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	04/14/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Registered Nurse (RN) 1 accurately documented a prescribed treatment for one of three sampled residents (Resident 1) on the Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments) when she irrigated (flush out medical device with fluid) Resident 1's indwelling catheter (thin, flexible, hollow tube inserted into the bladder to drain urine, typically into a collecting bag) with normal saline ([NS] a solution of salt and water) on 2/15/2026. This failure resulted in incomplete and inaccurate documentation for Resident 1, which prevented the facility from determining the amount of irrigating solution instilled through the indwelling catheter and verifying the corresponding drainage output relative to urine output. This failure had the potential to negatively impact Resident 1's health and non-continuity of care. 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]. Resident 1 had diagnoses including aphasia (a disorder that makes it difficult to speak), respiratory failure (serious condition where the lungs cannot properly supply oxygen to the blood) and neuromuscular dysfunction (lack of bladder control caused by damage to the nerves, spinal cord, or brain) of the bladder.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 12/20/2025, the MDS indicated Resident 1's cognition (ability to register and recall information) was severely impaired and was dependent (helper does all the effort, resident does none of the effort to complete the activity) on staff for all activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 1's Physician's Orders, dated 2/1/2026, the Physician's Orders indicated an as-needed (PRN) order was received to irrigate Resident 1's indwelling catheter irrigation with 60 milliliters ([mL] small unit of volume) of normal saline for catheter clogging. During a review of Resident 1's initial Change of Condition ([COC] a document indicating a significant change in condition), dated 2/15/2026, indicated nursing interventions done as follows, cold NS irrigation to indwelling catheter with clear to amber color return.During a review of Resident 1's MAR, dated 2/15/2026, there was no documentation indicating RN 1 documented that she irrigated Resident's indwelling catheter on 2/15/2026. During an interview on 4/14/2026 at 12:10 p.m., the Quality Assurance (QA) Nurse stated based on her review of Resident 1's Medical Records, there was no documentation indicating irrigation of NS was administered to Resident 1 on 2/15/2026. The QA nurse stated all treatments and medications should be documented timely and accurately in the resident's chart to ensure everyone on the care team knows exactly what's been done. The QA Nurse stated when records are clear and correct, the next nurse knows exactly what was given, when it was given, and why.During a telephone interview on 4/14/2026 at 3 p.m., RN 1 stated she could not remember how much NS she used to irrigate Resident 1's indwelling catheter on 2/15/2026 and could not recall the amount of drainage or urine that resulted from the irrigation. RN 1 stated it is important to chart accurately at the time of care so Resident 1's medical record clearly communicates the resident's care to all staff.During an interview on 4/14/2026 at 4:10 p.m., the Director of Nursing (DON) stated all licensed nurses must document (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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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications and treatments immediately after administering them. The DON stated that all incomplete documentation can lead to medication errors and inaccurate communication between team members which may ultimately harm the resident. The DON stated based on her review of Resident 1's Medical Records, she could not determine the amount of NS used to irrigate Resident 1's indwelling catheter on 2/15/2026 or the amount of irrigation output which leads to an incomplete assessment of Resident'1 condition.During a review of the facility's policy and procedure (P&P) titled, Catheter Irrigation, Open System, revised 10/2010, the P&P indicated the following information is to documented in the resident medical record, the date and time the procedure was performed, the name and title of the individual who performed the procedure, the amount of solution used to irrigate, the amount returned as drainage and the amount of urine drained and the signature and title of the person recording the data.During a review of the facility's P&P titled, Charting and Documentation, revised 7/2017, the P&P indicated: the following information is documented in the resident medical record, medications administered, treatments or services performed, documentation in the medical record will be objective, complete and accurate.