kitchen tour at 9:37 a.m., with the CDM in the kitchen, two (2) frying pans were found with signs of over usage, such as scratched, discolored and coating worn off cooking surface. The CDM confirmed the frying pans should have been replaced. During an interview on 3/19/26 at 4:05 p.m., the CDM stated scratched mugs and scratched frying pans could lead to cross-contamination (bacteria that transfers from one surface to another) and should be replaced. A review of the United States (US) Food and Drug Administration (FDA) 2022 Food Code, section 4-202.11, titled, Food Contact Services, indicated, .Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts. During an interview on 3/18/26 at 8:30 a.m., Resident 49 stated she often received large spoons with the meal tray, and it was impossible to eat without spilling food all over her chest. During a concurrent observation and interview on 3/18/26 at 9:20 a.m. with the CDM in the kitchen, the spoon storage area was observed. There were two containers of stored spoons, one contained standard size spoons, and one contained large serving spoons. The spoons were approximately 20 in count. The CDM could not explain when the large serving spoons were given to a resident. During an interview on 3/18/26 at 11:32 p.m., DA 1 (Dietary Aide 1) stated the facility didn't have enough regular sized spoons, so serving spoons and soup spoons were being used in place of regular spoons. During an interview on 3/18/26 at 3:26 p.m., the SLP (Speech Language Pathologist) stated there was no reason for ordering such an overly large sized spoon for rehabilitation purposes. During an interview on 3/18/26 at 4:12 p.m., the Occupational Therapist (OT) stated she had not ordered any large size spoons for any residents. The OT concurred that it would be difficult to eat with such a large serving spoon and could cause food spillage. 2. During a concurrent observation and interview on 3/17/26, during the initial kitchen tour at 8:46 a.m., with the CDM in the kitchen, one (1) serving spoon ladle and three (3) steamtable pans were found stored wet. The CDM confirmed that these should have been dried before storing. A review of the facility's policy and procedure (P&P) titled, Manual Warewashing (3-Compartment Sink [manual warewashing, ensuring dishes are cleaned, rinsed, and sanitized to prevent infection]), revised 2024, indicated, .All silverware and cookware will be air dried prior to storage.) During a concurrent observation and interview on 3/17/26, during the initial kitchen tour at (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8:48 a.m., with the CDM in the kitchen, a stored blender was noted wet and with light brown food residue on the blade. The CDM confirmed this finding and took the blender to be washed again. During a concurrent observation and interview on 3/17/26, during the initial kitchen tour at 8:52 a.m., with the CDM in the kitchen, a can opener was found with light brown residue on the blade. A drawer was opened and found with food debris next to the clean scoops. The CDM confirmed these items were not up to the facility's standards. During multiple observations on 3/17/26, 3/18/26 and 3/19/26 at various times, the stove was found with greasy buildup on burners, and the oven was found with an old spill inside. During a review of the cleaning log on 3/17/26 at 9:40 a.m., the stove and oven was listed as being deep cleaned every Wednesday. During an observation on 3/19/26 at 11:46 a.m., the steam table (a food warming table) ledge was found with food crumbs and old spills on the surface. This ledge was holding the clean steam table pan lids. During an interview on 3/19/26 at 4:05 p.m., the CDM stated dirty items, old spills and food debris, were not acceptable and should have been cleaned properly as they could lead to cross contamination. 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) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. A review of the facility's P&P titled, Environment, revised 2025, indicated, .All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition.All food contact surfaces will be cleaned and sanitized after each use. 3. During a concurrent observation and interview on 3/17/26, during the initial kitchen tour at 8:33 a.m., with the CDM in the kitchen, fish fillets and carrots were found not closed properly in the freezer. The CDM said they should have been closed tightly. During a concurrent observation and interview on 3/17/26, during the initial kitchen tour at 8:46 a.m., with the CDM in the kitchen, a white powdery substance was found in a large measuring cup, inside a plastic bag, which was unlabeled and undated. The CDM stated that the powdery substance was thickener (substances used to increase the thickness of liquids and foods) but was unable to state when it was opened or when it should be discarded. A plastic container of garlic powder and one (1) container of beef broth base were found unlabeled. The CDM confirmed that these should have been labeled. During an interview on 3/19/26 at 4:05 p.m., the CDM stated the food items needed to be labeled and dated to ensure food safety. The CDM also stated that food products needed to be closed properly to prevent cross contamination. A review of the facility's P&P titled, Food Storage: Cold Foods, revised 2023, indicated, .All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. A review of the facility's P&P titled, Food Storage: Dry Goods, revised 2023, indicated, .All dry goods will be appropriately stored in accordance with the FDA Food Code. A review of the US FDA 2022 Food Code, section 3-602.11, titled, Food Labels, indicated, .(B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; (2) If made from two or more ingredients, a list of ingredients and sub-ingredients. A review of the US FDA 2022 Food Code, section 3-305.13, titled, Vended Time/Temperature Control for Safety Food, Original Container, 1/18/23 version, indicated, The possibility of product contamination increases whenever food is exposed .Once the original seal is broken, the food is vulnerable to contamination. A review of the US FDA 2022 Food Code, section 3-302.11, titled Packaged and Unpackaged Food -Separation, Packaging, and Segregation, 1/18/23 version, indicated, (A) FOOD shall be protected from cross contamination by .storing the food in packages, covered containers, or wrappings . 4. During a concurrent observation and interview on 3/17/26, during the initial kitchen tour at 8:49 a.m., with the CDM in the kitchen, Dietary Aide (DA 2) discussed the process of manual 3 compartment dishwashing (used in commercial kitchens for the manual washing, rinsing, and sanitizing of dishes and utensils). DA 2 stated that dishes were placed in the sanitizer and then quickly removed from the sanitizer. DA 2 read aloud the sanitizing directions that were placed over the sink and stated that the dishes/utensils were supposed to be held in the sanitizer for 60 seconds. During a concurrent observation and interview on (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3/17/26, within the initial kitchen tour at 8:57 a.m., DA 3 demonstrated the process of checking the concentration of the red bucket (sanitizing bucket). DA 3 put the concentration test strip (a rapid, single-use diagnostic tools that determine the strength of chemical solutions) into the green bucket of sudsy water for 4 seconds. The strip did not show the correct sanitation level. DA 3 read the bottle instructions, put a new strip in the solution for 10 seconds, with the result of inadequate sanitation level. DA 3 stated the bucket appeared to be cleaning solution and not sanitation solution. During a concurrent observation and interview on 3/17/26 at 3:01 p.m., the [NAME] (Ck 2) showed the department surveyors the manual dishwashing area. Ck 2 verbalized that the washing process included putting the dishes in the sanitizer solution but did not know how long to keep the dishes in this solution. Ck 2 stated the dishes need to be kept in the sanitizer solution for 60 seconds. During a concurrent observation and interview on 3/17/26 at 3:17 p.m., DA 4 demonstrated how to check the sanitizer solution in the red bucket. DA 4 put the test strip in the solution for 4 seconds and removed the test strip. DA 4 stated the color was good even though it was very faint and did not reach the correct concentration level. DA 4 then read the instructions and retested for 11 seconds, bringing the color to the correct level. During an interview on 3/19/26 at 4:05 p.m., the CDM stated the staff should be following the correct sanitization procedures. The CDM further stated that not following the correct procedures could lead to cross contamination of food and utensils. A review of the facility's P&P titled, Manual Warewashing (3-Compartment Sink), revised 2024, indicated, .Sanitize in the third sink: Chemical sanitizer testing and concentrations used according to manufacturer guidelines.) A review of the facility's P&P titled, Environment, revised 2025, indicated, .The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces.

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	555387	A. Building B. Wing	03/20/2026

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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. Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan (a dynamic, individualized, and multidisciplinary document outlining a resident's medical, functional, and psychosocial needs) for 2 out of 20 sampled residents when:1. A care plan for the use of psychotropic medication (mind altering medication) was not developed for Resident 8.2. The care plan interventions for an indwelling suprapubic catheter were not followed for Resident 47.These failures had the potential to place Resident 8 for not receiving effective and person-centered care, and Resident 47 at increased risk for infection. Overall, these could negatively impact the health, safety, and well-being of Residents 8 and 47. Findings: 1.During a review of Resident 8's admission Record, the record indicated Resident 8's diagnosis included depression (mental depression with feeling of sadness), anxiety disorder (persistent or excessive worrying that interferes with daily life), post-traumatic stress disorder (or PTSD a mental condition triggered by experiencing or witnessing a traumatic events with flashbacks and nightmares), and Lewy bodies dementia (a type of memory loss with hallucinations and fluctuating alertness). The record additionally indicated that Resident 8 was a responsible party (being fully accountable for own health care decisions). During a concurrent interview and record review on 3/19/26 at 2:29 PM with Licensed Nurse 3 (LN 3), Resident 8's medical record titled, MEDICATION ADMINISTRATION RECORD [MAR, a list of the resident's ordered medications and times they were given or held], dated 3/1/26 to 3/31/26 and Resident 8's care plans were reviewed. LN 3 confirmed that following order: . diazepam Oral Tablet 10 MG [MG, milligram - a unit of measurement] . Give 1 tablet by mouth every morning and at the bedtime for Anxiety. was started on 3/11/26. During a review of Resident 8's care plans, the care plan indicated a care plan for the medication diazepam 10 MG oral tablet had not been developed. LN 3 acknowledged the findings and stated that care plans served as a framework for the care provided by nursing staff. LN 3 explained that nurses were responsible for developing care plans and implementing interventions as guiding tools, as well as following those interventions to evaluate their effectiveness. LN 3 further stated that without a developed care plan, nurses were unable to assess the effectiveness of the medication or monitor improvement in the resident's health status. LN 3 further added that when a care plan was not developed, it appeared that no interventions were implemented and that there was a lack of coordination of care. During an interview on 3/20/26 at 7:44 AM with LN 5, LN 5 stated that nurses were required to develop a care plan for psychotropic medications when a medication was initiated to monitor its effectiveness in managing the resident's behaviors during the treatment period. LN 5 explained that care plans should have been individualized based on the resident's current health and psychological condition and served as a tool to guide nursing staff in providing care. LN 5 further stated in the absence of a developed care plan for the psychotropic medication, nurses were unable to effectively evaluate the medication's effectiveness. During an interview on 3/20/26 at 11:19 AM with the DON, the DON stated that care plans should have been individualized and included person-centered goals and interventions to improve residents' health conditions. The DON added that care plans served as guidelines to direct nursing staff in providing appropriate care. The DON further stated that her expectation of the nursing staff was to develop a care plan for Resident 8's psychotropic medication, diazepam, implement appropriate interventions, evaluate the effectiveness of the medication in managing the resident's behaviors, and notify the Medical Director (MD) regarding its effectiveness. The DON further added that this expectation was not met. 2.During a review of Resident 47's admission Record, the record indicated Resident 47's diagnosis included Neuromuscular dysfunction of bladder (a neurogenic bladder where nervous system damage disrupts signals between the brain, spinal cord [a long, thin, tubular bundle of nervous tissue and cells, serving as the main pathway for information connecting the brain and the rest of body], and bladder muscles, causing loss of control, incontinence, or retention [inability to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	empty the bladder]), and the presence of urogenital implants (indicates the existence of a permanent artificial devices supporting urinary function). During a concurrent observation and interview on 3/17/26 at 12:27 PM with Resident 47, Resident 47 was observed in a sitting position in bed with a suprapubic catheter (a thin, flexible tube surgically inserted through the lower abdomen directly into the bladder to drain urine. Potential complications include infections such as urinary tract infection [UTI, a common infection caused by bacteria entering the bladder, or kidneys]) in place. The catheter drainage bag was noted to be inside the privacy bag that was placed directly on the floor to the left side of the resident. Resident 47 further stated that he had the suprapubic catheter for several months due to an inability to urinate. During a review of Resident 47's medical record titled, Order Summary Report, indicated there was an order to perform suprapubic catheter care every shift that was initiated on 8/23/25. The order reflected it was an ongoing intervention, and its continued presence on the active orders list suggested it remained in effect without documented discontinuation. During a review of Resident 47's care plan initiated on 10/29/25, in the section titled, Focus, indicated, . [Resident 47] Requires indwelling suprapubic catheter due to: other: BPH [benign prostatic hyperplasia- a condition characterized by an enlarged prostate gland and causes frequent urination, weak stream, or difficulty starting urination] . In the section titled, Interventions, indicated, .Keep catheter off floor. During an interview on 3/19/26 at 11:06 AM, LN 4 stated nurses were responsible for developing care plans and initiating person-centered interventions for each resident based on their individual needs. LN 4 explained that interventions should be regularly reviewed and followed, as they served as guidelines for proving care to residents. LN 4 further stated according to the care plan goal for a suprapubic catheter, the drainage bag should be kept off the floor and should not come into contact with the floor for infection control and prevention purposes. LN 4 further added that placing the suprapubic catheter drainage bag on the floor increased the risk of infection when the care plan intervention was not followed. During a concurrent interview and record review on 3/19/2026 at 11:47 AM with the IP, Resident 47's care plan for indwelling suprapubic catheter, created on 10/29/25 was reviewed. The review indicated the suprapubic catheter should have been kept off the floor. The IP stated that Resident 47 was at risk for infection due to the indwelling suprapubic catheter. The IP explained that the drainage bag should be positioned below the bladder level and kept off the floor at all times as per care plan interventions. The IP further stated that her expectation of the nursing staff was to monitor Resident 47 to ensure the catheter bag was not in contact with the floor and that care plan interventions were followed to reduce the risk of infection and further complications. The IP further added that her expectation was not met by the nursing staff. During an interview on 3/19/26 at 4:27 PM with the DON, the DON stated that the suprapubic catheter drainage bag should not have touched the floor at any time and should be hung slightly above the floor. The DON further stated that her expectation was for the nursing staff to follow the care plan interventions; however, the expectation was not met. During a review of the facility provided policy and procedure (P&P) titled, CARE PLAN COMPREHENSIVE, dated 8/25/21, the review indicated, . PURPOSE. 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. PROCEDURE.1. h. Aid in preventing or reducing declines in the resident's functional status and/or functional levels. 4. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes.

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	555387	A. Building B. Wing	03/20/2026

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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. Based on observations, interviews, and record review, the facility failed to prepare meals adequately when; 1.Meals prepared were bland and lacked flavor for 4 out of 73 residents (Resident 18, Resident 49, Resident 55 and Resident 64), and 2. Pureed foods (a smooth, thick, pudding-like consistency created by blending, mashing, or straining food, requiring no chewing) were not prepared by methods that conserve nutritive value, flavor, and appearance when recipes were not followed, and water was used to thin the prepared foods. These failures had the potential for malnutrition, weight loss, impaired wound healing, and increased susceptibility to disease. Findings: 1. During an interview on 3/17/26 at 2:22 p.m. with Resident 55, Resident 55 stated the food tasted bad. Resident 55 was noted to have multiple outside food items and beverages on the bedside table. Resident 55 stated that his family brought in food because the facility food was not appetizing. During an interview on 3/18/26 at 8:30 a.m. with Resident 49, Resident 49 stated the food was not up to her expectations, especially at breakfast. Resident 49 gave the example of food being cold, lacking flavor, and that the oatmeal was too runny and was able to be eaten through a straw. During an interview on 3/19/26 at 12:45 p.m. with Resident 64, Resident 64 stated the food was bland and needed more seasoning and garnishing. During an interview on 3/19/26 at 12:55 p.m. with Resident 18, Resident 18 stated, the food was nasty and very bland. Resident 18 also stated that the food was not visually appealing and lacked taste and seasoning. During the tasting of a test meal on 3/18/26 at 12:58 p.m., the two department surveyors found both the regular and pureed foods tasted bland and lacked seasoning. The stir fry entree lacked Asian flavorings such as ginger and soy sauce. The green beans and rice had no seasoning added and tasted uninteresting. During an interview on 3/19/26 at 11:38 p.m. with the Regional Dietary Manager (RDM), the RDM concurred that the food lacked seasoning and stated that he had been talking to the management about it for some time, hoping to make some flavor enhancements. A review of www.Mayoclinic.org article titled, Loss of taste and smell: Natural with aging?, indicated, Some loss of taste and smell is natural with aging. Loss of taste and smell can have a significant effect on quality of life. It often leads to decreased appetite and poor nutrition. It can sometimes contribute to depression. A review of www.osufacts.okstate.edu article titled, Nutrition for Older Adults: Taste, Smell and Nutrition, indicated in the tips section, . to use herbs, spices and lemon juice . to increase the flavor of foods. 2. During a return visit to the kitchen on 3/19/26 at 11:01 a.m., the [NAME] 1 (Ck1) was preparing the lunch meal. The menu for the lunch meal indicated Lasagna, Italian Vegetables, and a Roll. Review of the lunch menu for the vegetarian diet for 3/19/26 indicated vegetarian meatballs, marinara sauce, (continued on next page)

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	555387	A. Building B. Wing	03/20/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and pasta. After making various textured versions of the lunch meal, the Ck 1 took out a 19-ounce tub of tofu and cut it into quarters. The Ck 1 took two (2) of the quarters (approximately 9 1/2 ounces) and placed them in the food processor bowl. The Ck 1 next added an unmeasured amount of canned tomato sauce and blended the mixture. No recipe was followed, and no other seasonings were added. Once blended, the Ck 1 found the mixture too thin and added an unmeasured amount of thickener twice. The Ck 1 decided the mixture was too thick and added hot water to the mixture to thin it three times, before being content with the texture. The Ck 1 then poured the mixture into a steam table pan and placed it in the warmer in preparation for the lunch meal. No taste testing of product was observed. Review of puree instructions found at website idaho.gov, https://publicdocuments.dhw.idaho.gov, indicated Do not serve a pureed meal to one of your clients if you would not be willing to eat it yourself! It further indicated in the directions for making pureed foods to: Start with just the food (drained, no extra liquid) Add small amounts of liquid to reach desired consistency Never puree with water. Review of website www.GInutrition.virginia.edu indicated when pureeing food: Liquids to try are milk, broth, fruit or vegetable juice, liquid nutritional supplements (such as Ensure , Boost , or the store brand equivalent), Lactaid milk, kefir, etc. Choose whichever liquid will taste best (e.g., use chicken broth with chicken, milk with sweets).

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	03/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement appropriate infection prevention and control measures for a census of 73, when:1. Resident 47's suprapubic catheter (a thin, flexible tube surgically inserted through the lower abdomen directly into the bladder to drain urine. Potential complications include infections such as urinary tract infection [UTI, a common infection caused by bacteria entering the bladder, or kidneys]) drainage bag was observed positioned on the floor; 2. Staff failed to perform proper hand hygiene during medication administration for Resident 4, Resident 23, Resident 42, Resident 58, and Resident 77; and,3. Staff failed to follow infection control protocols when nutritional drinks were transferred from one resident's room to another.These failures in infection prevention and control practices had the potential to contribute to the spread of infection among residents and staff within the facility.Findings: 1.During a review of Resident 47's admission Record, the record indicated Resident 47's diagnosis included Neuromuscular dysfunction of bladder (a neurogenic bladder where nervous system damage disrupts signals between the brain, spinal cord [a long, thin, tubular bundle of nervous tissue and cells, serving as the main pathway for information connecting the brain and the rest of body], and bladder muscles, causing loss of control, incontinence, or retention [inability to empty the bladder]), and presence of urogenital implants (indicates the existence of a permanent artificial devices supporting urinary function). During a review of Resident 47's medical record, titled Order Summary Report, reflected to active orders as of 3/18/26, indicated, Perform Suprapubic Catheter [a thin, flexible tube surgically inserted through the lower abdomen directly into the bladder to drain urine. Potential complications include infections such as urinary tract infection; a common infection caused by bacteria entering the bladder, or kidneys] Care every shift ., with a start date of 4/30/24. This order reflected an ongoing intervention, and its continued presence on the active orders list indicated it remained in effect without documented discontinuation. During a concurrent observation and interview conducted on 3/17/26 at 12:27 PM, Resident 47 was observed in a sitting position in bed with a suprapubic catheter in place. The catheter drainage bag was noted to be inside the privacy bag that was placed directly on the floor to the left side of the resident. Resident 47 further stated that he had the suprapubic catheter for several months due to an inability to urinate. During a concurrent observation and interview conducted on 3/17/26 at 12:38 PM in Resident 47's room, Licensed Nurse (LN) 3 confirmed that Resident 47's suprapubic catheter drainage bag was found on the floor. LN 3 stated that the catheter drainage bag should have been hung from Resident 47's bed frame and not placed on the floor. LN 3 further explained that Resident 47 was at increased risk for infection due to the presence of an indwelling suprapubic catheter. LN 3 acknowledged that the observed placement of the drainage bag on the floor posed an infection control and prevention concern. During an interview on 3/18/26 at 9:55 AM, LN 2 stated that indwelling catheter drainage bags were required to be off the floor at all times to prevent contamination and reduce the risk of UTI. During an interview on 3/19/26 at 11:47 AM, the Infection Preventionist (IP) stated her expectation from nursing staff was to ensure that Resident 47's suprapubic catheter drainage bag was not placed on the floor, was hung from the bed frame, and remained below bladder level while in bed. The IP (continued on next page)

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	03/20/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	further stated that Resident 47 was prone to infection due to having an indwelling catheter, which could be a potential site for organism entry into the body. During an interview on 3/19/26 at 4:47 PM, the Director of Nursing (DON) stated her expectation was that nursing staff ensured Resident 47's suprapubic catheter drainage bag was properly secured to the bed frame while the resident was in bed, not positioned on the floor, and hung above the floor. The DON further stated that her expectation was not being met. During a review of Resident 47's care plan dated 10/29/25, in the section Goal, indicated, Resident will have no signs and symptoms of urinary tract infection., and in the section Focus, indicated, Resident requires indwelling suprapubic catheter. In the section, Interventions, indicated, Keep catheter off floor. During a review of the facility provided policy and procedure (P&P) titled Suprapubic Catheter Care, revised in 10/2010, indicated, . The purpose of this procedure is. to prevent infection of the resident's urinary tract. Preparation 1. Review the resident's care plan. 2. During a medication administration observation on 3/18/26 at 4:40 p.m. at Unit 2, LN 6 wheeled Resident 23 to her room to administer her medication. LN 6 prepared Resident 23's medication and when it was done, she entered Resident 23's room and handed the pills to her. LN 6 went back to her medication cart and prepared the medication for Resident 42 who was in the same room in bed A. LN 6 handed the pills to Resident 42. LN 6 went back to her medication cart and went to the next room. LN 6 did not perform hand hygiene after giving medication to Resident 23 and did not perform hand hygiene before and after medication administration for Resident 42. During a medication administration observation on 3/18/26, at 5:11 p.m. at Unit 2, LN 6 prepared Resident 77's medication and when it was done, she entered Resident 77's room and handed the pills and inhaler (medication in spray or powder form that you breath in) to him. LN 6 went back to her medication cart and made her way to Resident 58's room without performing hand hygiene after giving resident 77's medication. LN 6 then prepared Resident 58's medication, entered the room and handed Resident 58's pills. LN 6 went back to her medication cart and prepared Resident 4's medication who was in the same room in bed A. LN 6 then entered the room and gave the medication to Resident 4. LN 6 did not perform hand hygiene before and after medication administration for Resident 58 and Resident 4. LN 6 was not available for interview after her medication administration in Unit 2. During an interview on 3/19/26 at 12:03 p.m. with the IP, the IP stated hand hygiene should be performed when entering and exiting the room, before and after medication administration, and going from bed A to bed B in the same room. The IP also stated cross contamination would be the biggest risk for bacterial and viral infections (microorganisms that can cause diseases) among the residents without proper hand hygiene practices. During an interview on 3/19/26 at 3:16 p.m. with the DON, the DON stated she would expect the nursing staff to perform hand hygiene either to wash hands or use hand sanitizer before and after medication administration. The DON also stated this practice would prevent the risk for cross-contamination among residents and the spread of infection. During a review of the facility's policy titled, Administering Medications, revised 4/2019, the policy (continued on next page)

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	03/20/2026

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, .Staff follows established facility infection control procedures (e.g., handwashing.) for the administration of medications. During a review of the facility's policy titled, Handwashing/Hand Hygiene, dated 9/18/23, the policy indicated, .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.Wash hands with soap.and water.When hands are visibly soiled.Use an alcohol-based hand rub containing at least 62% alcohol.Before and after contact with the resident. During a review of the facility's job descriptions titled, Licensed Practical (Vocational) Nurse (LPN)(LVN), revised May 2022, the job description indicated, .Adhere to the facility infection prevention and control practices. During a review of the facility's job descriptions titled, Registered Nurse (RN), revised 7/2024, the job description indicated, .Adhere to the facility infection prevention and control practices. 3. During a review of Resident 1's admission RECORD, dated 3/19/26, the record indicated, Resident 1 was admitted to the facility with diagnoses including dysphagia (difficulty swallowing) and encounter for attention to gastrostomy (a surgical procedure that creates an opening (stoma) through the abdominal wall directly into the stomach, usually to insert a feeding tube (G-tube) to allow nutrition, medication, and fluids to be delivered directly to the stomach). During a review of Resident 1's Minimum Data Set, (a resident assessment tool) dated 2/13/26, the MDS under the swallowing/nutrition Status revealed, Resident 1 had a feeding tube on admission and while a resident in the facility. During a review of Resident 1's Care Plan Report (a form where you can summarize a person's health conditions, specific care needs, and current treatments), dated 2/11/26, the care plan indicated, .Resident has an enteral feeding tube [a method of delivering liquid nutrition directly into the stomach via a tube] to meet nutritional needs. During a review of Resident 1's Order Summary Report, active physician's orders as of 3/19/26, the order indicated, .Enteral Feed Order two times a day.use [feeding formula] 1.5 CAL if 1.2 CAL [CAL-the caloric density of the formula in calories per milliliter/ml, unit of measurement] is not available [feeding formula] 1.2 CAL Administer continuous via Pump. During a medication administration observation and interview on 3/17/26 at 3:02 p.m. at Unit 2 with LN 6, LN 6 was in Resident 1's room preparing for Resident 1's enteral feeding. The bag for the enteral formula was full, and tube passed through the pump ready for feeding. There were also 4 unopened cartoons of feeding formula 1.5 CAL of 230 ml each cartoon and an unopened package of feeding tube that were on Resident 1's bedside table. After LN 6 finished preparing Resident 1's enteral feeding, she took the 4 cartoons of feeding formula and the feeding tube and brought the items to another resident's room. LN 6 stated she was preparing Resident 1's enteral feeding to be ready for her scheduled feeding time. LN 6 also stated the 4 cartoons of feeding formula and the new feeding tube that were on Resident 1's bedside table that she took and brought to another resident was for the resident who was also on enteral feeding. LN 6 stated she should not have done that to transfer items from one resident to another. LN 6 further stated she did not observe infection control practices and increased the risk for cross contamination and infection from one resident to another. (continued on next page)

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	555387	A. Building B. Wing	03/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/26 at 12:03 p.m. with the IP, the IP stated cross contamination would be the biggest risk for bacterial and viral infections (microorganisms that can cause diseases) among the residents without proper infection control practices. During an interview on 3/19/26 at 3:16 p.m. with DON, the DON stated once an item or items were in one resident's room, it should not have been transferred to another resident's room. The DON also stated this practice would increase the risk for cross contamination and potentially could spread infection to residents, staff, and visitors. During a review of facility's policy titled, Infection Prevention and Control Program, dated 9/18/23, the policy indicated, .An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. During a review of the facility's job descriptions titled, Licensed Practical (Vocational) Nurse (LPN)(LVN), revised 5/2022, the job description indicated, .Adhere to the facility infection prevention and control practices. During a review of the facility's job descriptions titled, Registered Nurse (RN), revised 7/2024, the job description indicated, .Adhere to the facility infection prevention and control practices.

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	03/20/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to inform and document an informed consent (a signed document requires healthcare providers to disclose risks, benefits, alternatives to ensure patients make educated decisions about their care or medication use) for increasing the diazepam (a mental health drug used to treat anxiety) dosage in one out of 5 sampled residents (Resident 8) that were reviewed for unnecessary drug use based on facility's policy on resident's rights.This failure had the potential to violate Resident 8's right to be aware of the consequences (risks versus benefits) of higher drug dosage usage that could contribute to adverse effects including dizziness, excessive sedation, fall risk and bone fracture.Findings: During a review of Resident 8's admission Record, the record indicated Resident 8's diagnosis included depression (mental depression with feeling of sadness), anxiety disorder (persistent or excessive worrying that interferes with daily life), post-traumatic stress disorder (or PTSD a mental condition triggered by experiencing or witnessing a traumatic events with flashbacks and nightmares), and Lewy bodies dementia (a type of memory loss with hallucinations and fluctuating alertness). The record additionally indicated that Resident 8 was self-responsible party (being fully accountable for own health care decisions). During a concurrent interview and record review on 3/19/26 at 2:29 PM with Licensed Nurse 3, (LN 3) Resident 8's medical record titled, AFTER VISIT SUMMARY [when residents see a specialist outside the facility], dated 3/5/26 and MEDICATION ADMINISTRATION RECORD [MAR, a document used by healthcare professionals to track, document, and verify the medications administered to a patient], dated 3/1/26 to 3/31/26 were reviewed. The AFTER VISIT SUMMARY indicated,. Today's medication changes. diazepam [VALIUM]-medication strength, how much to take, how to take this, when to take this, reasons to take this, additional instructions. diazepam 10mg [mg is milligram, a unit of strength]. generalized anxiety disorder. take one tablet in the morning and one tablet at bedtime scheduled What changed. medication strength. how much to take. how to take this. when to take this. reasons to take this. Resident 8's clinical record titled, MEDICATION ADMINISTRATION RECORD [MAR], dated 3/1/26 to 3/31/26, contained the following order that started on 3/11/26: . diazepam Oral Tablet 10 MG. Give 1 tablet by mouth every morning and at the bedtime for Anxiety. The review indicated the updated order with dosage increase was approved by the primary medical doctor (MD) in the facility and initiated on 3/11/26. The medical record did not show documentation that the MD recorded a discussion with Resident 8 on diazepam dosage increase and its risks or benefits. LN 3 acknowledged there was a lack of informed consent documentation for the diazepam dose increase. LN 3 stated, except in emergency situations where a physician might override the requirement, informed consent should have been obtained prior to initiating or increasing psychotropic medications. LN 3 stated that the physician was responsible for discussing the medication's purpose, necessity, potential side effects, and risks and benefits with the resident and/or the resident's representative. LN 3 further stated the physician should have documented the informed consent prior to administration of diazepam. During an interview on 3/20/26 at 7:44 AM with LN 5, LN 5 was asked to explain the workflow on processing residents' after-visit summary orders (a document provided to residents after a medical appointment, summarizing the visit, diagnosis, treatments plans, and necessary follow-ups). LN 5 stated she reviewed all documents, including after-visit summary instructions, whenever residents returned from outside provider visits and identified any changes in medication orders. LN 5 indicated that she followed the instructions outlined in the after-visit summaries. LN 5 stated that when there was an increase in medication dosage, or a new psychotropic (mental health/mind altering drugs) medication order, she notified the Medical Director (MD). LN 5 added if the MD agreed with the new order or changes, informed consent was obtained from the resident or the resident's representative by the MD. LN 5 stated signed consents were documented in the resident's medical record prior to implementation of new medication orders. LN 5 further stated nurses should not have administered psychotropic medications without a documented informed consent. During a (continued on next page)

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	03/20/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concurrent phone interview and review of Resident 8's electronic medical record for informed consents, on 3/20/26 at 8:23 AM with the MD, the MD stated that Resident 8 had multiple chronic medical and psychiatric conditions. The MD stated Resident 8 had been evaluated and followed by a psychiatrist (mental health specialist doctor) for mental health conditions. The MD stated he reviewed Resident 8's electronic medical record and confirmed that informed consent was not obtained with medication dosage increase. The MD further stated that informed consent was required prior to the administration of psychotropic medications, including when there was a new order or an increased dosage, and that consent should have been obtained from the resident and, or the resident's representative and it was not. The MD stated that he was unsure how the requirement had been missed for Resident 8. During a concurrent interview and record review on 3/20/26 at 11:19 AM with the Director of Nursing (DON), Resident 8's medical record was reviewed for informed consent. The DON acknowledged informed consent had not been obtained or documented in Resident 8's medical record for diazepam dosage increase. The DON stated it was her expectation and best practice to obtain informed consent for new, or dose increases for psychotropic medications in accordance with regulatory requirements. The DON further stated that this expectation was not met in this instance. During a review of an undated facility provided document titled, Informed Consent for Psychotropic Drugs Pharmacy Services, The review indicated, . Purpose. It outlines responsibilities for obtaining, verifying, and documenting informed consent to protect resident rights, promote safety, and facilitate appropriate use of these medications for residents with behavioral or psychotic symptoms, such as those associated with dementia. Facilities must also comply with any additional state-specific requirements. Scope. This policy applies to all residents Medicare- and/or Medicaid-certified skilled nursing facilities (SNFs) prescribed psychotropic drugs, including new initiations, dose increases. Definitions. Informed Consent. Consent must be obtained prior to initiation or increase.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. Based on observation, interview, and record review, the facility failed to provide appropriate care and services to one of six residents (Resident 1) who receive nutrition, fluids, and medications through a gastrostomy tube (GT- also referred to as an enteral feeding/tube feeding- a tube inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medications when swallowing is not possible or safe) when Resident 1's percutaneous endoscopic gastrostomy tube (PEG tube-a tube inserted through the skin and abdominal wall directly into the stomach for the delivery of nutrition, fluids, and medications) placement was not checked before medication administration.This failure had the potential to result in Resident 1 developing infection and even death.Findings:During a review of Resident 1's admission RECORD, dated 3/19/26, the record indicated Resident 1 was admitted to the facility with a diagnosis which included dysphagia (difficulty swallowing), quadriplegia (paralysis of all four limbs, arms and legs, and the torso), cerebral palsy (a brain disorder that appears in infancy or early childhood that affects body movement, muscle coordination, and posture), and an encounter for attention to gastrostomy.During a Review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool), under the cognitive Patterns, dated 2/13/26, the MDS revealed Resident 1's Brief Interview for Mental Status (BIMS-a tool to assess mental functioning) score was entered as 0 indicating, .resident is rarely/never understood. The MDS also revealed under the Swallowing/Nutrition Status, Resident 1 had a feeding tube on admission, while not a resident, and while a resident in the facility.During a review of Resident 1's Order Summary Report, the report indicated an active physician's orders as of 3/19/26, the order report indicated, .Enteral feed: Check tube placement prior to each feeding, flush [the process of delivering water through the tube with a syringe to prevent from clogging], or Medication Administration every shift.During a review of Resident 1's Care Plan Report, (a form where you can summarize a person's health conditions, specific care needs, and current treatments) dated 3/17/26, the report indicated, .Risk for complications r/t [related to] enteral feeding via PEG tube.Verify tube placement prior to feeding/medication.During a medication administration observation on 3/19/26 at 8:09 a.m. in Resident 1's room, Licensed Nurse (LN) 4 prepared three medications for Resident 1 to be administered via the PEG tube. LN 4 gathered all her equipment and together with the crushed medications and a half-filled cup of water, entered Resident 1's room and placed the medication and supplies on the bedside table after putting on her disposable gown and gloves. LN 4 did not bring her stethoscope (a medical instrument used for listening to internal body sounds such as the heart, lungs, and intestines) with her to the bedside.During a subsequent medication administration observation on 3/19/26 at 8:09 a.m. with LN 4, LN 4 disconnected the tube from the feeding formula and attached the syringe into the tube. She then poured approximately 1/4 full of the syringe with water to flush the tube then followed by the crushed medications dissolved with small amount of water. She then flushed another 1/4 full of water into the syringe to clear the tube from the remaining medicines that were still in the tube to prevent from clogging. LN 4 did not verify the placement of the gastrostomy tube by drawing 5 to 10 ml (ml-milliliters, a unit of measurement) of air into the syringe and push the air in while listening with a stethoscope for a growl or swoosh sound over the abdomen before flushing with water for medication administration.During a concurrent interview and record review on 3/19/26 at 1:07 p.m. with LN 4, Resident 1's Order Summary Report, active order as of 3/19/26 was reviewed. LN 4 stated that she had verified the placement of the PEG tube before medication administration 30 minutes earlier at 7:30 a.m. and there was no need to check the placement again 30 minutes after. LN 4 acknowledged the physician's order report clearly indicated to check placement prior to each feeding, flush, or medication administration and stated she had not followed the physician's order to check the tube placement prior to each flushing and medication administration. LN 4 stated she should have checked the placement. LN 4 also stated the tube could have been dislodged, and if dislodged the tube would not be in the proper place and there could be a potential for (continued on next page)

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	555387	A. Building B. Wing	03/20/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aspiration.During a concurrent interview and record review on 3/19/26 at 3:16 p.m. with the Director of Nursing (DON), Resident 1's Order Summary Report, active orders as of 3/19/26 was reviewed. The DON stated she would expect the nursing staff to follow the physician's order and check the PEG tube placement as ordered. The DON also stated the risk for aspiration could potentially lead to complications. The DON confirmed the order report indicated, .ASPIRATION PRECAUTIONS: Implement aspiration precautions at all times.Verify PEG tube placement prior to feedings, flushes, or medication administration.During a review of the facility's Policy titled, Enteral Nutrition, revised 11/2018, the policy indicated, .Risk of aspiration may be affected by.Failure to confirm placement of the feeding tube prior to initiating the feeding.During a review of the facility's Policy and Procedures (P&P) titled, ENTERAL TUBE MEDICATION ADMINISTRATION, dated 8/2014, the (P&P) indicated, .The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes.During a review of the facility's job descriptions titled, Licensed Practical (Vocational) Nurse (LPN)(LVN), revised 5/2022, the job description indicated, .Provide nursing services to residents in accordance with scope of practice, facility policies and professional standards of care.During a review of the facility's job descriptions titled, Registered Nurse (RN), revised 7/2024, the job description indicated, .Provide nursing services to residents in accordance with scope of practice, facility policies and professional standards of care.

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	03/20/2026

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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. Based on observation, interview, and record review, the facility failed to provide adequate care and services to promote healing and prevent pressure injury (a localized injury to the skin and/or underlying tissue because of prolonged pressure) for one of 20 sampled residents (Resident 3), when Resident 3's low-air loss mattress (LAL mattress, 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) was not correctly calibrated according to her current weight.This deficient practice had the potential to delay wound healing and place Resident 3 at increased risk for developing pressure injury and/or skin breakdown.Findings: During a review of Resident 3's admission Record, the record indicated Resident 3 was admitted to the facility with multiple diagnoses including morbid obesity (a serious, chronic disease defined as significant excess weight that could increase the risk, or cause of serious illness), and muscle weakness. During a concurrent observation and interview on 3/17/26 at 9:53 AM with Resident 3, Resident 3's LAL mattress was on the bedframe, and the setting was calibrated to 110 pounds (LBS-a unit of measurement). Resident 3 stated the mattress was in use due to multiple pressure injuries to her buttocks area (consists of two rounded muscles which are essential for walking, running, standing up from a chair, and a primary support for the body while in a seated position), with the purpose of promoting wound healing and preventing further skin breakdown. During a concurrent observation, interview, and record review conducted on 3/17/26 at 2:55 PM with Licensed Nurse (LN 1), Resident 3's medical record titled, Weights and Vitals Summary, dated 3/16/26 was reviewed. The record indicated Resident 3's most recent weight documented on 3/16/26, was 249.78 LBS. During a follow-up observation and interview with LN 1 at 2:57 PM, in Resident 3's room, LN 1 confirmed that the LAL mattress was not adjusted to reflect Resident 3's current weight because the mattress pump was set for 110 LBS, which did not correspond to Resident 3's actual weight. LN 1 stated that the purpose of the LAL mattress was to promote healing of existing wounds and prevent further skin breakdown. LN 1 further explained that Resident 3 had multiple skin injuries on the buttocks and stated that failure to properly set the LAL mattress pump could lead to worsening of those wounds' conditions. During a review of Resident 3's medical record titled Order Summary Report, with active orders as of 3/18/26, the following orders were noted: Low air loss mattress: Monitor setting based on residents Weight/ Functioning. initiated on 3/1/26; Right buttocks unstageable. initiated on 3/13/26; Left upper thigh posterior/buttock. initiated on 3/13/26; and, TX [treatment]- to Groin and bilat [bilateral] buttocks. initiated on 2/18/26. During an interview on 3/18/26 at 9:55 AM with LN 2, LN 2 explained that the purpose of LAL mattress was to relieve pressure on wound sites to promote the wound healing process. LN 2 stated that nurses were responsible for adjusting the pump setting based on the resident's current weight. LN 2 added that those settings should have been checked and adjusted every shift to ensure accuracy. LN 2 further stated that if the LAL mattress pressure was not properly adjusted according to the resident's current weight, the underlying metal bed frame could exert additional pressure on the wounds, potentially worsening the resident's condition. During an interview on 3/19/26 at 11:06 AM with LN 4, LN 4 stated that LAL mattress was used for preventative care and to promote wound healing. LN 4 explained that the pressure of mattress should have been adjusted according to the resident's current weight. LN 4 further stated improper adjustment of Resident 3's LAL mattress in relation to her current weight could result in inadequate support, allowing pressure from the metal bed frame to impact the wound areas and potentially contribute to further deterioration. During an interview on 3/19/26 at 4:27 PM with the Director of Nursing (DON), the DON stated that the purpose of LAL mattress for Resident 3 was to maintain skin integrity and prevent wound deterioration. The DON explained that nurses were expected to reference Resident 3's current weight and adjust the mattress pressure accordingly each shift. The DON further stated that nurses were instructed to calibrate and adjust the mattress settings based on Resident (continued on next page)

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	555387	A. Building B. Wing	03/20/2026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3's weight. The DON concluded that failure to adjust the LAL mattress pressure properly could negatively affect Resident 3's skin integrity.

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	555387	A. Building B. Wing	03/20/2026

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview, and record review, the facility failed to ensure timely medication processing and administration when there was a delay in both processing and administration of a prescribed mental health medication for one of 20 sampled residents (Resident 8). This failure had the potential to negatively impact Resident 8's health and place him at increased risk for a decline in psychological status.Findings: During a review of Resident 8's admission Record, the record indicated Resident 8's diagnosis included depression (mental depression with feeling of sadness), anxiety disorder (persistent or excessive worrying that interferes with daily life), post-traumatic stress disorder (or PTSD a mental condition triggered by experiencing or witnessing a traumatic events with flashbacks and nightmares), and Lewy bodies dementia (a type of memory loss with hallucinations and fluctuating alertness). The record additionally indicated that Resident 8 was a responsible party (being fully accountable for own health care decisions). During a concurrent interview and record review on 3/19/26 at 2:29 PM with Licensed Nurse 3 (LN 3), Resident 8's medical record titled, AFTER VISIT SUMMARY [when residents see a specialist outside the facility], dated 3/5/26 was reviewed. The review indicated,. Today's medication changes. diazepam (VALIUM)-medication strength, how much to take, how to take this, when to take this, reasons to take this, additional instructions. diazepam 10mg (mg is milligram, a unit of strength). generalized anxiety disorder. take one tablet in the morning and one tablet at bedtime scheduled What changed. medication strength. how much to take. how to take this. when to take this. reasons to take this. Further review of Resident 8's medical record titled MEDICATION ADMINISTRATION RECORD [MAR], dated 3/1/26 to 3/31/26, LN 3 confirmed that following orders: . diazepam Oral Tablet 5 MG (milligram, a unit of strength) . Give 1 tablet by mouth every 8 hours as needed for Anxiety. Start Date- 01/22/2026 . D/C Date (D/C Date, discontinue date) 03/11/2026.; and, . diazepam Oral Tablet 10 MG. Give 1 tablet by mouth every morning and at the bedtime for Anxiety. Start Date-03/11/2026. LN 3 acknowledged that prescribed medication was initiated with a six-day delay. LN 3 explained that when there was an increase in dosage or a new psychotropic medication was ordered by an outside provider, she first would notify the facility's Medical Director (MD), and if the MD agreed with the new order, she would proceed with implementation. LN 3 further stated that delays in both processing and administering prescribed mental health medications could lead to a worsening of Resident 8's mental health condition rather than improvement. During an interview on 3/20/26 at 7:44 AM with LN 5, LN 5 stated physician's orders, particularly those involving psychotropic medications, should be carried out without delay. LN 5 emphasized that delays in processing and administering those medications could result in worsening resident behaviors and a decline in psychological health status. During a concurrent phone interview and record review on 3/20/26 at 8:23 AM with the Medical Director (MD), Resident 8's medication orders were reviewed. The MD confirmed that the order for diazepam 10 MG was initiated on 3/11/26. The MD also verified that there was a prescription from an outside physician, dated 3/5/26, which reflected an increased dosage of the medication. The MD further stated that whenever there was a change in an existing medication prescribed by an outside physician, the facility's MD should have reviewed the order as soon as the notification was received from nursing staff, and if the MD agreed with the updated order, the nurse was expected to implement it in a timely manner. During a review of the facility provided policy and procedure (P&P) titled, Administering Medications, revised on 4/2019, the P&P indicated, . Policy. Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation. 4. Medications are administered in accordance with prescriber orders, including any required time frame. During a review of the facility provided P&P titled, Physician Orders, dated 3/22/2022, the review indicated, . PURPOSE This will ensure that all physician orders are complete and accurate. II. Physician orders will include the following. The date and time the order was received .