STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555387	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Creekside Center	9107 N. Davis Road 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47046 Based on interview, and record review, the facility failed to ensure adequate treatment and services were provided for one of five sampled residents (Resident 1) when, a. Resident 1 needed to be suctioned (secretions from the mouth and throat are removed with a device for individuals who are not able to swallow or clear their own secretions) and the suction machine was not present at his bedside; and, b. Resident 1's change in condition was not assessed and reported to the physician in a timely manner. These failures placed Resident 1 at risk for aspirating (when liquid or solids are inhaled and may cause breathing difficulty and pneumonia), and his condition to be unrecognized and untreated. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility in October 2021 with diagnoses included End Stage Renal Disease (irreversible kidney failure), Dysphagia (trouble swallowing) following a stroke, and Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). A review of Resident 1 ' s Physician Orders for Life-Sustaining Treatment (POLST), dated 6/2/23, indicated, Medical Interventions: if person has pulse and/or is breathing. Comfort Measures only: Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Transfer to hospital only if comfort needs can not be met in current location. A review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/23/24, indicated Resident 1's cognitive (memory) skill for daily decision making was severely impaired. Review of Resident 1 ' s hospital record, History and Physical, dated 8/16/24, indicated Resident 1 was, sent from [name of facility] for altered mental status. He appeared lethargic today. He also had a vomiting spell. Assessment/Plan pneumonia -could be aspiration. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1 ' s clinical record, HISTORY AND PHYSICAL EXAMINATION, dated 8/25/24, written by Resident 1 ' s facility physician (MD), indicated, .recently in hospital for aspiration pneumonitis [inflammation of lung tissue caused by inhaling food or liquid] . During a concurrent interview and record review on 10/2/24 at 3:13 p.m. with Licensed Nurse (LN) 4, LN 4 stated she was assigned to care for Resident 1 on 8/26/24 for the morning shift. LN 4 stated Resident 1 ' s family member (FM) visited on 8/26/24 in the morning and found Resident 1 had vomited. LN 4 stated Resident 1 ' s FM was upset that there was no suction machine at the bedside to remove the vomited liquid and secretions from his mouth. LN 4 stated she brought one in and suctioned Resident 1, and stated, there were a lot of secretions. LN 4 stated Resident 1 ' s condition was declining. LN 4 reviewed Resident 1 ' s clinical record and stated she did not document Resident 1 ' s change of condition in his record, and there were no further vital signs checked after 11:38 am. LN 4 stated she did not call Resident 1 ' s physician. During a concurrent interview and record review on 10/2/24 at 3:17 p.m. with LN 4, Resident 1 ' s clinical record titled, Order Summary Report was reviewed. Resident 1 ' s active physician order indicated, Suction orally PRN [as needed] for excessive secretions, as needed- order date 06/21/2023. LN 4 stated Resident 1 needed suction during his stay in the facility to maintain a patent airway because he was not able to swallow his secretions. During a concurrent interview and record review on 10/2/24 at 3:21p.m. with LN 4, Resident 1 ' s Treatment Administration Record for the months of July and August were reviewed. LN 4 confirmed there was no documentation Resident 1 was suctioned orally for oral secretions in the months of July and August. LN 4 verified she did not document suctioning Resident 1 on 8/26/24. There was no documented evidence Resident 1 was suctioned on 8/16/24, when he vomited prior to going to the hospital. During a concurrent interview and record review on 10/2/24 at 5:14 p.m. LN 3 stated she was the assigned nurse to care for Resident 1 on 8/26/24 for the evening shift. LN 3 stated Resident 1 ' s oxygen saturation (O2 Sat- a measurement of how much oxygen the blood is carrying as a percentage) dropped to the 80 ' s (a normal blood oxygen saturation level is between 95 % and 100%) even with oxygen on at 4 liters per minute (the rate of oxygen flow) with a nasal canula (a small plastic tube which fits into the nostrils for providing supplemental oxygen). LN 3 stated she texted the MD about Resident 1 ' s change in condition but the MD did not respond. LN 3 reviewed Resident 1 ' s clinical record and confirmed no vital signs were documented on 8/26/24 for the evening shift. LN 3 also stated when there was change in a resident ' s condition, vital signs should be checked more often to monitor the resident. A review of Resident 1's clinical record, Progress Note, dated 8/26/24, indicated, 1530 [3:30 p.m.] Received resident in stable condition, no s/s [signs and symptoms] of respiratory distress noted 1644 [4:44 p.m.] on 8/26/24, resident was unresponsive to verbal and tactile stimuli, heart and lung sounds are absent. During a review of Resident 1 ' s electronic clinical records titled, Weights and Vitals Summary, dated 8/26/24 indicated, Resident 1 ' s vital signs (Blood pressure, pulse, respirations, and temperature) readings were as follows: 8/26/24 at 5:37 a.m., Blood pressure 99/60, no pulse, no respirations, and no temperature were documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/26/24 at 8:46 a.m., Blood Pressure 122/70, no pulse, no respirations, and no temperature were documented. 8/26/24 at 11:38 a.m., Blood Pressure 110/60, no pulse, no respirations, and no temperature were documented. During a review of a facility document titled, STATION 1B VITALS, dated 8/26/24 indicated, Resident 1 ' s vital signs were not taken for the evening shift. During an interview on 10/2/24 at 5:32 p.m. with the Director of Nursing (DON), the DON stated her expectation was that nurses should have assessed, reported, and documented when there was a change in Resident 1 ' s condition. The DON explained Resident 1 ' s condition changed when he vomited during the morning of 8/26/24, and the MD should have been notified. The DON stated the vital signs should have been taken more often, and further stated when Resident 1 ' s condition started worsening, Resident 1 should have been transferred to the acute care hospital for higher level of care. The DON stated Resident 1 ' s daughter was not called until after Resident 1 passed away. During a telephone interview on 10/4/24 at 3:40 p.m. with the MD, the MD stated Resident 1 should have been transferred to the acute care hospital when his condition started deteriorating for higher level of medical treatment.