

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056166	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Meadow Creek Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 develop and implement a individualized care plan for one of three sampled residents (Resident 1) addressing Resident 1's safety from Resident 1's family member (FM) 2 who had history of non-compliant with the facility's rules and interrupted Resident 1's care. This deficient practice resulted in staff not having the necessary guidance and had the potential for interruption of medically necessary care and exposure to unsafe substances (alcohol). Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Resident 1's diagnoses included psychoactive substance abuse (the harmful or use of substances [alcohol, illicit drugs, prescription medications] that change how a person thinks, feels, or behaves), respiratory failure (when the lungs cannot adequately supply oxygen to the blood), chronic kidney disease (CKD- kidneys are permanently damaged and cannot properly filter waste and extra fluid from the blood), ventilator (a medical device to help support or replace breathing) and gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 2/27/2026, the MDS indicated Resident 1 cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 1's Respiratory Therapy (specialized healthcare field focused on treating and managing residents with breathing problem) Notes dated 2/16/2026, the Respiratory Therapist Notes indicated there was a meeting with social services regarding Resident 1's FM 2 intervening with Resident 1's care and exhibiting aggressive behavior towards staff. During an interview on 3/3/2026 at 12:53 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1's FM 2 acted suspicious when he would visit Resident 1. LVN 1 stated Resident 1's FM 2 brought in a beer on one occasion. During a concurrent interview and record review on 3/3/2026 at 1:26 p.m. with LVN 1, LVN 1 stated there was no care plan addressing FM 2's behaviors, such as bringing beer into the facility or interrupting Resident 1's care. LVN 1 stated a care plan should have been developed so all staff would be aware of the concerns related to Resident 1. During an interview on 3/3/2026 at 1:56 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated there should have been a care plan addressing FM 2's non-compliant behaviors, such as bringing beer into the facility. RNS 1 stated the care plan was essential because it outlines goals and interventions to ensure the resident's safety. During an interview on 3/4/2026 at 1:00 p.m. with the Director of Nursing (DON), the DON stated a care plan should have been developed to address FM 2's behaviors that were interrupting Resident 1's care. The DON stated the care plan was important because it has interventions to guide staff on how to safely and appropriately care for the residents. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to [NAME] the resident's physical, psychosocial and functional needs is (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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>developed and implemented for each resident. The comprehensive, person-centered care plan will incorporate identified problem areas, incorporate risk factors associated with identified problems, and aid in preventing or reducing decline in the resident's functional status and/or functional levels.</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow its policy and procedure (P&P) titled Safety and Supervision of Residents, which indicated proper resident supervision was a key part of maintaining safety, when a visitor (Family Member [FM] 2), known to pose a safety risk, was unsupervised in the facility for one of three sampled residents (Resident 1). The facility failed to ensure: 1) Family Member (FM) 2, who had documented evidence of providing Resident 1 with illicit substances (drugs that are prohibited by law due to their potential for abuse, addiction, and harm) at the current facility and previous facility, was not allowed to visit Resident 1 without staff's supervision on 2/27/2026. 2) Facility staff supervised FM 2's visit on 2/27/2026 rather than FM 1, who was asked to supervise the visit. These deficient practices resulted in Resident 1 becoming unresponsive, with hypoxia (condition when the body does not get enough oxygen), bradypnea (abnormally slow breathing rate), and altered mental status (change in a residents' baseline consciousness). Resident 1 required emergency administration of Narcan (emergency treatment for known or suspected drug overdose) and transfer to the General Acute Care Hospital (GACH) for evaluation and treatment on 2/27/2026. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Resident 1's diagnoses included psychoactive substance abuse (the harmful or use of substances [alcohol, illicit drugs, prescription medications] that change how a person thinks, feels, or behaves), respiratory failure (when the lungs cannot adequately supply oxygen to the blood), chronic kidney disease (CKD- kidneys are permanently damaged and cannot properly filter waste and extra fluid from the blood), ventilator (a medical device to help support or replace breathing) and gastrostomy tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). During a review of Resident 1's previous facility Progress Note dated 10/15/2025, the Progress Note indicated Resident 1 was briefly altered today (3rd episode in several days), occurs only during FM 2's visits. The Progress Note indicated the nurse suspects possible outside substance exposure. During a review of Resident 1's previous facility Progress Note dated 11/2/2025, the Progress Note indicated suspected drugs provided to Resident 1 by FM 2. During a review of Resident 1's previous facility Progress Note dated 11/3/2025, the Progress Note indicated, positive urine drug screen (UDS- laboratory test used to detect the presence of drugs in a person's urine) reflecting barbiturates (sleep inducing drug), and the suspected drugs provided by FM 2. During a review of Resident 1's IDT Meeting Notes dated 11/7/2025, the Notes indicated the IDT addressed concerns from Resident 1's previous facility stay, that FM 2 had been placed on supervised visits at the previous facility due to suspected drugs provided to Resident 1 by FM 2. During a review of Resident 1's Respiratory Therapy (specialized healthcare field focused on treating and managing residents with breathing problem) Notes dated 1/30/2026, the RT Note indicated FM 1 expressed concerns regarding FM 2 visiting Resident 1 and stated FM 1 did not trust FM 2. The RT Note indicated FM 1 believed FM 2 was giving Resident 1 something that could affect Resident 1's breathing. During a review of Resident 1's RT Notes dated 2/5/2026, the RT Notes indicated after FM 2 left, Resident 1's ventilator began alarming, Resident 1 was noted to have an altered level of consciousness (medical emergency representing any deviation from a normal, alert waking state) and was breathing at a rate of four breaths per minute (normal breathing ranges from 12 to 20 breaths per minute). The RT Note indicated Resident 1 became more arousable after aggressive stimulation (forceful or intense approach to stimulation). During a review of Resident 1's Physician Progress Note dated 2/26/2026, the Physician's Progress Note indicated there was a suspicion that Resident 1 may have been using drugs besides the one's prescribed to Resident 1 due to her altered mental status. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated (continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>2/27/2026, the MDS indicated Resident 1 cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 1's Nurse's Note dated 2/27/2026, the Nurse's Note indicated Resident 1's ventilator was alarming and Resident 1 was noted to have altered responsiveness, bradypnea, hypoxia, and pinpoint pupils (black, circular opening in the center of the eye that remain very small, even in bright light). The Nurse's Note indicated Resident 1 received Narcan (a life-saving medication that rapidly reverses opioid [strong pain medicine] overdose). The Nurse's Note indicated Resident 1 responded to the Narcan when Resident 1 became responsive and stable. The Nurse's Note indicated FM 1 was overheard stating Resident 1 may have taken something, and handed the ADM a clear box containing a powdery substance. The Nurse's Note indicated Resident 1's room belongings were gathered and a white powdery substance and straw wrapped with a napkin were found. During a review of Resident 1's Paramedic Run Sheet dated 2/27/2026, the Paramedic Run Sheet indicated Resident 1's family admitted to giving Resident 1 some sort of narcotic (drug used for pain relief and inducing sleep) substance causing patient to overdose. The Paramedic Run Sheet indicated Resident 1's family stated FM 2 and a drug dealer (individual involved in the illegal sale of illicit substance) have visited Resident 1 at the facility before, and both (FM 2 and drug dealer) have given Resident 1's drugs. During a review of Resident 1's GACH Emergency Department Provider Note Room dated 2/27/2026 at 5:11 p.m., the Note indicated Resident 1 presented to the emergency department for drug overdose (excessive, dangerous amount of a substance is consumed). The Note indicated Resident 1 was visited by FM 1 when found unresponsive. The Note indicated facility staff were called and noted Resident 1 to be apneic (breathing stop) with pinpoint pupils. The Note indicated facility gave Resident 1 Narcan 4 milligram (mg-unit of measurement) intramuscular (IM-injection to the muscle) and Resident 1 woke up and was responsive. Resident 1 was visited by FM 2 or drug dealer, likely given substances. Resident 1 did defecate (pass stool) herself and has been slightly combative. During a review of Resident 1's GACH Psychiatric Consult Note dated 2/28/2026 at 1:09 p.m., the Psychiatric Consult Note indicated, Resident 1 was found by FM 1 and facility staff on 2/27/2026 to have pinpoint pupils. Facility staff gave Narcan 4 mg and Resident 1 became responsive. The Note indicated per FM 1, FM 2 and a drug dealer provides Resident 1 with drugs. The Psychiatric Consult Note indicated Resident 1 reported accidental overdose on medication. During an interview on 3/3/2026 at 8:15 a.m., with the Administrator (ADM), the ADM stated FM 2 was restricted to supervised visits starting 2/26/2026 because he had previously interfered with Resident 1's care (unknown date). The ADM stated on one occasion, FM 2 arrived at the facility at 3:00 a.m. and was banging on the front door, which led the facility to limit his visiting hours and require supervision. The ADM stated that on 02/27/2026, he instructed FM 1, who was at Resident 1's bedside with FM 2, to supervise FM 2 due to FM 2's history of providing illicit substances to Resident 1. During an interview on 3/3/2026 at 11:10 a.m., with FM 1, FM 1 stated she had a feeling Resident 1 was on something because she knew the types of drugs she used in the past and Resident 1 kept nodding off (unintentionally falling into a light sleep). FM 1 stated prior to Resident 1 being transferred to GACH on 2/27/2026, Resident 1 handed her a box with a white powdered substance inside but did not indicate where she got it. FM 1 stated on 2/27/2026 the ADM asked her to monitor FM 2 during a bedside visitation. During an interview on 3/3/2026 at 11:25 a.m. with FM 3, FM 3 stated FM 2 was asked to leave the previous facility in October or November of 2025 because he was suspected of giving Resident 1 something that caused Resident 1 to exhibit unusual behavior. FM 3 stated the previous facility conducted a urine test, on Resident 1 which was positive for some drug (unknown). FM 3 stated she did not know what specific drug the urine test detected. During an interview on 3/3/2026 at 12:31 p.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated FM 2 was placed on supervised visits because he tried to bring unauthorized items (alcohol) into the facility. CNA 1 stated facility staff should be responsible for supervising FM (continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>2's visits and no other family members, as family members could potentially be involved if inappropriate items (alcohol) were being brought in. During a concurrent interview and record review on 3/3/2026 at 12:53 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated FM 2 was placed on supervised visits because he would bring drinks to Resident 1 even though Resident 1 was not allowed to eat or drink anything. LVN 1 stated on 1/14/2026 she observed a beer inside a clear bag that FM 2 had brought into the facility. FM 2's visits should have been supervised only by facility staff to ensure family members did not provide unauthorized items to Resident 1. During an interview on 3/4/2026 at 9:55 a.m. with Respiratory Therapist (RT) 1, RT 1 stated on 2/27/2026 at approximately 4:00 p.m., she responded to Resident 1's ventilator alarm and found Resident 1 difficult to arouse. RT 1 stated she suspected Resident 1 had consumed something (alcohol or drugs), and FM 1 told RT 1 Resident 1 had consumed something. During an interview on 3/4/2026 at 1:00 p.m. with the Director of Nursing (DON), the DON stated facility staff, not FM 1, should have supervised FM 2 during his bedside visit on 2/27/2026 for the safety of Resident 1. The DON stated the incident on 2/27/2026 could have been avoided if all visitors had been supervised by facility staff, as FM 2 appeared suspicious, agitated, and restless at the time of the event (2/27/2026). During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, dated 7/2017, the P&P indicated, Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify specific accident hazards or risks for individual residents. Resident supervision is a core component of the systems approach to safety.</p>		