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	06/25/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to have a system in place and develop a policy on how to supervise and monitor one of one resident (Resident 1) who was transported by court personnel to attend in person court proceedings on 6/22/2026. The facility was aware Resident 1 was a high risk for elopement and had repeated verbalized wanting to leave/elope (is when a patient leaves a healthcare facility against medical advice, when doing so poses an imminent threat to the patient's health or safety) the facility. As a result, on 6/22/2026 at approximately 3 P.M., Resident 1 eloped from the court during the resident's court proceedings and has not been located. Findings: During a review of Resident 1's admission record, datedˆ1/2/2026,ˆindicated Resident 1 was admitted ˆto the facility on 1/2/2026 with a diagnosis of paranoid schizophrenia (a severe brain disorder when a person loses touch with reality causing intense fears that others will harm them). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 4/15/2026,ˆindicatedˆResident 1 was cognitively intact (mental ability to make decisions) and was able to ambulate (to walk) without assistive devices. During a review of an e-mail (electronic mail) from Resident 1's Psychiatrist (PSY) to the Administrator (Admin), dated 6/24/2026, indicated, On Monday, 6/22/2026 at approximately 3 P.M, while I was in the process of completing testimony for (Resident 1) in her conservatorship trial and the court was rendering their opinion that the client remained gravely disabled, (Resident 1) became upset with the ruling and stated she did not want to return to the (Facility). Despite the court's admonishment to remain seated and complete her program at the (Facility), (Resident 1) then bolted from the courtroom. The Judge stated, ?(Resident 1) has exited the courtroom.' During a review of Resident 1's Interdisciplinary (IDT - is a coordinated group of medical and support professionals who collaborate to plan, deliver, and evaluate unified patient care) Care Conference notes, dated 3/8/2026, indicated, Resident verbalized wanting to leave the facility. Staff will continue to provide support, encouragement, and monitoring to assist the resident in progressing toward treatment goals. During a review of Resident 1's Social Services Progress Notes, dated 4/7/2026, indicated, Resident verbalized a desire to leave the facility and how, and Resident 1 was placed on 1:1 monitoring (when one staff member constantly watches one person) for 72 hours. The progress notes also indicated, (Resident 1) kept saying that we will miss her tomorrow and said she would break a window to leave. During a review of Resident 1's Elopement Evaluation Note, dated 4/7/2026, indicated: Does the resident have a history of elopement or an attempted elopement while at home: Yes. Does the resident have a history of attempting to leave the facility without informing staff: Yes. During a review of Resident 1's progress notes, dated 6/20/2026, indicated, She (Resident 1) shared that she contacted her conservator and expressed a desire to leave the facility and stated that she does not feel she can continue participating in the program. During an interview on 6/24/2026 at 2:16 P.M. with Certified Nursing Assistant (CNA) 1, CNA 1 stated, She (Resident 1) was excited to go to the court hearing on 6/22/2026 and also said that she wanted to leave the facility. CNA 1 stated she could not remember if she notified her supervisor of Resident 1's desire to leave the facility. During an interview on 6/25/2026 at 9:47 A.M. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated once a resident is transferred outside of the facility for their court proceeding, staff is not (continued on next page)

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aware of when they will return. LVN 1 stated he was on duty on 6/22/26 when Resident 1 was picked up and transported for court proceeding outside the facility. LVN 1 stated, The LVN/Charge nurse will perform a behavioral and elopement risk assessment prior to the resident transferring out of the facility for court proceedings. LVN 1 stated a resident requires a physician order to attend court proceedings outside the facility by a psychiatrist (a medical doctor who treats mental illness). LVN 1 stated that if a resident does not return from the court proceedings/hearing, the facility will call the court transport driver to receive an update on the resident. LVN 1 stated the facility staff do not know exactly when the resident will return. LVN 1 stated that residents usually just return by the end of the day. LVN 1 stated he did not talk to court staff who transferred (Resident 1) to court on 6/22/2026 did not know which facility staff handed over the resident to the court staff. During an interview on 6/25/2026 at 11:30 A.M. with the Social Services Director (SSD), the SSD stated he did not know if a physician's order was needed for a resident to transfer outside of the facility to attend in-person court proceedings. The SSD stated he did not know if the facility had a policy for resident transfer outside of facility for in-person court proceedings. During an interview on 6/25/2026 at 12:25 P.M. with the Director of Nursing (DON), the DON stated he did not know: The reason residents are not escorted by facility staff when transferred outside of the facility to attend in-person court proceedings. If court staff who transferred Resident 1 to the court proceeding on 6/22/2026 were aware Resident 1 was high risk for elopement. If the facility had a policy and procedures for when a resident is transferred/transported outside the facility to attend an in-person court proceeding. During an interview on 6/25/2026 at 12:35 P.M. with the Administrator (Admin), the Admin stated that Resident 1 was at risk for elopement and had verbalized to facility staff she wanted to leave the facility. The Admin stated that the court staff who transferred Resident 1 to attend court proceedings on 6/22/2026 were not licensed nurses. The Admin stated, She (Resident 1) has a right to leave. During an interview on 6/25/2026 at 1:49 P.M. with the PSY, the PSY stated: Resident 1 was found gravely disabled by the court, so she cannot provide food, shelter, clothing, and so is mandated to be in a locked facility. On 6/22/2026, Resident 1's conservator was present at Resident 1's court proceeding. I am not aware if the conservator is a licensed practitioner. During a concurrent interview and record review on 6/25/2026 at 3:08 P.M. with the Admin and DON, the Admin and DON stated a facility policy is a guideline that staff need to follow and and accessible to all staff in order to properly care for the residents. The Admin and DON stated that if a resident on 1:1 monitoring (a dedicated staff member is assigned to stay in the room and directly supervise a single high-risk patient and for patient safety) is left unsupervised could potentially cause harm to the resident or even result in death. The Admin and DON confirmed and stated that the facility does not have policy for when a resident attends court proceedings outside of the facility. During a review of the facility's policy and procedures (P&P) titled, Out on Pass, with a review date of 1/21/2026, indicated, The Facility will make reasonable efforts to ensure the resident safety and uphold resident rights. During a review of the facility's P&P titled, Wandering and Elopements, with a review date of 1/21/2026, indicated, The Facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.