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	09/17/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report immediately, or no later than 24 hours, an injury of unknown origin for one of three sampled residents (Resident 1). Resident 1 was found with swelling to his left elbow and an X-Ray (a procedure that takes pictures of the inside of the body to diagnose broken bones and other injuries) taken on 9/4/2025 confirmed Resident 1 had a left shoulder dislocation (an injury where the ends of bones at a joint are forced out of their normal position). Resident 1 was transferred to a General Acute Care Hospital (GACH) for further evaluation. This deficient practice resulted in the inability of the California Department of Public Health (CDPH) to investigate the injury of unknown injury in a timely manner and had the potential for facts related to Resident 1's injury to be lost and/or forgotten. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a brain disorder that occurs when an underlying condition causes a chemical imbalance in the blood that affects the brain), epilepsy (a chronic disorder of the brain characterized by recurrent brief episodes of involuntary movement that may involve a part of the body or the entire body, and are sometimes accompanied by loss of consciousness and control of bowel or bladder function), and intellectual disability (a person has limitations in their ability to learn, think, and solve problems, along with difficulties in practical, social, and communication skills needed for daily life). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 4/22/2025, the MDS indicated Resident 1 had severe cognitive (thought process) impairment. During a review of Resident 1's History and Physical (H&P) dated 8/29/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's SBAR ([situation, background, assessment, recommendation] a communication tool used by healthcare workers when there is a change of condition among the residents) dated 9/4/2025 and timed at 11:18 a.m., the SBAR indicated Resident 1's left elbow had redness in a circular shape surrounding the entire left elbow and part of the posterior (refers to the back or rear of a structure or organism) arm, edema (abnormally swollen due to an excess buildup of fluid in the body's tissues) and was warm to touch. The SBAR indicated Resident 1's physician ordered an X-Ray of Resident 1's left arm. During a review of Resident 1's Physicians Order Summary Report, dated 9/4/2025, the Physicians Order Summary Report indicated to obtain an X-Ray of Resident 1's left humerus (upper arm bone), and left shoulder to rule out a fracture, and to transfer Resident 1 to a GACH for further evaluation. During a review of Resident 1's X-Ray Report date 9/4/2025, the X-Ray Report indicated Resident 1 had moderate joint osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage [a specialized connective tissue that covers the ends of bones in joints]) and a dislocation at the glenohumeral joint (a ball and socket joint that connects the upper end of the humerus to the glenoid cavity [socket] of the scapula [shoulder blade]). During a review of Resident 1's the Physician Discharge Note dated 9/5/2025 and timed at 5:14 a.m., the Physician Discharge Note indicated Resident 1 was transferred to a GACH due to a left shoulder dislocation at the glenohumeral joint. During an interview on 9/12/2025 at 10:53 a.m., and a subsequent interview on 9/15/2025 at 9 a.m., the Director of Nursing (DON) stated she did not report this to CDPH because when they searched Resident 1's records from previous hospitalizations they found that Resident 1 had a shoulder issue from a long time ago. The DON stated they considered Resident 1's shoulder dislocation a chronic (persist for a long time, typically, for more than 12 months) issue not an acute (develops suddenly) issue. During an interview on 9/17/2025 at 1:13 p.m., the Administrator (ADM) stated Resident 1's left shoulder dislocation was not reported to CDPH because it was considered a chronic issue. The ADM stated the facility had a 24-hour window to report injuries from an unknown origin, and the facility found out why Resident 1's left shoulder was dislocated during their investigation and before 24 hours had surpassed. During a review of the facility's Policy and Procedure (P/P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 9/2022, the P/P indicated the facility will report all resident abuse (including injuries of unknown origin) to local, State and Federal agencies (as required by current regulations) and thoroughly investigate by facility management. Findings of all investigations are documented and reported. 1. If an injury of an unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 2. The investigator notifies the ombudsman that an investigation is being conducted. The ombudsman is invited to participate in the review process. 3. Within five (5) business

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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. (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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident, who used a ventilator (a machine used in healthcare to assist or perform breathing for a patient who cannot breathe adequately on their own), had a functional limitation in range of motion ([ROM] the direction a joint can move to its full potential) to both her upper and lower extremities (arms and legs) and required a two person physical assist with bed mobility, including turning and repositioning, did not sustain a facial injury for one of three sampled residents (Resident 2). The facility failed to: 1. Ensure Certified Nurse Assistant (CNA) 2 did not turn and reposition Resident 2 by herself, without assistance, placing Resident 2 on the tubing of a ventilator circuit (a system of tubes connecting a ventilator). 2. Ensure CNA 2 followed the facility's Policy and Procedure (P/P) titled, Repositioning revised on 5/2013, which indicated .use two people while tuning or moving the resident in bed. 3. Ensure CNA 2 followed the facility's P/P titled, Safety and Supervision of Residents, revised 7/2017, which indicated .resident safety, supervision, and assistance to prevent accidents are facility wide priorities. The care team shall target interventions to reduce individual risks related to hazards in the environment. These deficient practices resulted in Resident 2 sustaining a skin tear (a traumatic wound caused by friction when the upper layer of the skin becomes torn from the underlying layers) with minimal bleeding to her left upper lip, measuring 0.3 centimeters ([cm] a unit of measurement) x 0.1 cm x 0.1 cm.Findings: During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebrovascular accident ([CVA] stroke, loss of blood flow to a part of the brain), diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), dependency on a ventilator and residing on the facility's Sub Acute Unit (a medical care setting for Residents who need more intensive care than a standard nursing home). During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool) dated 7/22/2025, the MDS indicated Resident 2's cognitive (thought process) skills for daily decision making were severely impaired. The MDS indicated Resident 2 had a functional limitation in ROM to her bilateral (both) upper extremities (arms), her bilateral lower extremities (legs) 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) when rolling left and right. During a review of Resident 2's 48 Hour Baseline Care Plan dated 3/21/2025, the Care Plan indicated Resident 2 needed a two-person physical assist for bed mobility and was totally dependent on all aspects of self-care. During a review of Resident 2's Nurses Progress Note dated 9/5/2025, the Nurses Progress Note indicated Resident 2 had a skin tear to her left upper lip measuring 0.3 cm x 0.1 cm x 0.1 cm with a peri wound (the area of skin immediately surrounding an open wound) discoloration and minimal bleeding. During a review of Resident 2's Situation, Background, Assessment, Recommendation ([SBAR] a communication tool used by healthcare workers when there is a change of condition among the residents) dated 9/5/2025, the SBAR indicated Resident 2 was lying on her ventilator circuit while being cleaned by CNA 2, sustaining a skin tear on her left upper lip. During a review of Resident 2's Physicians Order Summary dated 9/5/2025, the Physicians Order Summary indicated to apply Vitamin A&D Ointment (a skin protectant that helps soothe, moisturize, and protect minor skin irritations) topically (applied directly to the skin) to the skin tear on Resident 2's upper lip every shift for 14 Days. During a telephone interview on 9/9/2025 at 10:47 a.m., Resident 2's Family Member (FM) 1 stated she received a phone call on 9/5/2025 from a Licensed Vocational Nurse (LVN 1) notifying her that Resident 2 sustained a cut on her face. FM 1 stated she asked LVN 1 how Resident 2 got the cut on her face because Resident 2 was unable to move her hands, LVN 1 could not tell her what happened. FM 1 stated later that day she received a phone call from the facility's Administrator (ADM) informing her that upon investigation he determined that CNA 2, when repositioning Resident 2, placed Resident 2 on top of her ventilator circuit on her left side, which caused Resident 2 to sustain an injury to her face. During an interview on 9/9/2025 at 12:11 p.m., the Treatment Nurse (LVN 1) stated on 9/5/2025, she entered Resident 2's room to perform a wound treatment to Resident 2 and observed her lying on her left side. LVN 1 stated following the wound treatment, she and CNA 2 turned Resident 2 on her back, that's when they both noticed blood on Resident 2's face and on her ventilator circuit. LVN 1 stated Resident 2 required a two-person assist for care and CNA 2 should have gotten another person to assist her when turning Resident 2 in bed. During an interview and on 9/10/2025 at 9:52 a.m., the Director of Staff Development (DSD) stated nurses who work on