

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A269	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER Meadowbrook Behavioral Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3951 East Blvd. Los Angeles, CA 90066	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45037</p> <p>Based on observation, interview, and record review the facility failed to thoroughly investigate non-consensual (without permission) sexual abuse allegation by Licensed Vocational Nurse (LVN) 2 for one of three sampled residents (Resident 1).</p> <p>This failure resulted in Resident 1 feeling afraid to remain in the facility because the resident felt LVN 2 would touch her and kiss her again.</p> <p>Findings:</p> <p>A review of Resident 1 ' Admission Record indicated Resident 1 was admitted on [DATE], with a diagnoses not limited to schizoaffective disorder, bipolar type (mental illness that combines symptoms) and hypertension (a condition where the pressure of blood in your blood vessels is consistently too high).</p> <p>A review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 10/21/2024, indicated Resident 1 had intact cognition (mental ability to understand and make decisions).</p> <p>A review of Resident 2 ' s Admission Record indicated Resident 2 was ad mitted on 11/4/2024 with a diagnoses not limited to paranoid schizophrenia (mental illness where someone experiences intense, persistent feelings of suspicion and distrust towards others), hyperlipidemia (havening too much fat in your blood).</p> <p>A review of Resident 2's MDS dated [DATE], indicated Resident ' s 2 cognition was not intact.</p> <p>A review of Resident 6 ' s Admission Record indicated Resident 6 was admitted on [DATE] with a diagnoses of but not limited to paranoid schizophrenia (a type of schizophrenia where someone experiences extreme paranoia, often believing that others art trying to harm them), essential hypertension (high blood pressure that is not due to another medical condition).</p> <p>A review of Resident 6's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 9/17/2024, indicated the resident 6 ' s cognition is intact.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/3/24 at 1:33 pm, Director of Nursing (DON) stated she was first made aware of the sexual abuse allegation incident between LVN 2 and Resident 1 on 11-28-24 by the Administrator. The DON stated she interviewed Resident 1 on 12/2/2024, however, the alleged sexual abuse took place around 11/2024 at around 12 midnight. DON stated LVN 2 walked over to Resident 1's bed, kissed Resident 1 and told Resident 1 to wake up at 2 am and meet LVN 2 in the conference room because LVN 2 had something for Resident 1. DON stated Resident 1 said that she woke up, checked the time and it was 2 am, and the resident went to the chart room. Resident 1 stated LVN 2 touched her pointing at her vagina. DON stated Resident 1 said that LVN 2 gave her noodles after touching her.</p> <p>During an interview on 12/3/24 at 1:49 pm, the Program Director (PD) stated Resident 1 first told the Primary Counselor (PC) about the alleged sexual abuse incident between LVN 2 and Resident 1. PD stated she interviewed Resident 1 via telephone on 11/28/2024 and Resident 1 told her that in 10/2024, LVN 2 touched her vagina, kissed her in the mouth, and told Resident 1 to meet him in the chart room at 2 am because he had something for Resident 1. PD stated Resident 1 said that when Resident 1 met LVN 2 in the chart room he pulled her close to him and touched her vagina and kissed her in the mouth and then gave her some noodles. PD stated staff are not supposed to have residents in the chart room.</p> <p>During an interview on 12/3/24 at 2:16 pm, Social Services (SS) stated that PC informed her of Resident 1 's alleged sexual abuse. The SS stated she interviewed Resident 1 on 11/28/2024 and that she notified the Administrator by telephone. SS stated the Administrator conducted a telephone interview with Resident 1 with her presence, and in the presence of the Program Manager. SS stated another resident (Resident 10 discharged from the facility) told SS that Resident 10 had sex with LVN 2 two times while she was a resident at the facility but later recanted the allegations. SS stated she interviewed Resident 1 on 11/28/2024 and Resident 1 said that LVN 2 came into her room and kissed her and touched her vagina. SS stated Resident 1 stated she met LVN 2 in the chart room at 2 am and that LVN 2 kissed Resident 1, touched the resident's vagina, and then gave the resident noodles to eat and then went back to her room. SS stated the staff are not supposed to bring outside food or buying clothes for the residents.</p> <p>During an interview on 12/3/24 at 2:30 pm, LVN 1 stated Resident 1 is very quiet and stays to herself. LVN 1 stated he has never asked any of the residents to meet him in the chart room. LVN 1 stated he has never brought clothes, shoes, or outside food for any of the Residents.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/4/24 at 8:33 am, PC stated she reported the alleged sex abuse incident between LVN 2 and Resident 1 on 11/28/2024 at 11:30 am. Stated Resident 1 met her by the time clock and asked to talk to her. Stated Resident 1 wanted to talk to her in private in the chart room with the door closed. PC stated resident 1 asked her if she knew LVN 2. PC stated that Resident 1 stated that LVN 2 came into her room he touched her vagina and kissed her and told her to meet him in the chart room at 2:00 am that he had something for her. PC asked Resident 1 when did the alleged abuse happen. PC stated that Resident 1 stated the alleged abuse happened around Halloween time in October. PC stated Resident 1 did not want to report him because she was in fear of the nurse getting fired and her being transferred to another facility. PC stated Resident 1 stated LVN 1 pulled her close to him rubbed on her vagina and kissed her in the mouth. PC stated Resident 1 reported to her because she feared no one else would believe her. PC stated after Resident 1 told her about the alleged abuse she to report the alleged abuse to the Program Manager, DON, and the Administrator on 11-28-2024 by telephone. PC stated she told Resident 1 that she did not do anything wrong. PC stated she told Resident 1 LVN 2 touches or kiss her again to report it right away to the staff. PC stated Resident 1 then stated she wanted to call and tell her mom and tell her what happened. PC stated Resident 1 reported to the Program Manager because she was still feeling uncomfortable about the alleged abuse from LVN 2. PC stated this was her first time dealing with this type of incident. PC stated LVN 2 is known for buying clothes and shoes for the female residents. PC stated LVN 2 purchased new clothing for Residents 6, 7, 8, 9, and 10 and takes them in the chart room.</p> <p>During an interview on 12/4/2024 at 9:26 am, LVN 2 stated he has been employed with the facility for 1 year and that he was the only LVN working 11/28/2024 night shift. LVN 2 stated he did have any encounter with Resident 1 on 11/28/2024 at approximately 10 pm. LVN 2 stated he gave Resident 1 some noodles because she is always hungry. LVN 2 stated he purchased clothes shoes, sweat jackets for some of the residents because he feels sorry for them because the residents do not have descent clothes and shoes. LVN 2 stated he is not supposed to be purchasing clothes and shoes for the residents and has never asked if he could give the residents food or clothing from the outside for the residents. LVN 2 stated he is not supposed to bring in outside food or clothing for the residents unless he clears it with the administrator. LVN 2 stated he has never touched or kissed Resident 1. LVN 2 stated he was in the chart room with Resident 1 alone but did not remember the exact date. LVN 2 stated it was approximately one or two months ago (10/2024/11/2024). LVN 2 stated the Staff Developer told him not to come to work during the investigation of alleged sex abuse on Resident 1. LVN 2 stated he has been in the chart room with other residents who were asking him for food. LVN 2 stated he is not supposed to be in the chart room alone with residents.</p> <p>During an interview on 12/4/24 at 11:00 am, the Administrator stated the nurses examined Resident 1 but did not take Resident 1 to the hospital for an further examination. Administrator stated the chart room a non-resident area and staff are not supposed to be in the chart room alone with the residents. Administrator stated staff are not supposed to purchase new clothes and shoes and are not supposed bring in outside food for the residents unless it is okayed by the dietician. Administrator stated LVN 2 said he resigning from the facility.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/4/24 at 11:53 am, Family Member (FM) 1 stated Resident 1 has been in the facility for two months. FM 1 stated Resident 1 first notified her about the sexual abuse but could remember the date. FM 1 stated Resident 1 loves to eat, is always happy and never depressed. FM 1 stated she called Resident 1 three days later (unable to recall the date) when Resident 1 and told her that a male nurse touched the resident's vagina and kissed the resident in a room. FM 1 stated she did not have a reason to doubt Resident 1. FM 1 stated Resident 1 told FM 1 that the resident did not want to stay in the facility.</p> <p>During an interview on 12/4/24 at 1:04 pm, th DON stated LVN 2 stated he was resigning. DON stated staff are not allowed to be in the chart room alone with residents, are not allowed to purchase clothes and shoes for the residents, and not allowed to bring in food from the outside for the residents unless they are cleared by the dietician. DON stated if a resident report to staff a sexual encounter it is reportable to the Department of Public Health as soon as possible. DON stated Resident 1 was not taken to the hospital because the doctor did not order to transfer Resident 1 to a hospital for further examination.</p> <p>During an interview on 12/4/24 at 1:38 pm, Resident 6 confirmed and stated that LVN 2 bought her clothes on two separate occasions about two months ago. Resident 6 stated LVN 2 had her come to the chart room to receive her clothing items. Resident 6 stated he was flirting with her but he never inappropriately touched her. Resident 6 stated LVN 2 made her feel very uncomfortable by the way he kept looking and smiling at her. Resident 6 stated she will never go back in the chart room with LVN 2 again.</p> <p>During an interview on 12/4/24 at 2:36 pm, Resident 1 stated that on 11/28/2024 at approximately 10 pm, LVN 2 came into her (Resident 1) room and touched her vagina (private part between her legs), kissed her in the mouth and told her to meet him (LVN 2) in the chart room at 2 am because he had something to give her (Resident 1). Resident 1 stated she met LVN 2 in the chart room at 2 am and while in the chart room LVN 2 touched her vagina and pulled her close to him and kissed Resident 1's mouth. Resident 1 stated LVN 2 is always in the chart room with different female residents every night he is on duty. Resident 2 stated when she was in the chart room with LVN 2 the door was partially closed. Resident 1 stated LVN 2 gave her noodles and then she went back to her room. Resident 1 stated she will be afraid if LVN 2 comes back to the facility because she feels LVN 2 would touch and kiss her again. Resident 1 stated she did not like and did not consent to LVN 2 touching and kissing her. Resident 1 stated she do not want to remain in the facility.</p> <p>A review of the facility's policy and procedures titled New Gen Healthcare Behavioral Health Region Supervision Level Protocol and Guidelines , undated, indicated residents on general supervision can move around the facility at will, except in areas that are designated as nonresident areas for safety reasons. Guidelines: 1. The assigned staff is responsible to observe the resident at designated intervals, document the observation in the resident's electronic medical record, and ensure that the resident is safe and stays in designated areas.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45037</p> <p>Based on interview and record review, the facility failed to ensure that the nursing staff met the skills and staff competency evaluation requirements and place them in the employee files for for out of four staff.</p> <p>This deficient practice had the potential for a knowledge, training, and certification deficit among the nursing staff, leading to inadequate or delay resident care.</p> <p>Findings:</p> <p>During a concurrent interview and record review on [DATE] at 1:33 pm, Director of Nursing (DON) of employee files for Licensed Vocational Nurses (LVN) 3 and LVN 2, and Certified Nursing Assistants (CNA) 1 and 2 were reviewed. There was no current LVN license, updated CPR card, annual competencies, or updated background check, and CNA license, cardiopulmonary resuscitation (CPR) care, annual competencies, and no abuse training found. The DON stated employee files should have update/current nursing license, CPR cards, abuse training records. DON stated the facility complete competencies annually includig abuse training. DON stated if annual competencies are not updated the nurses could forget their skills and knowledge in which could delay service to the residents. The DON stated skill and abuse training is mandatory at the facility.</p> <p>During an interview on [DATE] at 2:30 pm, LVN 1 stated he has not completed abuse training since he was hired. LVN 1stated he do not remember his last annual competency training and that it is important to complete annual competencies so that you don ' t forget how to care for the residents properly or forget how to complete certain task.</p> <p>During an interview on [DATE] at 9:26 am, LVN 2 stated he could not remember his last training for abuse, annual competencies, sexual harassment, and background check was when he was hired. LVN 2 stated it is very important to complete annual competencies so that the staff do not forget how to complete important task for the residents.</p> <p>A review of the Facility's policy and procedures titled Competency of Nursing Staff revised on ,d+[DATE], indicated, facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment.</p>		