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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Creek Post-Acute	7039 Alondra Blvd Paramount, CA 90723

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide sufficient licensed nursing staff to meet resident needs, as evidenced by the Facility Assessment (a required, facilityˆwide evaluation used to align the specific needs of the resident population with the facility's resources) identifying a required nightˆshift staffing level of one Registered Nurse (RN) and two Licensed Vocational Nurses (LVNs).This deficient practice resulted in enteral (liquid food) feedings being administered late, medications being administered late, and vital signs not being obtained by nursing staff. These failures had the potential to negatively impact residents' health and safety by delaying necessary treatments, monitoring, and identification of changes in condition. Findings:During an interview on 6/11/2026 at 7:11 a.m., with Certified Nurse Assistant (CNA 1), CNA 1 stated her shift was from 6:30 a.m. to 2:30 p.m. She stated she was responsible for nine residents during her shift. CNA 1 stated she felt rushed while providing resident care due to staffing shortages. She stated there were frequent callˆoffs occurring Monday through Sunday on all shifts. CNA 1 stated the residents were high acuity (the measurement of how sick a resident is and the intensity of the nursing care and medical supervision they require) and dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily), incontinence care (personal support provided to residents who cannot control their bladder or bowels), and repositioning. She stated when staff called off, she was assigned ten or more residents.During an interview on 6/11/2026 at 9:39 a.m., with LVN 5, LVN 5 stated she was responsible for 13 residents during her shift. She stated she did not feel able to complete her assignment due to the residents' acuity and the ongoing staff shortages. LVN 5 stated she did not feel she could provide quality care and felt rushed to complete her tasks. She stated the subacute unit (a specialized care area designed for residents needs of intensive medical, nursing, and rehabilitative support) was shortˆstaffed for CNAs, and this occurred daily. LVN 5 stated the staffing shortages caused delays in medication administration, resident assessments, and charting. LVN 5 stated when staffing was inadequate, residents could experience delays in medication administration, delays in repositioning, pain not being addressed in a timely manner, and an increased risk for falls.During a concurrent interview and record review on 6/12/2026 at 7:03 a.m. with the Registered Nurse Supervisor (RNS) 2, the Medication Administration Audit Report dated 6/3/2026 was reviewed, the Medication Administration Audit Report indicated the following:1.Enteral Feed Order Schedule Date: 6/3/2026 11:00 pm/Administration Time indicated- 6/4/2026 1:05 a.m.2.Check blood sugar order schedule: 6/3/2026 11:00 pm/ Administration Time indicated- 6/4/2026 1:04 a.m.3.Enteral Feed Order Schedule Date: 6/3/2026/Administration Time indicated- 6/4/2026 2:41 a.m.4.Oxygen: Monitor oxygen (O2) Saturation (measures blood oxygen level) every shift: Schedule Date: 6/3/2026 11:00 p.m./ Oxygen monitoring indicated 6/4/2026 2:44 amThe RNS acknowledged the enteral feedings, glucose monitoring, and oxygen saturation monitoring were completed late during on 6/3/2026 11 p.m. to 7 a.m., shift. The RNS stated the delays occurred due to the staffing shortage and the number of residents assigned during the shift.The RNS 2 stated she was assigned to the night shift and she works from 11:00 pm to 7:00 am. The RNS 2 stated she was the (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	only licensed nurse assigned to the skilled nursing facility (SNF) during her shift. The RNS 2 stated there were no Licensed Vocational Nurses (LVN's) scheduled for the night shift and stated this staffing pattern has been in place since September 2024. The RNS 2 stated she was informed by the Administrator that this was how the staffing would be assigned. The RNS 2 stated she was not aware of the facility assessment identified the need for one RN and two LVN's for the night shift. The RNS 2 stated she did not notify management regarding the absence of LVN coverage because the facility was not assigning LVN's to the night shift. The RNS 2 stated she was responsible for 47 residents on 6/3/2026, and was responsible for medication administration, enteral feeding administration, blood glucose monitoring, obtaining vital signs, and monitoring residents for changes in condition. The RNS 2 stated she was responsible for approximately 14 residents receiving gastrostomy tube (Gˆtube, a flexible tube inserted through the abdominal wall into the stomach and used to deliver hydration, medications, and nutrition) feeding, and six blood glucose checks during the shift. The RNS 2 stated she was unable to complete all required nursing duties during the shift. The RNS 2 stated at times she was unable to obtain resident's vital signs, medications were administered late, and enteral feedings were administered late. The RNS 2 stated the delays in medication administration and enteral feeding administration were due to the staffing level and the number of residents assigned to her. The RNS 2 stated management was not notified regarding the delayed medication administration or enteral feeding administration and could not explain why management was not notified. The RNS 2 stated the staffing shortage affected her ability to monitor resident. The RNS 2 stated she believes resident's needs were not adequately met during the night shift due to the staffing level and acuity of the residents. The RNS 2 stated inadequate staffing could result in blood glucose abnormalities not being identified timely, inability to monitor residents for changes in condition, pain not being addressed timely, and delayed medication administration. During a concurrent interview and record review on 6/12/2026 at 11:06 a.m., with the Director of Nursing (DON), reviewed the facility's Facility assessment dated [DATE]. The Facility Assessment indicated that the skilled nursing facility (SNF) required one RN and two LVNs for each night shift. The DON acknowledged the Facility Assessment identified the need for one RN and two LVNs. She stated that on 6/3/2026, during the night shift, only one RN was assigned to the SNF. The DON stated she was aware only one RN had worked that night and that no LVNs were scheduled. The DON stated the facility had not evaluated whether resident care would be affected by having only one RN available on the night shift. She stated the medication administration records had not been reviewed to determine whether medication passes were delayed and she was unaware if medications had been administered late because she had not reviewed the records. The DON stated she was also unaware whether treatments or assessments had been delayed because the facility had not evaluated the impact of the reduced staffing. She stated delays may have occurred due to the staffing shortage and believed the absence of the two LVNs contributed to these delays. The DON stated the facility should have provided the two LVNs identified in the Facility Assessment to ensure resident safety, timely medication administration, timely enteralˆfeeding administration, and completion of required monitoring, including vital signs. She stated no safeguards had been implemented to protect residents during the staffing shortage on the night shift and staffing shortages could result in unmet resident care needs and reduced quality of care.During an interview on 6/12/2026 at 1:00 p.m., with the Administrator (ADM), ADM stated the facility decided to staff the night shift with only one Registered Nurse (RN) beginning in September 2025. The ADM stated the facility did not complete an assessment or evaluation before reducing licensedˆnursing coverage on the night shift. He stated he was unaware that the Facility Assessment identified the need for one RN and two Licensed Vocational Nurses (LVNs) for the night shift. The ADM stated he was unaware that medications and enteral feedings were being administered late during the night shift. He stated the facility had not evaluated the impact of having only one RN assigned on the night shift on resident care needs, including medication administration, enteralˆfeeding administration, monitoring, and other required nursing services. The ADM was unable (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to provide evidence of any assessment, evaluation, or safeguards implemented to ensure resident needs continued to be met following the reduction in licensed^nursing staff coverage.During a review of the facility's policy and procedure (P&P) titled, Facility Assessment, dated 2017, the P&P indicated, A facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations. Determining our capacity to meet the needs of and care for our residents during emergencies is included in this assessment.During a review of the facility's P&P titled Staffing, Sufficient and Competent Nursing, dated 2022, the P&P indicated Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of five sampled residents (Resident 35, 55 and 68) were free of unnecessary physical restraints (any object or device that an individual cannot remove easily which restricts freedom of movement) by failing to:1.Ensure on-going assessment and reevaluation of restraints' continuous use were conducted and documented.2.Ensure less restrictive measures were attempted prior to initiating hand mitten (soft, padded hand covers designed to prevent patients from removing medical equipment) restraints.3.Follow Physician orders to apply the peek-a-boo mitten (a convenient mesh or cloth inspection flap, that caregivers to quickly check a resident's circulation and skin without having to remove the entire mitten) not a closed mitten restraint.4.Ensure the peek-a-boo mitten manufacturer guidelines were followed.5.Follow the facility's policy and procedure (P&P) titled, Use of Restraints, to ensure the restraint order had an end date.These failures had the potential to place Resident 35, 55 and 68 at risk for unnecessary prolonged use of restraints , impaired blood circulation, skin injuries and entrapment (an event in which a patient is caught, trapped, or entangled).Findings:During a review of Resident 35's admission Record, the admission Record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a long-term brain disorder that affects a person's ability to think clearly, manage emotions, make decisions, and relate to others) and epilepsy (a brain disorder that causes a person to have repeated, unexpected seizures). During a review of Resident 35's Minimum Data Set (MDS- a resident assessment tool) dated 4/27/2026, the MDS indicated Resident 35's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 35 was dependent (helper does all the effort) on activities of daily living (ADLs- routine activities such as bathing, dressing, and toileting a person performs daily to care for themselves).During a review Resident 55's admission Record, the admission Record indicated Resident 55 was admitted to the facility on [DATE] with diagnoses including hypertension (HTN- high blood pressure) and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury).During a review of Resident 55's MDS dated [DATE], the MDS indicated Resident 55's cognition was severely impaired. The MDS indicated Resident 55 was dependent on ADLs.During a review of Resident 68 admission Record, the admission Record indicated Resident 68 was admitted to the facility on [DATE] with diagnoses including HTN and quadriplegia.During a review of Resident 68's MDS dated [DATE], the MDS indicated Resident 68's cognition was severely impaired. The MDS indicated Resident 68 was dependent on ADLs.During an observation on 6/9/2026 at 9:28 a.m., in Resident 55's room, Resident 55 was observed to have a left closed hand mitten restraint.During an observation on 6/9/2026 at 9:28 a.m., in Resident 55's room, Resident 55 was observed to have a left closed hand mitten restraint.During an observation on 6/9/2026 at 10:20 a.m.,, in Resident 35's room Resident 35 was observed to have bilateral (two sides) closed hand mitten restraints.During an interview on 6/11/2026 at 9:42 a.m., with Certified Nurse Assistant (CNA 5), CNA 5 stated when a resident was in restraints, he released the restraints for 15 minutes every two hours but had no place to document that this was done. CNA 5 stated there should be a place to document the twoˆhour restraint releases, so nurses were aware they were being done.During a concurrent interview and record review on 6/11/2026 at 10:16 a.m., with Licensed Vocational Nurse (LVN 7), restraint orders and documentation for Residents 35, 55, and 68 were reviewed. LVN 7 stated there was no documentation from the CNAs indicating the restraints were released every two hours for 15 minutes. She stated the CNAs informed her when they released the restraints, and she would document it herself. LVN 7 stated the restraint orders for Residents 35, 55, and 68 did not contain end dates and there was no documentation showing that leastˆrestrictive measures had been attempted before applying the restraints. She stated staff should attempt using a sitter (oneˆtoˆone supervision (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and observation) before applying restraints.During a concurrent observation and interview on 6/12/2026 at 11:31 a.m., with the Director of Nursing (DON), the DON stated the facility did not use restraints but used peekˆaˆboo mittens, which did not enclose the entire hand and allowed the fingers to remain free. The surveyors accompanied the DON to observe the mittens being used for Residents 35, 55, and 68 and showed her that the mittens could fully wrap around the residents' hands. The DON stated she had been unaware the mittens could be used in this manner. She stated the CNAs and licensed nurses released the mittens every two hours for 15 minutes, but the CNAs did not document the releases. The DON stated that if it was not documented, it was not done.The Use of Restraints policy and procedure was reviewed with the DON. The policy stated there should be an end date for handˆmitten restraints to ensure reassessment of continued need. The DON stated the facility had not attempted leastˆrestrictive measures before applying the mittens, but should have, because the mittens limited movement, could be uncomfortable, and placed residents at risk for psychological distress. The DON stated the restraints for Residents 35, 55, and 68 were used improperly.During a review of the Medline Safety Check Hand Mitts Instruction Sheet, revised 6/23/2020, provided by the DON, the Instruction Sheet indicated, All other least restrictive options must be exhausted prior to restraint application. During a review of the facility's policy and procedure (P&P) titled, Use of Restraints, revised 4/2017, the P&P indicated, When the use of restraints is indicated, the lease restrictive alternatives will be used for the least amount of time necessary. The P&P indicated, Examples of devices that are/may be considered physical restraints include hand mitts. The P&P indicated, Restraint order shall include the type of restraint, and period of time for the use of the restraint.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the following for two of four sampled residents (Resident 35 and Resident 83), including:1.Failed to develop a comprehensive person-center care plan to address Resident 35's restraints.2.Failed to develop a comprehensive person-center care plan for Resident 83's communication.These failures had the potential to negatively affect the delivery of care and services to Residents 35 and 83.Findings:During a review of Resident 35's admission Record, the admission Record indicated Resident 35 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a long-term brain disorder that affects a person's ability to think clearly, manage emotions, make decisions, and relate to others) and epilepsy (a brain disorder that causes a person to have repeated, unexpected seizures).During a review of Resident 35's Minimum Data Set (MDS- a resident assessment tool) dated 4/27/2026, the MDS indicated Resident 35's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 35 was dependent (helper does all the effort) on activities of daily living (ADLs- routine activities such as bathing, dressing, and toileting a person performs daily to care for themselves).During a review of Resident 83's admission Record, the admission Record indicated Resident 83 was admitted to the facility on [DATE] with diagnoses including legal blindness, hearing loss, and mutism (inability to speak).During a review of Resident 83's MDS dated [DATE], the MDS indicated Resident 83's cognition was severely impaired. The MDS indicated Resident 83 was dependent on ADLs.During a concurrent interview and record review on 6/12/2026 at 10:15 a.m., with Licensed Vocational Nurse (LVN) 6, reviewed Resident 83's care plan titled Communication Deficit, initiated on 2/26/2026, related to the resident being blind, deaf (inability to hear), and mute (inability to speak). The care plan indicated interventions to monitoring the effectiveness of communication strategies and assistive devices. LVN 6 stated Resident 83 communicated by using sign language (a visual communication system that expresses meaning through hand gestures, facial expressions, and body language rather than spoken words). LVN 6 stated she did not understand everything he communicated. LVN 6 stated she traced words on Resident 83's hands, but not all staff knew how to do this. LVN 6 stated the staff were not following the care plan intervention to monitor the effectiveness of communication strategies.During a subsequent concurrent interview and record review on 6/12/2026 at 10:34 a.m., with LVN 6, reviewed Resident 35's care plan titled Bilateral Hand Mittens, initiated on 3/12/2026, related to the resident pulling lifeˆsustaining tubes. The care plan interventions included providing Resident 35 with daily opportunities for restraintˆfree time and physical activity. LVN 6 stated this intervention was not being implemented and the only time Resident 35's restraints were released was every two hours for 15 minutes.During an interview on 6/12/2026 at 12:19 p.m., with the Director of Nursing (DON), the DON stated a care plan was an individualized plan for the resident's care and the interventions were to be followed. The DON stated if staff reported the interventions were not being implemented, then they were not being implemented. The DON stated Resident 83's intervention to monitor the effectiveness of communication strategies was not appropriate because the staff did not know sign language.During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure dependent residents' received timely and appropriate assistance with activities of daily living (ADL- routine activities such as bathing, dressing, and toileting a person performs daily) care by failing to:1.Ensure four of five sampled residents (Resident 4, Resident 19, Resident 27, and Resident 42) fingernails were trimmed and free from accumulation of unknown substance underneath their fingernails.This failure resulted in Resident 4, Resident 19, Resident 27, and Resident 42 fingernails having irregular edges, accumulation of dark brown substances under the fingernails and had the potential to cause infection and impaired skin integrity.2.Ensure one of three sampled residents (Resident 58) was provided with a shower twice a week.This failure resulted in Resident 58 feeling unclean and neglected.3. Ensure Resident 11 received incontinent care in a timely manner.This failure placed Resident 11 at risk for loss of dignity, discomfort, skin irritation, moisture-associated skin damage ([MASD] is an inflammation and erosion of the skin caused by prolonged exposure to moisture), infection, and decreased quality of life. Findings: During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility 7/12/2023 with diagnoses including dementia (a progressive state of decline in mental abilities) and hypertension (HTN- high blood pressure). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 4's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 4 was dependent (helper does all the work) on ADLs. During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted to the facility 1/20/2026 with diagnoses including dementia and metabolic encephalopathy (brain dysfunction caused by a chemical imbalance in the body). During a review of Resident 19's MDS dated [DATE], the MDS indicated Resident 19's cognition was severely impaired. The MDS indicated Resident 19 was dependent on ADLs. During a review of Resident 27's admission Record, the admission Record indicated Resident 27 was admitted to the facility 6/6/2025 with diagnoses including cerebral infarction (loss of blood to part of the brain) and HTN. During a review of Resident 27's MDS dated [DATE], the MDS indicated Resident 27's cognition was severely impaired. The MDS indicated Resident 27 was dependent on ADLs. During a review of Resident 42's admission Record, the admission Record indicated Resident 42 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and anoxic brain damage (happens when your brain does not get oxygen). During a review of Resident 42's MDS dated [DATE], the MDS indicated Resident 42's cognition was severely impaired. The MDS indicated Resident 42 was dependent on ADLs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 58's admission Record, the admission Record indicated Resident 58 was admitted to the facility on [DATE] with diagnoses including quadriplegia (paralysis from the neck down, including legs and arms, usually due to a spinal cord injury) and attention deficit disorder (ADD-not being able to focus). During a review of Resident 58's MDS dated [DATE], the MDS indicated Resident 58's cognition was intact. The MDS indicated Resident 58 was dependent on ADLs. During an interview on 6/9/2026 at 11:38 a.m., with Resident 58, Resident 58, stated she was supposed to receive two showers a week but does not always get the second one. 1.During a concurrent observation and interview on 6/9/2026 at 2:51 p.m., with Certified Nurse Assistant (CNA) 3, CNA 3 stated the CNAs were responsible for cleaning and trimming resident fingernails. CNA 3 stated it was important to keep the residents' fingernails clean and trimmed to prevent bacteria from building up under their fingernails and prevent the residents from scratching themselves which could lead to wounds. CNA 3 stated Resident 4, 19, 27, and 42's fingernails were long and dirty and should have been cut and cleaned by the CNAs. CNA 3 stated CNAs document whether the residents' fingernails were clean and trimmed on a shower sheet in the shower binder at each nurse's station. During an interview on 6/11/2026 at 8:12 a.m., with the Infection Prevention Nurse (IPN), IPN stated it was important for the residents to have clean and trimmed fingernails because if not it can cause infection if they scratch themselves, having long fingernails can harbor bacteria, and it can affect the resident's dignity. 2.During a subsequent interview on 6/12/2026 at 8:22 a.m., with Resident 58, Resident 58 stated in the last few weeks, she has not been receiving showers regularly and it makes her feel dirty and disgusting. During a concurrent interview and record review on 6/12/2026 at 10:26 a.m., with Licensed Vocational Nurse (LVN) 6, the shower sheets for Resident 58 was reviewed. LVN 6 stated residents should receive eight showers a month, twice a week, and Resident 58 only received three showers for the month of May. LVN 6 stated not showering twice a week could result in Resident 58 feeling sad, upset, dirty, and as her needs were not being met. During a concurrent interview and record review on 6/12/2026 at 12:19 p.m., with the Director of Nursing (DON), the DON stated CNAs were responsible for trimming and cleaning resident fingernails, but any license nurse can do it. The DON stated residents should be showered twice a week. The DON stated having dirty, long fingernails and not receiving showers regularly could affect the residents' dignity because it was their right to receive care. The DON stated having long dirty fingernails could potentially lead to a resident scratching themselves. 3.During a review of Resident 11's admission Record dated 9/3/2025, the admission Record indicated Resident 11 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 11 with a diagnoses including contractures (a permanent tightening of muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of the bilateral (both) shoulder, anxiety (emotion characterized by feelings of tension, worried thoughts), dementia (loss of memory, language, problem-solving and other thinking abilities), and Alzheimer's (an irreversible, progressive brain disorder that slowly destroys memory and thinking skills). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's Care Plan titled Impaired physical functioning and ADL self-care deficit related to the following disease process/medical condition dated 8/2023, the Care plan indicated intervention to keep resident clean and dry. During a review of Resident 11's Care Plan titled Resident has bladder incontinence related to dementia at risk for skin breakdown dated 2/27/2024, the Care Plan indicated interventions including check the resident as required for incontinence, wash, rinse, and dry perineum and change clothing as necessary after incontinence episodes. During a review of Resident 11's History and Physical (H&P) dated 9/4/2025, the H&P indicated, Resident 11 does not have the capacity to understand and make decisions. During a review of Resident 11's MDS dated [DATE], the MDS indicated Resident 11 required substantial/moderated assistance (helper does more than half the effort) for toileting hygiene and was dependent (helper does all the effort) for shower/bathing. During a concurrent observation and interview on 6/11/2026 at 7:11 a.m., with CNA 1, observed Resident 11 in bed wearing an incontinence brief (diaper) containing urine and feces. CNA 1 stated she had begun her shift at 6:30 a.m. and completed rounds at the beginning of her shift to check residents' needs. She stated that, at the time of the observation, she had not yet completed rounds on Resident 11. She could not explain why she had not completed rounds or assessed Resident 11 for incontinent care needs. She stated Resident 11 was depended on staff for ADLs and wore incontinent briefs. She acknowledged the brief appeared to have been soiled for a prolonged period of time and stated, Honestly, the resident should not have been left this way. CNA 1 stated dependent residents required staff assistance with ADLs and incontinent care, and staff were expected to monitor residents and provide care in a timely manner. She stated the facility expected staff to round on residents every two hours and as needed. She further stated that leaving residents soiled for prolonged periods could result in skin irritation, pain, pressure ulcers (injury to skin and underlying tissue resulting from prolonged pressure on the skin), and decreased dignity. During an interview on 6/11/2026 at 10:05 a.m., with CNA 2, CNA 2 stated he worked the 10:30 p.m. to 6:30 a.m. shift. He stated Resident 11 was depended on staff for care, including toileting and repositioning. He stated he completed rounds on his assigned residents at the beginning of his shift, every two hours, and as needed. He stated he last provided incontinent care for Resident 11 on 6/11/2026 at 4:00 a.m. He stated residents who experienced prolonged exposure to urine and feces could develop skin damage and pressure ulcers. During an interview on 6/11/2026 at 11:04 a.m., with LVN 4, LVN 4 stated he communicated with the CNAs at the beginning of each shift regarding residents' care needs, including residents who dependent on staff for ADLs and incontinent care. LVN 4 stated he conducted rounds, monitored residents' conditions, and followed up with CNAs to ensure completion of resident care. He stated dependent residents should be checked every two hours and as needed to provide prompt incontinent care that maintains comfort, dignity, and skin integrity. He stated that if a dependent resident remained soiled and incontinent care was not provided timely, the resident could experience skin irritation, MASD, pressure injuries, infection, discomfort, odor, and loss of dignity. LVN 4 further stated delayed ADL and incontinent care could negatively affect the resident's physical wellˆbeing, comfort, and quality of life. During an interview on 6/12/2026 at 9:53 a.m., with the Director of Nursing (DON), the DON stated she (continued on next page)

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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Creek Post-Acute	7039 Alondra Blvd Paramount, CA 90723

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identified residents who required extensive or total assistance with ADLs through shift huddles and shift reports. She stated CNAs were expected to check residents for incontinence every two hours and as needed, and to provide incontinent care when required. She stated the facility did not have an auditing or monitoring process specifically to ensure residents were not left soiled. She stated that when staff found a resident soiled, they were expected to respond immediately and provide incontinent care. The DON stated the expectation for a resident who was dependent on staff for ADL care was the resident received timely and appropriate assistance, including prompt incontinent care, to maintain hygiene, dignity, comfort, and prevent potential complications such as skin breakdown. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, revised 3/2018, the P&P indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). The P&P indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. During a review of the facility's P&P titled, Dignity, revised 2/2021, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.

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	06/12/2026

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff were trained and competent to meet communication needs for one of three sampled resident (Resident 83).These failures had the potential for the facility not be able to assess the skills necessary to provide nursing services to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of Resident 83. Findings:During a review of Resident 83's admission Record, the admission Record indicated Resident 83 was admitted to the facility on [DATE] with diagnoses including legal blindness, hearing loss, and mutism (inability to speak).During a review of Resident 83's Care Plan titled Communication Deficit related to being blind, deaf, and mute, initiated 2/26/2026, the care plan indicated Resident 83 had goals to maintain his current level of communication by making sounds and sign language (a visual communication system that expresses meaning through hand gestures, facial expressions, and body language rather than spoken words). The care plan interventions indicated effective strategies such as touch and sign language.During a review of Resident 83's Minimum Data Set (MDS-resident assessment tool) dated 5/18/2026, the MDS indicated Resident 83's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 83 was dependent (helper does all the effort) on activities of daily living (ADLs- routine activities such as bathing, dressing, and toileting a person performs daily to care for themselves).During an interview on 6/9/2026 at 10:04 a.m., with Family Member (FM 1), FM 1 stated she was not sure how the staff communicated with Resident 83. FM 1 stated none of the staff had ever asked her how to properly communicate with Resident 83 or brought someone in who could communicate with him.During an interview on 6/11/2026 at 8:03 a.m., with Certified Nurse Assistant (CNA) 4, CNA 4 stated it was difficult to communicate with Resident 83 and that it would have been better for Resident 83 if staff knew how to communicate with him more effectively. CNA 4 stated not being able to properly communicate with Resident 83 could have caused him to feel frustrated.During an interview on 6/11/2026 at 9:13 a.m., with CNA 3, CNA 3 stated the staff had not received training on how to properly communicate with Resident 83. CNA 3 stated it would have been helpful for the staff to receive training because not being able to communicate with Resident 83 could have caused him to feel frustrated when his needs were not being met.During an interview on 6/11/2026 at 4:22 p.m., with the Director of Staff Development (DSD), DSD stated she had begun in-servicing the staff on how to communicate with Resident 83. The DSD stated not being able to communicate with Resident 83 could have caused him to feel that his needs were not being met.During an interview on 6/12/2026 at 7:41 a.m., with Registered Nurse Supervisor (RNS) 2, RNS 2 stated she had learned on her own how to communicate with Resident 83 because the staff had not been educated on how to communicate with him, as he could not hear, speak, or see. RNS 2 stated not being able to communicate with Resident 83 had been frustrating for both the staff and Resident 83, and it would have been helpful to learn how to better communicate with Resident 83.During an interview on 6/12/2026 at 12:19 p.m., with the Director of Nursing (DON), the DON stated the staff should have been educated on how to communicate with Resident 83 because it was important for the resident's care, safety, and dignity. The DON stated the facility was now educating the staff on how to competently communicate with Resident 83 by the DSD.During a review of the facility's policy and procedure (P&P) titled, Dignity, revised 2/2021, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated, The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. Cross reference F676

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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interview and record review the facility failed to implement infection control policies and procedures (P&P) when:a. The facility failed to educate and offer the annual influenza ([Flu] highly contagious respiratory infection) vaccine (medications used to prevent diseases usually given by injection or by mouth) to 59 out of 59 licensed practitioners (individual who is licensed or otherwise authorized by a state to provide health care services).b. The facility failed to implement the water management plan (plan that identifies hazardous conditions and steps to take to minimize the growth and spread of bacteria[germs]) thereby affecting 89 out of 89 residents.These failures had the potential to result in staff and residents contracting infectious diseases which can cause serious illness, hospitalization, and death.Findings:a. During a concurrent interview and record review on 6/9/2026 at 12:41 p.m., with the Infection Prevention Nurse (IPN), the facility's 2025-2026 Influenza and COVID-19 Vaccine Tracking Sheet for all staff was reviewed. The IPN stated there was no documented evidence for licensed practitioners' education on benefits and side effects was provided and the offering of 2025 to 2026 Flu vaccine. The IPN stated the roster did not include licensed practitioners and it should include everyone that has direct access to the residents.During a concurrent interview and record review with the IPN on 6/9/2026 at 12:41 p.m., the County of Los Angeles Department of Public Health Order of the Health Officer (HOO), Annual Immunization or masking requirement for healthcare personnel during Respiratory Virus season, revised 10/16/2025 was reviewed. The IPN stated the HOO defined healthcare personnel to include licensed care practitioners, all paid and unpaid employees, contractors, students, volunteers, and emergency services personnel who have direct patient contact or work in the patient care areas.During a review of the facility's P&P titled, Influenza Vaccine, reviewed 10/2022, the P&P indicated all employees will be provided with information regarding the requirement to receive the annual flu vaccine.b. During an interview on 6/9/2026 at 1:14 p.m., with the Maintenance Supervisor (MS), the MS stated he measures water temperatures and at the same time flushes it, quarterly the ice machine was maintained by a third-party company, and there were no other tasks regarding the water management plan. The MS stated there was no documentation of evidence of Water Management Plan implementation or logs.During a concurrent interview and record review on 6/9/2026 at 1:21 p.m. with the IPN, the facility's Water Management Program Water Safety Plan 2026 was reviewed. The IPN confirmed the Plan had tasks and procedures that were not implemented. The IPN stated there was no documented evidence of the performance of tasks outlined in detail in the Water Management Plan.During an interview on 6/9/2026 at 3:27 p.m. with the Director of Nursing (DON), the DON stated licensed practitioners need to be educated and offered the current flu vaccine for resident safety. The DON stated the facility needs to follow water management plan for resident safety.During a review of the facility's Water Management Program Water Safety Plan 2026, the plan indicated: 1. Specific control measures and procedures (actions implemented to eliminate or minimize risks) were provided in the plan.2. All Standard Operating procedures and Protocols were also developed in detail.3. A task planning chart was provided that summarizes control tasks throughout the year. Log sheets/ Verification Forms were provided to help document performance of tasks.4. The plan indicated preventative measures and steps to be performed routinely.

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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Creek Post-Acute	7039 Alondra Blvd Paramount, CA 90723

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review the facility failed to educate and offer the 2025 to 2026 COVID-19 ((highly contagious respiratory disease caused by Coronavirus which is transmitted thru coughing, talking, sneezing and touching contaminated surfaces) vaccine (biological preparation to help your body build resistance to specific, harmful diseases) to fifty-nine out of fifty-nine licensed practitioners (individual who is licensed or otherwise authorized by a state to provide health care services).This failure had the potential to result in staff and residents contracting COVID-19 which can cause serious illness, hospitalization, and death.Findings: During a concurrent interview and record review on 6/9/2026 at 12:41 p.m. with the Infection Prevention Nurse (IPN), the facility's 2025-2026 Influenza and COVID-19 Vaccine Tracking Sheet for All Staff' was reviewed. The IPN stated there was no documented evidence licensed practitioners received education on the benefits and side effects of the vaccines or that the 2025-2026 COVID-19 booster vaccine had been offered. The IPN stated the roster did not include physicians and should have included everyone who had direct access to residents.During an interview on 6/9/2026 at 3:27 p.m. with the Director of Nursing (DON), the DON stated licensed practitioners need to be educated and offered the current COVID-19 booster for resident safety.During a review of the facility's Policy and Procedure (P&P) titled, COVID-19 Vaccine, revised 6/22/2022, the P&P indicated all will be provided with information regarding the requirement to receive the COVID vaccine.

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	056166	A. Building B. Wing	06/12/2026

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Meadow Creek Post-Acute	7039 Alondra Blvd Paramount, CA 90723

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 83) was provided an effective means of communication.This failure placed Resident 83 at risk for psychosocial isolation and unmet needs.Findings:During a review of Resident 83's admission Record, the admission Record indicated Resident 83 was admitted to the facility on [DATE] with diagnoses including legal blindness, hearing loss, and mutism (inability to speak).During a review of Resident 83's Minimum Data Set (MDS-resident assessment tool) dated 5/18/2026, the MDS indicated Resident 83's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 83 was dependent (helper does all the effort) on activities of daily living (ADLs- routine activities such as bathing, dressing, and toileting a person performs daily to care for themselves).During an interview on 6/9/2026 at 10:04 a.m., with Family Member (FM 1), FM 1 stated she was not sure how the staff communicated with Resident 83. FM 1 stated none of the staff had ever asked her how to properly communicate with Resident 83 or brought someone in who could communicate with him.During an interview on 6/11/2026 at 8:03 a.m., with Certified Nurse Assistant (CNA) 4, CNA 4 stated it is difficult to communicate with Resident 83, and it would be better for Resident 83 if they knew how to better communicate with him. CNA 4 stated not being able to properly communicate with Resident 83 could cause Resident 83 to feel frustrated.During an interview on 6/11/2026 at 9:13 a.m., with CNA 3, CNA 3 stated the staff had not received training on how to properly communicate with Resident 83. CNA 3 stated it would have been helpful for the staff to receive training because not being able to communicate with Resident 83 could have caused him to feel frustrated when his needs were not met.During an interview on 6/11/2026 at 4:22 p.m., with the Director of Staff Development (DSD), DSD stated she had begun in-servicing the staff on how to communicate with Resident 83. The DSD stated not being able to communicate with Resident 83 could have caused him to feel that his needs were not being met.During a concurrent interview and record review on 6/12/2026 at 10:15 a.m., with Licensed Vocational Nurse (LVN) 6, Resident 83' Care Plan titled, Communication Deficit, related to Resident 83 being blind (inability to see), deaf (inability to hear), and mute (inability to speak), initiated 2/26/2026 was reviewed. Resident 83's care plan interventions included monitoring effectiveness of communication strategies and assistive devices. LVN 6 stated Resident 83 communicates by using sign language (a visual communication system that expresses meaning through hand gestures, facial expressions, and body language rather than spoken words) because he was deaf, blind, and mute. LVN 6 stated she does not understand everything Resident 83 communicates to her in sign language. LVN 6 stated she traces words on Resident 83's hands but not everyone knows how to do this.During an interview on 6/12/2026 at 7:41 a.m., with Registered Nurse Supervisor (RNS) 2, RNS 2 stated she had learned on her own how to communicate with Resident 83 because the staff had not been educated on how to communicate with him, as he could not hear, speak, or see. RNS 2 stated not being able to communicate with Resident 83 had been frustrating for both the staff and Resident 83, and it would have been helpful to learn how to better communicate with Resident 83.During an interview on 6/12/2026 at 12:19 p.m., with the Director of Nursing (DON), the DON stated the staff should have been educated on how to communicate with Resident 83 because it was important for the resident's care, safety, and dignity. The DON stated the facility was now educating the staff on how to competently communicate with Resident 83 by the DSD.During a review of the facility's P&P titled, Dignity, revised 2/2021, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated, The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs.Cross reference F726

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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Creek Post-Acute	7039 Alondra Blvd Paramount, CA 90723

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of one sampled resident (Resident 6) received respiratory tracheostomy (a surgical procedure that creates an opening in the neck and directly into the windpipe [trachea])suctioning (a critical medical procedure used to clear the trachea and lower airway of mucus, saliva, blood, or vomit when a person cannot cough effectively) every two hours as order.This failure had the potential to lead to Resident 6 experiencing respiratory distress (medical emergency characterized by difficulty breathing and low oxygen levels).Findings:During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with diagnoses of but not limited to acute respiratory failure, aphasia (a disorder that makes it difficult to speak), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), transient ischemic attack (a temporary blockage of blood flow to the brain) and pressure ulcer/injury Stage IV (wound that penetrate all layers of skin exposing muscles, tendons [tissue that unites a muscle with a bone] cartilage {tissue that lines a joint}, and bones caused by prolonged pressure on the skin)During a review of Resident 6's History and Physical (H&P), dated 5/16/2026, the H&P indicated Resident 6 had fluctuating capacity to understand and make decisions.During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool), dated 6/1/2026, the MDS indicated Resident 6 was dependent (helper does all the effort) on nursing staff for oral hygiene, toileting, showering, dressing, rolling from left to right and transferring. The MDS indicated Resident 6 received respiratory therapy, oxygen therapy, suctioning, and tracheostomy care. During a review of Resident 6's Order Summary, the Order Summary dated 5/15/2026 indicated for respiratory tracheostomy suctioning for airway clearance (therapies used to loosen and mobilize thick, sticky mucus from the lungs) as needed every two hours.During an observation on 6/09/2026 at 10:07 a.m. in Resident 6's room, Resident 6 lay in bed with a tracheostomy tube (a curved plastic or metal catheter inserted into a surgically created opening in the windpipe) in place. Resident 6 exhibited loud, audible lung sounds, was coughing, and appeared flushed with red skin coloration.During an observation on 6/9/2026 at 10:11 a.m., with Licensed Vocational Nurse (LVN) 8 knocked on Resident 6's door, entered the room, looked at Resident 6, and then walked out. At the time of the observation, Resident 6 laying on his left side and was coughing.During an observation on 6/9/2026 at 10:19 a.m., with Certified Nursing Assistant (CNA) 5, CNA 5 entered Resident 6's room and told Resident 6 We will fix you up.During an observation on 6/9/2026 at 10:26 a.m., with Certified Nursing Assistant (CNA) 5 donned a gown and gloves and stated he would clean Resident 6. CNA 5 closed the curtains, and Resident 6 continued to cough with audible lung sounds.During an observation on 6/9/2026 at 10:31 a.m., the wound care nurse was at Resident 6's bedside preparing to perform a dressing change.During an interview on 6/11/2026 at 3:45 p.m. with the Respiratory Therapist (RT), the RT stated his responsibilities included managing residents' airways, providing tracheostomy care, and suctioning the residents every two hours.During a concurrent interview and record review on 6/11/2026 at 3:57 p.m. with the Respiratory Therapist (RT), Resident 1's Medication Administration Audit Report, dated 6/11/2026, was reviewed. The Medication Administration Audit Report showed that Resident 6 was scheduled for tracheostomy suctioning on 6/9/2026 at 10:00 a.m. and did not receive suctioning until 12:22 p.m., over two hours later. The RT stated residents were suctioned every two hours around the clock and the registered nurse supervisors could also perform suctioning. The RT stated nursing staff were expected to inform him of any audible lung sounds, visible coughing, redness, cyanosis (a bluish or purplish discoloration of the skin, lips, or nail beds), or any signs of respiratory distress. The RT acknowledged that he did not suction the resident at 10:00 a.m. and did not perform suctioning until 12:22 p.m.During an interview on 6/11/2026 at 5:06 p.m. with the Director of Nursing (DON), the DON stated it was unsafe for a resident to miss being suctioned (continued on next page)

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	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because the resident could experience respiratory distress. The DON stated residents needed to be suctioned to keep their airways clear.During a review of the facility's policy and procedure (P&P), titled Suctioning the Lower Airway (Endotracheal [ET] or Tracheostomy Tube), date revised 10/2010, the P&P indicated, The purpose of this procedure is to remove secretions, maintain a patent airway, and prevent infection of the lower respiratory tract.During a review of the facility's P&P titled, Job description Respiratory Therapist, dated 1/2010, the P&P indicated, .Performs chest physical therapy treatments involving percussion, postural drainage (technique that uses gravity to clear mucus from the lungs), and suctioning, in order to mobilize secretions and mucus in the lungs and to clear airway blockage in the respiratory system.

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	056166	A. Building B. Wing	06/12/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 1) received pain medication after reporting a pain level of 5 out of 10 on the pain scale (0 indicating no pain and 10 indicating the worst pain imaginable).This failure resulted in Resident 1 experiencing an increased pain level of 10 out of 10 on the pain scale, and waiting one hour before receiving pain medication.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses of but not limited to atherosclerosis (the buildup of fats, cholesterol and other substances in and on the artery walls) of both legs, claudication (a symptom of muscle pain, cramping, or fatigue typically in the legs) of both legs, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet).During a review of Resident 1's History and Physical (H&P), dated 5/26/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 5/29/2026, the MDS indicated Resident 1 was dependent (helper does all of the effort) on nursing staff for toileting, showering, and dressing. The MDS indicated Resident 1 needed substantial to maximal assistance (helper does more than half the effort) with oral hygiene and personal hygiene. The MDS indicated Resident 1 needed partial to moderate assistance (helper does less than half the effort) with sitting up and lying down.During a review of Resident 1's Order Summary, the Order Summary indicated Resident 1 had a physician's order from 6/8/2026 to 6/10/2026 for Hydrocodone-Acetaminophen (a strong prescription combination medication used to manage moderate to severe pain) 5 milligram (mg-uit of measurement) /325 mg, to be administered one tablet through the gastrostomy tube (GT- a soft tube surgically inserted directly into the stomach to administer medication, fluids, and nutrition) every four to six hours for moderate pain rated 4 to 6 and for severe pain rated 7 to 10.During an observation on 6/09/2026 at 10:52 a.m., Resident 1 was lying in bed with necrotic (dead tissue) left toes wrapped in a gauze dressing. Resident 1 told Licensed Vocational Nurse (LVN) 5, I have pain 5 out of 10 in my left toes. LVN 5 told Resident 1 his pain medication was not due for another hour and offered him an ice pack. Resident 1 declined the ice pack.During a concurrent interview and record review on 6/11/2026 at 2:27 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Medication Administration Record (MAR) dated 6/2026 was reviewed. The MAR indicated Resident 1 received Hydrocodone/Acetaminophen 5/325 mg on 6/9/2026 at 12:20 p.m. for a reported pain level of 10 out of 10. LVN 1 stated the last time Resident 1 received pain medication before that dose was at 6:15 a.m. on 6/9/2026. LVN 1 stated LVN 5 was supposed to contact the physician to obtain an order allowing an earlier dose of pain medication. LVN 1 stated there was no documentation in Resident 1's record showing the physician was informed of Resident 1's reported pain level of 5. LVN 1 stated Resident 1 would experience increased discomfort, abnormal vital signs (including changes in temperature, blood pressure, pulse, and respiratory rate), and an elevated respiratory rate. LVN 1 stated this could affect pain management because Resident 1's pain level increased from 5 to 10 by the time the scheduled pain medication was due.During an interview on 6/11/2026 at 5:07 p.m. with the Director of Nursing (DON), the DON stated LVN 5 should have assessed the resident and called the physician to report the resident had a pain level of 5 out of 10 and the pain medication was not due for another hour. The DON stated the resident could experience a change of condition or distress, and pain management would be affected if the resident's pain was not relieved.During a review of the facility's policy and procedure (P&P), titled Pain Management, date revised 3/2025, the P&P indicated The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain .If pain has not been adequately (continued on next page)

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	056166	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Creek Post-Acute	7039 Alondra Blvd Paramount, CA 90723

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nursing staff administered the correct medication dose as ordered for one of three sampled residents (Resident 41). Resident 41 had a physician's order for Zinc Sulfate (a dietary supplement to replenish an essential element, Zinc) 220 milligrams (mg, unit to measure dose), one tablet daily. Resident 41 was administered four tablets of Zinc 50 mg instead. (One tablet of Zinc Sulfate 220 mg contains 50 mg of elemental zinc.)This deficient practice created the potential for a medication error that could negatively impact the resident's health condition.Findings:During a review Resident 41's admission Record, the admission Record indicated Resident 41 was originally admitted to the facility on [DATE] and recently readmitted on [DATE]. Resident 41's admitting diagnoses included, but not limited to acute post-hemorrhagic (after an internal bleeding event) anemia (low of red blood cells), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure), gastrostomy (a surgical opening through the skin of the abdomen to the stomach), and severe protein-calorie malnutrition (inadequate intake of protein and calories). During an observation on 6/11/2026 at 9:47 a.m., Licensed Vocational Nurse (LVN 3) was observed outside Resident 41's room preparing medications for administration. LVN 3 prepared fifteen (15) medications for Resident 41, including four (4) tablets of Zinc 50 mg. LVN 3 crushed the four zinc tablets and administered them via the resident's gastrostomy tube (Gˆtube, a flexible tube inserted through the abdominal wall into the stomach and used to deliver hydration, medications, and nutrition to individuals who cannot safely consume adequate calories by mouth). During a review of Resident 41's Order Summary dated 6/10/2026 at 8:40 a.m., the order indicated to administer Zinc sulfate 220 mg enterally (per G-tube) one capsule daily for supplement. LVN 3 gave four tablets of Zinc 50 mg, which equals 200 mg. During an interview and record review on 6/11/2026 at 1:23 p.m., with LVN 3, Resident 41's Order Summary was reviewed. LVN 3 stated she administered four Zinc sulfate 50 mg, which was not the correct dose. During an interview on 6/11/2026 at 3:10 p.m., with LVN 3, LVN 3 stated she was not aware that each Zinc Sulfate 220 mg dose contained 50 mg of elemental zinc. She stated she should have clarified the order when she had a question.During an interview on 6/11/2026 at 3:41 p.m., with the Director of Nursing (DON), the DON stated the drug information indicated Zinc Sulfate 220 mg was equivalent to 50 mg of elemental zinc. The DON stated the facility notified Resident 41's physician, who ordered monitoring of the resident's zinc level and monitoring for potential side effects, since the resident had received four times the prescribed dose (four Zinc 50 mg tablets). The DON stated the possible side effects included nausea and stomach upset. The DON stated nurses should have consulted a supervisor whenever they had a question about a medication order.During a review of the facility policy and procedures (P&P) titled, Administering Medications (revised April 2019), the P&P indicated medications are administered in accordance with prescriber orders. The policy also indicated individual administering medications checks the label three times to verify the right medication and right dosage before giving the medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Licensed Vocational Nurse (LVN 2) did not administer Norco (hydrocodone/acetaminophen, a narcotic pain medication) to one of one sampled residents (Resident 28) when the resident's assessed pain level was 3 out of 10 level on a pain scale rating from zero to ten (pain screening tool using numerical value to assess the level of pain ranging from 0 to 3-mild pain, from 4 to 6- moderate pain, and from 7 to 9-severe pain, and 10- the worse pain possible) and did not meet the criteria established in the painˆmedication order.This deficient practice had the potential for significant medication errors and/or medication overdose, which could worsen the resident's health condition. Findings:During a review of Resident 28's admission Record, the admission Record indicated Resident 28 was admitted to the facility on [DATE] with diagnoses, including but not limited to hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body), gastrostomy (a surgical opening through the skin of the abdomen to the stomach), and acute respiratory failure with hypoxia (a life-threatening condition where the lungs cannot adequately supply oxygen to the bloodstream).During a review of Resident 28's Physician Order, the order indicated hydrocodone/APAP (Norco) 5/325 milligram (mg-unit of measurement) dated 3/22/2026, give one tablet via gastrostomy tube (Gˆtube, a flexible tube inserted through the abdominal wall into the stomach and used to deliver hydration, medications, and nutrition every six hours as needed for moderate pain (scores 4-6) and severe pain (7-10).During a concurrent interview and record review on 6/10/2026 at 3:03 p.m., with Licensed Vocational Nurse (LVN 1), Resident 28's electronic Medication Administration Record (eMAR)was reviewed. LVN 1 stated Resident 28 received one dose of Norco on 6/10/2026 at 7 a.m., and that the documented pain level at the time was 3.During a concurrent interview and record review on 6/10/2026 at 3:05 p.m., with LVN 2, Resident 28's pain assessment was reviewed, the record showed a total score of 3: the resident demonstrated facial grimacing (facial expression of discomfort) (score 2) and tense body language (score 1). LVN 2 stated Resident 28 was nonˆverbal and the resident's pain level was assessed using the Pain Assessment in Advanced Dementia ([PAINAD] a 5-item observational tool used to evaluate pain in patients who cannot verbally communicate) Scale. LVN 2 stated the PAINAD section in the electronic health record allowed nurses to select the appropriate descriptions of the resident's physical behaviors, each corresponding to a score of 1 or 2, and the system automatically totaled the score.During an interview on 6/10/2026 at 3:08 p.m., with LVN 1, LVN 1 stated Resident 28's documented pain level on 6/10/2026 for the morning dose was 3, which was below the parameter, or painˆlevel criteria, established in the order; therefore, the resident should not have received the Norco. LVN 1 stated a pain score of 1 to 3 reflected mild pain, not moderate or severe pain.During a concurrent interview and record review on 6/10/2026 at 3:18 p.m., with the Director of Nursing (DON), Resident 28's eMAR was reviewed. The DON stated Resident 28 received one dose of Norco on 6/9/2026 with a documented pain level of 2, and one dose of Norco on 6/10/2026 with a documented pain level of 3. The DON stated nurses should not administer the medication when the resident's pain level does not meet the pain level required by the physician's order. During an interview on 6/11/2026 at 3:54 p.m., with DON, the DON stated administering a higher dose of a narcotic than needed could increase the resident's risk of addiction and lead to adverse effects.During a review of the facility policy and procedures (P&P) titled, Administering Medications (revised April 2019), the P&P indicated medications are administered in accordance with prescriber orders.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to store one of forty residents (Resident 66) frozen meals in a freezer set at zero (0) degrees Fahrenheit (F-unit of measurement) or below and the facility failed to ensure food items in the residents' refrigerator were labeled with the residents' names and not expired.These failures had the potential to result deterioration of food quality changes in texture, and loss of nutrient. Using expired food items increases the risk of bacterial growth which can cause foodborne illness (illness cause by food contaminated with bacteria, viruses, parasites, or toxins) such as nausea, vomiting (throwing up), and diarrhea (loose stool).Findings: During a review of Resident 66's admission Record, the admission Record indicated Resident 66 was admitted to the facility on [DATE] with a diagnosis including end stage renal disease (ESRD - irreversible kidney damage), type 2 diabetes (disorder characterized by difficulty in blood sugar control and poor wound healing) , severe protein calorie malnutrition (condition caused by extreme lack of both protein and calories in the diet).During a review of Resident 66's Minimum Data Set ([MDS] a resident assessment tool), dated 4/23/2026, the MDS indicated Resident 66's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 66 independently eats. During a review of Resident 66's Physician Order, dated 11/27/2025 at 2:17 p.m., indicated a Regular diet.During a concurrent observation and interview on 6/09/2026 at 9:40 a.m. with Licensed Vocational Nurse (LVN) 1, in the staff lounge, it was observed and LVN 1 confirmed the following observations in the residents refrigerator: a. freezer temperature was 10 F and there were food items that belonged to Resident 66 (frozen meals)b. opened, half used Perrier bottle with no resident name and no open date.c. used and unlabeled cup which was dirty and stained with red color in the cup d. texas hot sauce bottle with no resident namee. ketchup bottle with no resident name and expired on 4/28/2026f. mustard bottle with no resident name and expired 2025g. second mustard bottle expired 8/13/2025During an interview on 6/9/2026 at 9:58 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated staff needed to store residents' food at the correct temperatures. The IPN stated staff needed to ensure there were no dirty items or expired food in the residents' refrigerators. The IPN stated food items needed to be labeled with the residents' names. The IPN stated these practices helped prevent the growth of foodˆborne bacteria. During an interview on 6/9/2026 at 3:27 p.m., with the Director of Nursing (DON), the DON stated the freezer temperature needed to be 0 F or below, so food would not spoil. The DON stated expired foods need to be discarded to prevent food poisoning.During a review of the facility's policy and procedure (P&P) titled, Procedure for Refrigerated Storage, 2023. the P&P indicated the freezer temperature should be 0 degrees Fahrenheit or lower. During a review of the facility's P&P titled Food brought by Family/ Visitors, revised 3/2022, the P&P indicated the nursing staff will discard perishable foods on or before use by date. The P&P indicated the containers will be labeled with the resident's name and use by date.