STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056137	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Meadows Post Acute	14857 Roscoe Boulevard Panorama City, CA 91402

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of four sampled residents (Resident 3) when on 3/19/2026 at 10:55 a.m., Resident 4 hit Resident 3 in the right eye with a closed fist (a person's hand when the fingers are bent in toward the palm and held there tightly).This deficient practice resulted in Resident 3 being subjected to physical abuse while under the care of the facility. Resident 3, sustained purplish discoloration (purple or darkened area on the skin, usually caused by bruising or bleeding under the skin), a cut (an opening in the skin caused by trauma) measuring 0.5 centimeters (cm-unit of measurement) in length x 0.1 cm in width x 0.1 cm in depth above his right eye and pain on the right eye. Findings:a. During a review of Resident 3's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted Resident 3 on 12/5/2024 and readmitted Resident 3 on 1/16/2026, with diagnoses including chronic obstructive pulmonary disease (COPD-a long term disease that makes it hard to breathe due to damaged, inflamed and narrowed airways), heart failure (a condition where the heart cannot pump blood throughout the body effectively enough to maintain the body's normal function), and type 2 diabetes (a condition where the body cannot control the level of sugar in the blood).During a review of Resident 3's Physician Progress Note, dated 1/17/2026, the Physician Progress Note indicated Resident 3 has the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 2/2/2026, the MDS indicated Resident 3's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 3 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) in most areas of activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 3's Situation-Background-Assessment-Recommendation (SBAR-a document used to communicate a resident's major decline or improvement in status that will not resolve without intervention) Communication Form, dated 3/19/2026 and timed at 10:57 a.m., the SBAR Communication Form indicated on 3/19/2026 at 10:55 a.m., Resident 3 was sitting on a patio chair interacting with other residents including Resident 4, and without warning, Resident 4, who was sitting in a wheelchair in front of Resident 3, stood up and hit Resident 3 on the right upper eyebrow causing a cut measuring, 0.5 cm (in length) x 0.1 cm (in width), with a small amount of bleeding. The SBAR Communication Form indicated first aid treatment (treatment given at the time and location of an injury) was provided to Resident 3.During a review Resident 3's Skin Supplemental assessment dated [DATE], timed at 11:10 a.m., the Skin Supplemental Assessment indicated a Registered Nurse (unidentified) assessed Resident 3 and observed Resident 3 with a linear (a straight-line incision or wound) cut to the right upper eye measuring 0.5 cm x 0.1 cm x 0.1 cm with reddish discoloration.b. During review of Resident 4's Face Sheet, the Face Sheet indicated the facility admitted Resident 4 on 7/1/2024 with diagnoses including acute kidney failure (a sudden, often reversible loss of kidney (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	function), dysphagia (difficulty swallowing), and anemia (a blood condition where a person lacks enough health red blood cells to carry adequate oxygen to the body tissues).During a review Resident 4's Physician Progress Note, dated 4/9/2025, the Physician Progress Note indicated Resident 4 has the capacity to understand and make decisions. During review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4's cognition was intact. The MDS indicated Resident 4 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) in most areas of ADLs.During a review of Resident 4's SBAR Communication Form dated 3/19/2026 timed at 10:58 a.m., the SBAR Communication Form indicated on 3/19/2026 at 10:55 a.m., Resident 4 was on the patio interacting with other residents (unidentified) including Resident 3, in the presence of Activity Staff 1 (ACS 1) when suddenly Resident 4 stood up and raised his (Resident 4's) hand toward Resident 3. The SBAR Communication Form indicated that ACS 1 attempted to intervene; however, Resident 4 had already hit Resident 3 in the face.During a review of Resident 4's Progress Note, dated 3/20/2026, the Progress Note indicated the facility transferred Resident 4 to another facility on 3/20/2026.During a concurrent observation of Resident 3's right eye, and interview with Resident 3 in Resident 3's room on 3/20/26 at 3:45 p.m., Resident 3's cut to the right upper eye was covered with clear steri-strips (a bandage used to help close a cut and support healing), with purplish discoloration present. Resident 3 stated (on 3/19/26, at 10:55 a.m.) Resident 3 was in the patio with other residents including Resident 4 having a discussion, when Resident 4 stood up and used Resident 4's left closed fist to hit Resident 3's right eye area. Resident 3 stated Resident 3 was shocked because Resident 3 considered Resident 4 to be a friend. Resident 3 stated Resident 3's right eye ached and rated Resident 3's pain to be 2 out of 10 (on the numeric pain rating scale [a pain assessment tool that uses a scale ranging from zero {0- no pain} to 10 {worst pain imaginable} to quantify pain intensity). Resident 3 stated, I wish it didn't happen. During a concurrent observation of Resident 3's right eye in the presence of the Assistant Director of Nursing (ADON) and interview with the ADON in Resident 3's room on 3/20/2026, at 3:47 p.m., Resident's 3 right eye area had purplish discoloration and a cut covered with clear steri-strips. The ADON stated Resident 3 had an area of purplish discoloration approximately 1.0 cm x 1.0 cm in size next to Resident 3's right eye and a laceration (a tear or cut in the skin or tissue, typically caused by blunt or sharp trauma, often with irregular or jagged edges) measuring approximately 1.0 cm in length x 0.1 cm in width x 0.1 cm in depth covered with clear steri-strips. The ADON asked Resident 3 to rate Resident 3's pain on the numeric pain rating scale and Resident 3 responded that Resident 3's pain on the right eye area was 2 out of 10.During an interview on 3/20/2026, 4:22 p.m., with ACS 1, ACS 1 stated he witnessed Resident 4 using Resident 4's left hand to slap the right eye area of Resident 3, causing a laceration just above Resident 3's right eye area.During a concurrent interview with the Director of Nursing (DON) and record review on 3/23/2026 at 4:56 p.m., the facility's document titled, CDPH (California Department of Public Health) 5-Day Report, dated 3/23/26 was reviewed. The 5-Day Report indicated on 3/19/2025, Resident 4 stated he (Resident 4) felt his hand made contact with Resident 3's face. The DON stated Resident 4 used Resident 4's hand to strike the right eye area of Resident 3. During a concurrent interview with the Administrator (ADM) and record review on 3/24/2026 at 4:30 p.m., the facility's Policy and Procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 11/5/2025 was reviewed. The P&P indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The ADM stated that willful non-consensual contact between residents is abuse and abuse is never to be deemed unavoidable.