STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A355	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Paz Geropsychiatric Center	8835 Vans Street Paramount, CA 90723

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 - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39028 Based on observation, interview, and record review the facility failed to protect the residents' right to be free from physical abuse by another resident for two of four sampled residents (Resident 2 and 4). The facility failed to: a. Ensure Resident 1's physician was informed when he was exhibiting behaviors such as auditory hallucination ([AH] hear voices or noises that are not there), paranoid delusion ([PD] a type of serious mental illness where patient cannot tell what is real from what is imagined.), and visual hallucination([VH] perception of an external visual stimulus where none exists). b. Ensure Resident 3's physician was informed when he was exhibiting behaviors such as agitation ([AG] manifested by striking out), anxiety ([AX] persistent and excessive worry) and mood swings ([MS] extreme of sudden change of mood). These failures resulted in Resident 1 going to Resident 2's room and hit him in the face on 6/24/2024. Resident 3 hit Resident 4 in the face while she was sitting in the wheelchair on the hallway on 6/28/2024. Findings: a. During a review of Resident 1 ' s Admission Record, indicated Resident was admitted to the facility on [DATE], with diagnoses including schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and anxiety disorder (persistent and excessive worry that interferes with daily activities). During a review of Resident 1 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 3/28/2024, The MDS indicated, Resident 1 had intact cognitive (ability to learn, remember, understand, and make decision) ability in daily decision making. The MDS indicated Resident 1 had delusions (misconception or beliefs that are firmly held, contrary to reality). Resident 1 was independent for toileting, personal hygiene, and supervision with upper and lower body dressing. (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 - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Psychiatric Progress Notes dated 6/25/2024, the Psychiatric Progress Notes indicated, Resident 1 went to Resident 2's room on 6/24/2024 at nighttime and started to hit the resident on the face. The progress notes indicated Resident 1 reported he had a dream about being raped by Resident 2. The progress notes indicated Resident 1 has No understanding to his condition, poor coping skills, appears to have preoccupies aggressive content with command hallucinations, unwilling to have meaningful conversation. The progress notes indicated Resident 1 was put on 1:1 monitoring (health care staff whose role was to provide one to one observation to an individual patient for a period of time) for safety precautions. During a review of Resident 1 ' s Psychiatric Progress Notes dated 7/2/2024, the Psychiatric Progress Notes indicated, Resident 1 was seen in room for annual psychiatric evaluation (assessment of a resident ' s mental health). The progress notes indicated Resident 1 continue to have delusional beliefs about the altercation incident between Resident 2. The progress notes indicated Resident 1 keeps saying he was molested (sexual assault or abuse), and Resident 2 came to him multiple times when in fact Resident 1 had no contact with Resident 2. During a review of Resident 1 ' s Nursing Progress Notes dated 6/24/2024 timed at 8:30 p.m., the Nursing Progress Notes indicated, staff heard a commotion coming from Resident 2's room. The staff heard Resident 2's voice saying, He is hitting me. Staff saw Resident 1 leaving Resident 2's room. Staff interviewed Resident 1 and stated he had a dream that Resident 2 raped him. The Nursing progress notes indicated physician was informed and ordered medications and put Resident 1 on 1:1 monitoring fore assaultive behavior. During a review of Resident 1's Physician Order Summary Report dated 5/23/2024, indicated to Monitor for behavior: auditory hallucination (AH), labile mood (LM), paranoid delusion (PD), visual hallucination (VH). Place a positive (+) sign if behavior is present or a (-) if the behavior is absent. During a review of Resident 1's Medication Administration (MAR) for the month of 6/2024, the MAR indicated a positive (+) sign for AH on 6/10/2024, 6/11/2024, 6/12/2024, 6/13/2024, 6/19/2023, 6/20/2024, and 6/21/2024. The MAR indicated a positive (+) sign for PD on 6/12/2024, 6/13/2024, 6/16/2024, 6/19/2024, 6/20/2024, and 6/21/2024 and VH 6/10/2024, 6/11/2024, 6/12/2024, 6/16/2024, 6/19/2023, and 6/20/2024. During a review of Resident 2 ' s Admission Record, indicated Resident 2 was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder (a serious mental illness that affects how a person thinks, feels, and behaves), and type 2 diabetes mellitus (a condition in which the body fails to metabolize (process) glucose (sugar) correctly). During a review of Resident 2's Nursing Progress Notes dated 6/24/2024 at 8:20 p.m., indicated Certified Nursing Assistant (CNA- unknown) heard a commotion on Resident 2's room. CNA went to the room and heard Resident 2 saying He hit me. Resident 2 was assessed and observed a slight left cheek swelling. During a review of Resident 2's Nursing Progress Notes dated 6/25/2024 at 1:09 p.m. indicated to continue to monitor Resident 2 for safety related to being hit by Resident 1 on the face, sustained left face swelling. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/5/2024 at 11:07 p.m. with Resident 2, inside Resident 2's room, Resident 2 stated he had an altercation with a young man who walked into his room and started to hit in in his face. Resident 2 stated he was not doing anything, and Resident 1 started hitting him in his face. Resident 2 stated he had a headache, but it stopped. During an interview on 7/5/2024 at 11:15 a.m., with Resident 1, Resident 1 stated he was raped by a guy that is why I beat him up. During a concurrent interview and record review on 7/8/024 at 10:28 a.m., with the Director of Nursing (DON), the DON stated Resident 1 went to Resident 2's room (opposite to his room) and hit Resident 2 and accused him of raping him. Resident 1's MAR indicated Resident 1 have been exhibiting behaviors (AH, PD and VH). The DON stated the facility did not do anything to control his behavior until it escalated. The DON stated if staff sees resident (in general) to be more aggressive or delusional more than usual, staff should inform resident's physician. The DON it was important to inform resident physician with any change in behavior. b. During a review of Resident 3 ' s Admission Record, indicated Resident was admitted to the facility on [DATE], with diagnosis including schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). During a review of Resident 3 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 6/21/2024, The MDS indicated, Resident 3 had severe cognitive ability in daily decision making. The MDS indicated Resident 3 had delusions. Resident 3 was moderate assistance for toileting, personal hygiene, and upper and lower body dressing. During a review of Resident 3's Physician Order Summary Report dated 5/23/2024, indicated to Monitor for behavior: agitation (AG manifested by striking out), anxiety (AX) and mood swings (MS), paranoid delusions (PD). Place a positive (+) sign if behavior is present or a (-) if the behavior is absent. During a review of Resident 3's Medication Administration (MAR) for the month of 6/2024, the MAR indicated a positive (+) sign for AG, AX, and MS on 6/28/2024 (morning, afternoon and shift). During a review of Resident 3's Nursing Progress Notes dated 6/28/2024 at 3:32 p.m., indicated Resident 4 hit Resident 3 multiple times. Resident 4 had shown symptoms of increased agitation. During a review of Resident 4 ' s Admission Record, indicated Resident was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder (a disorder that affects a person's ability to think, feel, and behave clearly) and anxiety disorder. During a review of Resident 4 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool), dated 4/19/2024, The MDS indicated, Resident 4 had mild cognitive ability in daily decision making. The MDS indicated Resident 4 had delusions. Resident 4 was independent for toileting, personal hygiene, and upper body dressing. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's Nursing Progress Notes dated 6/28/2024 at 12:30 p.m., indicated at 11:40 a.m., Resident 4 was sitting up against the wall in her wheelchair when Resident 3 was observed hitting her in the forehead area with Resident 3'd fist (closed) while Resident 4 cover her face. The Director of Rehab (DOR) intervene and wheeled Resident 3 away form Resident 4. The progress notes indicated no injuries for Resident 4. During an interview on 7/8/2024 at 12:40 p.m., with the DOR, the DOR stated she was walking down the hallway when she noticed Resident 3 hitting Resident 4. The Dor stated Resident 4 was covering her face while Resident 3 was hitting her. The DOR stated there was nobody around and Resident 4 cannot scream loud. The DOR stated she does not know how long Resident 3 was hitting Resident 4. The DOR stated the incident happened before lunch. The DOR stated Resident 3 gets agitated easily with no apparent reason and Resident 4 was very quiet. During a review of the facility ' s policy and procedure (P&P) titled Abuse Prevention and Reporting, dated 1/30/2024, the P&P indicated . Is committed to protecting the physical and emotional wellbeing and personal possession of every resident. Any form of mistreatment of residents including but not limited to abuse, neglect, exploitation .are strictly prohibited. During a review of the facility ' s P&P titled, Notification of Physician/Prescriber, dated 2023, the P&P indicated, It is the policy of Telecare to provide evidence-based best practices including that the licensed nurse is responsible to inform the physician or other prescriber responsible for the medical or psychiatric care of the person served of any changes in the person served ' s emotional, behavioral, physical condition, and/or involvement in adverse events.