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	12/31/2025

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect the residents' right to be free from physical abuse for two of four sampled residents (Resident 3 and Resident 1). The facility failed to:1.Ensure Resident 4 did not push down Resident 3 who was trying to get up from the couch, held Resident 3's arm down and Resident 3 did not hold onto Resident 4's arm and kicked in an attempt to get up on 12/29/2025 at 5:30 p.m. during group activity in the living room.2. Ensure staff followed Resident 4's Care Plan titled, Resident 4 had been demonstrating psychotic behavior (actions or behaviors that reflect a disconnection from reality), verbally aggressive, intrusiveness (disruptive or interfering in someone's personal space), fixation on selective staff (attachment or preference toward certain staff) and inappropriate behavior toward others date created 8/11/2025, by intervening before agitation escalates, guide Resident 4 away from the source of distress, and engage in a calm conversation. 3. The Rehabilitation Activity Leader (RAL) did not leave Resident 4 and Resident 3 alone in the living room while they were having an altercation.These failures resulted in Resident 4 pushing down Resident 3 who was trying to get up from the couch, held Resident 3's arm down and Resident 3 did not hold onto Resident 4's arm and kicked in an attempt to get up on 12/29/2025 at 5:30 p.m. during group activity in the living room. 4.Ensure Resident 2 did not grab Resident 1's breast and hit her in in the face on 12/14/2025 approximately 1:30 p.m.This failure resulted in Resident 1 sustaining a four-centimeter (cm-unit of measurement) scratch to her left side of the face. Findings:1.During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] with diagnoses of but not limited to schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), cerebral ischemia (insufficient blood flow to the brain), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 3's Minimum Data set (MDS-a resident assessment tool), dated 11/25/2025, the MDS indicated Resident 3 had the ability to express ideas and wants. The MDS indicated Resident 3 had the ability to understand others and verbal content. The MDS indicated Resident 3 required supervision or touching assistance when transferring to the shower. The MDS indicated Resident 3 required setup or clean-up assistance from nursing staff with showering, eating and personal hygiene. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses of but not limited to schizophrenia (a mental disorder that is characterized by disturbances in thought) , major depressive disorder, insomnia (difficulty sleeping), and anxiety (emotion characterized by feelings of tension, worried thoughts). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had the ability to express ideas and wants . The MDS indicated Resident 4 had the ability to understand others and verbal content. The MDS indicated Resident 4 required setup or clean-up assistance from nursing staff with eating, showering and personal hygiene. During a review of Resident 4's Care Plan titled Resident 4 had been demonstrating psychotic behavior, verbally aggressive, intrusiveness, fixation on selective staff and inappropriate behavior toward others date created 8/11/2025, the Care Plan goals indicated Resident 4 will successfully be redirected as evidence by agreeing to engage in deescalation techniques to minimized episodes of aggression and inappropriate behaviors. The Care Plan interventions indicated when Resident 4 becomes agitated staff will intervene before agitation escalates, guide Resident 4 away from the source of distress, and engage in a calm conversation. During a review of Resident 4's Post-Event Assessment Form dated 12/29/2025, it was noted at approximately 5:30 p.m., Residents 3 and 4 were seated next to each other in the living room. Resident 3 blew his nose, prompting Resident 4 to express discomfort, stating, Why did you blow your nose here in front of me? Resident 3, who primarily communicates in a language other than English, responded in his native language. The Post-Event Assessment Form indicated Resident 4 stood up to leave, and Resident 3 also began to rise from his seat. Resident 4 then made physical contact with Resident 3, guiding him back onto the couch while verbally instructing him to stop. Resident 4 continued to hold Resident 3 down briefly, stating, Stop, stop. I can't let you go if you keep trying to kick or hit me. Staff immediately initiated Code [NAME] and intervened to separate both residents. During a review of Resident 4's Medication Administration Record (MAR), dated 12/2025, the MAR indicated on 12/29/2025 3 p.m. to 11 p.m. shift, Resident 4 had anxiety (feeling of fear, worry, or unease) manifested by (m/b) irritability, depressed mood (feeling of sadness, emptiness, or