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	02/19/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the Facility failed to:develop and update a person-centered care plan for two of six sampled residents (Resident 1 and 6) by failing to:a. Develop or update the care plan upon readmission on [DATE] when Resident 1 exhibited aggressive behaviors.b. Develop a specific care plan addressing Resident 6's aggressive behaviors, including defined interventions for monitoring the aggressive behavior.This deficient practice had the potential to result in inadequate behavioral monitoring, interventions and compromise resident's safety.Findings: a. During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 1/25/2024 and readmitted on [DATE] with diagnoses including schizophrenia (a chronic, sever brain disorder that causes people to lose touch with reality disrupting how they think, feel, and behave), and bipolar disorder (a chronic mental health condition that causes extreme, intense shifts in mood, energy, and behavior, far beyond normal ups and downs). During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 1/30/2026, the MDS indicated Resident 1's cognition (functions your brain uses to think, pay attention, process information, and remember things) was intact. The MDS indicated Resident 1 had no impairment on both upper and lower extremities During a review of Resident 1's progress notes, dated 2/6/2026 through 2/8/2026, the progress notes indicated following:On 2/6/2026 at 4:05 p.m., Resident 1 remained hyperverbal (talking more than usual, jumping from topic to topic) and exhibited aggressive behavior, including yelling and pulling down the privacy curtain.On 2/7/2026 at 10:40 a.m., Resident 1 refused to take oral medication this am when the medication was offered, Resident 1 threw the medication on the floor, refused Electro Cardio Gram (EKG a quick, safe, and painless test that records the heart's electrical activity).On 2/7/2026 at 1:20 p.m., Resident 1 was verbally abusive, irritable and loud to staff & peer, spitting at female peer (unidentified) on the patio.On 2/7/2026 7:15 p.m., Resident 1 has episodes of pacing around the hallway cursing at staff and other residents.On 2/8/2026 01:05 a.m., Resident 1 exhibited intermittent demanding behavior. During a review of Resident 1's Order Summary Report, dated 2/6/2026, the Order Summary Report indicated an order for safety precautions every 15 minutes (every 15-minutes patient safety check) for 48 hours related to re-admission. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 3/25/2025 with diagnoses including schizophrenia (a chronic, sever brain disorder that causes people to lose touch with reality disrupting how they think, feel, and behave), and convulsions (sudden, uncontrollable shaking or jerking of the muscles caused by abnormal electrical activity in the brain). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was cognitively intact. The MDS indicated Resident 2 required setup or clean-up assistance (helper assists only prior to or following the activity) with oral hygiene, showering, was independent with eating, toileting hygiene. During a review of Resident 2's Post Event Assessment Form, dated 2/8/2026, the form indicated certified nursing (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistant (CNA) 2 witnessed an altercation between Resident 1 and 2 when Resident 1 grabbed Resident 2's wrists. During a concurrent interview and record review on 2/17/2026 at 3 p.m., with Registered Nurse (RN) 1, Resident 1's medical record was reviewed. RN 1 stated the facility readmitted Resident 1 on 2/6/2026 from the General Acute Care Hospital (GACH), and aggressive behavior was identified as one of the primary concerns upon readmission. RN 1 stated Resident 1's physician placed Resident 1 on monitoring every 15-minutes safety precautions to assess behavior. RN 1 stated no care plan was developed or updated to address Resident 1's increased aggressive behaviors upon readmission prior to the incident on 2/8/2026 involving Resident 2. RN 1 stated these behaviors included loud and verbally abusive conduct, demanding behavior, medication non-compliance, and making false accusations toward staff. RN 1 stated these behaviors of Resident 1 were more severe compared to previous admissions. RN 1 stated upon readmission, staff are required to develop or update the person-centered care plan for Resident 1. RN 1 stated the care plan serves as the foundation for the resident care and provides guidance to staff regarding the resident's needs, behaviors, and interventions. During a telephone interview on 2/18/2026 at 8:06 a.m., with CNA 2, CNA 2 stated Resident 1 had been exhibiting worsening behaviors, including verbal aggression and demanding behaviors toward staff. CNA 2 stated Resident 1's behaviors had escalated, particularly in the days prior to the altercation with Resident 2 on 2/8/2026. During an interview on 2/19/2026 at 12:30 p.m., with RN 3, RN 3 stated person-centered care plans must be developed upon readmission, the care plan should be individualized to address the resident's specific needs and goals. RN 3 stated the care plan provides guidance to staff in implementing appropriate interventions for the residents. b. During a review of Resident 6's admission Record, the admission Record indicated the Facility admitted Resident 6 on 8/23/2023 and readmitted on [DATE] with diagnoses including paranoid schizophrenia . During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognition was intact. The MDS indicated Resident 6 was independent with eating, oral hygiene, toileting hygiene, showering, dressing, and personal hygiene. During a review of Resident 6's psychiatric (medical specialty in mental illness and mental health) progress notes, dated 1/21/2026, the notes indicated Resident 6 remained oppositional (someone who often disagrees with or resists rules, instructions, or authority) , verbally confrontational in interactions with staff and at a moderate risk for aggressive behavior. During an interview on 2/18/2026 at 12:40 p.m., with the Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 4 is known to be combative, need to approach carefully due to safety concerns. During a concurrent interview and record review on 2/18/2026 at 2:45 p.m. with RN 4, Resident 4's medical record was reviewed. RN 4 stated Resident 4 has a history of aggressive and assaultive behaviors, which could result in physical harm to other residents, including neighboring residents. RN 4 stated there was no specific care plan developed or updated to address, monitor, or prevent the potential for future assaultive behaviors. During a concurrent interview and record review on 2/19/2026 at 8:41 a.m., with the MDS Coordinator (MDSC), the MDSC stated a specific care plan should have been developed to address Resident 6's aggressive behaviors, including measurable goals and clearly defined interventions. The MDCS stated the care plan should include specific monitoring parameters and direction for staff to notify the physician as needed. During an interview on 2/19/2026 at 12:30 a.m., with Registered Nursing (RN) 3, RN 3 stated licensed staff are responsible for updating and implementing the individualized person-centered care plan as needed to ensure the resident's needs are met. During a review of the facility's policy and procedure (P&P), titled Resident Treatment Care Plan/Baseline Care Plan Resident, Treatment/Baseline Care Plan - Long Term Problems (SNF), undated, the P&P indicated following:The comprehensive care plan is an individualized written care plan based upon an initial and continuing assessment (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of resident needs with input, as appropriate, from the health professionals involved in the care of the resident.1. The care plan indicates the care to be given, the goals to be accomplished, the interventionsto be used, and the professional discipline responsible for each element of care.2. The goal(s) will be measurable/achievable and resident-centered or resident specific.The initial assessment by a licensed nurse will commence at the time of admission, and a careplan will be initiated.All required assessments from all disciplines will be initiated within 24 hours.All care plan problems will be identified as Priority (P), Active (A) or I Information only (not care planned). Priority problems are defined as: Problems or conditions which are most intrusive or debilitating in the resident's life at that time and may include but are not limited to: Behavioral Problems.Interventions: Plans should be written as concretely and specifically as possible with a minimal chance for ambiguity and uncertainty in the implementation of the plan.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation and record review the facility failed to accurately and completely maintain the 24-hour observation checklist (every 15 minutes safety monitoring observation checklist) for four of five sampled residents as evidenced by the following: a. CNA 1 documented Resident 3, 5, and 7's 10:00 and 10:15 a.m. observations in advance of the scheduled times on 2/18/2026.b. CNA 1 documented Resident 4's 9:45 a.m. 10:00 a.m. observation without having observed the patient on 2/18/2026. This deficient practice resulted in inaccurate documentation and had the potential to compromise resident safety and the reliability of required monitoring and observation. Findings:During a concurrent interview and record review on 2/18/2026 at 9:55 a.m. with Certified Nurse Assistant (CNA) 1, Resident 3, 5 and 7's 24-hour observation checklists, dated 2/18/2026 were reviewed. The observation checklists indicated 10:00 a.m. and 10:15 a.m. observations for the residents had already been completed. CNA 1 stated she conducted rounds at approximately 9:45 a.m. and documented the 10:00 a.m. and 10:15 a.m. observations in advance of the scheduled times. CNA 1 acknowledged this was an error and documentation should only occur after directly observing residents at the scheduled times. During an interview and record review on 2/18/2026 at 10:05 a.m. with CNA 1, Resident 4's observation check list, dated 2/18/26 was reviewed. The observation check list indicated the 9:45 a.m. and 10:00 a.m. entries were left blank. CNA 1 stated she did not observe the resident at 9:45 a.m. and 10:00 a.m., therefore did not complete the documentation. During an interview and record review on 2/19/2026 at 10:21 a.m. with CNA 1, Resident 4's 24-hour observations checklist, dated 2/18/2026 was reviewed. CNA 1 stated she documented 9:45 a.m. and 10:00 a.m. observation for the previous day after seeing the resident at approximately 10:14 a.m. in the hallway. CNA 1 stated she attempted to locate the resident earlier but was unable to find him and did not notify other staff. CNA 1 stated she completed the 9:45 a.m. and 10:00 a.m. entries because she believed the form could not be left blank, despite not having conducted the required observations. During an interview on 2/19/2026 at 10:46 a.m. with the Director of Staff Development (DSD), The DSD stated staff must directly observe the resident before completing the 24-hour observation checklist. The DSD stated pre-charting, including documenting 15 minutes in advance, is not acceptable practice, staff may not predict or assume a resident's status without direct observation. The DSD stated if a patient cannot be located at the scheduled observation time, staff must actively search for the resident and communicate with the assigned nurse to determine the resident's whereabouts and attempt to lactate the resident. The DSD stated documenting an observation after missing the scheduled time without having observed the patient may be considered false charting. The DSD stated the 24-hour observation checklist is typically implemented for residents requiring special monitoring due to safety concerns, fall risk, behavioral issues, assaultive behaviors, or sexually inappropriate behaviors, close monitoring is necessary to prevent escalation and ensure the safety of the residents and others. During an interview on 2/19/2026 at 12:30 a.m. with Registered Nursing (RN) 3, RN 3 stated there is no such practice as pre-charting, documentation must be accurate and completed after direct observation. Pre-charting or charting in advance is considered inaccurate documentation and required correction. RN 3 stated real-time charting is necessary to ensure effective monitoring and timely intervention. Accurate documentation supports appropriate clinical response and patient safety. RN 3 stated staff must be physically present on the unit to directly observe the residents prior to documenting, lack of time is not an acceptable justification, and required observations and documentation must be prioritized. During a review of the facility's Policy and Procedure (P&P) titled, Levels of Observation, undated, the P&P indicatedObservation rounding documentation represents a snapshot in (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	time of the activity and location of theclient at the time the rounding was performed.Every 15 minute (Q15):Risk assessment indicated that the person served level of risk can be observed and assessed every 15 minutes (Q15).Documentation is completed at 15 minutes to reflect rounding on a rounds sheet or electronic device During a review of the facility's P&P titled, General Documentation Guidelines, undated, the P&P indicated entries must be accurate, complete, descriptive, timely recorded within the required time period, promptly as events or observations occur, objectives ins to record facts and what is, do not assume., consistently following facility policy and standards of practice using eh same criteria when assessing or documenting. The P&P indicated legibility: do not document before an event occurs. Do not post-date.