STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056166	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Creek Post-Acute	7039 Alondra Blvd Paramount, CA 90723

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on interview and record review, the facility failed to provide accurate information in the Minimum Data Set ([MDS] comprehensive assessment and care screening tool) assessment for one of three sampled residents (Resident 1). This deficient practice had the potential to result in inaccurate care and services for the residents due to inappropriate MDS assessment and care screening tool practices. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face sheet indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including diabetes mellitus (blood sugar level too high), major depressive disorder (sad mood disorder), and hypertension (high blood pressure). During a review of Resident 1's MDS entry assessment, dated 8/13/2024, the MDS assessment under J1800 Health Conditions indicated the resident had no falls since admission/entry or reentry or the prior assessment, whichever is more recent. The MDS assessment was signed on 8/20/2024. During a review of Resident 1's Interdisciplinary Team ([IDT] different health care disciplines come together to help resident receive the care they need) Falls Progress Notes dated 8/12/2024, the IDT Falls Progress Notes indicated that Resident 1 had an unwitnessed fall on 8/10/2024 at 5:30 p.m. The IDT Falls Progress Notes also indicated the resident ' s most recent fall was in 5/2024 before the fall on 8/10/2024. During a concurrent interview and record review on 9/5/2024 at 12:40 p.m. with Minimum Data Set Coordinator, reviewed MDS 3.0 Section J-Health Conditions dated 8/13/2024. The MDSC stated she miscoded the assessment for Resident 1's MDS assessment on 8/20/2024 and then was trying to fix the mistake she made when she coded the resident ' s assessment. The MDSC stated she was aware that the resident had falls but do not know why it was coded with no falls. During a concurrent interview and record review on 9/5/2024 at 2:20 p.m. with the Director of Nursing (DON), reviewed MDS 3.0 Section J-Health Conditions dated 8/13/3024. The DON stated the MDSC was supposed to work with licensed staff and look over the medication list to plan the care needed for the resident. The DON stated the MDS assessment needed to be coded correctly because the assessment goes to the Center for Medicare/Medicaid Services (CMS). (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P/P) titled, Resident Assessments, revised March 2022, the P/P indicated The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews, and all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. During a review of the facility ' s job description, titled MDS Coordinator, (undated) the job description indicated Inform all assessment team members of the requirements for accuracy and completion of the resident assessment (MDS), ensure that each portion of the assessment is signed and dated by the person completing that portion of the MDS, and ensure that all members of the assessment team are aware of the importance of completeness and accuracy in their assessment functions and that they are aware of penalties including civil money penalties, for false certification.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39028 Based on interview and record review, the facility failed to ensure the resident, who was assessed as being at risk for falls, did not fall and sustained multiple lacerations (a cut refers to a skin wound) required hospitalization and suturing (stitches that holds wound edges together) for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Certified Nurse Assistant (CNA 1) asked another staff to assist transferring Resident 1 from a shower chair back to bed via a mechanical lift in attempt to remove linen and the sling from the lift underneath the resident while the resident was positioned too close to the edge of bed. 2. Ensure Resident 1's care plan titled, Self-care performance deficit included how staff will transfer the resident between surfaces to prevent falls. These deficient practices resulted in Resident 1 falling from a bed when CNA 1 was removing a mechanical lift sling and linen from a bed underneath the resident on 7/26/24. Resident 1 sustained two lacerations on the scalp (head), one on the right side of the head and another on the front of the head (unspecified location) and the right arm skin tear. On 7/26/24 at 12:15 p.m., Resident 1 was transferred to a General Acute Care Hospital (GACH), where the resident underwent suturing of lacerations and was admitted to the GACH's telemetry unit (unit for cardiac [heart] monitoring) for further evaluation and treatment. As of 8/7/2024, Resident 1 remains at the hospital. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including hemiplegia (paralysis of one side of the body), hemiparesis (weakness of one side of the body) following cerebral infarction (damage to the brain from interruption of its blood supply), type 2 diabetes mellitus (a condition in which the body fails to process sugar correctly), unspecified dementia (loss of memory, language, problem-solving and other thinking abilities) and limitation of activities due to disability. During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care-screening tool) dated 5/21/2024, the MDS indicated Resident 1 had severely impaired cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 1 was dependent (helper does all the effort, assistance of two or more helpers is required for the resident to complete the activity) on staff for transfer between surfaces and all activities of daily living (ADLs) including dressing, personal hygiene, oral hygiene, toileting, and showering. The MDS indicated Resident 1 was incontinent (inability to control bladder and bowel functions) of urine and bowel and had a history of falls with injuries. The MDS did not indicate the resident's need for mechanical lift. During a review of Resident 1's History and Physical (H&P) dated 12/20/23, the H&P indicated Resident 1 had no capacity to make decisions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's care plan titled Resident at risk for fall related to poor safety awareness, cognitive loss, and behavior of getting up unassisted, putting legs by the edge of the bed dated 5/21/2024, the care plan indicated the resident was recognized as risk for falls. The care plan goal for Resident 1 was to minimize episode of falls through the next review date of 9/7/2024. The Care Plan interventions included to provide extensive staff assistance to Resident 1 with getting in and out of bed and to conduct frequent visual check. During a review of Resident 1's care plan titled Self-care performance deficit dated 5/21/24, related to impaired function and mobility, cognition, diagnosis of dementia, and depression (persistent feeling of sadness and loss of interest in activities) indicated staff will assist Resident 1 with ADLs as needed. The care plan did not include information about mechanical lift for resident's transfer between surfaces or what staff approach would be During a review of Resident 1's Nurses Progress Note dated 7/26/24, the Nurses Progress Note indicated Resident 1 fell on [DATE] at 9:20 a.m., while CNA 1 was transferring the resident from shower chair to bed by using a mechanical lift by herself. The Nurses Progress Notes indicated Resident 1 was totally dependent on staff and required two-persons assistance with care. The Nurses Progress Note indicated Resident 1 sustained a bump on the forehead, skin tear on the right arm, and laceration on the right side of the head. The Nurses Progress Note indicated 911 (a phone number used to contact emergency services) was called and the resident was transferred to the GACH on 7/26/2024 at 12:15 p.m. During a review of Resident 1's GACH report titled History of Present Illness (HPI), the HPI indicated Resident 1, was being helped after shower to transfer back to bed when he fell from the bed to the floor and hit his head. The HPI indicated Resident 1 sustained two lacerations to his scalp which were repaired with sutures (a stitch or row of stitches holding together the edges of a wound) by emergency department (ED) physician. During a review of Resident 1's GACH report titled Clinical Impression, the report indicated Resident 1 had a head injury, fall after getting a shower, pneumonia (an infection of the lungs), and acute respiratory failure (caused by a disease or injury that affects the breathing) with hypoxia (low levels of oxygen). The Clinical Impression report indicated Resident 1's, lacerations were treated/repaired, oxygen three liter per minute ([L/min]-unit of oxygen flow measurement) via nasal cannula (a thin, small flexible tubes placed into nostrils that delivers oxygen) and antibiotic (medication to treat infection) was ordered for Resident 1. The Clinical Impression report indicated Resident 1 was admitted to the telemetry unit for further evaluation and treatment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/7/24 at 12: 46 p.m., CNA 1 stated she had a high workload and responsibilities that included residents' hygiene care, residents' feeding, bathing, ambulation (walking) assistance, and monitoring the resident's vital signs. CNA 1 stated she was attempting to transfer Resident 1 by using a mechanical lift from a shower chair to the bed after the resident was showered. CNA 1 stated she was intended to change the bed linens. CNA 1 stated when she lowered the lift's sling down the resident was positioned closed to the edge of the bed so when she was removing the sling and bed linen underneath the resident, the resident's leg slipped, causing him to fall. CNA 1 stated Resident 1 landed on the floor, resulting in a head injury and a skin tear on the arm. CNA 1 stated given how busy the facility's staff were, and her having assigned nine residents to care for with three of nine residents needed a shower on 7/26/2024, she felt she could not request an assistance from other staff to transfer Resident 1 to bed. CNA 1 stated Resident 1 needed a two-person assistance due to his weight and his total dependance on staff for assistance with all transfers. CNA 1 stated Resident 1's fall was avoidable if she had asked a second person to assist her with use of mechanical lift to transfer Resident 1 to bed. During an interview on 8/7/24 at 2:06 p.m., the Licensed Vocational Nurse (LVN 1) stated she was passing medications when the incident (Resident 1's fall) happened on 7/26/2024. LVN 1 stated a Restorative Nursing Assistant (RNA 1) summoned her to go to Resident 1's room. LVN 1 stated when she walked in Resident 1's room, the resident was on the floor and was bleeding from his head and a skin tear on his right arm. LVN 1 stated CNA 1 was removing Resident 1 linen and the sling from a mechanical lift underneath the resident when she rolled Resident 1 over that was when the resident fell . LVN 1 stated CNA 1 should have had an assistance from another staff to place Resident 1 back to bed as Resident 1 was very tall. LVN 1 stated Resident 1 fall was avoidable if CNA 1 had another staff to assist her with Resident 1 transfer to bed. During an interview on 8/7/24 at 3:09 p.m., the Occupational Therapist ([OT 1] a professional who provides services to increase and/or maintain a person's ability to participate in everyday life activities) stated Resident 1 required a two-persons assistance during care. The OT 1 stated CNAs and licensed staff were instructed to use two-persons assistance during Resident 1 transfers between surfaces as Resident 1 was a high risk for fall. The OT 1 stated Resident 1's fall could have been avoided if the resident had not been positioned so close to the edge of the bed, especially given his size. OT 1 stated when the resident shifted his body weight, he was too near the edge of the bed, which led to the fall. OT 1 stated for transfers Resident 1 required a mechanical lift with the assistance from two persons . During an interview on 8/7/24 at 4 p.m., the Administrator (ADM) stated on 7/26/2024 Resident 1 was transferred out to the GACH due to injuries related to his fall. The ADM stated Resident 1's fall was avoidable because if CNA 1 had used two persons assistance to transfer the resident back to bed, the resident would not have fallen. During a review of facility's policy and procedures (P&P) titled Falls Management dated 5/26/2021, indicated Residents will be assessed for fall risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of facility's P&P titled Safe Lifting and Movement of Residents dated 7/2017 indicated Nursing staff in conjunction with the rehabilitation staff, shall assess individual resident's needs for transfer assistance on an ongoing basis, staff will document resident's transferring and lifting needs in the care plan, such assessment shall include resident's preferences for assistance, resident's mobility (degree of dependency), resident's size, weight bearing ability, and the resident cognitive status.