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	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crystal Creek Post-Acute	9289 Branstetter Place 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure that clinical assessments and corresponding interventions were accurately documented for one out of three sampled residents (Resident 1) when staff administered a pain medication without documentation supporting the clinical indication or rationale for the intervention.This failure resulted in inaccurate and unreliable clinical documentation for Resident 1, compromised the integrity of the medical record, and impaired the facility's ability to evaluate the resident's condition, response to treatment, and ongoing care needs.FINDINGS:A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with multiple diagnoses which included orthopedic aftercare (medical care after surgery on a bone), spinal stenosis (narrowing of the spine that can cause pain), and chronic pain syndrome (pain that lasts longer than 12 weeks).A review of facility document titled, Weights and Vitals Summary, effective date range 3/23/26 through 3/24/26, under the category titled, Pain Level Summary, indicated Resident 1's pain level assessments utilizing a numeric pain scale 0 through 10 (0 indicates no pain and 10 indicates the most severe or extreme pain):3/24/26 at 12:40 AM = 03/23/26 at 11:01 PM = 03/23/26 at 10:08 PM = 03/23/26 at 8:04 PM = 0A review of facility document titled, Medication Administration Record, (MAR - a legal document that lists the drugs given to a resident based off the physician's order) dated 3/1/26 through 3/31/26, indicated Resident 1 had a physician's order for two (2) acetaminophen 500 milligram (mg, unit of measurement) tablets to be given by mouth every eight hours as needed for mild pain (0 through 3 pain score). The MAR further indicated on 3/23/26 at 11:09 PM, Licensed Nurse (LN) 1 administered acetaminophen to Resident 1 despite there was not an updated pain assessment completed that supported the administration of the pain medication. During a concurrent interview and record review on 4/09/2026 at 5:42 PM with LN 1, Resident 1's MAR, dated 3/1/26 through 3/31/26 and Weights and Vitals Summary, effective date range 3/23/26 through 3/24/26, under the category titled, Pain Level Summary were reviewed. LN 1 confirmed Resident 1 had a documented pain level of 0 out of 10 on 3/23/26 at 11:01 PM and acknowledged she administered acetaminophen to Resident 1 on 3/23/26 at 11:09 PM with a pain level of 0 (no pain). LN 1 further stated she was overwhelmed while managing multiple tasks that evening and had not performed an updated pain assessment.During a concurrent telephone interview and record review on 4/15/26 at 12:31 PM with the Director of Nursing (DON), Resident 1's MAR, dated 3/1/26 through 3/31/26 and Weights and Vitals Summary, effective date range 3/23/26 through 3/24/26, under the category titled, Pain Level Summary were reviewed. The DON confirmed there was no documentation in the Resident 1's medical record that supported the clinical rationale for the administration of acetaminophen on 3/23/26 at 11:09 PM. The DON stated she expected the nursing staff would have assessed Resident 1's pain level, administered medications based on Resident 1's clinical needs and physician orders, and documented Resident 1's response to the effectiveness of the pain medication. The DON further confirmed the documentation did not support the administration of a pain medication when Resident 1's documented pain level was 0 out of 10 on 3/23/26 at 11:01 PM. The DON acknowledged the record lacked evidence of appropriate assessment, justification for the administration of acetaminophen, and a follow-up pain assessment related to the effectiveness of the medication.A review of facility policy titled, Pain Assessment and Management, (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised March 2019, indicated, . 5. Implement the medication regimen as ordered, carefully documenting the results of the interventions. 1. Document the resident's reported level of pain with adequate detail.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure that physician-ordered pain management interventions were implemented for one out of three sampled residents (Resident 1) when staff failed to administer ordered pain medication in response to the Resident 1's reported pain. This failure could have resulted in Resident 1 experiencing unrelieved pain, placing the resident at risk for deterioration in condition and significant adverse outcomes.FINDINGS:A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with multiple diagnoses, including orthopedic aftercare (medical care after surgery on a bone), spinal stenosis (narrowing of the spine that can cause pain), and chronic pain syndrome (pain that lasts longer than 12 weeks).A review of facility document titled, Weights and Vitals Summary, effective date range 3/23/26 through 3/24/26, under the category titled, Pain Level Summary, indicated Resident 1 had a documented pain level of 4 out of 10 (a pain scale of 0 through 10 utilized; 0 indicates no pain; 1 through 3 indicates mild pain; 4 through 6 indicates moderate pain; and 7 through 10 indicates severe pain). On 3/23/26 at 8:04 p.m.; however, there was no documentation of any pain intervention or reassessment at or around that time.A review of facility document titled Narcotic Emergency Drug Kit, (eKIT - supply of medication kept at the facility for immediate use medication when the pharmacy medications are not yet available) dated 4/2/26, indicated the facility maintained an emergency medication supply containing controlled pain medications, including but not limited to:Hydromorphone (Dilaudid) - taken via tablet or injection (shot)Morphine sulfate - taken via oral solution or injection Oxycodone (Roxicodone) - taken via tabletHydrocodone/acetyl-p-aminophenol (Norco) - taken via tablet The document indicated that these medications were available for emergency use.A review of facility document titled, Order Summary Report, dated 3/23/26 through 4/10/26, indicated the following active PRN (as needed) pain medication orders for Resident 1:hydromorphone Oral Tablet 4 mg - Give 1.5 (one and a half) tablets by mouth every four (4) hours as needed for moderate to severe pain (pain rating of 4 through 10 out of 10).hydromorphone Oral Tablet 4 mg - Give 1 tablet by mouth every four (4) hours as needed for moderate to severe pain; Alternatives to be used prior to administering PRN (as needed) included repositioning, distraction, breathing techniques, gentle massage, relaxation techniques, music, and other non-pharmacological interventions.acetaminophen tablet 325 mg - Give 2 tablets by mouth every four (4) hours as needed for mild pain (1 through 3 out of 10), not to exceed 4 grams in 24 hours. Non-pharmacological interventions to be attempted included repositioning, dim lighting, quiet environment, snacks, therapeutic touch, redirection, music, guided imagery, distraction, exercise, deep breathing, socialization, and other measures.acetaminophen tablet 500 mg - Give 2 tablets by mouth every eight (8) hours as needed for pain; not to exceed 3 grams in 24 hours. Non-drug interventions to be attempted included repositioning, distraction, breathing techniques, and gentle massage.However, there was no documentation that any of the above PRN pain medications or non-pharmacological interventions were implemented when the resident reported a pain level of 4 on 3/23/26 at 8:04 PM.During a concurrent interview and record review on 4/9/26 at 5:42 PM with the Licensed Nurse (LN 1), Resident 1's Weights and Vitals Summary, effective date range 3/23/26 through 3/24/26, under the category titled, Pain Level Summary, was reviewed. LN 1 verified the document indicated Resident 1 had a reported pain level of 4 out of 10 (moderate pain) on 3/23/26 at 8:04 PM and stated the ordered pain medication was not available at the time of the pain assessment. LN 1 stated she had not considered calling the doctor or pharmacy to obtain medications available through the facilities eKIT. LN 1 further stated she attempted to administer acetaminophen (used for mild pain); however, Resident 1 refused. LN 1 confirmed she did not document Resident 1's refusal for the pain medication. During a telephone interview on 4/14/26 at 2:16 PM with the Pharmacy Operations Manager (POM), the POM stated resident prescriptions are transmitted electronically through the facility's electronic medication administration record (eMAR- a legal document that listed the drugs given to resident) system. The POM stated routine medication deliveries occurred prior to (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:00 PM and confirmed that staff had the ability to utilize medications available through the eKIT when ordered medications were not yet available or had run out. The POM further stated that facility staff were expected to follow established guidelines, including notifying the physician and the pharmacy when medications were not available.During a telephone interview on 4/14/26 at 2:43 PM with the Nurse Practitioner (NP), the NP stated the nursing staff should have notified him regarding the missing pain medications and that he could have provided additional orders, including authorizing the use of medications available through the eKIT. The NP stated the nursing staff could have contacted both the pharmacy and him directly and obtained orders and facilitated timely medication administration.During a concurrent telephone interview and record review on 4/15/26 at 12:31 PM with the Director of Nursing (DON), Resident 1's documents titled, Weights and Vitals Summary, effective date range 3/23/26 through 3/24/26, under the category titled, Pain Level Summary, Order Summary Report, dated 3/23/26 through 4/10/26, and the Medication Administration Record, (MAR) dated 3/1/26 through 3/31/26 were reviewed. The DON confirmed that although a physician's order for pain medication was placed, no pain medication was administered when Resident 1 reported pain on 3/23/26 at 8:04 PM. The DON further confirmed there was no documentation of any intervention or reassessment completed. The DON stated that staff were expected to administer medications as ordered and to reassess and document the resident's response to the interventions that were implemented.A review of the facility policy titled, Pain Assessment and Management, revised March 2020, indicated, . 2. Pain Management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. 3. Discuss with the resident (or legal representative) his or her goals for pain management and satisfaction with the current level of pain control.

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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 that physician-ordered medications were administered as prescribed for one out of three sampled residents (Resident 1) when nursing staff omitted multiple scheduled medications. This failure resulted in Resident 1 not receiving essential prescribed medications, placing the resident at risk for worsening of underlying conditions, inadequate symptom control, and potential adverse outcomes.FINDINGS:A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with multiple diagnoses, including orthopedic aftercare (medical care after surgery on a bone), spinal stenosis (narrowing of the spine that can cause pain), hyperlipidemia (elevated levels of fats like cholesterol and triglycerides in the blood), and chronic pain syndrome (pain that last longer than 12 weeks).Review of facility document titled, Medication Administration Record, (MAR- a legal document that listed the drugs given to resident) dated 3/1/26 through 3/31/26, indicated the following medications were scheduled for administration on 3/23/26 at 9 PM and were not administered as ordered: Amitriptyline (medication to treat depression) 50 milligrams (mg- unit of measurement) tablet - Give 1 tablet by mouth at bedtime. Gabapentin (medication to treat neuropathy) 600 mg tablet - Give 2 tablets by mouth at bedtime. Simvastatin (medication to treat hyperlipidemia) 20 mg tablet - Give 1 tablet by mouth at bedtime. Dicyclomine (medication to treatment irritable bowel syndrome) 10 mg capsule - Give 2 capsules by mouth four times daily. A review of Resident 1's document titled, Progress Notes, indicated that on 3/23/26 at 11:03 PM, the licensed nurse (LN) 1 documented that multiple prescribed medications (including those listed above) had not yet been delivered from the pharmacy.During a concurrent interview and record review on 4/9/26 at 5:42 PM with LN 1, Resident 1's MAR, dated 3/1/26 through 3/31/26 was reviewed. LN 1 confirmed that the prescribed medications scheduled for 9:00 PMN were not available at the time they were due. LN 1 acknowledged that no alternate measures were taken to obtain the medications and stated she did not notify the physician or the pharmacy regarding the unavailable medications. LN 1 further stated she was overwhelmed that evening while managing multiple tasks.During a telephone interview on 4/14/26 at 2:43 PM with the Nurse Practitioner (NP), the NP confirmed that he was not notified regarding the missed or unavailable medications. The NP stated that facility staff should have contacted him and reported the missing medications. The NP stated he could have provided an order to access medications through the Emergency Medication Kit (eKIT- medications stored at the facility for use until new ordered medications are available from the pharmacy).The NP further stated the nursing staff were expected to notify him of any missed medications and could have contacted the pharmacy and the provider and facilitated timely medication access. The NP reported he had not received any calls or text messages regarding the medication delay.During a concurrent telephone interview and record review on 04/15/2026 at 12:31 PM with the Director of Nursing (DON), Resident 1's MAR, dated 3/1/26 through 3/31/26 and Order Summary Report, dated March 2026 were reviewed. The DON confirmed that scheduled medications were not administered as ordered and that staff failed to notify the physician and pharmacy when medications were not available. The DON stated that staff were expected to administer medications as prescribed and to follow appropriate notification procedures when medications are unavailable.A review of facility policy titled, Administering Medications, revised 4/2019, indicated, Policy Statement - Medications are administer in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified.