STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055557	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Post Acute	35253 Avenue H Yucaipa, CA 92399

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46917 Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and management of a gastrostomy tube (G-tube- tube inserted through the abdomen into the stomach that delivers nutrition, hydration, and medications) was implemented in accordance with the facility's policy and procedure for three of six residents (Residents 18, 19, and 6) reviewed for g-tube when a Licensed Vocational Nurse (LVN 2) did not check Residents 18, 19, and 6's G-tube placement (listening to gurgling sound when flushing air through the g-tube to confirm for correct position) before administering medications. These failures had the potential to place Residents 18, 19, and 6 at increased risk of aspiration (when food or liquids enter the lungs). Findings: 1. During a review of Resident 18's Admission Record (contains demographic and medical information), it indicated Resident 18 was admitted to the facility on [DATE], with diagnoses which included acute respiratory failure with hypoxia (condition where there is not enough oxygen in the body), seizures (sudden, uncontrolled burst of electrical activity in brain), and chronic obstructive pulmonary disease (chronic inflammatory lung disease that obstructs airflow). During a review of Resident 18's Physician Order, dated February 4, 2024, it indicated Resident 18 had an order for licensed nurses to Check tube placement/patency, Every shift; 07:00 AM - 7:00 PM - 7:00 PM - 7:00 AM. A medication administration observation was conducted on June 4, 2024, at 8:01 AM, in Resident 18's room, with LVN 2. Resident 18 was lying in bed, listening to the radio, with the head of the bed elevated. LVN 2 attached a syringe onto the G-tube, checked for residual (fluid/contents that remain in the stomach), then proceeded to flush the G-tube with 30 mL (milliliters - unit of measurement) of water and administered cranberry (supplement) 425 mg (milligram - unit of measurement). LVN 2 did not check for G-tube placement. 2. During a review of Resident 19's Admission Record, it indicated Resident 19 was admitted to the facility on [DATE], with diagnoses which included sepsis (a body's extreme reaction to infection), cerebral infarction (reduced blood flow to brain by narrowed vessels), and encephalopathy (group of conditions that cause brain dysfunction). (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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Creekside Post Acute	35253 Avenue H Yucaipa, CA 92399

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 19's Physician Order, dated April 17, 2024, it indicated Resident 19 had an order for licensed nurses to Check tube placement/patency, Every shift; 07:00 AM - 7:00 PM - 7:00 PM - 7:00 AM. A medication administration observation was conducted on June 4, 2024, at 8:23 AM, in Resident 19's room, with LVN 2. Resident 19 was lying in bed, listening to the radio, with the head of the bed elevated. LVN 2 attached a syringe onto the G-tube, checked for residual, then proceeded to flush the G-tube with 30 mL of water and administered sodium bicarbonate (supplement) 650 mg. LVN 2 did not check for placement of the G-tube site. 3. During a review of Resident 6's undated Admission Record, it indicated Resident 6 was admitted to the facility on [DATE], with diagnoses of anoxic brain damage (complete lack of oxygen to the brain causing death of brain cells), cerebral infarction (disrupted blood flow to the brain-stroke) , contracture of muscle, right upper arm (stiffness or constriction in the connective tissues causing deformity), and contracture of muscle, left upper arm. During a review of Resident 6's Physician Order, dated October 5, 2023, it indicated Resident 6 had an order for licensed nurses to Check tube placement/patency, Every shift; 07:00 AM - 7:00 PM - 7:00 PM - 7:00 AM. A medication administration observation was conducted on June 4, 2024, at 9:01 AM, in Resident 6's room, with LVN 2. Resident 6 was lying in bed, watching television, with the head of the bed elevated. LVN 2 attached a syringe onto the G-tube, checked for residual, proceeded to flush the G-tube with 30 mL of water and administered pantoprazole (medication use to prevent stomach ulcers) 40 mg. LVN 2 did not check for placement of the G-tube site. During an interview with LVN 2, on June 4, 2024, at 10:11 AM, LVN 2 stated he should have checked Residents 18, 19, and 6's G-tube placement prior to medication administration. During a concurrent interview and record review, with the Director of Nursing (DON), on June 4, 2024, at 12:23 PM, the DON reviewed the facility's policy and procedure (P&P) titled, Maintaining Patency of a Feeding Tube (Flushing), revised December 2011, and stated the P&P was not followed by LVN 2. During a review of the facility's policy and procedure (P&P) titled, Maintaining Patency of a Feeding Tube (Flushing), revised December 2011, it indicated, .The following equipment and supplies will be necessary when performing this procedure . 5. Stethoscope . 7. Verify placement of tube by injecting air into tube while listening to abdomen with stethoscope for a bubbling sound.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46917 Based on observation, interview, and record review, the facility failed to ensure medications being received by the residents were explained prior to administration to three of eight residents (Residents 18, 19, and 6) reviewed for medication administration. These failures had the potential to result in Residents 18, 19, and 6 being denied their right to know what medication is being given and breaking one of the seven rights of medication administration. Findings: 1. During a review of Resident 18's Admission Record (contains demographic and medical information), it indicated Resident 18 was admitted to the facility on [DATE], with diagnoses which included acute respiratory failure with hypoxia (condition where there is not enough oxygen in the body), other seizures (sudden, uncontrolled burst of electrical activity in brain), and chronic obstructive pulmonary disease (chronic inflammatory lung disease that obstructs airflow). An observation of medication administration for Resident 18 by LVN 2 was June 4, 2024, at 8:01 AM, in Resident 18's room. Resident 18 was lying in bed, listening to the radio, with the head of the bed elevated. LVN 2 administered medications to Resident 18 without providing explanation as to which medications were being received . 2. During a review of Resident 19's Admission Record, it indicated Resident 19 was admitted to the facility on [DATE], with diagnoses which included sepsis (a body's extreme reaction to infection), cerebral infarction (reduced blood flow to brain by narrowed vessels), and encephalopathy (group of conditions that cause brain dysfunction). An observation of medication administration for Resident 19 by LVN 2 was conducted on June 4, 2024, at 8:23 AM, in Resident 19's room. Resident 19 was lying in bed, listening to the radio, with the head of the bed elevated. LVN 2 administered medications to Resident 19 without providing explanation as to which medications were being received . 3. During a review of Resident 6's Admission Record, it indicated Resident 6 was admitted to the facility on [DATE], with diagnoses of anoxic brain damage (complete lack of oxygen to the brain causing death of brain cells), cerebral infarction (disrupted blood flow to the brain-stroke) , contracture of muscle, right upper arm (stiffness or constriction in the connective tissues causing deformity), and contracture of muscle, left upper arm. During a medication administration observation was conducted on June 4, 2024, at 9:01 AM, in Resident 6's room, with LVN 2. Resident 6 was lying in bed, watching television, with the head of the bed elevated. LVN 2 administered medications to Resident 18 without providing explanation as to which medications were being received . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on June 4, 2024, at 10:13 AM with LVN 2, LVN 2 stated he should have explained the medications to Residents 18, 19, and 6 prior to administration. LVN 2 further stated it is part of the rights of medication administration for the residents to know what they are being given. During a concurrent interview and record review on June 4, 2024, at 12:26 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Administering Medications through an Enteral Tube, revised November 2018 was reviewed. The P&P indicated, . Steps in the Procedure . 4. Prepare the resident: a. confirm the identity of the resident. b. explain the procedure to the resident . The DON stated the P&P was not followed. The DON further stated that his expectation was for all nurses to explain medications to their residents. During a concurrent interview and record review on June 4, 2024, at 12:25 PM with the DON, the facility's undated P&P titled, Resident Rights was reviewed. The P&P indicated, Employees shall treat all residents with kindness, respect, and dignity . o. be notified of his or her medical condition and of any changes in his or her condition . p. be informed of, and participate in, his or her . treatment. The DON stated the P&P was not followed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49231 Based on observation, interview, and record review, the facility failed to ensure storage of medications was secure for one of one medication room, when the medication refrigerator inside the medication room was found unlocked. This failure had the potential to increase the risk of unauthorized access, misuse, and/or harm to highly vulnerable population of 49 residents. Findings: During a concurrent observation and interview, on June 3, 2024, at 10:24 AM, with the Infection Preventionist (IP), the medication room was inspected. The medication refrigerator was unlocked. The IP acknowledged the finding and stated the refrigerator needs to be locked when not in use. During a concurrent interview and record review, on June 4, 2024, at 9:24 AM, with the Director of Nursing (DON), the DON reviewed and acknowledged the facility's undated policy and procedure (P&P), titled Policy and Procedure for Med Pass, and stated that based on the P&P for medication storage the medication refrigerator should also always be locked. During a review of the facility's undated policy and procedure (P&P), titled Policy and Procedure for Med Pass, it indicated . Schedule II, III, and IV controlled medications (including refrigerated items) are stored separately from other medications in a locked drawer or compartment designated for that purpose, under double lock.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46917 Based on observation, interview, and record review, the facility failed to document the Restorative Nursing [nursing interventions that promote the residents' ability to adapt and adjust] Weekly Summary for one of six residents (Resident 6) reviewed for limited range of motion (ROM- full movement potential of a joint.). This failure had the potential to result in inaccurate progress or regression in range of motion exercises which could negatively impact the range of motion for Resident 6. Findings: During an observation on June 3, 2024, at 11:16 AM, in Resident 6's room, Resident 6 was laying down in bed with a stuffed plush carrot toy in his right hand and splint (strip of rigid material used for supporting a bone) on the left hand. During a review of Resident 6's Admission Record (contains demographic and medical information, it indicated Resident 6 was admitted to the facility on [DATE], with diagnoses of anoxic brain damage (complete lack of oxygen to the brain causing death of brain cells), cerebral infarction (disrupted blood flow to the brain-stroke) , contracture (s permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of muscle, right upper arm (stiffness or constriction in the connective tissues causing deformity), and contracture of muscle, left upper arm. During a review of Resident 6's History and Physical Examination dated June 10, 2023, it indicated .poor rehabilitation potential . During a review of Resident 6's Functional Abilities and Goals dated April 14, 2024, it indicated .Impairment on both sides . Upper extremity [shoulder, elbow, wrist, hand] . Lower extremity [hip, knee, ankle, foot]. During a review of Resident 6's Medication Review Report dated June 6, 2024, it indicated the following RNA orders from the physician: a. RNA Program for PROM (Passive Range of Motion- ROM that is achieved when outside force causes the movement of a joint) to BLE (Bilateral lower extremities) QD (every day) 3X (times) /WK (week) OR AS SAFELY TOLERATED. b. RNA PROGRAM: Apply Carrot to R (right) hand 3x/week to decrease risk of contraction and maintain ROM. c. RNA PROGRAM: Apply Elbow Extension orthotics (splint to extend the elbow joint) to both elbows, 3x/week, to decrease risk of flexion contracture. d. RNA PROGRAM: Apply Resting Hand Splint to L (left) hand QD 3x/week x 3hrs per day. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on June 6, 2024, at 10:24 AM, with Restorative Nursing Assistant (RNA 1), RNA 1 reviewed Resident 6's Restorative Nursing Weekly Summary and could not find documentation for RNA Weekly Summaries from April 26, 2024, to June 6, 2024. RNA 1 stated there should have been documentation for that elapsed time. RNA 1 could not provide a rationale as to why the documentation was missing. During a concurrent interview and record review, on June 6, 2024, at 10:28 AM, with Restorative Nursing Assistant Lead (RNA Lead), RNA Lead reviewed Resident 6's Restorative Nursing Weekly Summary and could not find documentation for RNA Weekly Summaries from April 26, 2024, to June 6, 2024. RNA Lead stated there should have been documentation for the elapsed time of six weeks. During a concurrent interview and record review, on June 7, 2024, at 9:07 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Range of Motion Exercises, revised October 2010, was reviewed. The P&P indicated, .Documentation . 5. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure. 6. Any problems or complaints . 8. The signature and title of the person recording the data. The DON stated the P&P was not followed.