

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

REV #1 06.12.2025

PRINTED: 05/27/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/08/2025
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NAME OF PROVIDER OR SUPPLIER CREEKSIDE REHABILITATION & BEHAVIORAL HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 850 SONOMA AVE SANTA ROSA, CA 95404
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of two (2) complaints #CA00960848 and #CA00960262 and two (2) facility reported incidents (FRI) #CA00958997 and #CA00959240. The inspection was limited to the specific incidents investigated and does not represent the findings of a full inspection of the facility. The Department was unable to substantiate a violation of the regulations for complaint #CA00960848 and FRI #CA00958997. The Department substantiated a violation of regulations for complaint #CA00960262 and FRI #CA00959240.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		

Atom Vaughn

POC and EOC approved 6/19/25 BIC 6/5/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE RN Dan	(X6) DATE 6/12/25
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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.

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F550	<p>Continued From page 2</p> <p>to endure an undignified experience being left for hours, on a soiled bedpan, feeling "helpless" and "embarrassed" with an increased potential for skin breakdown.</p> <p>Findings:</p> <p>A review of Resident 1 's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted to the facility in April 2025, for surgery aftercare following a right lower leg fracture, with a history of falling, and difficulty walking.</p> <p>During an interview on 5/8/25 at 3:34 p.m. Resident 1 stated he was left on a bedpan for hours in the middle of the night and no one responded to his call light even though he pushed it multiple times. Resident 1 stated he felt "helpless" and "embarrassed" being left like that on a dirty bedpan, and he notified a nurse immediately the next morning.</p> <p>During an interview on 5/8/25, at 1:13 p.m. with the facility Administrator (ADM), the ADM confirmed Resident 1 had been left on a bedpan for a prolonged period. The ADM stated he thought this incident occurred due to a communication breakdown between CNA 1 and CNA 2 that night, when they changed assignments in the middle of the shift. The ADM stated the facility used to have a process they used to assign residents to CNAs for all shifts including the night shift, but the facility was not using that process when this incident occurred. The ADM stated going forward, the old process of assigning residents to specific CNAs would be</p>	F 550	<p>How facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into quality assurance system: and include dates when corrective action will be completed. The corrective action dates must be acceptable to the State Agency.</p> <p>Department heads/Interdisciplinary Team will identify resident concerns through daily Angel rounds, via review of monthly Resident Council minutes, and during quarterly care conferences.</p> <p>Findings will be reviewed in QAPI for three months.</p>	<p>5/27/25</p> <p>6/3/25 through 9/3/25</p>

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F 550	Continued From page 3 <ul style="list-style-type: none"> brought back into practice. The ADM stated the two CNAs involved, CNA 1 and CNA 2, were placed on suspension from 4/27/25 through 5/1/25, and were counseled about resident dignity and communication. During an interview on 5/8/25 at 1:56 p.m. with CNA 3, CNA 3 stated the normal process after leaving a resident on a bedpan, is to provide privacy, leave the call light within reach so that the CNAs know when to go back and assist the resident with being taken off the bedpan. CNA 3 acknowledged leaving a resident on a bedpan for hours could potentially cause the resident's skin to break down, causing injury. During an interview on 5/8/25 at 4:00 p.m. Licensed Nurse 1 (LN 1) stated the normal process, when a resident needs assistance for anything, is to push the call light for assistance, and then staff, a certified nurse assistant (CNA) or a nurse, should respond to the resident's call within a few minutes. During an interview on 5/8/25 at 4:13 p.m. with the DON, the DON confirmed when Resident 1 was left on a soiled bedpan for hours without any response to his multiple attempts for assistance from facility staff, was a "dignity issue." The DON added, the associated risk for Resident 1 in the facility's failure to ensure Resident 1's preservation of dignity, she thinks would be, possible "embarrassment" experienced by Resident 1. The DON stated that her expectation is that staff provide residents with dignity, respond to call lights timely, and not leave residents on bedpans for extended periods of time, per facility policy. 	F 550			

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F 550	Continued From page 4 During a review of the facility policy and procedure titled, "Dignity", revised February 2021, indicated, " ...Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem ... Residents are treated with dignity and respect at all times ... The facility culture supports dignity and respect for residents ... standards of care that compromise dignity are prohibited ... Staff are expected to promote dignity and assist residents; for example: ... b. promptly responding to a resident ' s request for toileting assistance ..." During a review of facility policy and procedure titled, "Bedpan/Urinal, Offering/Removing," revised February 2018, indicated, "The purpose of this procedure is to provide the resident with bedpan and/or urinal assistance ... Do not allow the resident to sit on a bedpan for extended periods. This is not only uncomfortable to the resident, it also causes skin breakdown ... Put the toilet tissue and call light within easy reach of the resident ... Allow the resident as much privacy as possible ... Tell the resident to call you when he or she has finished..... leave the room to give the resident privacy..... When the resident calls that he or she has finished, return to the room ... Remove the bedpan .."	F 550			