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	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Behavioral Health Center	3951 East Blvd. Los Angeles, CA 90066

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 28) participated in care plan meetings to discuss his psychotropic (A drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medications according to the facility's policy and procedures (P&P), Care Planning - Interdisciplinary Team, reviewed 1/21/2026. This deficient practice had the potential to violate Resident 28's right to be an active participant in his own care. Findings: A review of Resident 28's admission Record indicated the facility admitted the resident on 10/14/2024 with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought) and general anxiety disorder (a mental health condition with feeling of worry, anxiety, or fear interfering with one`s daily activities). A review of the Minimum Data Set (MDS - a resident assessment tool), dated 1/24/2026, indicated Resident 28's cognition (ability to think, read, learn, remember, reason, express thoughts and make decisions) was intact. The MDS also indicated the resident had hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality). A review of Resident 28's risk for complications care plan, initiated 10/14/2024, indicated the resident was at risk for complications related to the use of psychotropic medications including Seroquel, Zyprexa and Trazodone. The care plan goal was for the resident medication to be effective without side effects. The care plan interventions included for staff to monitor for changes in mental status and functional level and report to physician, monitor for continued need of medication as related to behavior and mood and to provide informed consent to resident or healthcare decision maker. A review of Resident 28's Physician Orders indicate the physician ordered the resident to receive the following:On 1/26/2026, Trazodone 100 milligrams (mg) by mouth at bedtime for problematic sleep related to schizophrenia and generalized anxiety disorderOn 2/9/2026, Seroquel (antipsychotic medication) XR 300 milligrams (mg) by mouth at bedtime for delusions related to schizophrenia and generalized anxiety disorderOn 3/10/2026, Zyprexa (an antipsychotic medication) 20 mg by mouth at bedtime for schizophrenia manifested by delusions A review of Resident 28's interdisciplinary team (IDT - a group of healthcare professionals from different disciplines [nurses, social worker, therapist, physician, etc.] Care Conference (CC) forms indicated the following:On 2/18/2026 an IDT CC was held to discuss Resident 28's psychotropic medication management. The IDT CC indicated the Program Director (PD) and Registered Nurse Supervisor (RNS) 1 attended the meeting. The form did not list Resident 28 as an attendee.On 3/6/2026 an IDT CC was held to discuss Resident 28's weight. The attendees listed included PD, DSD, the Registered Dietician (RD), Resident 28 and Resident 28's conservator (CONSV).On 3/11/2026 an IDT CC was held to discuss Resident 28's psychotropic medication management. The IDT CC indicated the PD, RNS 1, the Director of Staff Development (DSD) and Assistant Program Director (APD) attended the meeting. The form did not list Resident 28 as an attendee. During an interview on 3/31/2026 at 8:25 AM Resident 28 stated he hasn't been able to speak to anyone about his medications. Resident 28 stated he has a diagnosis of schizophrenia and Resident 28 stated his medications are making him more confused and he has started hearing more (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	voices since beginning his current medications. Resident 28 stated he has attended IDT meetings but his medications were not addressed. During a concurrent interview and record review on 4/1/2026 at 11:22 AM, Resident 28's IDT CC forms were reviewed. RNS 1 stated all residents are educated on their medications and any changes to their medications. RNS 1 further stated the resident and the resident's responsible party are part of the IDT Care Conference. RNS 1 also stated Resident 28's last care conference to discuss his medications were held on 3/11/2026 and the resident's increased dosage of Zyprexa was discussed. RNS 1 also stated that there was no indication that Resident 28 attended the conference or was invited. RNS 1 stated the resident should have input and be involved in their own care planning so we know if the medication is working. A review of the facility's policy and procedures (P&P), Care Planning - Interdisciplinary Team, reviewed 1/21/2026, indicated,The care plan is based on the resident's comprehensive assessment and is developed by an Interdisciplinary Team which (Deludes but is not necessarily limited to the following personnel.a. The resident's Attending Physician.b. A registered nurse with responsibility for the resident.c. The Dietary Manager/Dietitian.d. The Social Services Worker responsible for the resident.e. The Activity Director/Coordinator.f. Specialized Rehabilitative Service Therapists, as applicable.g. To the extent practicable, the participation of the resident and the resident's representative(s).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure licensed nurses notify the physician for orders for blood glucose monitoring twice daily as indicated in the plan of care under the physician's progress notes for one of the three residents (Resident 1). This deficient practice of failing to notify the physician for orders as indicated in the physician's plan of care had the potential to cause adverse effects of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) for Resident 1. Findings: During a review of Resident 1's admission Record (face sheet - a document containing demographic and diagnostic information) indicated Resident 1 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]), Type 1 diabetes mellitus with ketoacidosis without coma (a serious medical emergency where insulin deficiency causes high blood sugar and accumulation of acid often leading to symptoms like nausea, abdominal pain, and extreme thirst without causing loss of consciousness; it requires immediate hospitalization for intravenous insulin and fluids) and long term use of insulin (safe and effective for managing diabetes when monitored by a doctor, essential for Type 1). During a review of Resident 1 care plan (CP - a guideline for nurses to help them create and achieve a solid plan of action in the treatment of a patient) with an initiation date of 12/05/2025 and a target date of 4/05/2026, indicated, Resident 1 had a diagnosis of diabetes, dependent on insulin. The CP goal indicated Resident 1 will be free of all signs and symptoms of hypoglycemia (low blood sugar of <60 milligrams per deciliter [mg/dL]=a unit of measurement used to express the concentration blood glucose within a specific volume of blood) and hyperglycemia (high blood sugar > 400 mg/dL). The CP interventions included access and record blood glucose levels. During a review of Resident 1 Minimum Data Set (MDS - a resident assessment tool) dated 1/13/2026, indicated, Resident 1's cognition is intact (a person's thinking and reasoning abilities are functioning properly and are not significantly impaired). The MDS also indicated, Resident 1 does not use any mobility devices (helps a person walk or move from place to place when one has a disability or injury) when ambulating (walking). During a review of Resident 1's Progress Notes (captures the details of a patient's health status, treatment progress, and any changes in their condition over time) history and physical (H&P - a physician's complete patient examination) dated 1/05/2026, 1/20/2026, 1/29/2026, 2/06/2026 and 3/03/2026 indicated, Resident 1 had the diagnoses of type 1 diabetes mellitus with ketoacidosis without coma, paranoid schizophrenia and long-term use of insulin. The Progress Notes also indicated to continue blood glucose monitoring twice daily. During a review of Resident 1's blood glucose level monitoring in January 2026, Resident 1's blood glucose levels were checked from 1/01/2026 until 1/06/2026. The blood glucose levels were as follows:1/01/2026 at 9:55 AM = 112 mg/dL1/01/2026 at 8:06 PM = 142 mg/dL1/02/2026 at 9:41 AM = 125 mg/dL1/02/2026 at 8:43 PM = 88 mg/dL1/03/2026 at 8:42 AM = 127 mg/dL1/03/2026 at 8:08 PM = 124 mg/dL1/04/2026 at 8:44 AM = 130 mg/dL1/04/2026 at 8:10 PM = 122 mg/dL1/05/2026 at 8:55 AM = 139 mg/dL1/06/2026 at 8:41 AM = 135 mg/dL During a review of Resident 1's medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for January 2026, indicated, Resident 1's insulin medication glargine (a long-acting insulin that provides a steady, 24-hour blood sugar control) started on 12/18/2025 at 9 PM and was discontinued on 1/06/2026 at 1:52 PM. The order also indicated to hold this insulin when the blood glucose level is less than 100 mg/dL. During a review of Resident 1's MAR for February, March, and April 2026 indicated, Resident 1 had an order for metformin (oral medication used primarily to treat diabetes by lowering blood sugar levels). The MAR for February, March and April 2026 also indicated metformin was started on 12/03/2025 with no end date. During an interview on 4/03/2026 at 1:02 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Nurse Practitioner (NP) 1's plan of care indicated continue blood glucose monitoring twice daily. LVN 1 stated LVN 1 did not know how often nurses checked or read a physician or nurse practitioner's plan of care. LVN 1 stated the physician [or NP] needs to tell the nurse their order. During an interview on 4/03/2026 at 1:47 PM with Registered Nurse Supervisor (RNS) 1, RNS 1 did not provide an answer when asked what was the physician's progress note if it's not read by the nurses. RNS 1 stated a blood glucose monitoring will, tell me whether [Resident 1] is hyperglycemic or hypoglycemic. RNS 1 stated we [nurses] are suppose to read the physician's progress notes but we all don't read the progress notes. During a review of the facility's undated policy and procedure (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 Diabetes - Clinical Protocol revised 3/2025, indicated blood glucose monitoring for the resident on oral mediation(s) who is well controlled to monitor blood glucose levels at least twice weekly (or more frequently.) and for resident receiving oral medication(s) who is poorly controlled, monitor blood glucose levels twice to four times daily as needed. During a review of the facility's P&P titled Physician Orders with a review date of 1/21/2026 indicated, other orders will include a description complete enough to ensure clarity of the physician's plan of care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow the facility's policy and procedure (P&P) titled, Smoking, by not performing quarterly smoking assessments for two of two sampled residents (Resident 35 and Resident 71). This deficient practice placed Resident 35 and Resident 71 at increased risk for injury related to smoking. a. A review of Resident 35's admission record indicated the facility admitted the resident, on 11/18/2025 with diagnoses that included paranoid schizophrenia (type of schizophrenia associated with feelings of being persecuted or plotted against), Syphilis (a common, curable sexually transmitted infection (STI) caused by bacteria (tiny, single-celled living organisms found everywhere in the world). A review of Resident 35's Quarterly Minimum Data Set (MDS- a resident assessment tool), dated 3/3/2026, indicated Resident 35's cognition (mental ability to make decisions of daily living) was intact. A review of Resident 35's Smoking Evaluation, dated 11/20/2025, indicated Resident 35 could safely smoke without the use of a smoking apron. A review of Resident 35's Smoking Evaluation indicated Resident 35's last smoking evaluation was completed on: 03/30/2026 [more than 4 months later]. A review of Resident 35'sMay smoke with supervision care plan, initiated 11/20/2025, the resident's supervisory needs were made based on the smoking assessment. A review of the same care plan indicated the goal was for Resident 35 to smoke safely. The same care plan interventions included to supervise Resident 35 with smoking in accordance with assessed needs, inform and remind patient application of smoking areas and times, and Inform family and significant others that the patient needs supervision while smoking. During a concurrent interview and record review on 4/3/2026 at 12:21 PM, Resident 35's smoking assessments were reviewed with the Registered Supervisor (RNS) 1. RNS 1 stated Resident 35's last smoking assessment was completed on 03/30/2026 and prior to that the smoking assessment was done on 11/20/2025. RNS 1 further stated there should have been a smoking assessments completed by in February 2026. RNS 1 stated the smoking assessment is completed to evaluate if the resident could smoke safely. RNS 1 further stated by not completing a smoking assessment Resident 35 was at risk for smoking injury and it could affect the resident's health. A review of the facility's policy and procedures (P&P) titled, Smoking, reviewed 1/21/2026, indicated, It was the policy of this facility to accommodate residents who desire to smoke by taking reasonable precautions, providing a safe environment for them, and protecting the non-smoking residents. Smoking whether it is traditional tobacco or herbs (does not include marijuana or its derivatives) smoked in cigarettes, pipes, cigars, or electronic cigarettes are governed by this policy. A licensed Nurse will evaluate residents who express a desire to smoke, upon admission, quarterly, annually, significant change of condition identification, As needed, and present it to the Interdisciplinary Team (IDT) for review. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A review of Resident 71's admission record indicated the facility admitted the resident, on 3/1/2021 with diagnoses that included paranoid schizophrenia (type of schizophrenia associated with feelings of being persecuted or plotted against), high cholesterol and high blood pressure. A review of Resident 71's MDS, dated [DATE], indicated Resident 71's cognition (mental ability to make decisions of daily living) was intact. A review of Resident 71's Smoking Evaluation, dated 3/12/2025, indicated the resident could safely smoke without the use of a smoking apron. A review of Resident 71's Smoking Evaluations indicated a Resident 71's last two smoking evaluations were completed on: 9/12/2025 then again on 4/1/2026 [more than 6 months later]. A review of Resident 71'sMay smoke with supervision care plan, initiated 3/1/2021, the resident's supervisory needs was made based on the smoking assessment. A review of the same care plan indicated the goal was for the resident to smoke safely. The same care plan interventions included to supervise Patient (Resident 71) with smoking in accordance with assessed needs, inform and remind patient application of smoking areas and times, and Inform family and significant others that the patient needs supervision while smoking. During an observation on 4/2/2026 at 9:46 AM, Resident 71 was observed entering the smoking patio. Facility staff handed Resident 51 a pack of cigarettes. Resident 71 removed one cigarette from the pack and returned the pack to the staff member. The staff member then lit Resident 71's cigarette and Resident 71 proceeded to smoke on the patio. During a concurrent interview and record review on 4/3/2026 at 12:21 PM, Resident 71's smoking assessments were reviewed with the Registered Supervisor (RNS) 1. RNS 1 stated Resident 71's last smoking assessment was completed on 4/1/2026 and prior to that the smoking assessment was done on 9/12/2025. RNS 1 further stated there should have been smoking assessments completed by in December 2025 and March 2026. RNS 1 stated the smoking assessment is completed to evaluate if the resident could smoke safely. RNS 1 further stated by not completing a smoking assessment Resident 71 was at risk for smoking injury and it could affect the resident's health. A review of the facility's policy and procedures (P&P) titled, Smoking, reviewed 1/21/2026, indicated, It was the policy of this facility to accommodate residents who desire to smoke by taking reasonable precautions, providing a safe environment for them, and protecting the non-smoking residents. Smoking whether it is traditional tobacco or herbs (does not include marijuana or its derivatives) smoked in cigarettes, pipes, cigars, or electronic cigarettes are governed by this policy. A licensed Nurse will evaluate residents who express a desire to smoke, upon admission, quarterly, annually, significant change of condition identification, As needed, and present it to the Interdisciplinary Team (IDT) for review.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide timely nutritional intervention/s to prevent continuous significant weight loss for one of two sampled residents (Resident 51) who had weight loss, by failing to: 1. Initiate a change of condition (COC- refers to a significant alteration in a person's physical, mental, or functional health status compared to their previous baseline, often requiring new interventions) form for an 18 pounds (lbs - unit of measurement) weight loss documented on 3/3/2026.2. Conduct a weight variance Interdisciplinary team (IDT - a group of healthcare professionals from different disciplines [nurses, social worker, therapist, physician, etc.] that provide care for the residents) when Resident 51 experienced weight loss.3. Revise the interventions on Nutritional Risk Weight Loss care plans. This deficient practice placed the resident at risk for continued weight loss. Findings: A review of Resident 51's admission Record indicated the facility admitted the resident on 11/24/2025 with diagnoses including included paranoid schizophrenia (type of schizophrenia associated with feelings of being persecuted or plotted against), high cholesterol and high blood pressure. A review of Resident 51's admission History and Physical, dated 11/24/2025, indicated the resident's current weight was 241 lbs. A review of the Minimum Data Set (MDS - a resident assessment tool), dated 3/3/2026, indicated Resident 51 cognitive (ability to learn, reason, understand, make decisions, and make needs known) skills for daily decision-making was intact. The MDS indicated the resident was could independently perform all activities of daily living (ADLs- activities such as bathing, dressing, eating and toileting a person performs daily) The MDS also indicated the resident weighed 224 lbs had experienced a weight loss of 5% or more in the last month or a loss of 10% in the last 6 months and was not on a physician-prescribed weight loss regimen. A review of Resident 51's weight log indicated Resident 51 weight was as follows:On 11/24/2026 - 241 lbsOn 11/27/2026 - 236 lbsOn 12/3/2026 - 232 lbs (4.5 % weight loss)On 1/1/2026 - 224 lbsOn 2/4/2026 - 224 lbsOn 3/3/2026 - 206 lbs (8.1% weight loss) A review of Resident's 51 SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form, dated 1/5/2026, indicated the resident had an eight pound weight loss and the physician recommended an registered dietitian evaluation. A review of Resident SBAR forms indicated no change of condition was initiated for the 3/32026 18 lb weight loss. A review of Resident 51's weight loss care plan, initiated 1/5/2026, indicated the resident's weight went from 230 lbs to 224 pounds in one month and the resident was at risk for further weight loss due to parodic [sporadic/periodic?] refusal of breakfast. The goal was for the resident to consume 50 percent (%) or more of breakfast daily. The care plan interventions included for the Certified Nursing Assistant (CNA) to inform the charge nurse of breakfast or meal refusal, for the CNA to monitor and document the residents meal intake at lunch and dinner and report poor intake for the charge nurse for follow up and for a registered dietician evaluation for recommendations. A further review of the care plan indicated no new interventions were put in place when the resident continued to lose weight on 3/3/2026. A review of Resident 51's Nutritional Risk Care plan, initiated 1/6/2026, indicated the resident experienced a significant weight loss of 5.1% in one month. The care plan goal was for the resident to avoid a change in weight of greater than or equal to five percent. The care plan interventions included to weigh monthly, offer snacks and honor [NAME] preferences within the meal plan. A further review of the care plan indicated the care plan was not updated or revised after 1/6/2026 and not after the resident's continued weight loss on 3/3/2026. During a concurrent interview and record review on 4/1/2026 at 11:02 AM, Resident 51's electronic health chart was reviewed. The Registered Nurse Supervisor (RNS 1) stated residents are weighed monthly. If a significant change is noted, we do a change in condition right away, we contact the physician and the interdisciplinary team (IDT, - a group of healthcare professionals from different disciplines [nurses, social worker, therapist, physician, etc.] that provide (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care for the residents) meets to determine if the weight loss is favorable or not favorable. RNS 1 further stated Resident 51 was 241 pounds when he was first admitted in November 2025. RNS 1 further stated Resident 51 started losing weight and the weight loss was care planned and the dietician recommended the resident to have a half sandwich as a morning snack to improve caloric intake and to maintain his weight. RNS 1 further stated Resident 51 did cut his hair recently but that could not account for an 18 pound weight loss. RNS 1 stated Resident 51's his nutrition care plans were not updated and IDT was not held since the significant weight loss was discovered on 3/3/26. RNS 1 stated a Weight Variance IDT should have been held. The care plan is for continuity of care and to know the changes that need to be made for the resident's health and to prevent the weight loss from continuing. During an observation on 4/1/2026 at 12:03 PM, Resident 51 ate 100% of lunch. During an interview on 4/3/2026 at 11:59 AM, Resident 51 stated he was happy with is weight loss and he went to his first IDT meeting for his weight loss a couple of days ago. Resident 51 also stated his hair did not account for the 18 lb weight loss. The Registered Dietician for the facility was not available to interview. A review of the facility's policy and procedure (P&P) titled, Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol, reviewed 1/21/2026, indicated, The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time. The P&P also indicated The staff will report to the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake. The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis, and wishes.a. Treatment decisions should consider all pertinent evidence and relevant issues (e.g., food intake, resident/ patient wishes, overall condition and prognosis, etc.), and should not be based solely on lab or diagnostic test results (albumin, cholesterol, swallowing studies, etc.).

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform a physician of an abnormal laboratory (lab) result for one of four sampled residents (Resident 61) according to the facility's policy and procedures (P&P) titled Change in Condition: Notification of reviewed 1/21/2026. This deficient practice placed the resident at risk for not having appropriate treatment for abnormal laboratory results and as a result on 11/13/2025, Resident 61 was transferred to a general acute hospital (GACH) from a doctor's appointment for chronic anemia. Findings: A review of Resident 61's admission record indicated the facility admitted the resident on 4/19/2017 and was re-admitted on [DATE] with diagnoses that included chronic kidney disease stage 4 (sever kidney damage and are not properly filtering waste from the blood), iron deficiency anemia(a condition where the body does not have enough healthy red blood cells) and anemia in chronic kidney disease. A review of Resident 61's care plan on Anemia (low blood count), initiated 7/1/2020, indicated the resident has anemia due to chronic kidney disease. The same care plan also indicated due to the anemia Resident 61 was at risk for low hemoglobin, weakness, shortness of breath and fatigue. The same care plan goal indicated that the resident be observed for signs and symptoms of anemia complications. The care plan interventions included administer medication as ordered, assess for increased fatigue and shortness of breath and lab work as ordered and notify the physician of results per policy. A review of Resident 61's lab result, dated 5/15/2025, indicated the resident's hemoglobin (HGB - the protein contained in red blood cells that is responsible for the delivery of oxygen to the tissues) level was 9.7 grams per deciliter (g/dl - a unit of volume)]. The lab result also indicated this was a low value (L) and the normal reference range was 11 to 18 g/dl. A review of Resident 61's lab result, dated 11/11/2025, indicated the resident's hemoglobin (HGB - the protein contained in red blood cells that is responsible for the delivery of oxygen to the tissues) level was 8.8 grams per deciliter (g/dl - a unit of volume)]. The lab result also indicated this was a low value (L) and the normal reference range was 11 to 18 g/dl. A further review of the lab result indicated this was 0.9 points less than the previous lab result on 5/15/2025. A review of Resident 61's Nurses Progress Note, dated 11/13/2025, indicated the resident went to Nephrology (pertaining to the kidneys) appointment for regular follow-up with escorts. The note also indicated the physician sent the resident to a GACH due to chronic anemia from the appointment. The Progress Note further indicated Resident 61's responsible party was informed. A review of Resident 61's Emergency Department (ED - the department of a hospital that provides immediate treatment for acute [sudden onset] illness and trauma) Progress Note, dated 11/13/2025, indicated Resident 61 was sent to the ED by for the evaluation of chronic anemia and kidney disease by the resident's nephrologist (a medical doctor that specializes in kidney diseases). The Progress Note indicated Resident 61 was experiencing some chest pain. The Progress Note further indicated the resident's anemia was due to a gastrointestinal bleed at this time and the resident was given intravenous (inside a vein) fluids of normal saline (a blood volume substitute mad e of salt and water, a temporary substitute for lost blood). The Progress Note also indicated the plan was to admit the resident for continued care and management which would include close monitoring and treatment of unstable vital signs, cardiorespiratory and neurological status, while maintain tight balance of fluid, respiratory, and cardiac interventions. A review of Resident 61's Nurses Progress Note, dated 11/14/2025, indicated the resident returned from the GACH at 7:45 PM. The Note further indicated Resident 61 had two blue discolored areas on the right upper arm (one 2cm, another one 4cm long in size). During a concurrent interview and record review on 4/3/2026 at 3:19 PM, Resident 61's electronic medical chart was reviewed with RN 1. RN 1 stated Resident 61 went to the ED on 11/13/2025 and returned on 11/14/2025 due to anemia. Upon review of Resident 61's lab results dated 11/11/2025, RN 1 stated Resident 61's hemoglobin was 8.8 [g/dl]. RN 1 stated this was a low (continued on next page)

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	04/03/2026

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.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	number and required the physician to be notified. Upon review of Resident 61's progress notes and change of condition forms, RN 1 stated, there was no evidence the physician was notified of the lab result. RN 1 further stated RN 1 stated nursing staff is to notify the physician of abnormal labs that way the physician could change the residents medications, perform further tests or send the resident to the ED for treatment. A review of the facility's policy and procedures (P&P), titled Change in Condition: Notification of, reviewed 1/21/2026, indicated, The purpose was to ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition. Facility must immediately inform the resident, consult with the Resident's physician and/or Nurse Practitioner, and notify, consistent with his/her authority, Resident Representative where there is: A significant change in the Resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications). A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment).A review of the facility's P&P, titled, Lab and Diagnostic Test Results - Clinical, reviewed 1/21/2026, indicated When test results are reported to the facility, a nurse will first review the results.a. If staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor,charge nurse, etc.) should follow or coordinate the procedure.2. Before contacting the physician, the person who is to communicate results to a physician will gather, review, and organize the information and be prepared to discuss the following (to the extent that such information is available): a. The individual's current condition and details of any recent changes in status, including vital signs and mental status; b. Major diagnoses, allergies, current medications, any recent pertinent lab work, actions already taken to address results treat the resident/patient and pertinent aspects of advance directives (for example, limitations on testing and treatment); c. Why the lab and diagnostic tests were obtained (for example, as a routine screen or follow-up; to assess a condition change or recent onset of signs and symptoms, or to monitor a serum medication level; d. How test results may relate to the individual's current condition and treatment; and e. Any concerns and questions the physician will be expected to address regarding the resident.3. A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition.4. A nurse will try to determine whether the test was done. a. As a routine screen or follow-up; b. To assess a condition change or recent onset of signs and symptoms; or c. To monitor a drug level. 1. The reason for getting a test often affects the urgency of acting upon the result 2. If the reason for performing the test cannot be identified, the nurse should proceed as though the tests were ordered to assess a condition change or recent onset of signs and symptoms.

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

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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 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of 27 resident rooms (rooms [ROOM NUMBER]) accommodated no more than 4 residents per room. Rooms 3, and 4 had six residents, and 5 had five residents. This deficient practice had the potential to affect the delivery of care and safety of the residents, especially during an emergency. Findings: During initial tour of the facility on 3/31/2026 at 10:52 AM Rooms 3, 4 and 5 were observed. In room [ROOM NUMBER], there were six beds in the rooms all with curtains. Resident 28 stated there are no problems with the number of residents in this room. Everyone comes and goes as they please without any difficulty. During record review, the facility's room waiver request letter, dated 3/31/2026, the letter indicated the facility, serves individuals diagnosed with chronic and persistent mental illnesses, often accompanied by significant behavioral and emotional disturbances. Unlike traditional geriatric or physically compromised skilled nursing facility populations, our residents are generally ambulatory, physically stable, and capable of independent egress without staff assistance.

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	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Behavioral Health Center	3951 East Blvd. Los Angeles, CA 90066

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** AmendedBased on observation, interview, and record review, the facility failed to meet the requirement of 80 square feet per resident in 17 out of 27 resident rooms (Rooms 1, 3, 5, 7, 8, 9, 13, 15, 17, 18, 20, 21, 23, 24, 25, 26, and 27) did not meet the requirement of 80 square feet per resident. This deficient practice had the potential to result in inadequate usable living space for resident Rooms 1, 3, 5, 7, 8, 9, 13, 15, 17, 18, 20, 21, 23, 24, 25, 26, and 27. Findings: During record review, the facility's room waiver letter and the client accommodations analysis form completed by the facility on 3/31/2026, indicated the following seven rooms provided less than 80 square feet of livable space per resident.room [ROOM NUMBER]. Beds 2. Room Size (ft.) 140.6. Sq. Ft/Bed 70.3room [ROOM NUMBER]. Beds 6. Room Size (ft.) 140.6. Sq. Ft/Bed 78.1room [ROOM NUMBER]. Beds 5. Room Size (ft.) 336. Sq. Ft/Bed 67.2room [ROOM NUMBER]. Beds 2. Room Size (ft.) 138. Sq. Ft/Bed 69room [ROOM NUMBER]. Beds 2. Room Size (ft.) 138. Sq. Ft/Bed 69room [ROOM NUMBER]. Beds 2. Room Size (ft.) 138. Sq. Ft/Bed 69room [ROOM NUMBER]. Beds 2. Room Size (ft) 236.3. Sq. Ft/Bed 78.8room [ROOM NUMBER]. Beds 3. Room Size (ft) 236.3. Sq. Ft/Bed 78.8room [ROOM NUMBER]. Beds 2. Room Size (ft) 156.8. Sq. Ft/Bed 78.4room [ROOM NUMBER]. Beds 2. Room Size (ft) 156.8. Sq. Ft/Bed 78.4room [ROOM NUMBER]. Beds 3. Room Size (ft) 236.3. Sq. Ft/Bed 78.8room [ROOM NUMBER]. Beds 3. Room Size (ft) 236.3 Sq. Ft/Bed 78.8room [ROOM NUMBER]. Beds 3. Room Size (ft) 236.3. Sq. Ft/Bed 78.8room [ROOM NUMBER]. Beds 3. Room Size (ft) 236.3. Sq. Ft/Bed 78.8room [ROOM NUMBER]. Beds 3. Room Size (ft) 236.3. Sq. Ft/Bed 78.8room [ROOM NUMBER]. Beds 3. Room Size (ft) 236.3. Sq. Ft/Bed 78.8room [ROOM NUMBER]. Beds 3. Room Size (ft) 236.3. Sq. Ft/Bed 78.8 During a concurrent observation and interview on 3/31/2026 at 10:52 AM Resident 28 stated the room gave each resident adequate space. During record review, the facility's room waiver request letter, dated 3/31/2026, the facility, serves individuals diagnosed with chronic and persistent mental illnesses, often accompanied by significant behavioral and emotional disturbances. Unlike traditional geriatric or physically compromised skilled nursing facility populations, our residents are generally ambulatory, physically stable, and capable of independent egress without staff assistance.