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| 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 12/10/2025 |
| 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.

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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 - Minimal harm or potential for 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. (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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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Cross Reference F742 Based on interview and record review, the facility failed to protect one of four residents (Resident 3) from inappropriate touching by Resident 4 according to facility policy and procedures (P&P - policy explains the rules and presents them in a logical framework while procedures outline the step-by-step implementation of various tasks) titled Abuse Prohibition, with a review date of 2/23/2021. The facility was aware that Resident 3 was unable to defend himself from Resident 4 and that Resident 4 had a behavior of poor personal boundaries and inappropriate physical contact with residents and staff. This deficient practice caused Resident 3 to experience psychological stress and emotional distress by stating that Resident 4 should not be touching him (Resident 3). This deficient practice increased the risk for peer conflict and safety concerns and posed a significant risk to the safety and well-being of other residents in the facility. Findings: During a review of Resident 4's admission record (face sheet - a document containing demographic and diagnostic information) indicated Resident 4 was admitted to the facility on [DATE] with the following diagnoses: paranoid schizophrenia (a serious mental disorder characterized by prominent symptoms like intense paranoia, delusions [fixed, false beliefs not based in reality], and hallucinations [seeing, hearing, feeling things that are not there]). During a review of Resident 4's Care Plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) initiated on 7/13/2017 with revision dates of 4/30/2021, 2/07/2025, and 7/31/2025, indicated, Resident 4 had demonstrated repeated bizarre or inappropriate social behaviors related to poor boundaries as evidenced by incidents of standing too close, hovering, or touching others. The CP interventions included to encourage psych/behavioral health consultation, participate in Special Treatment Program for management of physical behaviors, engage in 1:1 (one to one - a staff provides dedicated, focused attention and assistance to a single individual, ensuring their needs and well-being are met with personalized support) counseling focused on social skills to encourage appropriate social interactions with peers/staff. During a review of Resident 4's Behavior Monthly Summary for 2024 for behavior manifestation of intense staring, standing too close, intrusiveness as evidenced by poor boundaries indicated, Resident 4 had the following number of episodes during the day shift (7 AM to 3 PM) from 1/2024 through 12/2024: January=61 February=50 March=58 April=58 May=61 June=63 July=63 August=56 September=63 October=62 November=62 December=28 The Behavior Monthly Summary for 2024 indicated a total 684 episodes for behavior manifestation of intense staring, standing too close, intrusiveness as evidenced by poor boundaries. During a review of Resident 4's Behavior Monthly Summary for 2024 for behavior manifestation of masturbating in public and inappropriate touching indicated, Resident 4 had the following number of episodes during the day shift (7 AM to 3 PM) from 1/2024 through 12/2024: January=23 February=23 March=29 April=30 May=38 June=39 July=36 August=41 September=36 October=46 November=48 December=6 The Behavior Monthly Summary for 2024 indicated a total 395 episodes for behavior manifestation of intense staring, standing too close, intrusiveness as evidenced by poor boundaries. During a review of Resident 4's history and physical (H&P - a physician's complete patient examination) dated 7/24/2025 indicated, Resident 4 had the diagnosis of paranoid schizophrenia and is under a conservatorship (a legal process for adults with severe mental illness who are gravely disabled; they cannot provide for their basic needs and manage their medical treatment, and placement to facilities due to their illness). During a review of Resident 4's Physician Progress Notes (a doctor's written record that documents a patient's health status, treatment, and care plan) dated 9/25/2025 indicated, Resident 4 had a routine medical follow-up but the physician did not receive any new, specific complaints. During a review of Resident 4's Psychotherapy Progress Notes (a standardized tool used by psychologists to record resident's mental and emotional state, behavior and any changes in their condition, to inform care planning and treatment) dated 10/06/2025, indicated, at the time of consultation, Resident 4 was experiencing paranoia, anxious, intrusive, impulsive, had delusional thinking, auditory hallucination, and was disoriented. During a review of Resident 4's Psychotherapy Progress Notes dated 10/24/2025 indicated, Resident 4 reported remembering previous discussion about the importance of maintaining physical boundaries with the other residents. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 10/31/2025, indicated, Resident 4 has an intact cognition (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired). During a review of Resident 4's Nursing Progress Notes dated 11/25/2025 at 12:09 PM Resident 4 was grabbing others but redirected to walk. During a review of Resident 4's Nursing</p> | | |

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| <p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>(continued on next page)</p> |

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| <p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Cross Reference F600 Based on interview and record review, the facility failed to notify the psychologist (PSY - a mental health professional with advanced education [usually a doctorate] who studies the mind, emotions, and behavior, using talk therapy, assessment, and interventions to help individuals cope with life issues, mental disorders, or improve overall wellness, focusing on psychological strategies rather than medication) for one of four residents (Resident 4) who had several documented incidents of repeated inappropriate behaviors of touching Resident 3, other residents, and staff. This deficient practice caused Resident 3 to experience psychological stress and emotional distress by stating that Resident 4 should not be touching him (Resident 3). This deficient practice increased the risk for peer conflict and safety concerns and posed a significant risk to the safety and well-being of other residents in the facility. Findings: During a review of Resident 4's admission record (face sheet - a document containing demographic and diagnostic information) indicated Resident 4 was admitted to the facility on [DATE] with the following diagnoses: paranoid schizophrenia (a serious mental disorder characterized by prominent symptoms like intense paranoia, delusions [fixed, false beliefs not based in reality], and hallucinations [seeing, hearing, feeling things that are not there]). 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