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	06/02/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the door to the front entrance of the facility was secured after business hours (7:30 p.m. - 8 a.m.) This deficient practice resulted in the door to the front entrance of the facility being left open and unlocked by wedging a surgical mask between the door and the door frame, disabling the door's locking mechanism. This deficient practice placed residents' who resided in the facility at risk for acts of theft and harm by unauthorized individuals entering the facility and elopement (resident leaves facility without supervision).Findings: On 5/31/2026 at 6 a.m., upon entering the facility to conduct a complaint investigation, the front door to the entrance to the facility was observed with a surgical mask wedged between the door and the door frame, used to keep the door open by not allowing the locking mechanism to engage. There was no one observed monitoring the entrance to the facility. During a review of the facility's undated list of Residents Who Wander Around the Facility, the list of Residents Who Wander Around the Facility indicated two Residents were listed. During a review of the facilities Census dated 5/30/26 at 6:04 a.m., the Census indicated there were 88 residents who resided in the facility. During an interview on 5/31/2026 at 6:15 a.m., the Registered Nurse Supervisor (RNS) stated the front door should be locked after 7:30 p.m., and opened at 8 a.m. The RNS stated everyone's safety was at risk when the front door was not locked, anyone off the street could walk into the facility. During an interview on 5/31/2026 at 7:51 a.m., the housekeeper stated the front entrance was left open with a surgical mask because it was easier for staff in the morning to get into the facility. The housekeeper stated it was not safe for anyone in the facility when the front entrance was not locked because anyone could walk into the facility. During an interview 5/31/2026 at 12:57 p.m., the Administrator (ADM), stated the facility's front door should be locked after hours (7:30 p.m. - 8 a.m.) to ensure everyone's safety inside the facility. The front door's lock should not have been disabled by placing a surgical mask between the door and the door frame. The ADM stated a resident could elope, and people who were not authorized to enter the facility could enter the building without knowledge of the facility staff. 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 he facility strives to make the environment as free from accident hazards as possible. 1. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly. 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed ensure a physician for one of three sampled residents (Resident 1) responded to facility staff phone calls or contacted the facility's Medical Director when Resident 1 reported symptoms of pain and burning during urination As a result of this deficient practice, Resident 1's evaluation, diagnosis, and treatment were delayed. This deficient practice placed Resident 1 at risk for worsening symptoms/infections and had the potential to turn into sepsis (a life-threatening response to an infection).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]. Resident 1 had a diagnosis of a urinary tract infection ([UTI] an infection in the bladder/urinary tract). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 5/16/2026, the MDS indicated Resident 1 had severe cognitive impairment (memory and thinking problems). The MDS indicated Resident 1 was not assessed for the ability to perform toileting hygiene due to medical conditions or safety concerns. 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 5/26/2026 and timed at 7 p.m., the SBAR indicated Resident 1 reported pain and burning during urination. The SBAR indicated the physician was notified on 5/26/2026 at 10:53 p.m. During a review of Resident 1's Alert Charting, dated 5/27/2026 and timed at 1:45 a.m., and 3:30 p.m., the Alert Charting indicated Resident 1 was still waiting for orders (for UTI) this was endorsed to the next shift for follow up. During a review of Resident 1's Physician's Orders, dated 5/27/2026 and timed at 3:55 p.m., the Physician's Orders indicated to collect urine for a urinalysis (a laboratory test that examines the physical, chemical, and microscopic properties of urine), and culture and sensitivity ([C&S] a laboratory test that grows bacteria or fungi from a patient's sample to identify the specific germ causing an infection and determine which antibiotics or medications will effectively treat it) with a straight catheter (a thin, flexible, hollow tube inserted into the bladder through the urethra to drain urine) as indicated. During a review of Resident 1's Nurses Notes, dated 5/28/2026 and timed at 12:58 p.m., the Nurses Notes indicated the facility received a call from the laboratory (lab) indicating Resident 1's UA/C&S required recollection due to incomplete labeling. During a review of Resident 1's Lab Results Report, dated 5/29/2026, the Lab Results Report indicated another UA/C&S was collected on 5/29/2026 at 12:06 a.m. During a review of Resident 1's Physician's Orders, dated 5/29/2026 and timed at 6:45 a.m., the Physician's Orders indicated to give Resident 1 Cephalexin (an antibiotic, closely related to penicillin, an allergic reaction to penicillin could trigger a reaction to Keflex) oral capsule 500 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) three times a day for UTI symptoms x five days. During a review of Resident 1's Nurses Notes, dated 5/29/2026 and timed at 7:40 a.m., the Nurses Notes indicated Resident 1 was allergic to penicillin ([PCN] an antibiotic). Resident 1's physician was notified, Cephalexin was discontinued and endorsed to the next shift for an alternative medication. During a review of Resident 1's Lab Results Report, dated 5/29/2026 and timed at 10:03 a.m., the Lab Results Report indicated Resident 1 was positive for leukocytes (specialized cells of the immune system that protect the body from infections, diseases, and foreign invaders) and bacteria in the urine. During a review of Resident 1's Physician's Orders, dated 5/29/2026 and timed at 10:48 a.m., the Physician's Orders indicated to give Resident 1 Macrobid (an antibiotic) oral capsule 100 mg twice a day for UTI symptoms x five days. During a review of Resident 1's Medication Administration Record (MAR), dated 5/2026, the MAR indicated Resident 1 received her first dose of Macrobid oral capsule 100 mg on 5/29/2026 at 5 p.m. (2 days and 22 hours after symptoms of burning and urination were first reported on 5/26/2026 at 7 p.m.). During an interview on 5/29/2026 at 10:18 a.m., Licensed Vocational Nurse (LVN) 1 stated on 5/26/2026 at 7 p.m., during the medication pass, Resident 1 complained of burning and pain when (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she urinated. LVN 1 stated she called Resident 1's physician in the evening (5/26/2026) and in the morning (5/27/2026) but he did not respond. LVN 1 stated she endorsed Resident 1's complaint to the 11 p.m. to 7 a.m. shift. LVN 1 stated she did not know to call the Medical Director.During an interview on 5/29/2026 at 12:37 p.m., Registered Nurse (RN) 1 stated on 5/27/2026 she called Resident 1's physician via phone and then she texted him, but the physician did not respond until 3:55 p.m., after her third attempt. The physician instructed her to collect Resident 1's urine for a UA/C&S. RN 1 stated she tried to collect urine from Resident 1 but she refused. RN 1 stated she received a call from the pharmacy on 5/29/2026 at 7:30 a.m., stating Resident 1 was allergic to Cephalexin and to notify Resident 1's physician. RN 1 stated she notified the physician of Resident 1's allergy to PCN and obtained a new order for Macrobid 100 mg capsule twice daily. During an interview on 5/29/2026 at 1:40 p.m., the Director of Nursing (DON) stated when the physician did not respond to the nurses calls following one to three attempts within an hour, they should have contacted the Medical Director. The DON stated a delay in treating Resident 1's UTI placed her at risk of becoming septic and 24 hours was a reasonable expectation to begin treatment. During a review of the facility's Policy and Procedure (P/P) titled Acute Condition Changes dated 3/2018, the P/P indicated the nursing staff will contact the physician based on the urgency of the situation and the attending physician or practitioner will respond in a timely manner to notification of problems or changes in condition and status. The nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to date food brought in from an outside source and placed in a refrigerator used to keep residents' food for one out of three residents (Resident 1). This deficient practice resulted in the inability to determine the date Resident 1's food was placed in the refrigerator had the potential to cause Resident 1 food borne illness (food poisoning: any illness resulting from the food spoilage of contaminated food, pathogenic bacteria, viruses, or parasites that contaminate food, as well as toxins).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]. Resident 1 had a diagnosis including metabolic encephalopathy (brain dysfunction resulting from a disruption in the body's chemical processes). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 5/16/2026, the MDS indicated Resident 1 had severe cognitive impairment (memory and thinking problems). The MDS indicated Resident 1 was not assessed for the ability to perform toileting hygiene due to medical conditions or safety concerns.During an observation of a refrigerator used to store resident's food, located in the employee lounge, on 5/31/2026 at 9:26 a.m., a bag of food was found inside the residents' refrigerator. The bag of food was labeled with Resident 1's name but without a date. Inside the bag there were multiple undated food items: five containers of soup, cheese in a zip lock bag, and a macaroni dish. During an interview on 5/31/2026 at 9:42 a.m., the Infection Preventionist Nurse (IPN) stated residents' food stored in the residents' refrigerator should be labeled with the resident's name and date it was placed in the refrigerator to prevent food borne illnesses, and food left longer than three days should be thrown away. During a review of the facility's Policy and Procedure (P/P) titled Food Brought by Family/Visitors dated 3/2022. The P/P indicated food brought by family/visitors will be labeled with the resident's name, the item, and use by date.