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	05/02/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45891 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident ' s (Resident 1) privacy when Resident 2 walked into the restroom while Resident 1 had her pants down while urinating. This failure resulted in Resident 1 feeling embarrassed, bad, and nasty. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Admission Record indicated the facility admitted Resident 1 on 6/15/2024 with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and schizophrenia (a mental illness that is characterized by disturbance in thought). During a review of Resident 1 ' s Minimum Data Set (MDS-a resident assessment tool) dated 3/28/2025, the MDS indicated Resident 1 was cognitively intact (ability to think and understand). During a review of Resident 2 ' s Admission Record (Face Sheet), the Admission Record indicated the facility admitted Resident 2 on 5/28/2022 with diagnoses including schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptoms). During a review of Resident 2 ' s Minimum Data Set (MDS- a resident assessment tool) dated 3/7/2025, the MDS indicated Resident 2 had diagnoses including severe cognitive impairment (a significant decline in thinking, memory, and other mental abilities). During a review of Resident 2 ' s Psychiatric Progress Notes, dated 4/9/2025, the progress notes indicated Resident 2 was resistant to being redirected (shifting focus from distressing thoughts or emotions) and had episodes of poor impulse control (sudden, forceful, irresistible urges to do something that may violate the rights of others or conflict with social norms). During a review of Resident 2 ' s Care Plan dated 12/5/2024, the care plan indicated to implement a safety plan to closely monitor and minimize any triggers for aggression and reassess and revise treatment plan as needed. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/2/2025 at 1:33 p.m. with Resident 1, Resident 1 stated she was in the restroom when Resident 2 opened the door while Resident 1 was peeing and had my pants down. Resident 1 stated she felt bad, nasty and embarrassed because it was a man in a female restroom. During an interview on 5/2/2025 at 1:39 p.m. with the Director of Nursing (DON), DON stated if a male resident goes into a female resident ' s restroom, the female may not feel safe, traumatized or re-traumatized. The DON stated Resident 1 ' s dignity was compromised because she was seen with her pants down. During a review of the facility's policy and procedure (P&P) titled, Resident ' s Rights, undated, the P&P indicated, This facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes, maintains or enhances their quality of life . Resident ' s rights include the resident ' s right to the following: be treated with respect, kindness, and dignity .be free from abuse.

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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 - 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** 45891 Based on observation, interview, and record review the facility failed to ensure one out of four sampled residents (Resident 1) was free from physical abuse (any intentional act causing injury or trauma to another person or animal by way of bodily contact) by Resident 2. As a result, Resident 2 entered Resident 1 ' s bathroom as Resident 1 was sitting on the toilet with her pants down around her ankles and Resident 2 punched Resident 1 on the right cheek, leaving a red mark on Resident 1 ' s right cheek. Resident 1 felt stated she felt mad, nasty, and embarrassed a man (Resident 2) was in her (Resident 1 ' s) female bathroom while her pants were down during the physical altercation. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptoms), benign prostatic hyperplasia (BPH, enlarged prostate [a small, walnut-shaped organ in the urinary system]), and overactive bladder. During a review of Resident 2 ' s undated care plan titled Mental Health Recovery: Resident 2 presented with a history of multiple psychiatric hospitalization s with a diagnosis of schizoaffective disorder, as evidenced by (AEB) disorganized thought process (a state where thinking is scattered, illogical, and difficult to follow), aggressive behavior, and paranoid (a mental disorder in which a person has an extreme fear and distrust of others) delusions (misconceptions or beliefs that are firmly held, contrary to reality). The care plan goal was Resident 2 would demonstrate a reduction in aggressive behavior AEB utilization of adaptive coping strategies. The care plan interventions included implementing a safety plan (unspecified plan) to closely monitor and minimize any triggers for aggression. During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily life). During a review of Resident 2 ' s Minimum Data Set (MDS, a resident assessment tool) dated 3/7/2025, the MDS indicated Resident 2 had severe cognitive impairment (problems remembering things, concentrating, making decisions and solving problems). The MDS indicated Resident 2 experienced hallucinations (to see, hear, feel, or smell something that does not exist) and delusions. The MDS indicated Resident 2 had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others). During a review of Resident 1 ' s MDS dated [DATE], the MDS indicated Resident 1 was cognitively intact and had no behavioral symptoms. (continued on next page)

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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 - Few	During a review of Resident 2 ' s Psychiatric (related to mental illness and its treatment) Progress Notes dated 3/5/2025, the Progress Notes indicated Resident 2 was resistant to being redirected, had episodes of agitation, poor impulse (the ability to resist a drive to perform an action) control, and yelling and screaming when his needs were not met immediately. The progress note indicated Resident 2 ' s mood was irritable with angry outbursts. During a review of Resident 1 ' s Post Event Assessment Form dated 4/19/2025, the Post Event Assessment Form indicated Resident 1 went to the nurses ' station on 4/19/2025 at 2 p.m. and reported she had been hit by a male resident (Resident 2). Resident 1 was assessed and was noted to have slight redness on her right cheek. The Post Event Assessment Form indicated Resident 2 reported he had not realized he was in the wrong room and when he realized the restroom was occupied, he tried to use the trash can in the restroom to urinate but Resident 1 did not allow him to take the trash can. Resident 2 expressed remorse for the incident with Resident 1 (although Resident 2 did not admit to hitting Resident 1). The assessment indicated Resident 1 had pain in her left cheek. During a review of Resident 1 ' s Interdisciplinary (brings together knowledge from different health care disciplines to help people receive the care they need) Team Note dated 4/21/2025, the IDT note indicated on 4/19/2025, Resident 1 was struck in the face by a male peer (Resident 2) while Resident 1 was using the restroom. Resident 1 reported the male (Resident 2) entered the restroom, attempted to remove a trash can, and upon Resident 1 intervening to stop Resident 2 from removing the trash can, Resident 2 hit Resident 1 in the face. The IDT Note indicated Resident 1 had complained of pain to the left cheek and an ice pack was provided. During an observation on 5/2/2025 at 10:31 a.m., outside of Resident 1 ' s room, the hallway was empty with no staff in the hallway. During an interview on 5/2/2025 at 11:36 a.m., certified nursing assistant (CNA) 2 stated Resident 2 had a history of getting very upset if things did not go his way. CNA 2 stated Resident 2 became explosive at times. CNA 2 stated Resident 2 frequently threatened facility staff. CNA 2 stated Resident 2 was ambulatory and walked around freely in the facility. CNA 2 stated Resident 2 used to go into other patient ' s rooms (both male and female) in the past and take their clothes. During an observation on 5/2/2025 at 12:19 p.m., Resident 2 was pacing (walking back and forth) in the hallway in front of Resident 1 ' s room and there was no staff present in the hallway. The nurse ' s station could not be seen from Resident 1 ' s hallway. During an interview on 5/2/2025 at 12:33 p.m., Resident 2 stated he did not remember an incident occurring with Resident 1. During an interview on 5/2/2025 at 12:25 p.m., housekeeper (HK) 1 stated Resident 2 did not stay in his room much. HK 1 stated Resident 2 liked to walk around a lot, Resident 2 screamed a lot and threatened to hit staff. During an interview on 5/2/2025 at 12:45 p.m., licensed vocational nurse (LVN) 1 stated Resident 2 became agitated easily. (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 5/2/2025 at 12:58 p.m., social worker (SW) 1 stated Resident 2 was one of the lower functioning (having difficulties in areas like communication, social interaction, and self-care, which can impact his ability to participate fully in society) residents on her case load and Resident 2 was forgetful and needed frequent redirection. SW 1 stated Resident 2 had a history of aggression and altercations with other residents in the past (unknown date or situation) but nothing recently until the altercation with Resident 1 (4/19/2025). During an interview on 5/2/2025 at 1:20 p.m., SW 2 stated Resident 1 was fixated and upset a male (Resident 2) went into her (Resident 1 ' s) restroom. SW 2 stated Resident 2 informed her (SW 2) Resident 2 entered the restroom and tried to take Resident 1 ' s trash can from the restroom but when Resident 1 grabbed the trash can from Resident 2, he struck Resident 1 in the face. During an interview on 5/2/205 at 1:33 p.m., Resident 1 stated on 4/19/2025 she was in the restroom with the door closed sitting on the toilet with her pants down when Resident 2 opened the door of the restroom while she was peeing. Resident 1 stated they got into a struggle over her trash can and Resident 2 punched her in the face causing her glasses to fall off her face and then he (Resident 1) ran away. Resident 2 stated the punch in the face was painful and after she was finished using the restroom she went to the nurse ' s station and told a nurse (registered nurse (RN) 1) what occurred. Resident 1 stated RN 1 took a picture of her right cheek and then gave her an ice pack for the pain. Resident 1 stated she felt, bad, nasty and embarrassed that a man (Resident 2) was in her restroom. During an interview on 5/2/2025 at 2:38 p.m., the director of nursing (DON) stated Resident 2 acted on impulse and became agitated easily. The DON stated in March of 2024 there was another unprovoked incident where Resident 2 hit another resident (unknown) in the cheek when the resident would not move out of Resident 2 ' s doorway. The DON stated during this incident on 4/19/2025, Resident 2 punched Resident 1 after he entered Resident 1 ' s restroom and tried taking her trash can. The DON stated the potential outcome of residents entering other residents ' rooms (uninvited) was altercations occurring such as the one on 4/19/2025 between Resident 1 and Resident 2. The DON stated the potential outcome of a male entering a female restroom was the female resident could feel unsafe, victimized and her dignity could be compromised. The DON stated staff had to make frequent rounds (every 1 hour during the day and every 30 minutes between midnight and 6:30 a.m.) to ensure resident safety. During an interview on 5/2/2025 at 3:31 p.m., RN 1 stated on 4/19/2025, Resident 1 came to the nurse ' s station reporting a male came into her restroom and hit her. Resident 1 pointed out Resident 2 in the hallway. RN 1 stated Resident 1 ' s right cheek was slightly red when she assessed her following the incident. RN 1 stated Resident 1 reported pain on her right cheek so an ice pack was given but Resident 1 was mostly upset a male was in her restroom. During a review of the facility ' s policy and procedure (P/P) titled Abuse Prevention and Reporting dated 11/15/2024, the P/P indicated Resident to Resident abuse was aggressive or inappropriate behavior by one resident towards another comprised resident-to-resident abuse. The P/P indicated physical abuse included hitting, grabbing, and threatening gestures.

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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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45891 Based on observation, interview, and record review, the facility failed to provide supervision for one of one male resident (Resident 2) with history of wandering from entering an occupied female ' s restroom (Resident 1). This failure resulted in Resident 1 being exposed with her pants down and punched in the right cheek. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Admission Record indicated the facility admitted Resident 1 on 6/15/2024 with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and schizophrenia (a mental illness that is characterized by disturbance in thought). During a review of Resident 1 ' s Minimum Data Set (MDS-a resident assessment tool) dated 3/28/2025, the MDS indicated Resident 1 was cognitively intact (ability to think and understand). During a review of Resident 2 ' s Admission Record (Face Sheet), the Admission Record indicated the facility admitted Resident 2 on 5/28/2022 with diagnoses including schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptoms). During a review of Resident 2 ' s Minimum Data Set (MDS- a resident assessment tool) dated 3/7/2025, the MDS indicated Resident 2 had diagnoses including severe cognitive impairment (a significant decline in thinking, memory, and other mental abilities). During a review of Resident 2 ' s Psychiatric Progress Notes, dated 4/9/2025, the progress notes indicated Resident 2 was resistant to being redirected (shifting focus from distressing thoughts or emotions) and had episodes of poor impulse control (sudden, forceful, irresistible urges to do something that may violate the rights of others or conflict with social norms). During a review of Resident 2 ' s Care Plan dated 12/5/2024, the care plan indicated to implement a safety plan to closely monitor and minimize any triggers for aggression and reassess and revise treatment plan as needed. During observations on 5/2/2025 at 10:38 a.m.,12:19 p.m., and 1:37 p.m., no facility staff were observed in the resident hallways between resident rooms 14 through19, and resident rooms 4 through 11. During an interview on 5/2/2025 at 11:35 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 2 had previous history of wandering into other resident ' s rooms whether male or female. During an interview on 5/2/2025 at 1:33 p.m. with Resident 1, Resident 1 stated she was in the restroom when Resident 2 opened the door while Resident 1 was peeing and had my pants down. Resident 1 stated she felt bad, nasty and embarrassed because it was a man in a female restroom. (continued on next page)

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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	During an interview on 5/2/2025 at 1:39 p.m. with the Director of Nursing (DON), DON stated if a male resident goes into a female resident ' s restroom, the female may not feel safe, traumatized or re-traumatized. The DON stated Resident 2 had poor impulse control. The DON stated if staff were in the hallway, they could have prevented Resident 2 from going into Resident 1 ' s room. During a review of the facility ' s policy and procedure (P&P) titled, Levels of Observation, undated, the P&P indicated, To identify the minimum requirements for levels of observation and observation rounds (Safety Rounds) .supports engagement adequate to assess and address the risk of harm to an individual and/or others .Those who demonstrate increased behavior and/or presenting risk will be assessed and placed on the appropriate level of observation. Elevated risks may include danger to self, danger to others, assault . Rounding focuses on the whereabouts/location of the person served, behavior and activities as determined necessary for safety.