

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2025
NAME OF PROVIDER OR SUPPLIER LA Paz Geropsychiatric Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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. (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 - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of three sampled residents (Residents 63) were free from sexual abuse by another resident (Resident 146). The facility failed to: 1. Supervise Resident 146 with history of inappropriate sexual comments towards staff and residents, showing his private part, standing too close to staff and not giving enough boundaries. This failure had the potential to result in Resident 63 experiencing unwanted sexual contact, placing the resident at risk for emotional trauma, psychological harm, and a compromised sense of safety within the facility. Findings: During a review of Resident 63's admission Record, the admission Record indicated Resident 63 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hyperlipidemia (abnormally high levels of cholesterol and or triglycerides in the blood), and vitamin D deficiency (it occurs when the protective cartilage that cushions the ends of the bones wears down over time). During a review of Resident 63's Minimum Data Set (MDS - a resident assessment tool) dated 10/6/2025, the MDS indicated Resident 63 had the ability to understand others with clear comprehension. The MDS indicated Resident 63 needed setup or clean-up assistance from staff with eating and showering. The MDS indicated Resident 63 was independent with oral hygiene, toileting, dressing, personal hygiene, transferring and walking. During a review of Resident 146's admission Record, the admission Record indicated Resident 146 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, drug induced subacute dyskinesia (a type of involuntary movement disorder that develops gradually over weeks to months after taking certain medications), insomnia (trouble falling asleep or staying asleep), and anxiety (emotion characterized by feelings of tension, worried thoughts). During a review of Resident 146's Psychiatric Progress Notes, dated 12/18/2024, the Psychiatric Progress Notes indicated Resident 146 continued having inappropriate behavior such as showing his private part to staff during a shower, standing too close to staff and not giving enough boundaries. During a review of Resident 146's MDS dated [DATE], the MDS indicated Resident 146 had the ability to understand others with clear comprehension. The MDS indicated Resident 146 needed supervision or touching assistance with showering and transferring. The MDS indicated Resident 146 needed setup or clean-up assistance with eating and personal hygiene. The MDS indicated Resident 146 was independent with oral hygiene, toileting, dressing, transferring and walking. During an interview on 10/21/2025 at 9:45 a.m. with Resident 63, in Resident 63's room. Resident 63 stated two days after being admitted to the facility she was in the hallway using the phone when Resident 146 touched her on the hips and buttocks. Resident 63 stated she was scared and told Certified Nursing Assistant (CNA) 8 and a male Social Worker (SW) 1. Resident 63 stated she sees Resident 63 during meals and Resident 63 approaches her for conversation. Resident 63 stated the incident happened during the night on 10/1/2025 at 8:30 p.m. During an interview on 10/22/2025 at 3:45 p.m. with Certified Nursing Assistant (CNA) 9, CNA 9 stated she was familiar with Resident 146. CNA 9 stated Resident 146 likes to talk to women and had to be watched for inappropriate behaviors last month (September 2025). CNA 9 stated she does not know what the inappropriate behaviors are. During a concurrent observation and interview on 10/23/2025 at 1:57 p.m., in the hallway with Resident 146, Resident 146 was talking to male and female residents. Resident 146 denied touching any residents without permission. During a concurrent interview and record review on 10/24/2025 at 10:03 a.m. with Licensed Vocational Nurse (LVN) 8, Resident 146's Sexual Activity Screening, dated 2/29/2024 was reviewed. The Sexual Activity Screening indicated Resident 146 exposed himself in public, kissed a female resident and touched a female resident's buttock. LVN 8 stated Resident 146 needs a lot of redirections for speaking inappropriate sexual comments towards staff and residents. During an interview on 10/24/2025 at 10:55 a.m. with Registered Nurse Supervisor (RNS) 2, RNS 2 stated she had not heard of Resident 146 sexually abusing residents. RNS 2 stated the facility has made the west hallway all female to redirect male residents from going into female rooms. RNS 2 stated the facility monitors for inappropriate sexual behaviors from the beginning of admission. During an interview on 10/24/2025 at 11:20 a.m. with Social Services (SW) 2, SW 2 stated she was aware Resident 146 was sexually inappropriate to residents and staff. SW 2 stated Resident 146 exposes himself to other residents, does inappropriate touching, and tried to kiss a staff member. SW 2 stated Resident 146 was placed on monitoring on 2/29/2024 for touching a female resident. During a review of Resident 146's Care Plan titled</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>(continued on next page)</p>

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<p>F 0943</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** Based on interview and record review, the facility failed to ensure Social Worker (SW) 2 received effective training on abuse reporting, related to identifying and reporting inappropriate sexual behavior of Resident 146 towards Resident 136 and 155. This deficient practice had the potential to result in incidents of abuse going unrecognized and unreported, placing residents at risk for harm. Findings: During a review of Resident 136's admission Record, the admission Record indicated Resident 136 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), and anxiety (a common mental health condition characterized by excessive worry, fear, and nervousness that can interfere with daily life). During a review of Resident 136's Minimum Data Set (MDS-resident assessment tool) dated 9/16/2025, the MDS indicated Resident 136 had the ability to understand others with clear comprehension. The MDS indicated Resident 136 needed supervision or touching assistance with eating. The MDS indicated Resident 136 needed setup or clean up assistance with showering and personal hygiene. The MDS indicated Resident 136 was independent with oral hygiene, toileting, dressing, transferring and walking. During a review of Resident 155's admission Record, the admission Record indicated Resident 155 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), extrapyramidal movement disorder (a group of involuntary movements that can occur as a side effect of certain medications), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the knee, and hip pain. During a review of Resident 155's MDS dated [DATE], the MDS indicated Resident 155 had the ability to understand others with clear comprehension. The MDS indicated Resident 155 needed setup or clean-up assistance with eating and showering. The MDS indicated Resident 155 was independent with oral hygiene, toileting, dressing, personal hygiene, transferring and walking. During a review of Resident 146's admission Record, the admission Record indicated Resident 146 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, drug induced subacute dyskinesia (a type of involuntary movement disorder that develops gradually over weeks to months after taking certain medications), insomnia (trouble falling asleep or staying asleep), and anxiety (emotion characterized by feelings of tension, worried thoughts). During a review of Resident 146's MDS dated [DATE], the MDS indicated Resident 146 had the ability to understand others with clear comprehension. The MDS indicated Resident 146 needed supervision or touching assistance with showering and transferring. The MDS indicated Resident 146 needed setup or clean-up assistance with eating and personal hygiene. The MDS indicated Resident 146 was independent with oral hygiene, toileting, dressing, transferring and walking. During a concurrent interview and record review on 10/24/2025 at 10:55 a.m. with Registered Nurse Supervisor (RNS) 2, Resident 146's Social Service Progress Notes dated 2/26/2024 and 2/27/2024 were reviewed. The Social Service Progress Notes dated 2/26/2024 indicated SW 2 met with Resident 146 to discuss boundaries and what inappropriate touching, grabbing, and looking was. The Social Service Progress Notes indicated SW 2 asked Resident 146 if he had tapped Resident 155 on the buttocks. The Progress Note dated 2/27/2024 indicated staff informed SW 2 that Resident 146 kissed Resident 136. The Social Service Progress Notes indicated nursing staff intervened to separate the residents. The Social Service Progress Notes indicated SW 2 educated Resident 146 on maintaining boundaries. The Social Service Progress Notes indicated SW 2 stated to Resident 146 if he plans to have a relationship with Resident 136 a consent must be given. The Social Service Progress Notes indicated SW 2 will continue to follow the plan of care. RNS 2 stated the facility has made the west hallway all female to redirect male residents from going into female rooms. RNS 2 stated the facility monitors for inappropriate sexual behaviors from the beginning of admission. During a review of Nurses Progress Notes dated 2/26/24, the Nursing Progress Notes indicated Resident 155 went to the nurse's station and reported Resident 146 tapped her buttocks. SW met with Resident 146. During an interview on 10/24/2025 at 3:31 p.m. with SW 2, SW 2 stated on 2/26/2024 she heard about Resident 146 touching Resident 136 inappropriately on the buttocks. SW 2 stated she did report the allegations to the Administrator. SW2 stated she assumed nursing staff would report it. SW 2 stated she was a mandated reporter and should have reported the allegations of abuse, investigate the allegations to rule out abuse. SW 2 stated if the allegations were not investigated the abuse will continue to happen to other residents. During an interview on 10/24/2025 at 4:13 p.m. with the Director</p>		