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	10/11/2024

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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on interview and record review, the facility failed to treat three out of four sampled residents (Resident 1, Resident 2, and Resident 3) with dignity and respect when certified nursing assistant (CNA 1) talked rudely (offensively impolite or ill-mannered) to the residents. This deficient practice had the potential to cause Resident 1, Resident 2, and Resident 3 to feel hurt, disappointed, offended, upset, angry, frustrated, and unsafe in their own home (the facility). Findings: 1. During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility 9/5/2024 with diagnosis of malignant neoplasm of the cerebellum (brain cancer), repeated calls, hemiplegia affecting the left side (unable to move the left side of body), and cerebral edema (brain swelling). During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/12/2024, the MDS indicated Resident 1 was moderately cognitively impaired (Problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 1 required substantial/ maximum assistance (staff does more than half the effort) for most activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) including toileting, bathing, dressing, and personal hygiene. 2. During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility 2/16/2024 with diagnosis of anxiety disorder (a mental illness that causes excessive and uncontrollable feelings of fear and worrying that can significantly impair a person's daily life), need for assistance with personal care, major depressive disorder (is a common and serious mental health condition that can impact how a person feels, thinks, and functions in daily life), and fall from bed. During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 was cognitively intact. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 3 ' s Admission Record, the Admission Record indicated Resident 3 was admitted to the facility 10/6/2021 with diagnosis of epilepsy (seizures), cerebral palsy (a group of neurological disorders that affect a person's ability to move, balance, and maintain posture), and encephalopathy (a group of conditions that cause brain dysfunction. Brain dysfunction can appear as confusion, memory loss, personality changes and/or coma in the most severe form). During a review of Resident 3 ' s MDS dated [DATE], the MDS indicated Resident 3 was cognitively intact. 4. During a review of Resident 4 ' s Admission Record, the Admission Record indicated Resident 4 was admitted to the facility 7/6/2024 with diagnosis of cellulitis (a skin infection that causes swelling and redness) of the left lower limb (left leg), hypertension (high blood pressure) and type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 4 ' s MDS dated [DATE], the MDS indicated Resident 4 was cognitively intact. During an interview on 10/11/2024 at 2 p.m., Resident 4 (room mate of Resident 1) stated on the night of 9/29/2024, he pressed the call light for Resident 1 because he told him he was wet, and they waited almost two hours for CNA 1 to answer the call light and when she did come into the room she said loudly and rudely, What! Who pressed the call button!? and Resident 4 informed CNA 1, Resident 1 was wet and needed assistance. Resident 4 stated CNA 1 went over to Resident 1 ' s side of the room quickly and began changing him, and it did not sound like she was being patient with him, but he could not really see what was happening because the privacy curtain was pulled shut, but he heard Resident 1 say ouch. Resident 4 stated that later Resident 1 had told him when CNA 1 was removing Resident 1 ' s shirt over his head, Resident 1 ' s hair got caught in the shirt and pulled his hair. Resident 4 stated CNA 1 just had a bad attitude, not friendly, and made it seem as though she did not want to help them. Resident 4 stated it was just unfortunate because the facility was their home. During an interview on 10/11/2024 at 2:18 p.m., Resident 3 stated, CNA 1 was not nice, had an attitude when changing him, and a bad tone of voice. Resident 3 stated CNA 1 did not make him feel good. During an interview on 10/11/2024 at 2:30 p.m., the social services director (SSD) stated on 9/30/2024 she was called over by the speech therapist (ST 1) to help interpret what Resident 1 was trying to say about abuse because he had a communication problem related to his brain tumor. The SSD stated when she interviews Resident 1, he kept saying abuse, abuse, peepee, 2 hours, pointing at his pelvic region, and she interpreted as he was left wet for 2 hours. When she asked him about which staff it was, he shook his head yes to the CNA Mirella ' s name who was assigned to him for the 3p.m.- 11 p.m. shift on 9/29/2024. The SSD stated this was not the first complaint against CNA 1 for her behavior against the residents. The SSD stated she talked to four Residents who were also being cared for by CNA 1 on 9/29/2024 and three out of four of those residents (including Resident 2 and Resident 3) all said the same thing, that CNA 1 was rude to them. During an interview on 10/11/2024 at 3:09 p.m., the director of staff development (DSD) stated CNA 1 was on her final warning before being let go due to complaints from residents about CNA 1 ' s care. The DSD stated that the facility was the resident ' s home and staff should not be rude to them in their home, it can make them feel uncomfortable and it should not happen. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/11/2024 at 3:41 p.m., Resident 2 stated CNA 1 was rude and rough when she provided care. Resident 2 stated CNA 1 just did things abruptly when he was not expecting it and felt as though she talks down to him. During an interview on 10/11/2024 at 4:03 p.m., the director of nursing (DON) stated Resident ' s rights were very important because the facility was their home, and the residents are individuals and must exercise their rights. The DON stated staff being rude to residents was not tolerable and against their resident rights. The DON stated that being rude to residents could affect their emotional well-being. During an interview on 10/11/2024 at 4:11 p.m., the administrator (ADMIN) stated CNA 1 was on her final warning of being written-up for resident complaints. During a review of the facility ' s policy and procedure (P/P) titled Resident Rights dated 12/2016, the P/P indicated employees were to treat residents with kindness, respect, and dignity.