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	02/24/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Care Plan was created for one of four sampled residents (Resident 1) who developed redness on his penile and scrotal area. This failure had the potential for Resident 1 to have further skin breakdown, increased risk of infection, pain, and diminished quality of life.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 nontraumatic intracerebral (inside the brain tissue) hemorrhage (sudden bleed), acute respiratory failure (serious condition where a person cannot breathe on their own), quadriplegia (paralysis from the neck down, including legs and arms usually due to spinal cord injury) and type 2 diabetes ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 11/24/2025, the MDS indicated Resident 1 had severe cognitive (ability to think and reason) impairment and was rarely or never understood by others. The MDS indicated Resident 1 was dependent on staff for oral hygiene, toileting hygiene, showering and dressing. The MDS indicated Resident 1 was at risk for developing pressure injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence).During a review of Resident 1's Change of Condition (COC), dated 1/17/2026, the COC indicated Resident 1 was noted with erythema (redness) and moisture association maceration (the softening, whitening, and breaking down of skin caused by prolonged exposure to moisture, such as sweat, urine, or wound drainage) to his scrotal area and penis.During an interview on 2/24/2026, at 11:57 a.m., Licensed Vocational Nurse (LVN) 1, stated she assessed Resident 1's skin on 1/17/2026 and created the COC, but failed to create a Care Plan to reflect Resident 1's COC. LVN 1 stated failure to develop a Care Plan to address Resident 1's skin changes could cause a delay in Resident 1 receiving timely assessments and consistent treatments.During an interview on 2/24/2026, at 4 p.m., the Director of Nursing (DON) stated Resident 1 is at risk for skin breakdown and all COCs must be identified and followed up with an appropriate Care Plan to address the goals and interventions. The DON stated a Care Plan is a tool used to communicate a resident's plan of care to the staff to ensure consistent care with all bedside care givers. The DON stated a lack of a comprehensive centered care plan, placed Resident 1 at further risk for skin breakdown due to potential lack of care and services.During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 4/2017, the P&P indicated the Interdisciplinary Team ([IDT] a team of health care workers from different specialties working together to meet the residents' care needs/goals) reviews and updates the care plan when there has been a significant change in the resident's condition.

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident (Resident 1), who had a known allergy (when the body's immune system overreacts to something that is normally harmless like food, medicine, pollen, or pests) to cortisone (medication that helps reduce swelling, redness, and allergic reactions in the body), licensed nurses verified the allergy prior to administering hydrocortisone (medication applied to the skin to reduce swelling, redness, itching, and irritation on the skin) for one of three sampled residents (Resident 1). These failures resulted in Resident 1 receiving five doses of hydrocortisone from 2/13/2025 to 2/15/2025, placing him at risk for an allergic reaction, including swelling, difficulty breathing, and other serious complications. 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 nontraumatic intracerebral (inside the brain tissue) hemorrhage (sudden bleed), acute respiratory failure (serious condition where a person cannot breathe on their own), quadriplegia (paralysis from the neck down, including legs and arms usually due to spinal cord injury) and type 2 diabetes ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's Allergy List, dated 11/15/2024, the Allergy List indicated Resident 1 had a documented cortisone allergy, with the severity listed as unknown. During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 11/24/2025, the MDS indicated Resident 1 had severe cognitive (ability to think and reason) impairment and was rarely or never understood by others. The MDS indicated Resident 1 was dependent on staff for oral hygiene, toileting hygiene, showering and dressing. The MDS indicated Resident 1 was at risk for developing pressure injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence).During a review of Resident 1's Change of Condition (COC), dated 2/13/2026, the COC indicated Resident 1 was noted with bilateral groin moisture associated with skin damage ([MASD] skin damage caused from prolonged exposure to moisture). The COC indicated Resident 1's physician was notified and an order was received for hydrocortisone to be applied to the affected area. During a review of Resident 1's Order Recap Report (physician's orders), dated 1/1/2026 to 2/28/2026, indicated Resident 1 was to receive Hydrocortisone External Ointment 2.5% topically to bilateral groin MASD every shift, ordered on 2/13/2026.During a review of Resident 1's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 2/2026, the MAR indicated Resident 1 received Hydrocortisone External Ointment 2.5 % every shift on the following days: 2/13/2026 during the night shift, 2/14/2026 during the day shift, 2/14/2026 during the night shift, 2/15/2026 during the day shift, and 2/15/2026 during the night shift. During a review of email communication between Registered Nurse (RN) 1 and the Director of Nursing (DON), dated 2/17/2026, the email indicated RN 1 failed to check Resident 1's allergies when the physician ordered hydrocortisone cream.During a telephone interview on 2/24/2026 at 2:48 p.m., Licensed Vocational Nurse (LVN) 3 stated she administered hydrocortisone to Resident 1 as ordered but did not check his allergies prior to giving the medication. LVN 3 stated failing to check Resident 1's allergies place him at risk for allergic reactions, including itching, swelling, and difficulty breathing.During an interview on 2/24/2026 at 4 p.m. the DON stated based on her investigation and review of Resident 1's documentation, three nurses administered hydrocortisone ointment without checking his documented allergies. The DON stated failing to verify his allergies prior to administering hydrocortisone placed Resident 1 at risk for skin irritation, further skin breakdown, increased discomfort, and potentially severe reactions, including anaphylaxis which could lead to difficulty breathing. During a review of the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility's policy and procedure (P&P) titled, Administering Medications, revised 4/2019, the P&P indicated the resident's allergies are checked/verified prior to administering medications.