Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555470	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Creek Post-Acute	9289 Branstetter Place 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure safety measures were in place while providing care for one of three sampled residents (Resident 2), when:1. During a change of bedding, without securing Resident 2's right side of the bed, Certified Nursing Assistant (CNA) 2 turned Resident 2 to her right side, away from the CNA.This deficient practice resulted in Resident 2 falling out of bed and onto the floor on 1/23/26. Resident 2 sustained injuries including a fracture (broken bone) to her right elbow.2. The staff did not implement interventions timely to prevent further falls and to reduce the impact of potential falls after Resident 2's fall incident on 1/23/26.This failure exposed Resident 2 to potential falls and associated injury.Findings:1. A review of Resident 2's admission RECORD, indicated that Resident 2 was admitted to the facility in 2025 with diagnoses which included intervertebral disc degeneration lumbar region (wear and tear of the discs in the lower back which compress nerves and cause pain), closed fracture right patella (broken kneecap), infection (presence of germs) of internal fixator right ankle (surgically reconnecting broken bones with screws, plates, rods, or nails), and unspecified fall (accidental fall where the exact nature of incident was not specified).A review of Resident 2's Fall Risk Assessment, dated 10/18/25, indicated, .Score: 25.Category: Moderate Risk for Falling.A review of Resident 2's SBAR (a communication tool for sharing information with teams and stands for Situation, Background, Assessment, and Recommendation or Requests) Nurse Progress Notes, dated 1/23/26, at 9:30 a.m., indicated, .Fall Details.1. Describe the problem/symptom: Resident alert awake and verbally responsive CNA states During care she [CNA 2] turned resident to the opposite side because she needs to change everything but before turn [sic] her [Resident 2] she said she make [sic] sure there should be enough space on the other side so she [Resident 2] would not fall so she turn [sic] her [Resident 2] and pulled the old flat sheet but according to her she held her [Resident 2] tooo [sic]. But when she let her [Resident 2] go to hold the curtain during care so that she can take out the old flat sheet but suddenly she [Resident 2] fell on the floor on her right side.2. Was fall witnessed? Yes.3a. Location of fall: Resident Room.4. Date & Time of Fall: 01/23/2026 09:00 [9 a.m.].5. What was the resident doing prior to the fall? Resident laid on her right side with [sic] holding curtain with both hands.6. Does the resident exhibit or complain of pain related to the fall? Yes.7. Location of pain: right elbow.8. Most recent pain level.Pain Level: 7.Date 01/23/2026 14:47 [2:47 p.m.].Pain Scale.Numerical [a method of rating level of pain numerically with 0 meaning no pain and 10 meaning worst pain].Body Observation.Location of injury.right humerus [arm] elbow.redness.Describe Range of Motion [ROM].ROM painful/limited in upper extremity.Possible contributing factors.Orthopedic condition [a medical issue that affects the musculoskeletal system (consists of the body's bones, muscles, tendons, ligaments, joints, and cartilage)].Muscle weakness.Date and time physician notified.01/23/2026 0900.Date and time Resident/Resident Representative notified.01/23/2026 1000 [10 a.m.].A review of Resident 2's Transfer Record, dated 1/23/26, at 3:16 p.m., indicated that Resident 2 was transferred (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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