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	02/19/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on interview and record review, the facility failed to ensure nursing staff notified the physician in a timely manner when one out of three residents (Resident 1) had blood pressure and temperature readings below the baseline, possibly leading to hypotension (low blood pressure) and/or hypothermia (abnormally low body temperature). This deficient practice had the potential of a delay in services for Resident 1 who was being monitored for sepsis prevention. 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 (a life-threatening condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low blood oxygen levels),), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), tracheostomy (a surgical procedure that creates an opening in the front of the neck and inserts a tube to provide an airway), urinary trach infections ([UTI], an infection of the urinary tract, which includes the kidneys, bladder, ureters, and urethra). During a review of Resident 1's history and physical (H/P), dated 11/16/24, the H/P indicated decision making capacity cannot be determined. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 11/22/24, the MDS indicated Resident 1 was rarely or never understood and was dependent (helper does all of the effort) with self-care abilities such as oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS also indicated Resident 1 was dependent with mobility abilities such as rolling left and right, sit to lying position, and tub/shower transfer. The lying to sitting, sit to stand, bed to chair transfer, toilet transfer and shower transfer were not attempted due to resident's medical conditions or safety concerns. (continued on next page)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Order Summary Report, the Order Summary Report indicated notify the medical doctor if the patient has any of the following symptoms such as temperature less than 96.8 or more than 99.0, heart rate more than 90 beats per minute, respiratory rate more than 20, acute change in mental status, oxygen saturation less than 90%, systolic blood pressure of less than 100 millimeter per mercury (mmHg) but if baseline is already less than 100 mmHg, than more than 5 mmHg lower than the baseline every shift every 12 hours for sepsis prevention. During a review of Resident 1's electronic medication administration record ([EMAR], a standardized record that organizes essential information about a patient and their prescribed medications) for January 2025, the MAR indicated a blood pressure reading of 98/66 on 1/6/25, 96/68 on 1/7/25, 96/66 on 1/13/25, 94/65 on 1/20/25, 97/67 on 1/28/25, and 94/66 on 1/29/25. The MAR also indicated temperature reading of 96.6 on 1/6/25, 96.4 and 92.4 on 1/13/25, and 96.5 on 1/17/25. During a review of Resident 1's MAR for February 2025, the MAR indicated a blood pressure reading of 95/65 on 2/5/25, 92/67 on 2/10/25, 96/63 and 93/66 on 2/17/25. During a review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR)/Change of Condition (COC) assessments for January 2025 and February 2025, there was no notification that the medical doctor was notified on the blood pressure or temperature changes. During a review of Resident 1's Nurses Notes for January 2025 and February 2025, there was no notification that the medical doctor was notified on the blood pressure or temperature changes. During a concurrent interview and record review on 2/18/25 at 1:35 p.m. with Licensed Vocational Nurse (LVN) 1, the MAR for January 2025 and February 2025. LVN 1 stated Resident 1 has an order to check the vital signs such as heart rate, blood pressure, temperature, respiratory rate, oxygen saturation every 12 hours for sepsis prevention. LVN 1 stated the medical doctor should have been notified of the blood pressure and temperature changes. There was no documentation of the doctor being notified of the changes in blood pressure or temperature in the SBAR/COC or Nurses Notes. It was important to let the doctor know before the resident got worse because the resident can deteriorate quickly, especially since Resident 1 has a tracheostomy and gastrostomy. During a concurrent interview and record review on 2/18/25 at 2:00 p.m. with LVN 2, the MAR for January 2025 and February 2025 ,LVN 2 stated the medical doctor should have been made aware of the changes in blood pressure and temperature because it was a change in condition. There was an order to notify the doctor if the resident had any of the following symptoms, but the medical doctor was not notified, and there was no documentation indicating that the medical doctor was notified. During an interview on 2/19/25 at 3:17 p.m. with Director of Nursing, DON stated the medical doctor should have been notified on any changes in condition from the residents and should be following the doctor's orders to notify the doctor if the residents was displaying any symptoms, especially for sepsis prevention. (continued on next page)

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F 0580 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 Change in a Resident's condition or Status, revised May 2017, indicated facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) .the nurse will notify the resident's Attending Physician or physician on call when there has been a specific instruction to notify the Physician of changes in the resident's condition. During a review of the facility's P/P titled Blood Pressure, Measuring, revised September 2010, indicated hypotension is defined as blood pressure less than 100/60 mm/Hg hypotension should be reported to the physician. During a review of the facility's P/P titled Temperature, Axillary (Digital Thermometer), revised September 2013, indicated temperatures below 97-degree Fahrenheit and above 99 degree Fahrenheit must be rechecked with another thermometer and must be reported to the nurse supervisor.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on interview and record review, the facility failed to ensure one out of three sampled residents (Resident 1) received consultation care for his suprapubic catheter (a thin, flexible tube that is inserted through a small incision in the lower abdomen (pubic area) into the bladder). This deficient practice had the potential for Resident 1 to become septic because of recurrent urinary tract infections ([UTI], an infection of the urinary tract, which includes the kidneys, bladder, ureters, and urethra). 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 (a life-threatening condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low blood oxygen levels), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), tracheostomy (a surgical procedure that creates an opening in the front of the neck and inserts a tube to provide an airway), urinary trach infections. During a review of Resident 1's history and physical (H/P), dated 11/16/24, the H/P indicated decision making capacity cannot be determined. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 11/22/24, the MDS indicated Resident 1 was rarely or never understood and was dependent (helper does all of the effort, resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with self-care abilities such as oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent interview and record review on 2/18/25 at 3:54 p.m. with Quality Assurance (QA) Nurse, the Order Summary Report and comprehensive care plan was reviewed. QA Nurse stated Resident 1 was receiving antibiotics off and on since he was admitted to the facility in November 2024 for UTIs. QA Nurse stated Resident 1 should have had a consultation with the urology specialist for the suprapubic catheter, especially since Resident 1 was getting UTIs and receiving antibiotics almost every month since he was admitted . QA Nurse stated the importance of Resident 1 having a urology consultation was to make sure the suprapubic catheter was in place and functioning correctly and to monitor for signs and symptoms of infection. QA Nurse stated the urology specialist deals with all types of catheters, and they would be the one to know how to care for it. QA Nurse also stated Resident 1 needed to have a more comprehensive care plan because of his suprapubic catheter and frequent UTIs. During an interview on 2/19/25 at 3:17 p.m. with Director of Nursing (DON), DON stated Resident 1 should have had urology consulted on the case especially when Resident 1 was getting recurrent UTIs possibly due to the suprapubic catheter and the antibiotics kept changing. The urology specialist should have been consulted from the beginning when Resident 1 was receiving antibiotics due to the UTI. (continued on next page)

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F 0658 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 Care Plans, Comprehensive Person-Centered, revised December 2016, 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 the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident the comprehensive, person-centered care plan will reflect treatment goals, timetables and objectives in measurable outcomes; identify the professional services that are responsible for each element of care; aid in preventing or reducing decline in the resident's functional status and/or functional levels Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49573 Based on observation, interview and record review, the facility failed to ensure one of three sample residents (Resident 1) who had a suprapubic catheter: A. did not touch the floor while hanging on the side of the bed. B. was changed often in a timely manner. These failures had the potential to result in the transmission of infectious microorganisms to the suprapubic bag and increase risk of infection for Resident 1 who was on antibiotics for urinary tract infection ([UTI], an infection of the urinary tract, which includes the bladder, urethra, kidneys, and ureters). 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 (a life-threatening condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low blood oxygen levels), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), tracheostomy (a surgical procedure that creates an opening in the front of the neck and inserts a tube to provide an airway), UTI. During a review of Resident 1's history and physical (H/P), dated 11/16/24, the H/P indicated defer to psychiatry (a medical specialty that focuses on mental health, including diagnosing and treating mental, emotional, and behavioral disorders) and neurology (a medical specialty that focuses on diagnosing and treating conditions affecting the brain, spinal cord, and nerves) as decision making capacity cannot be determined. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 11/22/24, the MDS indicated Resident 1 was rarely or never understood and was dependent (helper does all of the effort, resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) with self-care abilities such as oral hygiene, toileting hygiene, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS also indicated Resident 1 was dependent with mobility abilities such as rolling left and right, sit to lying position, and tub/shower transfer. The lying to sitting, sit to stand, bed to chair transfer, toilet transfer and shower transfer were not attempted due to resident's medical conditions or safety concerns. During a review of Resident 1's Order Summary Report, the Order Summary Report indicate change suprapubic catheter drainage bag as needed for neurogenic bladder with extensive hydronephrosis ordered on 11/21/24. The Order Summary Report also indicated change the suprapubic catheter as needed if clogged, leaking, or accidently pulled as needed for neurogenic bladder with extensive hydronephrosis ordered on 12/11/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's electronic treatment administration record (TAR), for December 2024, January 2025 and February 2025, the TAR indicated the suprapubic catheter drainage bag was changed as needed for neurogenic bladder with extensive hydronephrosis on 12/11/24. The TAR also indicated the suprapubic catheter was changed as needed if clogged, leaking, or accidently pulled for neurogenic bladder with extensive hydronephrosis on 12/11/24. There were no other times the catheter and/or catheter bag was changed in January 2025 or February 2025. During an observation on 2/18/25 at 10:06 a.m. in Resident 1's room, Resident 1 lying on the bed with the head of bed up. Resident 1 had a tracheostomy with oxygen flowing at 2.5 liters and a tube feeding line attached to Resident 1's gastrostomy tube. The catheter bag hanging on the left side of Resident 1's bed. The catheter bag was in a privacy bag and the privacy bag was touching the floor. During a concurrent observation and interview on 2/18/25 at 10:06 a.m. in Resident 1's room with the Registered Nurse Supervisor (RNS), RNS stated the catheter bag should not be touching the floor. RNS stated it was an infection control issue and the catheter bag touching the floor was high risk for infection. The catheter bag did not have a date on it indicating when the bag was changed. RNS stated Resident 1 was already on antibiotics for UTI and the catheter bag on the floor can increase his risk for infection even more. RNS stated the signs and symptoms of infection were abnormal vital sign such as fever, and restlessness from the resident. During a concurrent interview and record review on 2/18/25 at 10:28 a.m. in Resident 1's room with RNS, the TAR for December 2024, January 2025 and February 2025. RNS stated the catheter bag was changed on 2/14/25 and on 2/17/25 but the TAR for February 2025 did not indicate the catheter bag was changed on those date. RNS stated if there was no documentation of the catheter change, the task was not done. RNS stated the importance of changing out the catheter and/or catheter bag was to decrease the risk of infection for Resident 1. RNS stated the catheter and catheter bag should be changed out monthly. During an interview on 2/19/25 at 2:51 p.m. with Director of Staff Development (DSD), DSD stated staff should be doing rounds on residents to make sure the catheter bags are not touching the floor due to infection control. During an interview on 2/19/25 at 3:17 p.m. with Director of Nursing (DON), DON stated catheter bags should not be touching the floor as it was an infection control issue. The catheter bags should be in the privacy bag hanging off the side of the resident's bed and not touching the floor. DON stated it was important for staff to do daily rounding to make sure the residents and lines connected to the residents are checked daily. Catheter bag and line should be changed out more frequently especially if the resident was getting recurrent UTI's. During a review of the facility's policy and procedure (P/P) titled Suprapubic Catheter Care, revised October 2010, indicated the purpose of this procedure is to prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract observe the resident for signs and symptoms of urinary tract infection and urinary retention. Report findings to your supervisor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P/P titled Suprapubic Catheter Replacement, revised October 2010, indicated documentation of the following information should be recorded in the resident's medical record such as the date and time the procedure was performed, the name and title of the individual(s) who performed the procedure, all assessment data obtained during the procedure, how the resident tolerated the procedure and signature and title of the person recording the data. During a review of the facility's P/P titled Infection Prevention and Control Program, revised on October 2022, indicated prevention of infection important facets of infection prevention include identifying possible infections or potential complications of existing infections; instituting measures to avoid complications or dissimilation: educating staff and ensuring that they adhere to proper techniques and procedures.