STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056137	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Meadows Post Acute	14857 Roscoe Boulevard Panorama City, CA 91402

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of three sampled residents (Resident 1) responsible party (RP) was informed of the Interdisciplinary Team (IDT - a group of professionals from different fields who collaborate to achieve a common goal for the resident) Care Conference on 4/8/2025. This deficient practice violated Resident 1's RP right to participate in decisions regarding Resident 1's care, treatment and services. Findings: During a review of Resident 1's admission Record, the admission Record indicated that Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Parkinson's Disease (a brain condition that causes problems with movement, mental health, sleep, pain and other health issues), rheumatoid arthritis (a chronic progressive disease causing inflammation in the joints and resulting in painful deformity and immobility especially in the fingers, wrists, feet and ankles) and type 2 diabetes mellitus (a chronic condition characterized by high blood sugar levels). During a review of Resident 1's Physician Progress Notes dated 4/7/2025, the Physician Progress Notes indicated Resident 1 can make needs known but can not make medical decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 4/11/2025, the MDS indicated that Resident 1 had moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and was dependent on staff with toileting hygiene, shower or bathing, dressing, personal hygiene, and mobility (movement). During a review of Resident 1's IDT Care Conference Note dated 4/8/2025, the IDT Care Conference Note indicated Resident 1 attended the conference however there was no documented evidence found indicating Resident 1's RP was informed or invited to participate in the Resident 1's IDT Care Conference. During an interview on 6/3/2025 at 10:43 a.m., with Resident 1's RP, Resident 1's RP stated that the facility should have notified him of Resident 1's Care Conference and provided him an opportunity to be informed of Resident 1's health status, care and treatment received, and to be an advocate for Resident 1's needs and inform the facility of any unaddressed concerns regarding Resident 1's care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/3/2025 at 12:05 p.m., with the Social Services Director (SSD), Resident 1's Physician Progress Notes dated 4/7/2025 and IDT Care Conference Note dated 4/8/2025 were reviewed. The SSD stated that Resident 1's RP should have been informed of the IDT Care Conference prior to the meeting scheduled on 4/8/2025, as it is the RP's right to be notified and involved in the resident's plan of care and treatment decisions. During an interview on 6/5/2025 at 2:45 p.m., with the Director of Nursing (DON), the DON stated that the facility should have notified Resident 1's RP prior to the meeting scheduled on 4/8/2025, as Resident 1 is able to express needs but lacks the capacity to make medical decisions. The DON stated notifying the RP is essential to uphold the resident's right to be informed and involved in their plan of care and treatment. The DON stated failure to notify the RP could result in delays in care planning and implementation of appropriate treatment interventions. During a review of the facility`s policy and procedure (P&P), titled Resident Rights last reviewed on 11/6/2024, the policy indicated federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to be informed of, and participate in, his or her care planning and treatment. During a review of the facility's P&P titled Care Planning - Interdisciplinary Team, last reviewed on 11/6/2024, the P&P indicated the resident, the resident's family and/or the resident's legal representative or guardian are encouraged to participate in the development of and revisions to the resident's care plan. Care plan meetings are scheduled at the best time of the day for the resident and family when possible.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide timely intervention following notification from an outpatient infusion clinic (a medical facility where residents receive medications and fluids through intravenous [IV - administered into a vein] without being admitted to the hospital) regarding Remicade (with the generic name infliximab, a medication used to treat a range of inflammatory medical conditions including rheumatoid arthritis [RA - a condition causing joint pain and inflammation]) treatment for one of six sampled residents (Resident 1) after Registered Nurse 1 (RN 1) received notification from the outpatient infusion clinic on 5/5/2025 at 12:15 p.m. that the outpatient clinic could not administer the Remicade IV due to Resident 1 being admitted to the facility. This deficient practice resulted in Resident 1 not receiving the Remicade IV treatment resulting in a delay of the treatment and placed Resident 1 at increased risk for joint inflammation, pain and deterioration in functional status. Findings: During a review of Resident 1's admission Record, the admission Record indicated that Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Parkinson's Disease (a brain condition that causes problems with movement, mental health, sleep, pain and other health issues), rheumatoid arthritis (a chronic progressive disease causing inflammation in the joints and resulting in painful deformity and immobility especially in the fingers, wrists, feet and ankles) and type 2 diabetes mellitus (a chronic condition characterized by high blood sugar levels). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 4/11/2025, the MDS indicated that Resident 1 had moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) and was dependent on staff with toileting hygiene, shower or bathing, dressing, personal hygiene, and mobility (movement). During a review of Resident 1's Progress Notes dated 5/5/2025, timed at 12:15 p.m., the Progress Notes indicated RN 1 received notification from the outpatient infusion clinic on 5/5/2025 that they (outpatient infusion clinic) could not administer the Remicade IV infusion due to Resident 1 being admitted to the facility. During an interview on 6/3/2025 at 10:30 a.m., with Resident 1, Resident 1 stated that he mentioned to RN 1 on multiple occasions his concern about when he would be receiving his Remicade IV therapy. Resident 1 stated that the Remicade IV treatment helps improve his mobility and makes it easier for him to move around. During an interview on 6/3/2025 at 1:10 p.m., with RN 1, RN 1 stated that she (RN 1) should have informed the Director of Nursing (DON) about the call received on 5/5/2025 regarding the Remicade IV infusion for Resident 1. RN 1 stated she believed notifying Resident 1's physician on 5/5/2025 was sufficient and assumed Resident 1 would receive the infusion after returning to his (Resident 1's) assisted living facility. RN 1 stated she (RN 1) did not inform the DON of the situation until 6/2/2025 after Resident 1 inquired again when he would be receiving his Remicade IV therapy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the DON on 6/5/2025 at 2:50 p.m., the DON stated that RN 1 should have notified her on 5/5/2025 that the outpatient infusion clinic was unable to administer the Remicade IV infusion treatment for Resident 1. The DON stated that timely notification would have allowed the facility to coordinate and provide the treatment while Resident 1 was admitted . The DON stated that RN 1's failure to communicate this information resulted in a delay in treatment, which could have led to increased joint pain, increased knee swelling and decreased mobility for Resident 1. During a review of the facility`s policy and procedure, titled Quality of Care, last revised on 3/20/2025, the policy indicated each resident shall be cared for in a manner that promotes and enhances quality care. To realize the benefits of quality health care, health services must be timely - reducing waiting times and sometimes harmful delays, equitable, integrated and efficient.