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	07/22/2025

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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included essential (primary) hypertension (when a person has abnormally high blood pressure that's not the result of a medical condition), paranoid schizophrenia (Persistent, false beliefs, often centered around persecution, where the individual believes they are being harmed or negatively affected by others). During a review of Resident 1's History and Physical (H&P) dated 10/30/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions, however, he can make needs known. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 6/4/2025, the resident's cognition (a person's mental ability to think, learn, remember, use judgement, and make decisions) was intact. The MDS indicated Resident 1 could communicate needs and wants; however, Resident 1 could not make medical decisions concerning care. During a review of Resident 1's Situation Background Assessment Recommendation (SBAR- is a structured communication framework that can help teams share information about the condition of a patient or team member or about another issue your team needs to address) Summary for providers dated 7/8/2025 at 10:44pm, the SBAR indicated that on 7/7/2025 at approximately 7:50pm, male peer (Resident 2) walked in the television (TV) room and hit resident (Resident 1) with close fist in the face area times three without provocation. The SBAR indicated a medical doctor (MD) and conservator (is a person appointed by a court to manage the financial affairs and/or healthcare decisions of an adult who is deemed unable to do so themselves due to a mental or physical disability) were notified, and the MD ordered X-ray to rule out (R/O) fracture (break in a bone). During a review of Resident 1's Care Plan (CP) titled Resident with Potential/risk to exhibit Psycho-Social (refers to anything that negatively impacts a person's mental well-being, like their thoughts, feelings, and emotions) distress related to abuse allegation, and initiated on 7/7/2025, indicated to monitor Resident 1 for potential for psychosocial harm, due to physical assault on two occasions, the first on 7/7/2025 and the second on 7/8/2025. During a review of Resident 1's Room Transfer/New Roommate Change Form., dated 7/7/2025 at 9 pm indicated Resident 1 (Resident 2's roommate) was moved to another room after an incident with roommate (Resident 2) on 7/7/2025. During a review of Resident 1's Progress Note dated 7/7/2025, the progress note indicated Resident 1 was placed on Q (every) 15 minutes monitoring (every 15 minutes report on the whereabouts and activity of the resident) checks for 72 hours per Medical Doctor (MD) 1 orders after witnessed incident of resident to resident (one resident abusing another resident withing the facility) abuse. During a review of Resident 1's Body Check Assessment Form dated 7/8/2025 indicated Skin coloration under right eye 1.5 cm X 3 cm, applied ice compress (cold therapy- is the application of cold to a body part to reduce pain, swelling, and inflammation [the body's response to injury or infection]) on affected area, and MD 1 notified. During a review of Resident 1's physician telephone order dated 7/8/2025 at 1:04pm, the physician telephone order indicated to perform stat (now) x-ray of the face to rule out fracture. During a review of Resident 1's Follow-up Documentation dated 7/10/2025 at 2:17pm, the follow up documentation indicated . Resident 1 has a purplish discoloration under right eye, swelling noted, and no visual disturbances noted. During a review of Resident 2's admission Record, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included essential hypertension paranoid schizophrenia During a review of Resident 2's H&P dated 10/30/2024, the H&P indicated Resident 2 did not have the capacity to understand and make decisions, however, the resident could make needs known. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident's cognition was intact. The MDS indicated Resident 2 could communicate needs and wants but did not have the capacity to make decisions concerning care. During a review of Resident 2's CP titled physical altercation related to poor impulse control and resolving interpersonal conflicts initiated on 4/17/2025 and revised on 7/8/2025, the CP indicated to monitor Resident 2 to help prevent potential future physical altercations, related to Resident 2 hit male peer (Resident 1) three times in the head on 7/7/2025. The CP also indicated that on 7/8/2025, Resident 2 hit male peer (Resident 1) in the face with his hands. The CP interventions indicated that Resident 2 was on (Q) (every) 15 minutes (every 15 minutes report on the whereabouts and activity of the resident) checks monitoring. During a review of Resident 2's Nursing Note dated 7/7/2025 at 9:23 pm, the nursing note indicated a change of condition (COC- acute change of condition (ACOC), or significant change of condition) that Resident 2 hit another resident (Resident 1) in the face three times without provocation