

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER Crystal Creek Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to accommodate the needs of four out of 35 sampled residents (Resident 45, Resident 52, Resident 93 and Resident 149) when Resident 45, Resident 52, Resident 93 and Resident 149's call light (device used to contact staff for assistance) were not within their reach. This deficient practice placed Resident 45, Resident 52, Resident 93 and Resident 149 at increased risk for unmet care needs, delayed staff response, and potential for accidents or injury. Findings: Review of Resident 45's admission Record indicated, Resident 45 was admitted to the facility with a diagnosis including hemiplegia and hemiparesis following cerebral infarction (paralysis or weakness on one side of the body caused by a stroke), atrial fibrillation (the most common type of irregular heartbeat (arrhythmia), where the heart's upper chambers quiver chaotically instead of beating effectively, causing an irregular, often rapid pulse. This poor coordination can lead to fatigue, palpitations, dizziness, shortness of breath, and chest pain, and significantly increases the risk of stroke, heart failure), aphasia (a language disorder from brain damage (often stroke/injury) that impairs speaking), and osteoarthritis (condition causing pain and stiffness within the joints) left wrist. During a concurrent observation and interview on 12/16/25 at 12:42 PM with Resident 45 in Resident 45's room, Resident 45 was sitting in her wheelchair and Resident 45's call light was observed hanging from the right-side bed rail down to the bed frame. Resident 45 stated the call light was not within reach and she could not call staff if she needed help. During a concurrent observation and interview on 12/16/25 at 12:45 PM with Certified Nursing Assistant (CNA) 5 in Resident 45's room, CNA 5 stated that Resident 45's call light was not within reach because it was on Resident 45's bed. CNA 5 stated call light should have been within reach of Resident 45. CNA 5 further stated that Resident 45 could have fallen when trying to reach for her call light to ask for help. Review of Resident 52's admission Record indicated, Resident 52 was admitted to the facility with a diagnosis including hemiplegia and hemiparesis following cerebral infarction, chronic obstructive pulmonary disease (chronic lung disease that causes breathing difficulty, shortness of breath, coughing, and reduced activity tolerance), congestive heart failure (chronic heart condition that causes shortness of breath, fatigue, and reduced activity tolerance), adult failure to thrive (unintentional weight loss with physical and functional decline), and unspecified mood disorder (mental health condition that affects a person's mood, emotions, and daily functioning). During a concurrent observation and interview on 12/16/25 at 2:49 PM with Resident 52 in Resident 52's room, Resident 52's call light was observed hanging from the right-side bed rail down to the bed frame. Resident 52 stated that if he needed help, staff could not come right away because he could not reach the call light to call for help. During a concurrent observation and interview on 12/16/25 at 2:54 PM with Licensed Nurse (LN) 2 in Resident 52's room, LN 2 stated that Resident 52's call light was not within reach because it was hanging from the bed rail down to the right side of the bed frame. LN 2 further stated that Resident 52 could be at risk for a fall if he could not use his call light to ask for help, as he might perform task without assistance. Review of Resident 93's admission Record indicated, Resident 93 was admitted to the facility with a diagnosis including early onset cerebellar ataxia (condition that begins at a young age and causes problems with balance, coordination, and movement), dysphagia (difficulty or trouble swallowing), glaucoma (eye disease that damages the (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nerve that helps you see and can slowly cause vision loss) , major depressive disorder, anxiety disorder, and palliative care (care that focuses on comfort and relief from symptoms during serious illness).During a concurrent observation and interview on 12/16/25 at 10:45 AM with Resident 93 in Resident 93's room, Resident 93's call light was observed not in bed and not within reach of Resident 93. Resident 93 stated that she could not find the call light, which she used to ask for help.During a concurrent observation and interview on 12/16/25 at 10:53 AM with LN 2 in Resident 93's room, LN 2 stated that Resident 93's call light was stuck on the bed frame between the headboards. LN2 stated that if residents could not reach or use the call light to ask for help, residents would be at risk for falls, injury, and unmet needs. LN 2 further stated that Resident 93 was on hospice care (care for people who are very sick and not expected to get better, with the goal of comfort rather than cure), and lack of access to call light could delay comfort measures for Resident 93. Review of Resident 149's admission Record indicated, Resident 149 was admitted to the facility with a diagnosis including, spinal stenosis (the narrowing of spaces within your spine, putting pressure on the spinal cord and nerves, causing pain, numbness, cramping, or weakness, often in the back, neck, arms, or legs), chronic obstructive pulmonary disease ((COPD) is an ongoing lung condition caused by damage to the lungs. The damage results in swelling and irritation, also called inflammation, inside the airways that limit airflow into and out of the lungs. This limited airflow is known as obstruction. Symptoms include trouble breathing), atrial fibrillation, pain in left hip and pain in leg.During a concurrent observation and interview on 12/16/25 at 11:32 AM with Resident 149 in Resident 149's room, Resident 149 was sitting in his wheelchair and Resident 149's call light was observed hanging from the bedside top drawer. Resident 149 stated the call light was not within reach and he could not call staff if he needed help. Resident 149 further stated he would not be able to call for help if he was having problems and unable to breathe.During a concurrent observation and interview on 12/16/25 at 11:33 AM with CNA 4 in Resident 149's room, CNA 4 stated the call light for Resident 149 was hanging from Resident 149's bedside top drawer. CNA 4 stated call light should be within reach of Resident 149. CNA 4 further stated Resident 149 could have fallen and hurt his arm when reaching for his call light to call for help. During an interview on 12/27/25 at 3:41 PM with LN 5, LN 5 stated all residents should have call light within reach. LN 5 stated when call light was within reach, residents could alert staff in case of an emergency. LN 5 stated the risk of not having call light within reach of resident was resident could have had a fall when trying to reach for a call light. During a record review of Resident 45's Care Plan, in the section titled focus initiated on 9/12/25, indicated, .ADL Self Care Performance Deficit. The section titled Interventions initiated on 9/13/25, indicated .Encourage [Resident 45] to use bell to call for assistance.During a record review of Resident 149's Care Plan, in the section titled focus initiated on 11/5/25, indicated [Resident 149] has Self Care Performance Deficit r/t muscle weakness, poor endurance, decline in balance/transfers/walking, pain. The section titled interventions initiated on 11/5/25, indicated . [Resident 149] requires weight bearing assistance.supervision/touching assistance.physical assistance. weight bearing assistance. During a concurrent interview and record review on 12/18/25 at 11:41 AM with the Assistant Director of Nursing (ADON), Resident 52's Care Plan, in the section titled Focus initiated on 12/3/25, indicated, . [Resident 52] found sitting on the floor, attempted to self-transfer. The section titled Interventions initiated on12/4/25, indicated .Keep [Resident 52's] call light within reach. was reviewed. Resident 93's Care Plan, in the section titled Focus initiated on 12/14/23, indicated Coordinate [Resident 93's] care with Bristol Hospice. The section titled Interventions initiated on 12/15/23, indicated, .Keep [Resident 93's] call light within reach. was also reviewed. Th ADON stated that the call light should always be within reach of the resident for safety. The ADON further stated that when a resident could not reach the call light, help from staff could be delayed and the risk of falls increased. During an interview on 12/18/25 at 1:16 PM with the Director of Nursing (DON), the DON stated that staff were expected to clip the call light near the resident to prevent it from falling out of bed and to ensure it remained within the resident's reach. The DON further stated that if the call light was not within (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reach, residents could experience delayed assistance, unmet needs, lack of care, and increased risk for accidents and skin issues. During an interview on 12/19/25 at 9:29 AM with the Administrator (ADM), the ADM stated all residents should have call light within reach to give the residents an opportunity to ask for assistance whenever needed. The ADM stated the risk of not having call light within reach of a resident was residents could not be able to alert staff for help in case of an emergency. The ADM further stated residents could sit in soiled brief for a long time when they are not able to call for help using call light. A review of facility's policy titled, Call System, Residents, dated September 2022, indicated, .Residents are provided with a means to call staff for assistance through a communication system that directly call a staff member or a centralized work station.Each resident is provided with a means to call staff directly for assistance.Call system communication may be audible or visible.The resident call system is routinely maintained.Calls for assistance are answered as soon as possible, but no later than 5 minutes .		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a care plan (a personalized document that outlines a person's health conditions, specific needs, goals, and the actions required to manage their well-being, ensuring consistent, coordinated, and effective support from caregivers or healthcare teams, helping everyone involved stay organized and focused on the individual's quality of life) was developed and revised for 2 of 35 sampled residents (Resident 9 and Resident 126), when: 1. A care plan was not developed for Resident 9 with a diagnosis of PTSD (Post-Traumatic Stress Disorder, is a mental health condition that can happen after someone experiences or witness a traumatic event such as violence, abuse war, serious accidents or disasters),2. A care plan was not developed for Resident 126's speech device (A battery-operated device held to the neck or placed in the mouth via a tube; it creates vibrations that are shaped into speech by the mouth, tongue, and lips).These failures had the potential for unmet care needs for Resident 9 and Resident 126. Findings: 1. During a concurrent interview and record review with the Director of Nursing (DON) on 12/18/25 at 7:40 AM, the DON reviewed Resident 9's undated admission RECORD, the EXT [external] REFERRAL SKILLED NURSING FACILITY, dated 10/26/22, and the resident's care plans. The DON confirmed that the physician order included PTSD on Resident 9's active problem list. The DON verified that the onset date of the resident's PTSD diagnosis was 10/26/22. The DON stated the facility did not have a care plan specific to PTSD until 12/17/25, thereby potentially delaying appropriate care for Resident 9 who lacked the capacity to make healthcare decisions. During an interview with the DON on 12/18/24 AT 4:15 PM, The DON stated the facility did not have Trauma Screening Tool when the facility was aware of Resident 9's PTSD diagnosis on 10/28/22. During an interview with the DON on 12/19/25 at 7:11 AM, the DON stated the facility did not have a comprehensive assessment for PTSD for Resident 9 since 10/28/22. A review of the facility's policy titled Care Plans, Comprehensive Person-Centered, revised on 3/22, the policy indicated .2. The comprehensive person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.3. The care plan intervention are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are.c. trauma-informed.11. Assessment of residents are ongoing, and care plans are revised as information about the resident and the residents' condition change. A review of the facility's policy titled Trauma Informed Care and Culturally Competent Care revised on 8/22, the policy indicated .To address the needs of trauma survivors by minimizing triggers and/or re-traumatization.3. For trauma survivors, the transition to living in an institutional setting.can trigger profound re-traumatization.Triggers are highly individualized.Organizational Strategies: Evaluate the need for trauma-informed practices as part of the facility assessment.Resident Assessment: Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. 2. A review of Resident 126's admission Record indicated Resident 126 was admitted to the facility in 2025 with diagnoses which included major depressive disorder (a serious mood disorder causing (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	persistent sadness, hopelessness, and loss of interest in activities), muscle weakness, dysphagia (difficulty swallowing food or liquids, making it hard to move them from the mouth to the stomach), tracheostomy status (a person has a surgically created opening (stoma) in their windpipe (trachea) for breathing) and acquired absence of larynx (the voice box (larynx) has been surgically removed (laryngectomy) or lost due to trauma, leading to permanent changes in breathing and speech, requiring the creation of a neck stoma for breathing and often speech rehabilitation). Review of Resident 126's INVENTORY OF PERSONAL EFFECTS, dated 11/14/2025, indicated, ITEMS OF SPECIFIC VALUE Description: Speech device for communication. Review of Resident 126's PERSONAL HISTORY AND PHYSICAL EXAMINATION, dated 11/17/2025, indicated, .E.E.N. T Throat Stoma Open.Summary (MEDICAL DIAGNOSIS) .laryngeal cancer, laryngectomy, tracheostomy. Review of Resident 126's Discharge Summary, dated11/9/2025, indicated, .laryngectomy.Hospital Course: In summary, [Resident 126] .communicates using a speech device following his laryngectomy. Review of Resident 3's Care Plan, initiated on 12/17/2025, indicated, .Focus: [Resident 126] has alteration in communication as evidenced by impaired ability to make self understood related to history of laryngeal cancer with permanent tracheostomy.Communicates using a speech device.Goal: [Resident 126] will be able to communicate needs and desires using speech device.Interventions: Change battery per patient request. Keep speech device charged and ready. Keep speech device within reach. During an observation and interview on 12/17/25 at 8:50 A.M., in Resident 126 room, Resident 126 used his speech device to communicate. During an interview and concurrent record review on 12/17/25 at 3:44 P.M., Licensed Nurse (LN) 5 stated Resident 126 was admitted to the facility on [DATE] with his speech device and there was no care plan implemented for Resident 126's speech device until 12/17/25. LN 5 stated Resident 126 used his speech device on 11/19/25 when LN 5 did MDS assessment ((Minimum Data Set) assessment is a mandatory, standardized tool used in U.S. skilled nursing facilities to comprehensively evaluate residents' health, functional abilities, and needs for care planning, quality improvement) for Resident 126. LN 5 stated the risk of not having speech device care plan was that staff would not know how the speech device functioned and how to take care of the speech device. LN 5 further stated Resident 126 would not be able to communicate with staff if the speech device stopped functioning. LN 5 stated staff would not know whether Resident 126 could take the speech device inside shower room and how to safely handle the speech device. During an interview on 12/17/25 at 4:20 P.M., Certified Nursing Assistant (CNA) 7 stated Resident 126 used speech device for communication. CNA 7 stated she did not know how to care for the speech device. CNA 8 further stated she did not know if Resident 126 could take his speech device in the shower. During an interview on 12/17/25 at 4:24 P.M., CNA 8 stated she did not know how the speech device for Resident 126 functioned. CNA 8 stated Resident 126 had used his speech device from the time he was admitted to the facility. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/19/25 at 9:29 A.M., the Administrator (ADM) stated there should have been a care plan for Resident 126's speech device. The ADM stated speech device care plan would have helped staff properly communicate and care for the speech device for Resident 126. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, dated March 2022 indicated, .The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS [Admission, Annual or Significant Change in Status), and no more than 21 days after admission.The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure three of 35 sampled residents had water or fluids available when, Resident 52 did not have water or fluids available at the bedside Resident 87 did not have water or fluids available at the bedside Resident 99 did not have water or fluids available at the bedside These failures had the potential to place Resident 52, Resident 87, and Resident 99 at risk for dehydration (when the body does not get enough fluids to function properly), falls, and/or choking. Findings: 1. During a review of Resident 52's admission Record, the record indicated Resident 52 was admitted to the facility with diagnoses that included adult failure to thrive (a decline in overall health due to poor nutrition or fluid intake) and tubule-interstitial nephritis (a kidney condition in which the kidneys become irritated and inflamed, making it harder to clean the blood and balance fluids.) During a concurrent observation and interview on 12/16/25 at 2:49 PM with Resident 52 in Resident 52's room, Resident 52 was lying in bed with a water pitcher placed on the nightstand table far from the resident and not within reach. Resident 52 stated that when he needed water, water was not readily available. During a concurrent observation and interview on 12/16/25 at 2:54 PM with the Licensed Nurse (LN) 2 in Resident 52's room, LN 2 checked Resident 52's water pitcher located on the nightstand table and found it empty. LN 2 stated that when water was not readily available, Resident 52 was at risk for dehydration. 2. During a review of Resident 87's admission Record, the record indicated Resident 87 was admitted to the facility with diagnoses that included chronic kidney disease (long term kidney damage that makes it difficult for the kidneys to clean the blood and balance fluids) and a history of falling. During a concurrent observation and interview on 12/16/25 at 11:20 AM with the Certified Nursing Assistant (CNA) 10 in Resident 87's room, Resident 87 was lying in bed without a water pitcher or fluids at the bedside. CNA 10 stated that Resident 87 did not have water readily available. CNA 10 stated that because Resident 87 was on thickened fluids (drinks that are made thicker, so they are easier and safer to swallow for people with swallowing problems), Resident 87 had to ask staff for water. CNA 10 stated that the CNAs had to ask nurses for thickening mixtures before they provided thicken fluids to residents on thickened fluids. CNA 10 further stated that this process delayed resident's access to water. During a concurrent observation and interview on 12/16/25 at 11:51 AM with Resident 87 in Resident 87's room, Resident 87 was lying in bed without water at the bedside. Resident 87 stated that each time he needed water to drink, it was not readily available because staff could not come right away to provide it. 3. During a review of Resident 99's admission Record, the record indicated Resident 99 was admitted to the facility with diagnoses that included Alzheimer's disease (a brain condition that slowly affects memory, thinking, and the ability to care for oneself) and diverticulosis of large intestine (condition where small pouches form in the colon and are often prevented with adequate fiber and fluid intake). During a concurrent observation and interview on 12/16/25 at 10:58 AM with Resident 99 in Resident 99's room, Resident 99 was lying in bed without a water pitcher or fluids at the bedside. Resident 99 stated that water was not readily available and each time water was needed, Resident 99 had to ask staff and wait for it to be provided. During a concurrent observation and interview on 12/16/25 at 11:08 AM with Licensed Nurse (LN) 2 in Resident 99's room, LN 2 stated that there was no water at Resident 99's bedside. LN 2 further stated that when residents could not find water at the bedside, they attempted to get up on their own, placing them at risk for falls. During a concurrent interview and record review on 12/16/25 at 11:13 AM with LN 2, Resident 99's Care Plan, initiated on 11/18/22 was reviewed. In the section titled, Focus, the record indicated, The resident [Resident 99] has dehydration or potential fluid deficit. In the section titled, Interventions, the record indicated, .Ensure the resident has access to water whenever possible. LN 2 stated that when water was not readily accessible to Resident 99, the resident was at risk for dehydration and choking. During an interview on 12/16/25 at 12:35 PM with LN 2, LN 2 stated that residents on (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thickened fluids should still have had water available at the bedside to prevent delays in providing fluids. During an interview on 12/18/25 at 10:01 AM with the Assistant Director of Nursing (ADON), the ADON stated the residents' water pitchers should have been available with fresh water. The ADON further stated that when water was not available at the bedside, residents lacked access to fluids, which could have increased the risk of dehydration. During an interview on 12/18/25 at 1:10 PM with the Director of Nursing (DON), the DON stated that fluids should have been accessible to the residents by always having [NAME] pitchers available at residents' bedsides. The DON further stated that when fluids were not available at the bedside, residents were at risk for dehydration. Review of facility policy and procedure (P&P) titled, Hydration - Clinical Protocol, revised 9/2017, the P&P indicated, . The staff will provide supporting measures such as supplemental fluids.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 store, prepare, and serve food in accordance with professional standards for food service safety when:1. The can opener blade had shards of metal, layers of food residue, and metal chipped at the tip of the can opener,2. Several tray line pans (standard commercial-grade baking sheets or pans used in kitchens) were found stacked wet in the ready to use areas,3. One kitchen staff was observed washing dishes and going back and forth from the dirty dishes to the clean dishes without washing their hands or changing their apron, These failures had the potential to lead to cross contamination (when bacteria or germs spread from one place to another) and food borne illness (an illness that causes nausea, vomiting, and/or diarrhea) for the 149 residents who receive meals from the facility kitchen. Findings:Findings:1. During the initial kitchen tour on 12/16/25 at 8:17 AM with the Registered Dietician (RD, a health professional who has special training in diet and nutrition) in the cook's preparation area, the can opener was observed to have the chipped tip, missing metal pieces, and a dried layer of food residue. The surroundings of the can opener had metal shavings and a black oily substance. The RD confirmed these finding and stated the chips of metal had the potential to get into the food that was prepared for the residents.During an interview on 12/18/25 at 4:15 PM with the RD, the RD stated the condition of the can opener that was observed during the initial kitchen walk through with the Department, did not meet his expectations. The RD stated his expectation was for the blade of the can opener to be cleaned after each use, for the can opener blade to be intact, and for the can opener to be free from food debris. The RD stated the condition the can opener placed a risk for the residents' food to have bacteria cross contamination and physical contaminants (any foreign object, such as glass, metal, plastic, hair, or natural debris) to be present in the food and presented a food safety hazard. During a review of the facility's policy and procedure (P&P) titled, CAN OPENER AND BASE, dated 2023, the P&P indicated, Proper sanitation and maintenance of the can opener and base is important to sanitary food preparation. Metal shavings and shredding can result from a dull cutting blade and worn out cogwheel [a rotating wheel] .The can opener should be thoroughly cleaned each work shift and, when necessary, more frequently.Replace the blade on the can opener, as needed.During a review of the facility's P&P titled, SANITATION, dated 2023, the P&P indicated, .The Food & [and] Nutrition Services Department shall have equipment of the type and in the amount necessary for the proper preparation, serving and storing of food.All equipment shall be maintained as necessary and kept in working order.All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas.Employees are to alert the FNS [Food and Safety Director] immediately to any equipment needing repair.During a review of the 2022 Food Code U.S. [United States] Food and Drug Administration Section 4-601.11 on Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, the Food Code indicated, .(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. The objective of cleaning focuses on the need . to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate, and insects and rodents will not be attracted. https://www.fda.gov/food/fda-food-code/food-code-2022 2. During a joint initial kitchen tour observation and interview on 12/16/25 at 8:58 AM with the RD, seven of 18 large tray line pans were noted on a shelf with water collected on the inside and at the bottom rim of the pans. The RD confirmed the pans were wet and instructed his staff to re-wash the wet pans. During an interview on 12/18/25 at 4:15 PM with the RD, the RD stated his expectations were for all dishes in the kitchen to be stacked and stored dry. The RD stated the dishes were supposed to be washed, placed on a rack to air dry, and then stacked in the assigned area. The RD stated stacked wet trays did not meet his expectations and placed the residents at risk for developing a foodborne illness because the moisture (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in on the pans attracted harmful germs and placed the resident at risk for illness. During a review of the facility's P&P titled, 3-COMPARTMENT PROCEDURE FOR MANUAL DISHWASHING, dated 2023, indicated, .Clean and sanitize all work surfaces. Set up area for air drying.All items are air-dried, which means no water droplets are present.3. During an observation on 12/17/25 at 11:13 AM in the facility's dishwashing area of the kitchen, Dietary Aide (DA) 1 washed dishes and handled both clean and dirty dishes without removing and replacing his apron and gloves or washing his hands. During an interview on 12/19/25 at 1:36 PM with DA 1, DA 1 stated when he washed the dishes, there were supposed to be multiple dishwashers. DA 1 acknowledged that he was going back and forth from a dirty area to a clean area when he washed the dishes. DA 1 stated he was unsure why he did that but understood that he was supposed to wash his hands before going from the dirty dishes to the clean dishes. During an interview on 12/18/25 at 4:15 PM with the RD, the RD stated his expectation was for multiple kitchen staff to have washed the dishes; one kitchen staff for the clean side and the other kitchen staff for the dirty side. The RD stated if a kitchen staff went from the dirty to the clean side, his expectation was for them to remove their apron and wash their hands. The RD stated the residents in the facility were placed at risk for developing a food borne illness (nausea, vomiting, diarrhea) when safe dishwashing practices were not maintained. During a review of the facility's P&P titled, HANDWASHING, dated 2023, indicated, POLICY: All employees will be instructed in the proper procedure of hand washing.Employee hands must be washed frequently in the hand washing sink or designated sink for hand washing. During a review of the facility's P&P titled, 3-COMPARTMENT PROCEDURE FOR MANUAL DISHWASHING, dated 2020, indicated, . Pay close attention to prevent cross-contamination of workers going from handling dirty dishes and then clean, touching face, body, dropping items on the floor.Wash hand and change gloves whenever cross-contamination occurs.During a review of the facility's P&P titled, SANITATION, dated 2023, indicated, .A minimum of two employees will be used when dishes are machine washed. One will handle the soiled [dirty] area, and one will handle the clean side. If an employee does need to go from soiled end to clean end, a strict hand washing routine must be followed.During a review of the undated Job Description (JD): Dietary Aide, the JD indicated, .Safety and Sanitation.Follow established safety policies and Infection Control and Universal Precautions policies and procedures when performing daily tasks. Maintain proper personal hygiene and cleanliness, practicing proper hand washing, glove, hairnet and apron use.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to offer, obtain informed consent and provide education to a resident or resident's representative (RP) about influenza (or the flu, is a contagious viral infection of the respiratory system that can range from mild to severe, causing symptoms like fever, cough, sore throat, muscle aches, and fatigue) vaccine for three out of five sampled residents when Resident 159, Resident 8 and Resident 110 was not offered the flu vaccine during the flu season. These failures had the potential for the residents and resident's responsible parties to not be fully informed about the risks and benefits, and potential side-effects of the flu vaccine prior to receiving or declining the vaccination. Findings: During an interview on 12/16/25, at 9:25 AM, with Resident 159, Resident 159 stated she asked for the flu vaccine several times. Resident 159 stated she did not refuse shots (vaccines), and she always got her shots every year for flu and pneumonia. Resident 159 stated she did not get the flu, COVID19 and pneumonia vaccine but she had asked for it, and she was told that she needed to sign, and she asked for the document to sign but they still did not give her the vaccine. During a concurrent interview and record review on 12/18/25, at 10:48 AM, with the Infection Preventionist (IP), the IP stated they started the flu clinic last September. Resident 110's immunization record was reviewed with the IP, indicated Resident 110 signed the consent for the flu vaccine on 5/3/25 upon admission to the facility. The IP stated Resident 110 was signed up for clinic this year back in September but on the day of vaccination, the resident decided not to proceed with the vaccination. The IP stated she had not documented about holding off Resident 110's flu vaccine, but it was not a refusal. The IP stated if it was not documented it was not done. Resident 8's immunization record was reviewed with the IP, the record indicated Resident 8 received flu vaccine on 10/4/24. The IP stated she had not given the flu vaccine to Resident 8 and had not had asked for the consent. Resident 159's immunization record was reviewed with the IP, the IP stated Resident 159 refused all the vaccines and there was no history documented. The IP stated Resident 159 was admitted after flu season, but for this year's flu season, she was not given the flu vaccine yet. The IP stated that the importance getting the residents vaccinated was for preventive care. The IP stated that the facility wanted to make sure that the residents have the option to receive the vaccine especially at this time there was high incidence of respiratory viruses, and with the resident's age which put them in being high risk of getting infected by the viruses. During an interview on 12/19/25, at 12:30 PM, with the Director of Nursing (DON), the DON stated if it was flu season, she expected the nurses particularly the IP to make sure immunization was offered. The DON stated they offer the flu vaccine to the resident or the RP if the resident is not the RP. The DON stated that the resident or the RP's decision regarding the flu vaccine should be documented, whether they agree to receive it or not. The DON stated if the resident said to hold off the vaccine or if they could not decide yet, the IP or the nurse needs to tell the resident that they will document refused for now and to advised the resident to let the staff know if they already want the vaccine. The DON stated if the resident or RP refused the vaccine, they need to document the reason for refusal. The DON stated it should be offered to all residents. The DON stated if the vaccine was not offered to all residents, there was a possibility that the resident would acquire flu during flu season and if they get the flu vaccine, they can still get flu, but the risk is lesser. A review of the facility's policy and procedure (P&P) titled, Influenza Vaccine, revised March 2022, indicated, All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine.		

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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. Based on observation, interview, and record review the facility failed to ensure two of 35 sampled residents (Resident 2 and Resident 27) were treated with dignity, privacy and respect when: 1. Two staff members, Certified Nursing Assistant (CNA) 10 and CNA 11 did not protect Resident 2's privacy by leaving the room door and privacy curtain open while providing care, which allowed care activities to be seen by others passing by the room, and 2. Two staff members, licensed nurse (LN) 1 and certified nursing assistant (CNA) 1 called Resident 27 a feeder (a derogatory term used to describe someone who requires assistance with meals). This failure had the potential to negatively impact on Resident 2's and Resident 27's dignity and feelings of self-worth and could cause emotional discomfort to Resident 2 and Resident 27. Findings: 1. Review of Resident 2's admission Record, indicated Resident 2 was admitted to the facility with diagnoses including unspecified dementia (affects the person's ability to remember, think clearly, and understand daily activities), depression, schizoaffective disorders (condition that affects a person's thinking, mood, and behavior, causing problems with reality and emotions), and contracture left knee (the left knee is stiff and hard to move). During a concurrent observation and interview on 12/16/25 at 12:23 PM with LN 8 by the room door in Resident 1's room, LN 8 stated that CNA 10 and CNA 11 were providing personal care to Resident 2 without maintaining privacy because the room door and privacy curtain were left open. LN 8 stated that the room door and privacy curtain should be closed while providing care to prevent others passing by from seeing care activities. LN 8 further stated that providing care without privacy could affect a resident's self-esteem and dignity. During an interview on 12/16/25 at 12:32 PM, CNA 10 stated that she provided care to Resident 2. CNA 10 stated that she repositioned Resident 2, adjusted the resident's clothing, and asked CNA 11 to assist pulling Resident 2 up in bed. CNA 10 stated that she should have closed the privacy curtain to provide privacy while Resident 2 was receiving care. During an interview on 12/18/25 at 10:24 AM, the Assistant Director of Nursing (ADON) stated that the staff should close the privacy curtain or room door when providing care, such as changing clothes or repositioning. The ADON further stated that not closing the privacy curtain or room door while providing care was a dignity issue because it could reveal Resident 2's limited mobility to others. During an interview on 12/18/25 at 1:18 PM, the Director of Nursing (DON) stated that staff should ensure privacy by closing the privacy curtain or the room door when providing care, such as repositioning. The DON further stated that failing to maintain privacy during care was a dignity issue because residents should not be seen by others while in a helpless state. A review of the facility policy titled, Dignity, revised 2/2021, 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 . When assisting residents with care, residents are . provided with a dignified dining experience . Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care . (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Resident Rights, revised 2/2021, indicated, . Employees shall treat all residents with kindness, respect, and dignity .basic rights to all residents .These rights include .privacy and confidentiality . 2. A review of Resident 27's clinical record titled, admission RECORD, (contains clinical and demographic data) indicated Resident 27 was admitted to the facility with diagnoses which included dementia (a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, judgment, and behavior). During a concurrent interview and observation of Resident 27's breakfast tray, with LN 1, on 12/18/25 8:07 AM, LN 1 stated Resident 27 was a feeder. LN 1 stated she should not have called Resident 27 a feeder as it would affect her integrity and could negatively affect her feelings. During a concurrent interview and observation Resident 27's breakfast tray, with CNA 1, on 12/18/25 8:09 AM, CNA 1 stated Resident 27 was a feeder. CNA 1 stated she should not have called Resident 27 a feeder, stating it was a dignity issue. During an interview with the Registered Dietitian (RD), on 12/18/25 at 8:34 AM, the RD stated staff should not be calling the residents feeders. The RD explained it was a dignity issue and it could negatively affect the resident's feelings. During an interview with the Director of Nursing (DON) on 12/19/25 at 10:30 AM, the DON stated staff should not refer to residents as feeder. The DON explained that referring to residents as feeders as a dignity issue. A review of the facility policy titled, Dignity, revised 2/2021, 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 . When assisting residents with care, residents are . provided with a dignified dining experience .		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a resident who lacked the capacity to make medical decisions (the ability to understand medical information and make informed choices about healthcare) had an appropriate legal representative (a person legally authorized to make decisions for someone who cannot decide for themselves) to participate in healthcare decisions, when the facility failed to initiate a timely referral for a representative for one of 35 sampled residents (Resident 9) who was identified as lacking decision-making capacity, had no family, no Power of Attorney (POA, a person you choose to make decisions for you if you are unable to do so), while being listed as her own Responsible Party (RP, indicating the resident is considered able to make her own decisions, sign paper work, and consent to treatments and care decisions). This failure resulted in medical decision-making documents, including a Physician Orders for Life-Sustaining Treatment (POLST, a medical form that states what kind of life-saving treatment a person wants if they get very sick), being completed without verified informed consent and placed the resident at risk for delays, omissions, or inappropriate medical care. FINDINGS: During observation and an attempted interview of Resident 9 on 12/17/25 at 8:16 AM, Resident 9 was observed sitting up in bed and eating breakfast independently. During the attempted interview, Resident 9 was unable to answer simple questions. During an attempted interview on 12/17/25 at 8:30 AM with Resident 9's friend listed as Emergency Contact #1, the individual could not be reached. A review of the document titled, Physician Orders for Life-Sustaining Treatment, signed by the physician on 11/1/22, under Section D (Information and Signatures) revealed the following: The document did not indicate with whom the document was discussed. The document did not clearly identify who signed the form. The document did not indicate the date the document was signed. During a concurrent interview and record review with the Director of Nursing (DON) on 12/18/25 at 7:40 AM, the DON verified the following: Resident 9 does not have the capacity to make medical decisions, as indicated in the document titled EXT REFERRAL SKILLED NURSING FACILITY, dated 10/26/22. Resident 9 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease (a progressive brain disorder that slowly destroys memory, thinking, and daily functioning), Dementia (a condition affecting memory, reasoning, and the ability to perform everyday activities), and PTSD (Post -Traumatic Stress Disorder, a mental health condition where someone feels stressed or fearful long after a terrifying event). Resident 9 does not have the mental capacity to make healthcare decisions, as indicated in the document titled, Order Listing Report, dated 10/31/22. Resident 9 was listed as her own Responsible Party as documented on her undated admission RECORD. Resident 9 does not have family or legal representative on record, and no conservatorship or alternate legal authorization has been obtained. During the same concurrent interview and record review, the DON stated that because Resident 9 lacked the capacity to make medical decisions since the admission date and was listed as her own RP, the facility should have initiated a referral under the Epple Act (allows doctors to make necessary decisions for a patient who cannot decide for themselves and has no legal decision-maker) at the time of admission to address the resident's care needs. The DON further stated that the Epple Act process was no longer in use and had been replaced by CAPRIS (California Patient Representative Information System, a secure web-based system used to obtain a representative for residents who lack decision-making capacity, have no family and have no POA, guardian [a person legally appointed by the court to make decisions for someone who cannot make decisions for themselves] or conservator [person appointed by the court usually responsible for financial, medical or personal decisions]). The DON stated that CAPRIS allowed the facility to obtain timely consents needed for medical interventions, including behavioral health treatment, stating, .it is like a conservator but faster, so we can provide proper care. The DON stated the facility was currently auditing residents (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who lack decision-making capacity and/or family representation due to turnover within the Social Services Department and that facility would contact CAPRIS immediately to correct the POLST for Resident 9. The DON further stated that without a conservator or authorized representative, the facility was unable to make medical decisions on behalf of Resident 9, which placed the resident at risk for delays or omissions in appropriate care. During a concurrent record review and interview with the DON on 12/19/25 at 7:11 AM, the DON verified that Resident 9 did not have a Power of Attorney. During an interview with the Social Services Director (SSD) on 12/19/25 AT 11:07 AM, the SSD stated that when a resident lacked the mental capacity to make healthcare decisions and did not have a Power of Attorney, the Social Services Department was responsible for initiating the conservatorship process. The SSD stated that residents without capacity and without a conservator were at risk for inability to make informed decisions, unmet needs, potential neglect, and compromised safety. The SSD further stated her expectation was that an interdisciplinary team meeting (a group of different healthcare professionals meeting together to discuss about a patient and agree on the best plan of care) would be held to discuss Resident 9's case and determine the next steps. During an interview with the DON on 12/19/25 at 11:51 AM, the DON stated that when a resident lacked the mental capacity and had no family or legal representative, the social Services Department was responsible for pursuing conservatorship. The DON stated that while conservatorship was pending, the facility must coordinate with CAPRIS to obtain immediate consents necessary to provide care. A review of the facility's policy titled Resident Representative, revised on 2/21, the policy indicated, .If the resident is determined to be incompetent under the laws of the State by a court of competent jurisdiction, the rights of the resident will devolve to and will be exercised by the resident representative appointed to act on the resident's behalf. The facility will treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or authorized by the resident (in accordance with the applicable laws). Documentation designating that the representative has been delegated the necessary authority to exercise the resident's rights for decision-making issues is obtained by the director of nursing or designee. A review of the facility's policy titled Social Services, revised on 10/10, the policy indicated, .Our facility provides medically-related social services to assure that each resident can attain or maintain the highest practicable physical, mental, or psychosocial well-being. 3(b) & (j). Factors that have a potentially negative effect on psychosocial functioning include: The lack of family/social support system. legal services needs. 4 (a) & (b) The Social services department is responsible for: Obtaining pertinent social data about personal and family problems. Identifying individual social and emotional needs. A review of the facility's policy titled Advance Directives, revised on 9/22, the policy indicated, .The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Health care decision-making capacity refers to possessing the ability (as defined by State law) to make decisions regarding health care and related treatment choice. Legal Representative. a person designated and authorized by an advance directive or state law to make treatment decisions for another person in the event the other person becomes unable to make necessary health care decisions. A POLST paradigm form is not an advance directive. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. If a resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. Upon admission the interdisciplinary team assesses the resident's decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity. The interdisciplinary team conducts ongoing review of the resident's decision-making capacity and invokes the resident representative or health care agent if the resident is determined not to have decision-making capacity.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to ensure one of 35 sampled residents' (Resident 3) PRN (as needed) order for Ativan (a medication used reduce anxiousness) did not exceed 14 days without a documented clinical rationale for extending the medication timeframe order. This failure placed Resident 3 at increased risk for adverse outcomes, including over-sedation, falls, and the potential use of a chemical restraint (a medication used to control a person's behavior or restrict their freedom of movement for reasons other than a standard treatment). Findings: Findings: During a review of Resident 3's admission RECORD, the record indicated Resident 3's diagnosis included anxiety (feeling of fear, nervousness or restlessness). A review of Resident 3's Order Listing Report, dated 12/1/25, indicated, .Ativan Oral Tablet 0.5 MG [milligram - unit of measurement] (Lorazepam) Give 1 tablet by mouth every 6 hours as needed for Anxiety m/b [manifested by] severe restlessness for 30 days aeb [as evidenced by] constant moving aimlessly. During a concurrent interview and record review on 12/18/25 at 7:40 AM with the Director of Nursing (DON), the DON confirmed that the PRN Ativan order had been written for a 30-day duration. The DON stated that the facility typically applied a 14-day stop date for PRN psychotropic (drug that affects how the brain works and causes changes in mood, awareness, thoughts, feelings or behavior) medications. The DON stated that if a physician determined continued use of the PRN medication was clinically necessary, the physician would write the order for up to 90 days, provided there was a documented clinical justification. During a follow up concurrent interview and record review on 12/19/25 at 10:58 AM with the DON, the document titled, Progress Note, dated 12/18/25 was reviewed. The DON stated that after the Department identified the PRN medication order had been extended past the 14 days, the DON requested that the physician document the justification for the extension of the medication in Resident 3's medical record. The DON further stated that no previous clinical justification was available in Resident 3's medical record. A review if the facility's policy titled, Psychotropic Medication Use, dated 7/22, the policy indicated .PRN orders for psychotropic medication are limited to 14 days. (1) For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one resident (Resident 71), in a sample of 35 residents, had person-centered care plans (a personalized document outlining an individual's health, support, and personal needs, detailing what care is required, how it will be given (tasks, timing, by whom), and the goals, preferences, and choices of the person receiving it, ensuring consistent, high-quality, person-centered support) when care plans for Resident 71's diagnoses of diabetes and anxiety were not developed and implemented. This failure had the potential for health care needs to go unrecognized, negatively affecting Resident 71's health, well-being, and psychosocial health and well-being. Findings: A review of Resident 71's clinical record titled, admission RECORD, (contains clinical and demographic data) indicated Resident 71 was admitted on [DATE] to the facility with diagnoses which included diabetes (problems regulating blood sugar) and anxiety disorder (a mental health condition where you experience excessive, persistent worry, fear, or nervousness that doesn't go away and interferes with daily life, causing physical symptoms like a racing heart, trouble concentrating, and sleep issues, making it hard to control and enjoy everyday activities). A review of Resident 71's care plans indicated the facility had not developed and implemented care plans for Resident 71's diagnoses of diabetes and anxiety. A review of Resident 71's clinical document, untitled, containing physician orders indicated, . busPIRone [a medication used to treat anxiety] . every 12 hours for ANXIETY . M/B [manifested by] INABILITY TO RELAX . During an interview with the Director of Staff Development (DSD) on 12/18/25 at 1:19 PM, the DSD confirmed there was not a care plan developed and implemented for Resident 71's diagnosis of anxiety. The DSD explained the importance of having care plans in place was to ensure licensed nurses were aware of the resident's care plan for specific health issues. The DSD further explained without a care plan in place the resident may not get appropriate care. A review of Resident 71's clinical document, untitled, containing physician orders indicated, . Insulin Lispro [a rapid-acting insulin used to control high blood sugar] three times a day for DIABETES . and, . Insulin Lispro . Inject as per sliding scale [amount of insulin to inject based on blood sugar level] three times a day for DIABETES . During an interview with the DSD on 12/18/25 at 1:19 PM, the DSD confirmed there was not a care plan developed and implemented for Resident 71's diagnosis of diabetes. The DSD explained licensed nurses need to know how to care for a person with diabetes. The DSD further explained care plans are the roadmap on how to care for a resident with diabetes. The DSD explained the risk of Resident 71 not having a diabetic care plan in place was staff would not be aware of and understand specific interventions and it could cause Resident 71 to experience adverse physical effects. During an interview with the Director of Nursing (DON) on 12/19/25 at 10:25 AM, the DON stated Resident 71's diabetic and anxiety care plans should have been developed and implemented on admit. The DON explained the risk to Resident 71 not having a diabetic care plan would be if she had a change in condition related to diabetes staff would not be able to provide appropriate care. The DON further explained the risk to Resident 71 not having an anxiety care plan in place is staff would not be aware of interventions to utilize when Resident 71 was having anxiety. A review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, indicated, . A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan is developed within seven (7) days . and no more that 21 days after admission . The comprehensive, person-centered care plan . includes measurable objectives and timeframes . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . reflects currently recognized standards of practice for problem areas and conditions .		

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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 observation, interview, and record review, the facility failed to provide timely and proper pain relief for two of 35 sampled residents (Resident 72 and Resident 78), when: 1. Resident 72 complained of sore gums and discomfort, and the ordered Magic Mouthwash [medicated liquid mouthwash mixture used to relieve pain from mouth and throat sores] and dental evaluation were not carried out and/or administered to Resident 72; and, 2. Resident 78 did not receive comfort measures or pain medication in a timely manner when Resident 78 reported moderate to severe (strong) pain. These failures resulted in Resident 72 and Resident 78 experiencing continued pain, which affected Resident 72's and Resident 78's comfort and emotional well-being (the resident's ability to feel calm, secure, and free from worry). Findings: 1. Review of Resident 72's admission RECORD, indicated Resident 72 was initially admitted to the facility in the spring of 2025, with diagnoses that included depression (serious mood disorder causing persistent sadness, loss of interest in activities), and anxiety disorder (mental health condition marked by intense, persistent and excessive worry). Review of Resident 72's NURSES NOTES, dated 10/21/25, indicated, .Alert and orientated. On monitoring for. broken tooth to right lower side. No c/o [complaints of] pain or discomfort to site. No s/sx [sign and symptoms] of worsening. POC [plan of care] ongoing. Review of Resident 72's NURSES NOTES, dated 10/22/25, indicated, .alert and responsive, continues monitoring. broken tooth, pain to mouth. managed with PRN [as needed] pain medication. Able to verbalize needs to staff. Continue with current POC. Review of facility provided document titled, Oral Health Care We Come To You dated 10/22/25, indicated, .[name redacted, Resident 72]. Procedure. Full debridement [removal of plaque build-up]. heavy plaque. heavy calculus [calculus means buildup of plaque on teeth]. NV [next visit] Recommended. Recap [summary]. #28 [tooth number]-sharp. wants it extracted [pulled out] ASAP [as soon as possible] . Review of Resident 72's SOCIAL SERVICES PROGRESS NOTES, dated 10/28/25, indicated, Resident was seen by oral health on 10/28/25. Resident received services. Review of Resident 72's SBAR [Situation, Background, Assessment, Recommendation, a structured communication tool in healthcare to convey critical information of resident's condition to healthcare team] & [and] INITIAL COC [change of condition]/ALERT CHARTING & SKILLED DOCUMENTATION, dated 11/20/25, indicated, .SITUATION. Resident reports having sore gums and discomfort. Pain. New onset of sore gums. Initial COC Alert Charting Notes. MD [Medical Doctor] notified of the condition. Review of Resident 72's Physician Progress Note, dated 11/25/25, written by Nurse Practitioner (NP) 1, indicated, .Asked to see pt [patient] for sore mouth. Pt stated needs to see dentist. Will write referral [referring a resident for consultation, review, or further action]. Otherwise pt states all going well. Assessment. Mouth pain. PLAN. Dental referral. Magic Mouthwash. Review of Resident 72's Order Details, dated 11/25/25, written by Nurse Practitioner (NP) 1, indicated, .Order Summary. magic mouthwash. every 6 hours as needed for sore gums prior to meals. Review of Resident 72's Order Details, dated 11/25/25, written by Nurse Practitioner (NP) 1, (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, .Order Summary.CONSULT.dental evaluation for worsening sore gums. Review of Resident 72's Medication Administration Record for the month of 12/25, did not indicate any mouth wash or Magic Mouthwash was ordered or administered for Resident 72. During a concurrent observation and interview on 12/17/25 at 2:00 p.m., Resident 72 stated about a month ago the facility sent her to the hospital and while she was there, she received a mouth wash called, magic mouthwash, that helped numb her gums so she could tolerate eating food. Resident 72 stated she had not received the mouthwash at the facility and she had asked several staff members about the mouthwash and had verbalized to staff that the mouthwash helped her control the mouth pain. Resident 72 stated because she was missing teeth and her gums hurt, she was only able to eat certain foods. Resident 72 explained because of her mouth pain she received the same food every day. Resident 72 stated she wanted and needed new teeth because her teeth were missing or broken. Resident 72 stated she saw a dentist about a month ago in the facility and they told her they needed authorization from the insurance company to pull her teeth, and she had not received a status update. During a concurrent interview and record review on 12/18/25 at 12:40 a.m., with Licensed Nurse (LN) 4, Resident 72's clinical record titled, Physician Progress Note, dated 11/25/25, written by Nurse Practitioner (NP) 1 was reviewed. LN 4 stated she was aware Resident 72 had used mouthwash while she was recently in the hospital. LN 4 stated Resident 72 had asked her about the mouthwash, and she told her she would look into her orders but could not locate an order for a mouthwash. LN 4 stated Resident 72 had also inquired about the mouth wash with another nurse and LN 4 had thought that nurse would follow up. LN 4 stated she did not see anything in Resident 72's medical chart regarding new orders and acknowledged she had not called the doctor regarding the mouthwash. LN 4 stated she did not review Resident 72's progress notes in the medical record. During a record review of Resident 72's clinical record, LN 4 acknowledged there was a progress note written by the NP 1 regarding Resident 72's mouth pain and her order for magic mouthwash. LN 4 stated it had been at least a month since the progress note regarding the mouth wash was written. LN 4 acknowledged there was an order for the magic mouthwash and stated she was not sure why it was not on Resident 72's Medication Administration Record (MAR - a document that contains medications ordered, given or held). During a joint concurrent interview and record review on 12/18/25 at 1:07 p.m., with the Social Services Director (SSD) and the Social Services Assistant (SSA), the facility's Oral Health Care list, was reviewed. The SSD stated she was not familiar with Resident 72's plan of care and the Social Service Scheduler usually made the consultation appointments. The SSD and SSA stated they both were not aware of the consultation request ordered for Resident 72 that addressed a dental consultation for mouth pain. Through record review of Resident 72's clinical record, the SSD stated she could not locate a Social Services (SS) note regarding the scheduling of a dental consultation. The SSD stated the expectation was there should have been notes in the electronic medical records from SS regarding appointments that were received and scheduled. The SSA stated the dentist the facility used had come to the facility for their monthly visit on 12/11/25 and had performed resident examinations. Through record review of the facility's Oral Health Care list, the SSA confirmed Resident 72 was not on the list of residents scheduled to be seen nor was she examined by the dentist that day. The SSA stated had they had the consultation request she would have been seen on 12/11/25 for her dental needs. The SSD confirmed Resident 72's dental consultation ordered by the MD on 11/25/25 due to mouth pain. The SSD stated her expectation was the appointment should have been followed up on and scheduled within a week. The SSD stated follow up was important due to Resident 72's mouth pain. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/25 at 4:25 p.m., LN 7 stated she was familiar with Resident 72 and Resident 72 had lived in the facility for about a year. LN 7 stated Resident 72 had complained to her about her broken teeth, her tooth pain, and her gum pain. LN 7 stated she had given the magic mouthwash to other residents before, and the mouthwash came from the pharmacy. LN 7 stated the mouthwash was for Resident 72's mouth sores and helped alleviate pain. LN 7 stated the risk to Resident 72 that she did not receive the ordered mouth wash medication was worsening pain, eating less, and possible weight loss due to her nutritional intake being compromised. LN 7 stated regarding Resident 72 consult for the dentist, appointments were scheduled by Social Services (SS). LN 7 stated once the order was received from the doctor then the LN made SS aware through printing the order out and slipping the paper under the SS office door or they verbally told SS. LN 7 stated that since she worked the evening shift, she would also endorse the order to the next shift nurse for them to follow up. LN 7 stated there should have been a progress note written in the resident's electronic clinical record of nursing staff informing SS of the ordered dental consult. Through a record review of Resident 72's progress notes, LN 7 acknowledged there was no communication note written of a dental consult being ordered. LN 7 stated the risk to Resident 72 for her dental consultation not being followed up on was Resident 72 experiencing worsening pain and symptoms. During a concurrent interview and record review on 12/18/25 at 5:04 p.m., with the Director of Nurses (DON), Resident 72's clinical record was reviewed. The DON stated Resident 72's mouthwash order was dated 11/25/25 and the order required an LN to go into the electronic medical record and revise the order for it to appear on Resident 72's MAR. The DON explained since this was not completed the Magic Mouthwash order never went to the pharmacy to fill. The DON stated her expectation was once the doctor or nurse practitioner wrote a new order, the LN reviewed and updated the order, so it populated in the resident's MAR. The DON stated if a resident asked for medication and/or mouthwash for mouth pain, the nurse should have followed up with the doctor and/or checked the resident's orders. The DON stated the risk for the resident if this was not done was that the resident would not get medication and could have worsening pain and there was a risk of not eating or lack of nutrition due to the continued mouth pain. The DON acknowledged the order for a dental consult written by the NP and stated Resident 72 was most likely seen by the NP for her mouth pain, but nursing missed the order. The DON stated her expectation was Resident 72's order be carried out timely. The DON stated the risk of Resident 72's order not being addressed was her symptoms worsening and continued pain for the resident since the appointment had not been scheduled. The DON stated her expectation was Resident 72 should have been on the dentist consult list for the dentist's visit to the facility that occurred on 12/11/25. The DON stated the nurse should have notified social services of the dental appointment order. The DON stated the process for the new orders was that medical records would audit for new orders and send them to the nurses to review and they should have caught the new order. The DON stated her expectation was once the nurse received the order and they then notified the appropriate department or person that would be taking care of scheduling the appointment, it should have been documented in Resident 72's health record. The DON stated the risk for the consultation not being scheduled timely and/or being missed was the resident could have been in continuous pain, and the issue was not being addressed. During an interview on 12/19/25 at 9:33 a.m., Resident 72 stated her teeth had broken off at the gumline. Resident 72 stated it was upsetting to her because she was now on a soft food diet and eating foods with pudding texture and the foods stuck to her throat, were tasteless, and were not a pleasing texture. Resident 72 stated her preference was to eat a regular diet. Resident 72 stated she was emotional and upset because she wanted her mouth issues taken care of and was concerned that she could get mouth infections and be back in the hospital. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/19/25 at 10:05 a.m., with the Assistant Director of Nursing (ADON), Resident 72's Pain Assessment, completed on 11/17/25; Resident 72's care plan, dated 11/20/25; and Resident 72's Change of Condition, dated 11/20/25 were reviewed. The ADON acknowledged Resident 72's pain assessment was marked as general pain and there was no mention of specific areas of pain including her mouth. The DON stated it was important for the nurse to document specific pain so they could have addressed issues and interventions. Review of facility policy and procedure (P & P) titled, Pain-Clinical Protocol, revised 3/18, indicated, .The Physician and staff will identify individuals who have pain or who are at risk for having pain. This includes reviewing known diagnoses and conditions that commonly cause pain; for example, oral or dental pathology. It also includes review for any treatments that the resident currently is receiving for pain, including complementary and non-pharmacological treatments. The nursing staff will assess each individual for pain upon admission to the facility. whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated. The physician will help identify causes of pain; for example, by examining the resident directly, reviewing the resident's history, and via discussion with the resident and staff. The physician will help identify the extent to which underlying causes of pain can be addressed or reversed. With input from the resident to the extent possible, the physician and staff will establish goals of pain treatment; for example, freedom from pain with minimal medication side effects, less frequent headaches, or improved functioning, mood, and sleep. The physician will order appropriate non-pharmacological and medication interventions to address the individual's pain. Pain medications should be selected based on pertinent treatment guidelines. If the resident's pain is complex or not responding to standard interventions, the Attending Physician may consider additional consultative support. If a consultant is involved in managing pain, the attending physician will maintain an active role by reviewing the consultant's recommendations, addressing medical issues that affect pain, monitoring for complications related to treatment, and evaluating subsequent progress Review of facility P & P titled, Administering Medications, revised 4/19, indicated, .Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber's orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include. Enhancing optimal therapeutic effect of the medication. Honoring resident choices and preferences, consistent with his or her care plan. Review of facility P & P titled, Dental Services, revised 12/16, indicated, .Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Routine and 24-hour emergency dental services are provided to our residents through a contract agreement with a licensed dentist that comes to the facility monthly. referral to the resident's personal dentist. referral to community dentists. referral to other health care organizations that provide dental services. Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the stated plan. Review of facility provided document titled, Job Description: Licensed Vocational Nurse, undated, indicated, .The primary purpose of your job is to assist the RN's in giving services, organizing , developing and doing the day-to-day functions of the Nursing Service Department. Conducts initial and ongoing assessments of resident's health status. administers medications, and observes any changes (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in condition. Notifies the RN or healthcare provider of any significant changes or concerns. Administers medications as prescribed by the healthcare provider. Ensures accurate dosage, proper route, and timely administration. Monitors and records residents response to medications. Review of facility P & P titled, Dental Consultant, revised 4/07, indicated, .Dental care shall be provided through the services of a Consultant Dentist. Our facility does not maintain a resident dentist on staff and therefore does not provide on premises dental services. A consultant dentist is retained by our facility and responsible for providing consultation to physicians and providing other services relative to dental matters. assuring that emergency dental services are available. providing necessary information concerning other residents to appropriate staff, care planning conferences and/or committees. Review of facility policy and procedure (P & P) titled, Social Services, revised 10/10, indicated, .Our facility provided medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. The Director of Social Services is a qualified social worker and is responsible for. Consultation with other departments regarding program planning. priority setting of social services. Consultation of allied professional health personnel regarding provisions for the social and emotional needs of the resident and family. Medically related social services to maintain or improve each resident's ability to control everyday physical needs (e.g., appropriate adaptive equipment for eating.); and mental and psychosocial needs (.coping abilities.). Factors that have a potentially negative effect on psychosocial functioning include. Institutional attitudes and practices which affect the resident's dignity and sense of control. Disability or loss of function. Maintaining regular progress and follow-up notes indicating the resident's response to the plan and adjustment to the institutional setting. Maintaining appropriate documentation of referrals. Making supportive visits to residents and performing needed services (.coordinating resources and services to meet the resident's needs.). 2. During a review of Resident 78's admission Record, the record indicated Resident 78 was admitted to the facility with a diagnoses that included bilateral primary osteoarthritis of knee (pain in both knee joints caused by wearing down of the cushion between bones) and pressure ulcer of sacral region, stage 4 (very deep bedsore near the tailbone that can reach muscle or bone and causes severe pain). Review of Resident 78's PAIN ASSESSMENT INTERVIEWABLE & NON-INTERVIEWABLE (WGC)-V2), dated 10/10/25, indicated, . [Resident 78] States she has pain all over but most of the time it is in her arms. What makes the pain better? It depends sometimes medication sometimes repositioning. In the section MEDICATIONS/TREATMENTS/MODALITIES, the document indicated .Describe all methods of alleviating pain and their effectiveness: Medication and repositioning. Review of Resident 78's Care Plan, initiated on 6/5/24, in the section titled Focus, the document indicated, The resident has possible pain. In the section titled, Interventions, the document indicated, .Administer analgesia [pain relief] as per orders. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Offer non medication approaches such as repositioning, massage, immobilizing the area causing pain. During an observation on 12/16/25 at 12:08 PM in Resident 78's room, Certified Nursing Assistant (CNA) 9 answered Resident 78's call light (a handheld device that when activated, alerts the staff that the resident needs assistance). Resident 78 complained of pain and CNA 9 stated the nurse was on break and would return in about 10 minutes, and that Resident 78 would need to wait. CNA 9 then left the room. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/25 at 12:11 PM, Resident 78 stated that she had severe pain in her right arm. Resident 78 further stated that staff did not help right away and that she would need to wait a long time for her pain to be addressed. During an interview on 12/16/25 at 12:12 PM, CNA 9 stated that when a resident reported pain, CNA could ask about the pain level (using the numerical pain scoring system; 0=no pain and 10=severe pain) and location and could offer non-medication pain relief, such as repositioning. CNA 9 stated that a resident's pain needed to be communicated to the nurse right away, and that if the assigned nurse was on break, another nurse on the floor could assist with pain relief. CNA 9 stated that when she answered Resident 78's call light, she did not ask additional questions about the pain and did not offer non-medication pain relief. CNA 9 further stated that if resident's pain continued, it could worsen and could cause anxiety and increase the risk of a fall. During an interview on 12/16/25 at 12:39 PM, Resident 78 stated that she continued to have severe pain and that the nurse had not yet come to see her to provide pain relief. During an observation on 12/16/25 at 12:40 PM in Resident 78's room, CNA 10 answered Resident 78's call light. Resident 78 stated she had pain. CNA 10 stated she would notify the nurse. CNA 10 then left the room. During an interview on 12/16/25 at 12:48 PM with Licensed Nurse (LN) 2, LN 2 stated that when a CNA answered a resident's call light and the need was for pain relief, the CNA was expected to notify the nurse right away, especially if the pain level was above 5 (moderate pain or higher), so the pain could be addressed promptly. LN 2 further stated that if a resident's pain was not communicated to the nurse, the resident could experience increased pain, restlessness, and an increased risk of a fall. Review of Resident 78's doctor's order titled, Order Listing Report, the record indicated on 1/9/25, Resident 78 had a doctor's order to administer acetaminophen (pain reliver medication) Tablet 325 milligrams (mg-a unit measure) two tablets every six hours as needed for mild pain (pain level 1 through 3) and a doctor's order dated, 12/4/25 to administer oxycodone-acetaminophen (stronger pain medication) tablet 5-325 mg every six hours as needed for pain management. During a concurrent interview and record review on 12/18/25 at 10:52 AM with the Assistant Director of Nursing (ADON), Resident 78's Medication Administration Record (MAR), dated 12/2025 was reviewed. The MAR indicated that Resident 78 received oxycodone-acetaminophen on 12/16/25 at 1:04 PM for a pain level of 5 and acetaminophen on 12/16/25 at 6:24 PM for a pain level of three. Resident 78's care plan, initiated on 6/5/24, was also reviewed. In the section titled Focus, indicated [Resident 78] experience(s) Related to: wound and Pain Locations Medication Regimen containing Opioid Analgesic(s). (strong pain medicine like oxycodone-acetaminophen used for moderate to severe pain). In the section titled Interventions, indicated, .Observe effectiveness of pain management interventions. The ADON stated that Resident 78 waited 56 minutes to receive pain medication on 12/16/25 and that pain medication should have been provided as soon as possible. The ADON stated that when Resident 78 reported pain to CNAs, CNAs were expected to ask basic questions about the pain and offer non medication comfort measures, such as repositioning. The ADON stated that CNAs were expected to report the resident's pain to the nurse right away, and if the assigned nurse was on break, the covering nurse should be notified so the resident's pain could be addressed without delay. The ADON further stated that delays in pain management could cause restlessness and increase the risk of accidents, including falls. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/25 at 1:18 PM with the Director of Nursing (DON), the DON stated that staff were expected to include a resident's pain as part of vital signs (basic body measurements that show how the body is working, heart rate, temperature, blood pressure, and breathing rate) and that residents' pain should be assessed by a nurse as soon as possible. The DON further stated that if pain relief was not provided to residents in a timely manner, the pain could worsen and increase safety risks. Review of facility policy and procedure (P&P) titled Pain-Clinical Protocol revised on 03/2018, the P&P indicated, .Staff will provide the elements of a comforting environment, and appropriate physical and complementary interventions; for example, local heat or ice, repositioning. Review of facility policy and procedure (P&P) titled Activities of Daily Living (ADL), Supporting revised on 03/2018, the P&P indicated, .Care and services to prevent and/or minimize functional decline will include appropriate pain management.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to ensure that informed consent (explaining the risks, benefits, and choices to the resident or their representative [someone authorized to act on behalf of a resident]) for the use of bed rails (adjustable metal or plastic bars along the sides of a hospital bed) was obtained from the appropriate resident representative for one of 35 sampled residents (Resident 107), when the informed consent was obtained from Resident 107, who lacked decision-making capacity. This failure resulted in Resident 107's representative not being able to make an informed choice regarding the use of bed rails and placed Resident 107 at risk of entrapment (when a resident gets caught, trapped, or entangled in the spaces within or around the bed rails, mattress, or the bed frame) injury, or restraint (something that keeps a resident from free movement). Findings: During a review of Resident 107's admission Record, the record indicated Resident 1 was admitted to the facility with diagnoses that included dementia, (condition that causes memory loss, confusion, and trouble thinking or making decisions) schizophrenia, (mental illness that can cause confusion, unusual thoughts, or seeing or hearing things that are not real) and major depressive disorder. Review of Resident 107's doctor's order titled, Order Details, dated 11/1/25, indicated, .Order Summary: Bedrail: Left Side Grab bar. During a concurrent observation and interview on 12/16/25 at 11:24 AM with Resident 107 in Resident 107's room, Resident 107 had a bed rail on the left side of the bed. Resident 107 stated that he could not remember if staff members explained the pros and cons of a bed rail. During a concurrent interview and record review on 12/17/25 at 2:21 PM with Licensed Nurse (LN) 6, Resident 107's informed consent for bed rails titled, BED RAIL OBSERVATION/ASSESSMENT (WGC)-V3, dated 11/1/25 and Resident 107's doctor's order titled, Order Listing Report, dated 12/31/24 were reviewed. The BED RAIL OBSERVATION/ASSESSMENT (WGC)-V3 indicated that Resident 107 had signed the informed consent for the use of bed rails on 11/1/25. Resident 107's Order Listing Report indicated, MD [Medical Doctor] determines that [Resident 107] does NOT have the Mental Capacity to make Healthcare decisions. LN 6 stated that Resident 107's informed consent for bed rails was invalid because Resident 107 lacked decision-making capacity and was not fully alert to understand the safety issues related to bed rails. During a concurrent interview and record review on 12/18/25 at 11:45 AM with the Assistant Director of Nursing (ADON), Resident 107's BIMS [Brief Interview for Mental Status: an assessment of the resident's thinking and memory] TEMPORARY WORKSHEET., dated 11/26/25 was reviewed. The BIMS TEMPORARY WORKSHEET. indicated that Resident 107 BIMS score was 11 which indicated Resident 107 had moderately impaired cognition (13-15 = Intact, 8-12 = Moderate, 0-7 = Severe). The ADON stated that Resident 107 had a BIMS score of 11, which showed moderate cognitive impairment, and that Resident 107 did not have the capacity to make healthcare decisions. The ADON stated that Resident 107 could not understand the risks of using a bed rail. The ADON stated that informed consent should have been signed by the resident's representative, not the resident, and that the informed consent for the bed rail was not valid. ADON further stated that the use of a bed rail for Resident 107 was a safety concern and increased risk of entrapment. During an interview on 12/18/25 at 1:23 PM with the Director of Nursing (DON), the DON stated that an informed consent for bed rail use should have been signed by the family or resident's representative because Resident 107 lacked the capacity to make healthcare decisions and did not understand the risks of bedrails, including entrapment. The DON further stated that any consent signed by a resident without capacity was not valid. Review of Resident 107's Care Plan, initiated on 11/29/25, in the section titled, Focus, indicated, BED RAIL-Bed Rail: May have 1/4 bar side rail. In the section titled Interventions, indicated, .Educate the resident and/or resident representative on the risks and benefits of bed rail use as noted on the informed consent. Review of facility policy and procedure (P&P) titled, Bed Safety and Bed (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Rails, revised 8/22, the P&P indicated, .For the purpose of this policy bed rails include:.grab/assist bars.The use of bed rails is prohibited unless criteria for use of bed rails have been met, including.informed consent.Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services to meet the dental health needs for one of thirty-five sampled residents (Resident 72), when Resident 72's mouth wash and dental consult ordered on 11/25/25 were not carried out timely. This deficient practice had the potential to negatively affect Resident 72's dental health needs and could contribute to unnecessary pain and suffering. Findings: Review of Resident 72's admission RECORD, indicated Resident 72 was initially admitted to the facility in the spring of 2025, with diagnosis including but not limited to acute and chronic respiratory failure (lung disease often requiring long-term oxygen therapy), chronic obstructive pulmonary disease (long-term lung condition that blocks airflow and can make it hard to breath), dependence on supplemental oxygen, depression (serious mood disorder causing persistent sadness, loss of interest in activities), and anxiety disorder (mental health condition marked by intense, persistent and excessive worry). Review of Resident 72's NURSES NOTES, dated 10/21/25, indicated, .Alert and orientated. On monitoring for immovable mass to center of abdomen and broken tooth to right lower side. No c/o [complain of] pain or discomfort to site. No s/sx [sign and symptoms] of worsening. POC [plan of care] ongoing. Review of Resident 72's SBAR [Situation, Background, Assessment, Recommendation, and is a structured communication tool in healthcare to convey critical information of patient's condition to healthcare team, including MD] & INITIAL COC /ALERT CHARTING & SKILLED DOCUMENTATION, dated 11/20/25, indicated, .SITUATION. Resident reports having sore gums and discomfort. Pain. Resident Reports Pain? .Yes. Most Recent Pain Level. 4. Location. Sore gums. Notes. New onset of sore gums. Initial COC Alert Charting Notes. Resident complains of sore gums and discomfort, no active bleeding observed. Tylenol administered as ordered for pain, resident tolerated medication well, remains stable, no acute distress, denies other symptoms. MD [Medical Doctor] notified of the condition. Resident is self RP [Representative Party] and aware. Will continue to monitor. Review of Resident 72's Care Plan, initiated 11/20/25, indicated, .Resident has impaired oral/dental condition due to sore gums and discomfort. Resident will maintain oral mucosal integrity and decreased gum soreness. Assess gums for redness, swelling or bleeding. Monitor episodes of chewing problems. Notify provided if symptoms worsen or if infection is suspected. Perform oral assessment as needed. Review of Resident 72's Physician Progress Note, dated 11/25/25, written by Nurse Practitioner (NP) 1, indicated, .Asked to see pt [patient] for sore mouth. Pt stated needs to see dentist. Will write referral. Otherwise pt states all going well. Assessment. Mouth pain. Ventral hernia and lower and pain. PLAN. Dental referral. Magic Mouthwash. Continue current treatment plan and adjust care and medication as needed. Monitor neuro and mental status, pain control. Monitor ABD [abdomen] symptoms. Chart, medication, and labs reviewed. Review of Resident 72's Order Details, dated 11/25/25, written by Nurse Practitioner (NP) 1, indicated, .Order Summary. magic mouthwash. every 6 hours as needed for sore gums prior to meals. Review of Resident 72's Order Details, dated 11/25/25, written by Nurse Practitioner (NP) 1, indicated, .Order Summary. CONSULT. dental evaluation for worsening sore gums. Review of Resident 72's Medication Administration Record for the months of 11/2025 and 12/2025, did not indicate any mouth wash or Magic Mouthwash was ordered or administered. During a concurrent observation and interview on 12/17/25 at 2:00 p.m., Resident 72 stated about a month ago the facility sent her to the hospital and while she was there, she received a mouth wash called magic mouthwash that helped with numbing her gums so she could tolerate eating food. Resident 72 stated she was not receiving the mouthwash at the facility and she had asked several staff members about receiving the mouthwash and had told them it helped her with the pain in her mouth. Resident 72 further explained she still had not received the mouthwash and was in a lot of mouth pain. Resident 72 stated because of her missing teeth and her gums hurting she was only able to eat certain foods. Resident 72 explained because of her mouth pain she gets same food every day. During a concurrent interview and record review on 12/18/25 at 12:40 a.m., Licensed Nurse 4 stated she was aware (continued on next page)		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 72 was using mouthwash while she was recently in the hospital. LN 4 stated Resident 72 had asked her about the mouthwash, and she told her she would look into her orders but could not locate an order for a mouthwash. LN 4 stated Resident 72 had also inquired about the mouth wash with another nurse and LN 4 had thought that nurse would follow up. LN 4 stated she did not see anything in Resident 72's medical chart regarding new orders and acknowledged she did not call the doctor regarding the mouthwash. LN 4 stated she does not usually look at resident's progress notes in their medical record. During a record review of Resident 72's clinical record, LN 4 acknowledged there was a progress note written by the NP 1 regarding Resident 72's mouth pain and her order for magic mouthwash. LN 4 stated she was per diem [on call] and she would need to contact the doctor to get the order, and the NP could have placed the order for the mouthwash. LN 4 stated it had been at least a month since the progress note regarding the mouth wash. Through a record review of Resident 72's orders, LN 4 acknowledged the order for the magic mouthwash and stated she was not sure why it was not on Resident 72's MAR. During a concurrent interview and record review on 12/18/25 at 1:07 p.m., with the Social Services Director (SSD) and the Social Services Assistant (SSA), the SSD stated she was not familiar with Resident 72 and regarding scheduling consultation appointments the Social Service Scheduler usually makes the appointments, and she was not working that day. The SSD and SSA stated they both were not aware of the two consultation requests ordered for Resident 72 addressing a dental consult for mouth pain and abdominal surgeon consult. Through record review of Resident 72's clinical record, the SSD stated she could not locate a SS note regarding the scheduling of dental or abdominal surgeon consults. The SSD stated the expectation was there should be notes in electronic medical records from SS regarding receiving and scheduling of appointments. The SSA stated the dentist the facility uses had come to the facility for their monthly visit on 12/11/25 and had performed resident examinations. Through record review of the facility's Oral Health Care list, the SSA confirmed Resident 72 was not on the list of residents scheduled to be seen nor was she examined by the dentist that day. The SSA stated had they had the consultation request she would have been seen on 12/11/25. The SSD confirmed Resident 72's dental consult ordered by the MD on 11/25/25 due to mouth pain. The SSD stated her expectation was within a week for sure the appointment should have been followed up on and scheduled. The SSD stated she would send an email now to the dentist and this was important due to Resident 72's mouth pain. The SSD stated she would be calling the dentist Resident 72 had seen previously while in house (facility) for her progress notes as she was not sure what the treatment plan was. During an interview on 12/18/25 at 4:25 p.m., LN 7 stated she was familiar with Resident 72 and Resident 72 had lived in the facility for about a year. LN 7 stated Resident 72 had complained to her about her broken teeth, her tooth pain and her gum pain. LN 7 stated she was on hold earlier with the pharmacy regarding Resident 72's magic mouthwash. Resident 72 explained she was not able to speak with anyone from the pharmacy regarding what the holdup was on getting Resident 72 her mouth wash medication. LN 7 stated she had given the mouthwash to other residents, and the mouthwash would come from the pharmacy. LN 7 stated the mouthwash was for Resident 72's mouth sores and helps alleviate pain. LN 7 stated the risk to Resident 72 if she did not receive the ordered mouth wash medication would be worsening pain, her eating less, possible weight loss due to her nutritional value consumed being compromised. LN 7 stated regarding Resident 72 consult for the dentist, appointments were scheduled by Social Services (SS). LN 7 stated once the order was received from the doctor then the LN make SS aware through printing the order out and slipping the paper under the SS office door or they tell SS verbally. LN 7 stated that since she works the evening shift, she will also endorse the order to the next shift nurse for them to follow up. LN 7 stated there should be a progress note written in the resident's electronic clinical record of nursing staff informing SS of the ordered dental consult. Through a record review of Resident 72's progress notes, LN 7 acknowledged there was no communication note written of a dental consult being ordered. LN 7 stated the risk to Resident 7 for her abdominal surgeon and dental consult not being followed up on was Resident 72 experiencing (continued on next page)		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	worsening pain and symptoms. During a concurrent interview and record review on 12/18/25 at 5:04 p.m., the Director of Nurses (DON) reviewed Resident 72's clinical record, the DON acknowledged the order for a dental consult written by the NP and stated Resident 72 was most likely seen by the NP for her mouth pain but nursing missed the order for the consult. The DON stated her expectation was Resident 72's dental consult order be carried out timely. The DON stated the risk of Resident 72's order not being addressed was her mouth symptoms worsening and continued pain for the resident since the appointment had not been scheduled. The DON stated her expectation was Resident 72 should have been on dentist consult list for the dentist's visit to the facility that occurred on 12/11/25. The DON stated the nurse should have notified social services of the dental appointment order. The DON stated the process for new orders was that medical records audits for new orders and sends them to the nurses to review and they should have caught the new dental consult order. The DON stated her expectation was once the nurse receives the order and they then notify the appropriate department or person that will be taking care of scheduling the appointment and writes a note in the resident's chart document this. The DON stated the risk for the dental consultation not being scheduled timely and/or being missed was the resident could be in continuous pain and the issue not being addressed. During an interview on 12/19/25 at 9:33 a.m., Resident 72 stated social services had just come into to her room to tell her they have an appointment scheduled for her to see an outside dentist on 1/5/26. Resident 72 stated she needed the Magic Mouthwash for her mouth pain. Resident 72 stated she had swelling and blistering in her mouth which had happened while she was in the hospital. Resident 72 stated she was seen in October of 2025 by the dentist who comes to the facility and they cleaned her mouth. Resident 72 explained during that dental visit, the dentist told her she need upper dentures and needed her bottom teeth pulled. Resident 72 further explained there was no follow up with the dentist after that visit. Resident 72 stated she had asked the Certified Nurse Assistant (CNA) about her dental status a couple of times and did not receive any information. Resident 72 stated her teeth had broken off at the gumline. Resident 72 stated it was upsetting to her because she was now on a soft food diet and eating foods with pudding texture and the foods stick to her throat, were tasteless, and were a yucky texture. Resident 72 stated her preference was to eat a regular diet. Resident 72 stated she was emotional and upset because she wanted her mouth issues taken care of and was concerned that she could get mouth infections and be back in the hospital. Review of facility P & P titled, Medication and Treatment Orders, revised 7/2016, indicated, .Orders for medication and treatments will be consistent with principles of safe and effective order writing. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Review of facility P & P titled, Dental Services, revised 12/2016, indicated, .Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Routine and 24-hour emergency dental services are provided to our residents through a contract agreement with a licensed dentist that comes to the facility monthly. referral to the resident's personal dentist. referral to community dentists. referral to other health care organizations that provide dental services. Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the stated plan. Review of facility P & P titled, Resident Participation-Assessment/Care Plans, revised 2/2021, indicated, .The resident and his or her representative are encouraged to participate in the resident's assessment and in the development of and implementation of the resident's care plan. The resident/representative's right to participate in the development and implementation of his or her plan of care includes the right to participate in establishing his or her goals and expected outcomes of care. receive services and/or items included in the plan of care. Review of facility provided document titled, Job Description: Licensed Vocational Nurse, undated, indicated, .The primary purpose of your job is to assist the RN's in giving services, organizing, developing and doing the day-to-day functions of the Nursing Service Department. Conducts initial and ongoing assessments of resident's health status. administers (continued on next page)		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications, and observes any changes in condition. Notifies the RN or healthcare provider of any significant changes or concerns. Administers medications as prescribed by the healthcare provider. Ensures accurate dosage, proper route, and timely administration. Monitors and records residents response to medications. Review of facility P & P titled, Dental Consultant, revised 4/2007, indicated, .Dental care shall be provided through the services of a Consultant Dentist. Our facility does not maintain a resident dentist on staff and therefore does not provide on premises dental services. A consultant dentist is retained by our facility and responsible for providing consultation to physicians and providing other services relative to dental matters. assuring that emergency dental services are available. providing necessary information concerning other residents to appropriate staff, care planning conferences and/or committees. Review of facility policy and procedure (P & P) titled, Social Services, revised 10/2010, indicated, .Our facility provided medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. The Director of Social Services is a qualified social worker and is responsible for. Consultation with other departments regarding program planning. priority setting of social services. Consultation of allied professional health personnel regarding provisions for the social and emotional needs of the resident and family. Medically related social services to maintain or improve each resident's ability to control everyday physical needs (e.g., appropriate adaptive equipment for eating.); and mental and psychosocial needs (.coping abilities.). Factors that have a potentially negative effect on psychosocial functioning include. Institutional attitudes and practices which affect the resident's dignity and sense of control. Disability or loss of function. Maintaining regular progress and follow-up notes indicating the resident's response to the plan and adjustment to the institutional setting. Maintaining appropriate documentation of referrals. Making supportive visits to residents and performing needed services (.coordinating resources and services to meet the resident's needs.).		

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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. Based on observation, interview and record review the facility failed to ensure that staff utilized appropriate Personal Protective Equipment (PPE, special gear worn to protect themselves and others from germs) upon entering an isolation room for one of three sampled residents (Resident 37) when Licensed Nurse (LN) 3 was observed inside a contact isolation room (a room where a sick person is kept separate and staff use additional protective equipment, such as gloves and gowns, to prevent the spread of germs) checking Resident 37's pulse without wearing gloves or a gown. This failure increased the risk of spreading germs to staff, other residents and visitors in the facility. Findings: Review of Resident 37's admission RECORD, indicated that Resident 37 was admitted to the facility with the following diagnoses including, but not limited to, Acute Respiratory Failure with Hypoxia (lungs cannot get enough oxygen into the blood to meet the body's needs), and Pneumonia (lung infection that makes it hard to breathe). During a concurrent observation and interview with Resident 37 on 12/16/25 at 12 PM, it was noted that a contact isolation sign was posted outside the resident's room. Resident 37 stated that she had Pneumonia. During a concurrent observation and interview with LN 3 on 12/17/25 at 11:14 AM, it was observed that LN 3 was inside Resident 37's contact isolation room without wearing any PPE, including gloves or gown, while checking the resident's pulse. During the interview, LN 3 stated that he believed Resident 37 had pneumonia and that he entered the room to assess the resident's pulse. LN 3 acknowledged that he did not wear PPE. LN 3 stated that the risk of his actions was that he could become contaminated and potentially transmit bacteria to other residents. During a concurrent interview and record review with the Director of Nursing (DON) on 12/18/25 at 7:40 AM, the DON reviewed Resident 37's laboratory records and confirmed that the resident had ESBL (Extended-Spectrum Beta-Lactamase - is a hard-to-kill germ that spreads by contact from person to person, especially through hands, clothing, or shared equipment if proper protection was not used) detected in her urine. The DON stated that LN 3's provision of care to Resident 37 without wearing contact isolation PPE did not meet her expectations. During an interview with the Infection Preventionist (IP) on 12/19/25 AT 9:35 AM, the IP stated that LN 3 entering Resident 37's isolation room without PPE did not meet her expectations, as the room was designated for contact isolation and all staff were expected to adhere to PPE requirements. A review of the facility's policy titled Isolation - Categories of Transmission-Based Precautions revised 9/22, the policy indicated, .Transmission-based precautions are initiated when a resident has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. 1. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with resident or indirect contact with environmental surfaces. 7. Staff and visitors wear gloves. 8. Staff and visitors wear a disposable gown upon entering the room. A review of the facility's policy titled Personal Protective Equipment revised 10/18, the policy indicated, .The type of PPE required for a task is based on: a. the type of transmission-based precaution. Review of an online document published by the Centers for Disease Control and Prevention (CDC) titled Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007), updated on 9/2024, the guideline indicated, .II.E.2. When Contact Precautions are used. donning of both gown and gloves upon room entry is indicated to address unintentional contact with contaminated environmental surfaces. III.b.1 Contact Precautions. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens. https://www.cdc.gov/infection-control/media/pdfs/Guideline-Isolation-H.pdf		