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	10/28/2025

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 ensure the immediate reporting of an incident involving neglect for one of three sampled residents (Resident 1). Resident 1, who is ventilator (a machine used in healthcare to assist or perform breathing for a patient who cannot breathe adequately) dependent, was found with maggots (a baby fly that looks like a small, white, worm without legs) present around the tracheostomy site (a surgically created opening in the neck to assist with breathing).The facility failed to:1.Promptly report the incident to the California Department of Public Health (CDPH) as required by state regulations.2.Notify the resident's representative, who was designated to act on behalf of the resident in decision-making and to receive important health-related information.This deficient practice resulted in a delay in regulatory oversight and in informing the residents' representative, thereby impeding timely intervention. The failure to report and notify CDPH had the potential to place Resident 1 and other residents at risk for continued neglect or harm. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide [odorless gas]), chronic kidney disease (a medical condition in which a person's kidneys cease functioning on a permanent basis), dependence on renal dialysis (type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to), and dysphagia (difficulty swallowing food or liquids). During a review of Resident 1's History and Physical (H& P) dated 5/25/2024, 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]resident assessment tool) dated 9/14/2025, the MDS indicated Resident 1 was dependent (helper does all the effort; resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) for oral hygiene, toileting hygiene, shower/bath, and personal hygiene. During an observation on 10/23/2025 at 10:30 a.m. in Resident 1's room, Resident 1 was observed lying in bed with a tracheostomy and gastrostomy tube ([GT] a soft tube surgically inserted directly into the stomach to administer medication, fluids and nutrition) in place. Resident 1 was non-verbal (they do not use spoken words to communicate) and not responsive to her environment (showing no engagement with staff or her surroundings. Resident 1's oral cavity (mouth) was observed unclean with a thick, yellowish coating noted on the tongue and inner lips, and dried secretions were observed around the corners of the mouth. Resident 1's lips were dry and cracked. During a review of Resident 1's Care Plan titled Respiratory dated 5/22/2025, the Care Plan interventions/tasks approach indicated oral care every shift to include: lips, teeth, tongue, buccal wall (inner lining of the cheek), and pharynx (cavity behind the nose and mouth). During an interview on 10/23/2025 at 11:00 a.m. with Certified Nurse Assistant (CNA) 1, in the social service office, CNA 1 stated that he was responsible for 14 residents during his morning shift (7 am to 3 pm shift). CNA 1 stated that he cannot complete his assignments due to the acuity (level of medical and care needs) of the residents in the sub-acute unit (specialized medical setting for patients who are no longer in need of acute hospital care but still require more intensive skilled nursing and rehabilitation). CNA 1 stated that he has brought his concerns to the Administrator. CNA 1 stated that despite raising these concerns, no changes had been made to address staffing levels, and he continued to have trouble completing all assigned care tasks, including providing scheduled showers and bed baths. CNA 1 stated that the Respiratory Therapist (RT) 1 discovered approximately 20 maggots around Resident 1's tracheostomy site on 10/22/2025 at approximately 7:00 a.m. CNA 1 stated Registered Nurse (RNS) 2 asked him to provide Resident 1 with a shower immediately on 10/22/2025. CNA 1 stated that he was assisted by CNA 2 and RT 4 also was present during Resident 1' s shower as the resident was a ventilator dependent. CNA 1 stated that during the shower, CNA 1 observed two to three additional maggots around the left side of Resident 1's neck. CNA 1 stated that both the outgoing Registered Nurse Supervisor (RNS) 2 and the incoming day shift (RNS) 3 were aware that maggots had been observed on Resident 1 by RT 1 on 10/22/2025. CNA 1 stated that RNS 2 appeared upset upon learning of the situation and instructed staff not to discuss the incident (maggots on Resident 1's tracheostomy site) . CNA 1 stated that RNS 2 expressed that she did not want to report the findings to the necessary entities. CNA 1 stated that Resident 1's scheduled shower days were Mondays and Thursday and should receive a bed bath on other five days of the week. CNA 1 stated that at times, residents were not

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based interview, and record review, the facility failed to ensure that one of three residents (Resident 1), who was a ventilator (a machine used in healthcare to assist or perform breathing for a patient who cannot breathe adequately) dependent received personal hygiene care, including regularly scheduled showers and bed baths, to prevent maggots (a baby fly that looks like a small, white, worm without legs) infestation around tracheostomy and a Stage III pressure injury (a full-thickness skin loss that extends into the subcutaneous tissue [fat layer]) to the left lateral (relating to or situated on the side) side of the resident's neck. The facility failed to: 1. Ensure Resident 1 was provided with regularly scheduled showers and bed baths to promote the resident's cleanliness in accordance with the facility's policy and procedure (P&P) titled, Bath, Shower/Tub, dated 2018, which indicated, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. 2. Ensure Resident 1, provided with the sanitary care to prevent the development of maggot infestation around tracheostomy site and a Stage III pressure injury to the left lateral side of the neck. These deficient practices resulted in Resident 1 developing maggots around the tracheostomy and a Stage III pressure injury to the left lateral side of the neck requiring transfer to an acute care hospital (GACH) on 10/23/2025 for further evaluation and treatment. These deficient practices placed Resident 1 at risk of infection, airway obstruction (when something blocks the path for air to get into their lungs, making it hard to breathe) and compromised respiratory status (trouble breathing).Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide [odorless gas]), chronic kidney disease (a medical condition in which a person's kidneys cease functioning on a permanent basis), dependence on renal dialysis (type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to), and dysphagia (difficulty swallowing food or liquids). During a review of Resident 1's History and Physical (H& P) dated 5/25/2024, 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]resident assessment tool) dated 9/14/2025, the MDS indicated Resident 1 was dependent (helper does all the effort; resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) for oral hygiene, toileting hygiene, shower/bath, and personal hygiene. During an observation on 10/23/2025 at 10:30 a.m. in Resident 1's room, Resident 1 was observed lying in bed with a tracheostomy (a surgical procedure that creates an opening in the trachea (windpipe) in the front of the neck) and gastrostomy tube ([GT] a soft tube surgically inserted directly into the stomach to administer medication, fluids and nutrition) in place. Resident 1 was non-verbal (they do not use spoken words to communicate) and not responsive to her environment (showing no engagement with staff or her surroundings. Resident 1's oral cavity (mouth) was observed unclean with a thick, yellowish coating noted on the tongue and inner lips, and dried secretions were observed around the corners of the mouth. Resident 1's lips were dry and cracked. During a review of Resident 1's Care Plan titled Respiratory dated 5/22/2025, the Care Plan interventions/tasks approach indicated oral care every shift to include: lips, teeth, tongue, buccal wall (inner lining of the cheek), and pharynx (cavity behind the nose and mouth). During an interview on 10/23/2025 at 11:00 a.m. with Certified Nurse Assistant (CNA) 1, in the social service office, CNA 1 stated that he was responsible for 14 residents during his morning shift (7 am to 3 pm shift). CNA 1 stated that he cannot complete his assignments due to the acuity (level of medical and care needs) of the residents in the sub-acute unit (specialized medical setting for patients who are no longer in need of acute hospital care but still require more intensive skilled nursing and rehabilitation). CNA 1 stated that he has brought his concerns to the Administrator. CNA 1 stated that despite raising these concerns, no changes had been made to address staffing levels, and he continued to have trouble completing all assigned care tasks, including providing scheduled showers and bed baths. CNA 1 stated that the Respiratory Therapist (RT) 1 discovered approximately 20 maggots around Resident 1's tracheostomy site on 10/22/2025 at approximately 7:00 a.m. CNA 1 stated Registered Nurse (RNS) 2 asked him to provide Resident 1 with a shower immediately on 10/22/2025. CNA 1 stated that he was assisted by CNA 2 and RT 4 also was present during Resident 1' s shower as the resident was a ventilator dependent. CNA 1 stated that during the shower, CNA 1 observed

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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. (continued on next page)

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F 0842 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 maintain complete and accurate clinical records for one of three sampled residents (Resident 1). The facility failed to: 1. Document on Resident 1's Electronic Health Record (EHR-a digital system used to document and manage a resident's health information) the discovery of maggots around Resident 1's tracheostomy site (a surgically created opening in the neck to assist with breathing) on 10/22/2025.2.Document a change in condition, the SBAR Situation, Background, Assessment, Recommendation (SBAR) communication tool to inform or escalate the issue to appropriate clinical staff. These deficient practices had the potential to compromise the continuity of care, delay necessary medical intervention, and negatively impact the resident's health and safety.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide [odorless gas]), chronic kidney disease (a medical condition in which a person's kidneys cease functioning on a permanent basis), dependence on renal dialysis (type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to), and dysphagia (difficulty swallowing food or liquids). During a review of Resident 1's History and Physical (H& P) dated 5/25/2024, 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]resident assessment tool) dated 9/14/2025, the MDS indicated Resident 1 was dependent (helper does all the effort; resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) for oral hygiene, toileting hygiene, shower/bath, and personal hygiene. During a concurrent interview and record review on 10/23/2025 at 12:45 p.m. with Registered Nurse Supervisor (RNS) 1 in social services office, Resident 1's electronic health record (EHR) was reviewed. RNS 1 stated that there was no documentation indicating the presence of maggots or any related concerns. RNS 1 stated that if such a concern (maggots at the tracheostomy site) had existed, it should have been documented using the SBAR communication tool, included in the Nursing Progress Notes, and reported to the physician, the resident's family. RNS 1 stated that proper documentation and timely reporting were critical for ensuring effective communication among care team members, enabling the physician to make informed treatment decisions, keeping the family informed of significant changes, and ensuring regulatory oversight to protect resident safety. RNS 1 stated that failure to document or report such concerns could result in delayed or inadequate care, worsening the wound, increased risk of infection, and potential non-compliance with state and federal regulations.During a concurrent interview and record review on 10/23/2025 at 3:35 p.m. with the Director of Nursing (DON) in social services office, Resident 1's Physician's Order Summary Report dated 10/22/2025 at 10:54 a.m., was reviewed. The Physician's Order Summary Report dated indicated to transfer Resident 1 to GACH for evaluation of wound on the left side of the neck. The DON stated she was first informed by RNS 3 on 10/22/2025 at approximately 10:00 a.m. that Resident 1 had maggots present around the tracheostomy site and in the left side of the neck wound. The DON stated she assessed the resident but did not observe any maggots at that time. The DON stated that she was aware of the maggot concern when the transfer order was written and stated that the omission of this information from the order was inappropriate, as it failed to accurately reflect the resident's condition. The DON stated she did not know why RNS 3 failed to document the presence of maggots and lack of documentation could be perceived as withholding information. The DON stated that, given the nature of the incident, there should have been an incident report, progress notes documenting the change in condition, and an update to the resident's care plan. During an interview on 10/24/2025 at 11:54 a.m., with RNS 3, stated she informed MD 1 that maggots had been found around Resident 1's tracheostomy site. RNS 3 stated she did not document the incident in the resident's electronic health record (EHR), did not complete a SBAR form, and did not submit a change of condition report. RNS 3 stated that she informed Resident 1's family member about the hospital transfer but stated that she did not inform her that Resident 1 was being transferred for re-evaluation of her wound and maggots' infestation. RNS 3 stated that her response to the incident was not consistent with facility policy or nursing standards of practice. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2021, the P&P indicated, The nurse will record in the resident's medical record information relative to changes in the

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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. (continued on next page)

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F 0880 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 observation, interview, and record review, the facility failed to ensure that staff followed proper infection prevention and control practices while providing tracheostomy care for one of three sampled residents (Resident 3). The facility failed to:1. Ensure staff adhered to infection control protocols during tracheostomy (a surgical procedure that creates an opening in the trachea (windpipe) in the front of the neck) care (procedure involving the routine cleaning and management of a tracheostomy tube and surrounding skin to maintain airway patency and prevent infection).2.Ensure Respiratory therapist (RT) 3 was not wearing artificial (acrylic) nails while providing tracheostomy care to Resident 3 on 10/24/2025.This failure placed ventilator (a machine that delivers oxygen to the lungs to assist with breathing) dependent residents at risk for cross-contamination (the transfer of bacteria, viruses, microorganisms, or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) and infection. Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including acute respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide [odorless gas]), dependence on renal dialysis (type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to), ventilator (a machine used in healthcare to assist or perform breathing for a patient who cannot breathe adequately) dependence and tracheostomy (a surgical procedure that creates an opening in the trachea (windpipe) in the front of the neck). During a review of Resident 3's Minimum Data Set ([MDS]resident assessment tool) dated 7/22/2025, the MDS indicated Resident 3 was dependent (helper does all the effort; resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) for oral hygiene, toileting hygiene, shower/bath, and personal hygiene. During an interview on 10/23/2025 at 3:35 p.m. in the social service office with the Director of Nursing (DON), the DON stated that artificial nails were not permitted to be worn by staff in the facility, as they can harbor bacteria and increase the risk of infection transmission. The DON emphasized that poor infection control practices, including failure to provide regular bathing and oral care, combined with contamination risks from artificial nails, can contribute to skin breakdown, infection, and risk for maggots (a baby fly that looks like a small, white, worm without legs) infestations. During an observation on 10/24/2025 at 1:35 p.m. the Respiratory Therapist (RT) 3 was observed in resident room performing tracheostomy care and suctioning to Resident 3. RT 3 was observed wearing acrylic (artificial) nails. During an interview on 10/24/2025 at 1:50 p.m. with the Respiratory Therapist (RT) 3 in the social service office, RT 3 confirmed that she was wearing acrylic (artificial) nails at the time and stated that this was a violation of facility policy, which prohibits staff from wearing artificial nails while providing direct care-particularly for residents in the sub-acute unit-due to the increased risk of harboring bacteria and causing cross-contamination. RT 3 stated that failure to provide proper oral care can lead to bacterial buildup, increase the risk of aspiration pneumonia (lung infection), and cause infection at the tracheostomy site, especially in immunocompromised (a condition in which a person has a weakened or impaired immune system, making them more vulnerable to infections and illness) residents. RT 3 also stated that poor oral hygiene can contribute to infestation, such as maggots, due to the accumulation of debris and bacteria in the mouth, which may attract flies. RT 3 stated that if not addressed promptly, flies may lay eggs in areas with poor hygiene, leading to infestation. During a concurrent interview and record review on 10/27/2025 at 8:58 a.m. in the social service office with the Infection Preventionist (IP), the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 8/2019 was reviewed. The IP stated that poor oral hygiene and inadequate personal hygiene can create conditions conducive to bacterial growth and odor, which may attract flies. The IP stated that if flies are drawn to a resident due to poor hygiene, they may lay eggs on the skin or within wound areas, which could subsequently develop into maggots if not promptly identified and treated. The IP stated that he was not aware of any current system in place to ensure that staff are adhering to the artificial nail policy. The IP stated that staff wearing artificial nails pose an infection control risk to the residents, especially those who are severely ill or immunocompromised. The IP stated that artificial fingernails can harbor bacteria, fungi, and other microorganisms even after handwashing, which may increase the risk of cross-contamination and infection transmission during resident care. The IP stated that for residents with open wounds, tracheostomies, or ventilators, exposure to bacteria from contaminated nails