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	01/29/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review, the facility failed to turn and reposition every two hours, more often as needed, one of one dependent (helper does all the effort) resident (Resident 1) who was assessed at a very high risk for developing a pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). This deficient practice increased Resident 1 ' s risk for developing a facility-acquired, Stage II (Partial-thickness loss of skin, presenting as a shallow open sore or wound) pressure injury on the right posterior lower leg area measuring 2 centimeters [(cm) unit of measurement] in length, 4 cm in width and 0.3 cm in depth. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Acute Respiratory failure (condition where the person cannot breath), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), attention to tracheostomy (a surgical airway management procedure which consists of making an incision on the front of the neck to open a direct airway to the trachea), dependent on ventilator (a medical device to help support or replace breathing), type 2 diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), aphasia (a disorder that makes it difficult to speak), dementia (a progressive state of decline in mental abilities), and need for assistance of personal care. During a review of Resident 1 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 10/23/2024, the MDS indicated Resident 1 ' s cognitive skills (ability to think and reason) for daily decision-making were severely impaired. The MDS indicated Resident 1was dependent (helper/or assistance of one or two persons does all the effort to complete activity) with all activities of daily living (ADLs- activities a person performs daily) like toileting hygiene and rolling left and right (ability to roll from lying on back to left and right side and return to lying on back on the bed). The MDS indicated Resident 1 was at risk for developing pressure injuries. The MDS indicated Resident 1 was in a turning/ repositioning program (a set of practices for moving a patient to relieve pressure on their skin and soft tissues to prevent pressure injuries). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Braden Scale (a scoring tool used to predict residents ' risk of developing a pressure injury, total scores range from 6 - 23. A lower score indicating a higher risk of developing a pressure injury) assessment, dated 11/6/2024, the Braden Scale assessment indicated Resident 1 ' s score was 9 indicating Resident 1 was at very high risk for developing a pressure injury. The Braden Scale indicated Resident 1 ' s skin was very moist, the resident was bedfast (confined to bed), was completely immobile (does not make even slight changes in body or extremity position without assistance, required moderate to maximum assistance when moving, complete lifting without sliding sheets was impossible, and the resident frequently slides down in bed requiring frequent repositioning with maximum assistance. During a review of Resident 1 ' s (untitled) care plan, dated 5/7/2024, the care plan indicated Resident 1 had a pressure ulcer. The care plan goal indicated The pressure ulcer will show signs of healing and remain free from infection. The Care Plan intervention indicated to turn and reposition Resident 1 every two hours, more often as needed. During a concurrent interview and record review on 1/29/2025 at 10:33 a.m., with the TX, Resident 1 ' s Task: Turning and repositioning every 2 hours and as needed, from 12/31/2024 to 1/29/2025, was reviewed and the document indicated Resident 1 was not turned and repositioned every 2 hours and as needed. TX stated if it was not documented it was not done and charting indicated Resident 1 was not turned and repositioned every 2 hours and as needed on 12/31/2024, 1/1/2025, 1/3/2025 1/4/2025, 1/5/2025, 1/6/2025, 1/16/2025, 1/17/2025, 1/18/2025, 1/20/2025, 1/22/2025, 1/25/2025, and 1/28/2025. During a concurrent interview and record review on 1/29/2025 at 10:33 a.m., with the Treatment Nurse (TX) Resident 1 ' s Skin Assessment Pressure Injury, dated 1/7/2025, was reviewed and the document indicated Resident 1developed a facility acquired a Stage II Pressure injury on the right posterior lower leg measuring 2.0 cm in length, by 4 cm in width, and 0.3 cm in depth, No drainage, no odor, no redness, no signs and symptoms of any infection. The pressure injury was 20% eschar (dry, hard crusty layer of dead tissue),80% epithelial (new, pink, shiny tissue that grows from the edges of the wound, representing the final stage of healing where the skin is regenerating to cover the damaged area). The document indicated the Podiatrist (DPM - specialist in the prevention, diagnosis, and treatment of lower extremity disorders, diseases and injuries) ordered to cleanse the pressure injury with normal saline (sterile clear solution to irrigate wounds), pat dry, apply Santyl (ointment used to remove damaged tissue from skin ulcers) daily, then cover with dry dressing. TX stated this pressure ulcer on the right lower posterior leg was preventable since the staff did not turn and reposition Resident 1. Resident 1 was at very high risk for developing pressure ulcers. During an interview with a Certified Nurse Assistant (CNA) 2 on 1/29/2025 at 11:38 a.m., CNA 2 stated she was not able to turn all the residents every two hours. During an interview on 1/29/2025 at 2:10 p.m., with the Director of Nursing (DON), the DON stated if nursing care was not documented it was not done. The DON stated staff need to turn and reposition the residents at least every 2 hours and as needed and need to document that it was completed to prevent pressure injury development. During a review of Pressure Injury Prevention Points Portable Document Format (PDF) published by the National Pressure Injury Prevention Advisory Panel, copyright 2020, the PDF indicated the following pressure injury prevention points: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Consider bedfast and chairfast individuals to be at risk for development of pressure injury. 2. Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. 3. Turn and reposition all individuals at risk for pressure injury, unless contraindicated due to medical condition or medical treatments. 4. Continue to reposition an individual when placed on any support surface. 5. Reposition weak or immobile individuals in chairs hourly (www.npiap.com) During a review of the facility ' s policy and procedure (P&P) titled, Pressure Ulcers/Skin Breakdown revised 4/2018, the P&P indicated the facility will assess and document residents risk factors for developing pressure ulcers. The P&P indicated the physician will order pertinent wound treatments, including pressure relieving surfaces, wound cleansing approaches. During a review of the facility ' s P&P titled Admission Criteria, reviewed 12/2016, the P&P indicated the facility will admit only those residents who ' s medical and nursing care needs can be met. The physician will identify medical interventions related to wound management. The P&P indicated the physician will guide the care plan as appropriate, especially when new wounds develop despite existing interventions. The P&P indicated current approaches should be reviewed for whether they remain pertinent to the resident/patient's medical conditions, are affected by factors influencing wound development or healing, and the impact of specific treatment choices made by the resident/patient or a substitute decision-maker. During a review of the facility ' s P&P titled Care Plans, Comprehensive Person Centered, reviewed 12/2016, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44055 Based on interview and record review, the facility failed to ensure sufficient nurse staffing to provide care for one of one dependent (helper does all the effort) resident (Resident 1) in the subacute unit (dedicated area within the facility that provides a higher level of intensive nursing care compared to the standard Skilled Nursing Facility care). This deficient practice resulted in Resident 1 not being turned and repositioned every two hours, increased Resident 1 ' s risk for developing a facility-acquired, Stage II (Partial-thickness loss of skin, presenting as a shallow open sore or wound) pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), and has the potential to affect thirty seven Subacute residents in the facility. Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including Acute Respiratory failure (condition where the person cannot breath), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), attention to tracheostomy (a surgical airway management procedure which consists of making an incision on the front of the neck to open a direct airway to the trachea), dependent on ventilator (a medical device to help support or replace breathing), type 2 diabetes mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), aphasia (a disorder that makes it difficult to speak), dementia (a progressive state of decline in mental abilities), and need for assistance of personal care. During a review of Resident 1 ' s Minimum Data Set ([MDS], a resident assessment tool), dated 10/23/2024, the MDS indicated Resident 1 ' s cognitive skills (ability to think and reason) for daily decision-making were severely impaired. The MDS indicated Resident 1was dependent (helper/or assistance of one or two persons does all the effort to complete activity) with all activities of daily living (ADLs- activities a person performs daily) like toileting hygiene and rolling left and right (ability to roll from lying on back to left and right side and return to lying on back on the bed). The MDS indicated Resident 1 was at risk for developing pressure injuries. The MDS indicated Resident 1 was in a turning/ repositioning program (a set of practices for moving a patient to relieve pressure on their skin and soft tissues to prevent pressure injuries). During a review of Resident 1 ' s (untitled) care plan, dated 5/7/2024, the care plan indicated Resident 1 had a pressure ulcer. The care plan goal indicated The pressure ulcer will show signs of healing and remain free from infection. The Care Plan intervention indicated to turn and reposition Resident 1 every two hours, more often as needed. During a phone interview on 1/29/2025 at 8:25 a.m., with Certified Nurse Assistant (CNA) 3, CNA 3 stated the CNAs were assigned ten residents each and the heavy acuity (level of medical complexity and care needs a resident requires) of the residents in the subacute unit makes it difficult to realistically and adequately care for residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/29/2025 at 10:33 a.m., with the Treatment Nurse (TX), Resident 1 ' s Task: Turning and repositioning every 2 hours and as needed, from 12/31/2024 to 1/29/2025, was reviewed and the document indicated Resident 1 was not turned and repositioned every 2 hours and as needed. TX stated if it was not documented it was not done and charting indicated Resident 1 was not turned and repositioned every 2 hours and as needed on 12/31/2024, 1/1/2025, 1/3/2025 1/4/2025, 1/5/2025, 1/6/2025, 1/16/2025, 1/17/2025, 1/18/2025, 1/20/2025, 1/22/2025, 1/25/2025, and 1/28/2025. TX stated Resident 1 was at very high risk for developing pressure ulcers and the pressure ulcer on the right lower posterior leg was preventable since the staff did not turn and reposition Resident 1. TX 1 stated 10 dependent residents per CNA is very difficult. During a concurrent interview and record review on 1/29/2025 at 10:33 a.m., with the Treatment Nurse (TX) Resident 1 ' s Skin Assessment Pressure Injury, dated 1/7/2025, was reviewed and the document indicated Resident 1developed a facility acquired a Stage II Pressure injury on the right posterior lower leg measuring 2.0 cm in length, by 4 cm in width, and 0.3 cm in depth, No drainage, no odor, no redness, no signs and symptoms of any infection. The pressure injury was 20% eschar (dry, hard crusty layer of dead tissue),80% epithelial (new, pink, shiny tissue that grows from the edges of the wound, representing the final stage of healing where the skin is regenerating to cover the damaged area). During an interview with a CNA 2 on 1/29/2025 at 11:38 a.m., CNA 2 stated she was not able to turn all the residents every two hours. CNA 2 stated they are overworked and need help. CNA 2 stated on 1/19/2025 each CNA was assigned 11-12 residents each. During an interview on 1/29/2025 at 2:10 p.m., with the Director of Nursing (DON), the DON stated staffing should be based on acuity to ensure adequate care is rendered. During an interview and record review on 1/29/2025 at 2:27 p.m., with the administrator (ADMIN), the Subacute ' s Nursing Staffing Assignment/ Sign in Sheet, dated 1/19/2025, was reviewed and the sheet indicated, in the AM shift (6:30 a.m. to 2:30 p.m.), each CNAs had 11- 12 residents each. The ADMIN stated the 4th CNA on the schedule was sent home because census (number of residents) was low. The ADMIN stated staffing was based on in-house census and not based on residents ' acuity. During a review of the facility ' s policy and procedure (P&P) titled, Staffing revised 10/2017, the P&P indicated the staffing numbers, and the skills requirements f direct care staff are determined by the needs of each resident ' s plan of care and the facility assessment. During a review of the facility ' s P&P titled Admission Criteria, reviewed 12/2016, the P&P indicated the facility will admit only those residents who ' s medical and nursing care needs can be met. During a review of the facility ' s P&P titled Care Plans, Comprehensive Person Centered, reviewed 12/2016, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is implemented for each resident. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s Facility Assessment 2024, revised 2/14/2024, the facility assessment indicated the facility provides services that furnished to attain or maintain the residents ' highest practicable physical, mental, and psychological wellbeing. The assessment indicated the facility will have sufficient staff to meet the needs of the residents at any given time and the facility will consider the census and acuity levels impacting staffing needs. Cross-reference F686