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	11/26/2024

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on observation, interview and record review, the facility failed to ensure one of eight sampled resident ' s (Resident 6), call light was answered in a timely manner. This deficient practice resulted in Resident 6, who was continent (ability to voluntarily control her ability to urinate and deficate) or bowel and bladder functions, having to urinate on herself, making her feel ignored and disrespected. This deficient practice had the potential for Resident 6 to developed skin related issues related to being left wet with urine and/or soiled with feces. Findings: During a review of Resident 6 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral infarction (a stroke) with left side hemiplegia (paralysis [inability to move] to one side of the body), and dependency on a ventilator (a machine that breathes for the person of helps the person to breathe). During a review of Resident 6 ' s MDS, dated [DATE], the MDS indicated Resident 6 was able to make decisions that were consistent and reasonable, was always continent (full control) of bladder and bowel functions and was dependent on two or more persons to complete her ADLs. ily to care for themselves). During a review of Resident 6 ' s Order Summary report (Physician ' s Order) dated 10/8/2024, the Physician ' s Order indicated to cleanse Resident 6 ' s skin with soap and water, pat dry, apply a barrier cream, and leave the skin open to air every day and every shift. During a review of Resident 6 ' s Care Plan regarding impaired physical functioning and ADL self-care deficit dated 1/29/2024, the goal of the Care Plan was for Resident 6 to be kept clean, dry, and well-groomed with interventions for the nursing staff to assist and/or provide total ADL care to Resident 6 as needed. During a review of Resident 6 ' s care plan on at risk for skin breakdown related incontinence, and dependency on staff for ADL assistance dated 1/29/2024. The Care Plan ' s goal was for Resident 6 to be free from development of open skin areas or skin breakdown with interventions including to keep Resident 6 clean and dry. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/22/2024, on Nursing Station Two at 2:48 p.m., the call light panel was observed with a light and an audible sound was heard to indicate Resident 6 needed assistance. There were five nursing staff at the nursing station talking to each other, but they did not respond to the call light. At 2:54 p.m. , one nurse was observed sitting at the nursing station charting, multiple nurses were observed walking past the nursing station, another nurse was observed standing by a medication cart that was located close to the nursing station, and none of the nurses responded to the lighted call light panel or audible alarm to see what resident(s) needed assistance. At 2:58 p.m., while in the hallway near Nursing Station Two an alarm was heard indicating the call light in Resident 6 ' s room was activated. Three nurses were observed sitting near the hallway near Nursing Station Two and none of them responded to the call light alarm to see what resident was requesting assistance. During an observation on 11/22/2024, on Nursing Station One at 3:11 p.m., the call light indicator above Resident 6 ' s room was lit and an alarm indicating a resident(s) needed assistance could be heard. Two nurses were observed sitting near the hallway close to the front Nursing Station One. The two nurses looked at the call light indicator, which was lit up, above Resident 6 ' s room, but none of them responded to see what resident needed assistance. During an interview on 11/22/2024 at 3:36 p.m., Resident 6 stated she pressed her call light about thirty minutes prior because she needed assistance using her bed pan (a devices used under a resident who is unable to leave her bed to go to the restroom) to urinate. Resident 6 stated she could not hold her urine anymore and had to urinate on herself, which made her feel uncomfortable and undignified. Resident 6 stated one nursing staff responded to her call light but left and did not return as promised and other facility staff passed her room but did not stop to ask what she needed. Resident 6 stated this made her feel ignored and disrespected. During an interview on 11/22/2024 at 4:30 p.m., Registered Nurse Supervisor 2 (RNS 2) stated the nursing staff must not allow the residents to be exposed to their wastes for a long time because the residents will feel neglected and undignified and will potentially have complications of skin breakdown and infection. During an interview on 11/25/2024 at 10:01 a.m., the Director of Nursing (DON) stated all nursing staff were responsible for answering call lights immediate to assist with resident care need, emergencies and safety concerns. During a review of the facility ' s Policy and Procedure (P/P) titled, Activities of Daily Living (ADL), Supporting revised 3/2018, the P/P indicated the residents who are unable to carry out activities of daily living independently will receive services necessary to maintain good grooming, personal hygiene, elimination (toileting) and mobility. During a review of the facility ' s P/P titled, Quality of Life- Dignity revised 8/2009, the P/P indicated each resident of the facility shall be cared for in a manner that promotes and enhances quality of life, dignity, and respect to maintain the residents ' grooming, hygiene and promptly responding to the residents ' request for toileting assistance. During a review of the facility ' s P/P titled, Call Lights revised 3/2018, the P/P indicated the call lights in the facility are provided to each resident to assure residents receive prompt assistance, regardless of who is assigned to each resident.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on observation, interview, and record review, the facility failed to ensure Restorative Nursing Assistant 1 (RNA 1) provided range of motion ([ROM] full movement potential of a joint) exercises and/or a splint application for two out of eight sampled residents (Residents 1 and 8). These deficient practices resulted in Resident 1 ' s order for passive range of motion ([PROM] the movement of a joint when an outside force, such as a person or machine, moves the body part while the person is relaxed) exercises to her lower extremity ([LE] leg), active assistive range of motion ([AAROM] a type of ROM exercise that involves moving an injured body part with assistance from another person or mechanical device) exercises to her bilateral (both) upper extremities ([BUE] arms), and LLE, a splint application to her right knee and Resident 8 ' s order for PROM to his BLE not being completed. These deficient practices placed Resident 1 and Resident 8 at risk for decline in ROM, mobility, physical functioning, and contractures (loss of motion of a joint). Findings: a. During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness or an inability to move on one side of the body) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1 ' s History and Physical (H&P) dated, 6/13/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. 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 ' s cognition was severely impaired, and she sometimes had the ability to understand and be understood by others. The MDS indicated Resident 1 was totally dependent on staff for rolling left to right in bed, bed to chair transfers, chair to bed transfers, and personal hygiene. The MDS indicated Resident 1 had functional limitation in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk for injury) in one upper (shoulder, elbow, wrist, and hand) and one lower (hip, knee, ankle, and foot) extremity. The MDS indicated Resident 1 did not walk during the assessment period. During a review of the facility ' s Order Listing Report dated 11/20/2024, the Order Listing Report indicated Resident 1 had the following orders: 1. On 10/31/2024 -RNA to perform PROM exercises to Resident 1 ' s right LE five times a week, as tolerated. 2. On 10/31/2024 - RNA to perform AAROM to Resident 1 ' s BUE and LLE five times a week, as tolerated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 10/31/2024 - RNA to apply a splint to Resident 1 ' s right knee three to six hours daily, five times a week, as tolerated. During a review of Resident 1 ' s untitled Care Plan, initiated 10/31/2024, the Care Plan indicated Resident 1 required RNA program for BUE and BLE. The Care Plan goal indicated for Resident 1 to maintain current RUE and RLE ROM and strength through the target date of 3/11/2025. Under this Care Plan, the interventions included RNA to perform AAROM exercises on Resident 1 ' s BUE and LLE five times a week as tolerated, PROM exercises on Resident 1 ' s RLE five times a week as tolerated, and for the RNA to apply a splint to Resident 1 ' s right knee three to six hours per day, five times a week as tolerated. During an observation on 11/22/2024 at 8:30 a.m., in Resident 1 ' s room, Resident 1 was observed in bed, lying on her back. Resident 1 ' s knee splint was observed sitting on top of her nightstand. During an observation on 11/22/2024 at 11:52 a.m., in Resident 1 ' s room, Resident 1 was observed in bed, lying on her left side. Resident 1 ' s knee splint was observed sitting on top of her nightstand. During an observation on 11/22/2024 at 12:55 p.m., in Resident 1 ' s room, Resident 1 ' s knee splint was observed sitting on top of her nightstand. During an observation on 11/22/2024 at 2:25 p.m., in the facility ' s front lobby, Resident 1 was observed sitting in her wheelchair without a knee splint on her right knee. During an observation on 11/22/2024 at 3:01 p.m., in the facility ' s front lobby, Resident 1 was observed sitting in her wheelchair without a knee splint on her right knee nor was she receiving RNA therapy. During a phone interview on 11/22/2024 at 9:16 a.m. Resident 1 ' s Family Member (FM 1), stated he was concerned that Resident 1 was not receiving RNA services which included ROM exercises and a right knee splint application. FM 1 stated when he visited Resident 1, he would never see the RNA perform ROM exercises on Resident 1 nor would he see Resident 1 wearing her right knee splint. FM 1 stated he brought this to the facility ' s attention several times, and the facility stated per documentation, Resident 1 was in fact receiving RNA services as ordered. During a concurrent interview and record review on 11/22/2024 at 3:40 p.m., with RNA 1, Resident 1 ' s Task Report dated 11/22/2024 was reviewed. The Task Report indicated Resident 1 received seven minutes of PROM on her BLE on 11/22/2024 at 2:59 p.m. RNA 1 stated on 11/22/2024, she documented she performed PROM on Resident 1 ' s BLE at 2:59 p.m. but she must have accidentally documented she provided those services by mistake because she did not perform PROM exercises to Resident 1. RNA 1 stated she was the only RNA on the skilled side of the facility for over 30 residents who required RNA services, along with her providing RNA services, she also assisted the Certified Nursing Assistants (CNAs) with transfers, passing snacks to residents, and helping change and reposition residents. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 11/22/2024 at 3:43 p.m. with RNA 1, Resident 1 ' s Task Report dated 11/22/2024 was reviewed. The Task Report indicated not applicable was documented on 11/22/2024. RNA 1 stated if she was unable to perform RNA therapy for a resident, she would document on the Task Report not applicable since the therapy was not provided. RNA 1 stated on 11/22/2024 she documented not applicable because she was not able to perform PROM to Resident 1. During a concurrent interview and record review on 11/22/2024 at 3:45 p.m. with RNA 1, Resident 1 ' s Task Report dated 11/22/2024 was reviewed. The Task Report indicated RNA 1 applied Resident 1 ' s splint to her right knee on 11/22/2024 at 2:59 p.m. RNA 1 stated she documented she applied Resident 1 ' s right knee splint but admitted she did not apply the splint. b. During a review of Resident 8 ' s Face Sheet, the Face Sheet indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including a contracture (a stiffening/shortening at any joint, that reduces the joint ' s range of motion) of the right and left knees, abnormal posture, and dementia. During a review of Resident 8 ' s H&P dated 10/19/2024, the H&P indicated Resident 8 had the capacity to understand and make decisions. During a review of Resident 8 ' s MDS dated [DATE], the MDS indicated Resident 8 had mild cognitive impairment and had the ability to understand and be understood by others. The MDS indicated Resident 8 required substantial/maximum assistance (helper does more than half of the effort) from staff for rolling left to right in bed, oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 8 did not walk during the assessment period. During a review of the facility ' s Order Listing Report dated 11/20/2024, the Order Listing Report indicated for the RNA to provide PROM exercises to Resident 8 ' s BLE, five times a week as tolerated, ordered on 10/29/2024. During a review of Resident 8 ' s untitled Care Plan, initiated 10/29/2024, the Care Plan indicated Resident 8 required an RNA to provide ROM exercises. The Care Plan ' s goal indicated Resident 1 would not have further loss of joint mobility, prevent decline, and to maintain Resident 8 ' s current ROM. Under this Care Plan, the interventions indicated the RNA would perform PROM exercises on Resident 8 ' s BLE five times a week as tolerated. During a concurrent interview and record review on 11/25/2024 at 3:08 p.m. with RNA 1, Resident 8 ' s Task Report dated 11/25/2024 was reviewed. The Task Report indicated not applicable was documented on 11/25/2024. RNA 1 stated on 11/25/2024, she documented not applicable because she was not able to perform PROM exercises to Resident 8 ' s BLEs because she got behind with her workload and was not able to get to Resident 8. During an interview on 11/25/2024 at 3:54 p.m., the Director of Rehabilitation (DOR) stated, residents receive RNA services to maintain their ROM, and to prevent further decline to their extremities. The DOR stated if residents were not getting RNA services as ordered by the physician, it placed the resident at risk for developing contractures and further decline in ROM. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/26/2024 at 1:01 p.m., the Director of Staff Development (DSD), stated she oversees the RNA program, and audits the RNA weekly summary report, but stated she did not compare the RNA Task Report to the RNA weekly summary report to ensure RNA services were being provided. The DSD stated RNA services needed to be provided as ordered because the residents who don ' t receive RNA therapy could be at risk for a further decline in their ROM. During an interview on 11/26/2024 at 1:47 p.m., the Director of Nursing (DON), stated the purpose of the RNA program was to maintain resident ' s current level of function to their joints. The DON stated missed RNA treatments could potentially cause a resident to experience a decline in overall function, mobility, and activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). During a review of the facility ' s RNA Job Description, dated 6/12/2009, the Job Description indicated the RNAs duties and responsibilities include interacting with the assigned resident on an individualized basis to improve and maintain function in physical abilities and ADLs and to prevent further impairment. The Job Description indicated the RNA is to perform all assigned task in accordance with the facility ' s established P&Ps, and as instructed by the supervisors. The Job Description indicated for the RNA to follow work assignments, and/or work schedules in completing and performing the assigned tasks. During a review of the facility ' s policy and procedure (P&P), titled Resident Mobility and Range of Motion, revised 7/2017, the P&P indicated residents with limited ROM will receive treatment and services to increase and/or prevent a further decrease in ROM. The P&P indicated residents with limited mobility will receive appropriate services, equipment, and assistant to maintain or improve mobility unless reduction in mobility was unavoidable. During a review of the facility ' s P&P, titled Restorative Nursing Services, revised 7/2017, the P&P indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence. The P&P indicated restorative goals may include but are not limited to supporting and assisting the resident in adjusting or adapting to changing abilities; developing, maintaining, or strengthening his/her physiological and psychosocial resources; and maintaining his/her dignity, independence, and self-esteem.

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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** 45537 Based on interview and record review, the facility failed to ensure Restorative Nurse Assistant 1 (RNA 1) did not falsify records for one of eight sampled residents (Resident 1) indicating Resident 1 received RNA services that were not provided to her. These deficient practices resulted in RNA 1 documenting Resident 1 was provided seven minutes of passive range of motion ([PROM] the movement of a joint when an outside force, such as a person or machine, moves the body part while the person is relaxed) exercises, to her bilateral lower extremities ([BLE] both of her leg) and a splint (a rigid material or apparatus used to support an impaired joint) was applied to her right knee on 11/22/2024 at 2:59 p.m., when those services were not provided. These deficient practices resulted in Resident 1 ' s RNA services as ordered by the physician, not being provided as documentation indicated and placed Resident 1 at risk for development of contractures (loss of motion of a joint) further decline in mobility and physical functioning. 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] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness or an inability to move on one side of the body) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1 ' s History and Physical (H&P) dated, 6/13/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. 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 ' s cognition was severely impaired, and she sometimes had the ability to understand and be understood by others. The MDS indicated Resident 1 was totally dependent on staff for rolling left to right in bed, bed to chair transfers, chair to bed transfers, and personal hygiene. The MDS indicated Resident 1 had functional limitation in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk for injury) in one upper (shoulder, elbow, wrist, and hand) and one lower (hip, knee, ankle, and foot) extremity. The MDS indicated Resident 1 did not walk during the assessment period. During a review of the facility ' s Order Listing Report dated 11/20/2024, the Order Listing Report indicated Resident 1 had the following orders: 1. On 10/31/2024 -RNA to perform PROM exercises to Resident 1 ' s right LE five times a week, as tolerated. 2. On 10/31/2024 - RNA to apply a splint to Resident 1 ' s right knee three to six hours daily, five times a week, as tolerated. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/22/2024 at 8:30 a.m., in Resident 1 ' s room, Resident 1 was observed in bed, lying on her back. Resident 1 ' s knee splint was observed sitting on top of her nightstand. During an observation on 11/22/2024 at 11:52 a.m., in Resident 1 ' s room, Resident 1 was observed in bed, lying on her left side. Resident 1 ' s knee splint was observed sitting on top of her nightstand. During an observation on 11/22/2024 at 12:55 p.m., in Resident 1 ' s room, Resident 1 ' s knee splint was observed sitting on top of her nightstand. During an observation on 11/22/2024 at 2:25 p.m., in the facility ' s front lobby, Resident 1 was observed sitting in her wheelchair without a knee splint on her right knee. During an observation on 11/22/2024 at 3:01 p.m., in the facility ' s front lobby, Resident 1 was observed sitting in her wheelchair without a knee splint on her right knee nor was she receiving RNA therapy. During a phone interview on 11/22/2024 at 9:16 a.m. Resident 1 ' s Family Member (FM 1), stated he was concerned that Resident 1 was not receiving RNA services which included ROM exercises and a right knee splint application. FM 1 stated when he visited Resident 1, he would never see the RNA perform ROM exercises on Resident 1 nor would he see Resident 1 wearing her right knee splint. FM 1 stated he brought this to the facility ' s attention several times, and the facility stated per documentation, Resident 1 was in fact receiving RNA services as ordered. During a concurrent interview and record review on 11/22/2024 at 3:40 p.m., with RNA 1, Resident 1 ' s Task Report dated 11/22/2024 was reviewed. The Task Report indicated Resident 1 received seven minutes of PROM on her BLE on 11/22/2024 at 2:59 p.m. RNA 1 stated on 11/22/2024, she documented she performed PROM on Resident 1 ' s BLE at 2:59 p.m. but she must have accidentally documented she provided those services by mistake because she did not perform PROM exercises to Resident 1. RNA 1 stated she was the only RNA on the skilled side of the facility for over 30 residents who required RNA services, along with her providing RNA services, she also assisted the Certified Nursing Assistants (CNAs) with transfers, passing snacks to residents, and helping change and reposition residents. During a concurrent interview and record review on 11/22/2024 at 3:45 p.m. with RNA 1, Resident 1 ' s Task Report dated 11/22/2024 was reviewed. The Task Report indicated RNA 1 applied Resident 1 ' s splint to her right knee on 11/22/2024 at 2:59 p.m. RNA 1 stated she documented she applied Resident 1 ' s right knee splint but admitted she did not apply the splint. During an interview on 11/26/2024 at 1:01 p.m., the Director of Staff Development (DSD) stated it was not appropriate for RNA 1 to document in Resident 1 ' s clinical record that RNA services were provided to Resident if she (RNA 1) did not provide those services to Resident 1. The DSD stated the RNA documentation must accurately reflect the care and/or services provided. During an interview on 11/26/2024 at 1:47 p.m., the Director of Nursing (DON), stated RNAs should not document that RNA services were provided when they (RNAs) have not actually provided the care to the resident. The DON stated missed RNA treatments could potentially cause a resident to experience a decline in overall function, mobility, and activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s RNA Job Description, dated 6/12/2009, the Job Description indicated the RNAs duties and responsibilities include charting appropriately. During a review of the facility ' s policy and procedure (P&P) titled, Charting and Documentation, revised 7/2017, the P&P indicated documentation in the medical record will be accurate.