STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A269	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Behavioral Health Center	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)
F 0600 Level of Harm - Actual harm Residents Affected - Some	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** 44253 Based on interview and record review, the facility failed to protect two of six sampled residents'(Resident 1 and Resident 4) right to be free from physical abuse when: - On 3/21/2025, Primary Counselor (PC) 1 physically fought Resident 1 inside Resident 1's assigned room and - On 4/2/2025 Resident 5 hit Resident 4 in the nose These deficient practices resulted in Resident 1 and Resident 4 being subjected to abuse and requiring x-rays after the assault and had the potential for all residents (77) to feel powerless and unprotected in the facility. Findings: A. A review of Resident 1's Admission Record indicated the facility admitted the resident on 8/28/2024, with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). A review of Resident 1's History and Physical (H&P), dated 10/30/2024, indicated the resident could not make medical decisions but could make needs known. The H&P further indicated the resident's psychological insight/judgement was appropriate. A review of Resident 1's Care Plan for the Potential/Risk to exhibit Psycho-Social Distress, revised on 3/24/2025, indicated Resident 1 had the potential to have psycho-social distress related to an abuse allegation on 3/24/2025. The care plan goal was for Resident 1 to experience no psycho-social distress and for staff to observe no psycho-social distress in the resident. The care plan interventions indicated to allow the resident to verbalize feelings, for staff to provide education regarding the importance of utilizing coping skills and psychology/behavioral health consult as indicated. (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 0600 Level of Harm - Actual harm Residents Affected - Some	A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/13/2025 indicated the resident's cognitive skills (ability to think, remember and make decisions) for daily decision making was intact. The MDS also indicated Resident 1 was independent with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) but had trouble concentrating on things such as reading the newspaper. A review of Resident 1's Change in Condition (COC - a deviation from a patient's baseline state of health, often involving a sudden or clinically significant worsening) Evaluation, dated 3/22/2025 at 1:33 PM, indicated Resident 1 presented a swollen right palm to the charge nurse and reported falling in the bathroom around 9 PM the night before (on 3/21/2025). The COC also indicated the physician ordered an x-ray of the resident's hand. A review of Resident 1's COC, dated 3/24/2025, indicated Resident 1 reporting having a physical altercation with a staff member on 3/21/2025 at 9:30 PM. The COC further indicated the resident reported that resident's previous statement of falling in the bathroom was not true. The COC indicated the resident further stated he had an abrasion to the right abdominal area due to a scratch when the resident fell to the floor during the altercation. The COC indicated the resident further stated he used his right hand to prevent a fall, but the resident's stomach hit the edge of the roommate's bedside table. A review of Resident 1's Interdisciplinary Care Conference note, dated 3/25/2025, indicated the meeting was conducted on 3/25/2025. A review of the facility's written Follow-Up Investigation Report letter, dated 3/27/2025, indicated Resident 1 reported to the Director of Nursing (DON) the allegation of physical abuse towards Resident 1 by PC 1 on 3/24/2025. Resident 1 reported that he didn't fall but allegedly got into a physical altercation with PC 1. Resident 1 further reported PC 2 watched the altercation by PC 1 which occurred in the resident's room. The Follow-Up Investigation Report letter also indicated PC 2 reported witnessing a fight between Resident 1 and PC 1 after PC 1 and PC 2 approached Resident 1. The Follow-Up Investigation Report also indicated Resident 6 (Resident 1's roommate) witnessed the fight between Resident 1 and PC 1. The Follow-Up Investigation Report also indicated that on 3/28/2025, PC 1 and PC 2 were terminated. During an interview on 4/4/2025 at 10:44 AM, Resident 1 stated there was a physical fight between Resident 1 and PC 1 about two Fridays ago in March 2025. Resident 1 stated PC 1 and Resident 1 previously had physical and verbal altercations in the past. Resident 1 stated developed a bruise on his right abdomen from the fight with PC 1. During an interview on 4/4/2025 at 11:29 AM, Resident 6 stated that Resident 6 and Resident 1 shared a room. Resident 6 stated about a week ago at around 8 PM, Resident 1 and PC 1 fought inside Resident 6's room while PC 2 watched. Resident 6 stated watching the staff fight a resident made them feel unsafe and Resident 6 would like to move to a different facility. During a telephone interview with PC 1 on 4/4/2025 at 1:32 PM, PC 1 started to relay what happened and then the phone disconnected. On 4/4/2025 PC 1 was contacted via telephone, but the phone call went straight to automated voicemail (VM) which indicated that a VM could not be left because a VM was not set up. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 4/4/2025 at 1:57 PM, the Administrator (ADM) stated they investigated Resident 1's abuse allegation. ADM stated Resident 1's roommate saw the altercation between Resident 1 and PC 1. The ADM further stated based on the facility's investigation and witness statement, a physical altercation did take place between Resident 1 and PC 1 and PC 1 and PC 2 were fired. B. A review of Resident 4's Admission Record indicated the facility admitted the resident on 10/8/2024 with diagnoses that included schizoaffective disorder and high blood pressure. A review of Resident 4's MDS, dated [DATE], indicated the resident could be understood and could understand others. The MDS also indicated the resident's cognition was intact and the resident was independent with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). A review of Resident 4's potential/risk to exhibit psycho-social distress care plan, initiated 11/28/2024, indicated the resident was at risk for negative psychological impact after reporting an abuse allegation in November 2024. The care plan indicated the resident was at risk for negative psychological impact due to an episode on 4/2/2025 when the resident struck a female peer back. The care plan interventions included to assist the resident in identifying coping skills other than hitting back and to provide the resident one on one with resident to explore feelings and thoughts as needed. A review of Resident 4's nose pain care plan, initiated 4/2/2025, indicated the resident exhibited nasal (of the nose) pain related to a physical altercation that day [4/2/2025] with a female peer. The care plan interventions included for staff to monitor for non-verbal signs or symptoms of pain such as increase in agitation, grimace, resistance to care and to medicate for pain as ordered. The interventions also included an x-ray of the Resident 4's facial bones to rule out injury related to a resident-to-resident physical altercation and to report to the physician any significant changes in the resident's condition or significant/abnormal x-ray result. A review of Resident 4's Radiology Results Report, dated 4/2/2025, indicated the resident had an x-ray of the facial bones due to physical trauma to the nose. The Radiology Results Report further indicated there was no significant soft tissue swelling and there was no evident of fracture. c. A review of Resident 5's admission record indicated the facility admitted the resident on 9/5/2024 with diagnoses of schizoaffective disorder, right eye blindness and insomnia (trouble falling asleep or staying asleep). A review of Resident 5's MDS, dated [DATE], indicated the resident's skills (mental action or process of acquiring knowledge and understanding) for daily decision-making were intact. The MDS also indicated the resident's cognition was intact and the resident was independent with all ADLs. A review of Resident 5's COC, dated 4/2/2025, indicated Resident 5 had a physical altercation with a female peer. The COC also indicated the resident began yelling and cursing at the female peer while waiting in the medication line. The COC further indicated Resident 5 walked over to female peer's room and started swinging. Resident 5 was hit on both arms and chest with closed fist. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	A review of Resident 5's Individual Psychotherapy Progress Note, dated 4/2/2025, indicated the practitioner met with the resident after the resident's altercation with another resident. The Individual Psychotherapy Progress Note also indicated the resident was observed by staff instigating the altercation. The Individual Psychotherapy Progress Note further indicated the practitioner met with the nursing supervisor and advised a safety plan should include monitoring the resident every 15 minutes and staff supervision to avoid further contact with the other resident [Resident 4]. A review of Resident 5's Verbal and Physical Behavior care plan initiated 4/2/2025, the day of the alleged abuse, indicated Resident 5 exhibited verbally aggressive behavior with profanity and physically hit a female peer. The interventions included to assist the resident in identifying coping skills related to anger/agitation towards others, encourage the resident to participate in anger management to assist in management of verbal and physical aggressive behaviors. During an interview on 4/4/2025 at 9:13 AM, Resident 5 stated while walking in the facility hallway, Resident 4 was standing inside the resident's doorway that opened onto the hallway. Resident 5 approached Resident 4 and the two were yelling at each other. Resident 5 stated Resident 5 then hit Resident 4 first and then Resident 4 struck Resident 5 repeatedly and then PC 1 came over and separated Resident 4 and Resident 5. Resident 5 stated previously there was tension between Resident 5 and Resident 4. Resident 5 stated that Resident 4 and Resident 5 had been in verbal altercations previously, but it had never turned physical before. During an interview on 4/4/2025 at 9:30 AM, Resident 4 stated Resident 5 came up to my door and said why you are always staring at me. I said I wasn't staring at you and then (Resident 5) hit me and then I hit (Resident 5) back to protect myself. Resident 4 stated the fight lasted about for a minute before staff arrived to break it up. Resident 4 stated Resident 4 and Resident 5 had gotten into verbal fights in the past and this was the first time the interaction turned physical. Resident 4 stated both Residents 4 and 5 received an x-rays of their faces after the altercation. During an interview on 4/4/2025 at 12:24 PM, PC 3 stated Resident 4 and Resident 5 were yelling at each other. PC 3 stated then Resident 4 and Resident 5 started hitting each other. PC 3 stated although there were staff members closer to the fighting residents, PC 3 had to run over to Residents 4 and 5 because other staff members were not intervening. PC 3 stated the staff should have intervened when Resident 4 and Resident 5 first started yelling at each other. PC 3 stated the fight between Resident 4 and Resident 5 was inevitable because staff did not approach when Resident 4 and Resident 5 first started yelling. During an interview on 4/4/2025 at 2:04 PM, the Administrator (ADM) stated the facility's investigation between Resident 4 and Resident 5 was ongoing, however, it appeared that the investigation will be substantiated as staff witnessed the altercation. During a phone interview on 4/4/2025 at 2:31 PM Licensed Vocational Nurse (LVN) 1 stated LVN 1 and other staff heard Resident 4 and Resident 5 yelling back and forth at each other. LVN 1 stated Resident 5 then crossed to Resident 4's room and started punching Resident 4. LVN 1 further stated Resident 4 was to get a facial x-ray due to the resident stating they were hit in the nose. A review of the facility policy and procedures titled, Abuse Prohibition, revised 10/25/2024, indicated physical abuse includes hitting, slapping, pinching, kicking, etc.com, as well as controlling behavior through corporal punishment . The facility will protect patients from further harm .