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	04/28/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review, the facility failed to protect the residents right to be free from physical abuse for one of three sampled residents (Resident 1). The facility failed to: 1. Ensure Licensed Vocational Nurse (LVN)1 redirected Resident 1 and Resident 2 away from each other after she observed Resident 1 placing her hand on Resident 2's back. 2. Ensure facility staff provided immediate 1:1 supervision for Resident 1 after an altercation with Resident 2. These failures resulted in Resident 2 being assaulted by Resident 1 on 4/22/2026 and a second allegation of physical abuse on 4/22/2026, when Resident 3 alleged Resident 1 punched her in the face and nose. These failures had the potential to place other residents who resided in the facility at risk for abuse. Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1 had diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety (extreme worry) and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 1's the Minimum Data Set ([MDS] a resident assessment tool), dated 1/23/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired and was dependent (helper does all the effort, resident does none of the effort to complete the activity) on staff for toilet hygiene, showering, lower body dressing, and putting on and taking off footwear. The MDS indicated Resident 1 had delusions (unshakable beliefs in something that is untrue). During a review of Resident 2's admission Record (Face Sheet), the Face Sheet indicated Resident 2 was initially admitted to the facility on [DATE]. Resident 2 had diagnoses including schizophrenia, anxiety and major depressive disorder. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was moderately impaired). During a review of Resident 3's admission Record (Face Sheet), the Face Sheet indicated Resident 3 was initially admitted to the facility on [DATE]. Resident 2 had diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood and behavior), cataracts (cloudy area in the lens of the eye that blocks light, causing blurry or dim vision) and blepharochalasis (a disorder characterized by recurrent, painless, swelling of the upper eyelids, leading to thin, wrinkled, paper-like skin and stretched, saggy tissues). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognition was intact. During a review of the facility's Summary Investigative Report, dated 4/28/2026, the Summary Investigative Report indicated on 4/22/2026 LVN 1 witnessed Resident 1 push Resident 2 out of her wheelchair, unprovoked. The Summary Investigative Report indicated LVN 1 witnessed the incident in the safety mirror (specialized, reflective surfaces designed to increase visibility, enhance surveillance, and prevent accidents or theft by eliminating blind spots).During a review of the facility's Summary Investigative Report, dated 4/28/2026, the Summary Investigative Report indicated on 4/22/2026 the Clinical Director (CD) and Social Worker (SW) were made aware by Resident 3 that she (Resident 3) was hit in the face by her roommate, Resident 1. The Summary Investigative Report indicated the incident occurred moments after Resident 1 was (continued on next page)

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 - Some	interviewed for the previous interaction with Resident 2 as CD and SW were standing outside Resident 1 and Resident 3's shared room. During an interview on 4/24/2026 at 2:30 p.m., Resident 3 stated that Resident 1 hit her in the face and in the nose. Resident 3 stated Resident 1 pulled open the curtain between their beds and reached out to punch her. During a telephone interview on 4/28/2026 at 10:40 a.m., LVN 1 stated she was sitting at the nurses' station when she heard a loud verbal exchange between Resident 1 and Resident 2. LVN 1 stated she looked in the security mirror and saw Resident 1 standing near Resident 2, who was sitting in a wheelchair. LVN 1 saw Resident 1 place her hand on Resident 2's back and then push Resident 2 out of the wheelchair and onto the floor. LVN 1 stated she could not reach the residents in time to redirect them because the incident happened too quickly and she was not within arm's reach of the residents and was not in their line of sight to get their attention. LVN 1 stated she did not recall seeing other staff nearby who could have redirected the residents or deescalated the situation. LVN 1 stated Resident 1 had unpredictable, impulsive behaviors and had been newly readmitted on [DATE]. She stated the most effective way to prevent residentˆtoˆresident altercations was close monitoring and redirecting residents when they were too close to each other or when their behaviors escalated.During an interview on 4/28/2026 at 2:39 p.m., the CD stated on 4/22/2026 at approximately 3:30 p.m., the SW notified her that Resident 1 pushed Resident 2 out of her wheelchair and onto the floor. The CD stated she, LVN 1, and the SW interviewed Resident 1 in her room. Resident 1 stated, through a phone translator, that she pushed Resident 2 because she was angry. The CD stated she observed Resident 1 responding to internal stimuli and appearing agitated during the interview. Resident 1 admitted she was hearing voices at that time. The CD stated that after the interview, she, LVN 1, and the SW stepped out of the room to discuss next steps, leaving Resident 1 unsupervised with her roommate, Resident 3. The CD stated she was standing outside the room when she heard Resident 3 yell that Resident 1 hit her. She stated she saw Resident 1 backing into the hallway with her fists clenched, followed by Resident 3, who reported that Resident 1 hit her. The CD stated staff placed Resident 1 on 1:1 supervision after this alleged incident. She acknowledged they had not implemented immediate supervision earlier because, although they separated Resident 1 from Resident 2, they did not consider the risk of an altercation with Resident 3. During an interview on 4/28/2026 at 4 p.m., the Administrator (ADM) stated the facility was responsible for ensuring all residents were free from abuse and for implementing safeguards to prevent it. The ADM stated he could not confirm that a zone monitor was present in the area where Resident 1 and Resident 2 had their altercation and explained that the facility assigned one staff member to serve as the zone monitor, responsible for patrolling the building, redirecting residents, and tracking their whereabouts. The ADM stated it was impossible for the zone monitor to be present to redirect all residents with escalating behaviors because the facility allotted only one staff member for that role and the facility had always used one zone monitor and had not previously experienced issues. The ADM stated one staff member in that role was sufficient to maintain resident safety and the facility installed security mirrors to enhance resident monitoring for all staff. The ADM acknowledged that in order to redirect residents to safety, a staff member should be physically close enough to the residents or residents to effectively prevent an altercation.During a review of the facility's undated Policy and Procedure (P&P) titled, Zone Management Policy, the P/P indicated zone management system places priority on visual supervision and antecedent management in order to minimize the likelihood for intrusive, aggressive or risky behaviors in the facility. Zone monitoring responsibilities for enhancing safety in the environment may include but are not limited to the following: observe behaviors of clients in the milieu, monitor and reduce noise and crowding, redirect high risk residents from one another, intervene when clients start to have a verbal altercation and alert charge nurse to assess the need for as needed medication. During a review of the facility's P&P titled, Residents' Rights, dated 4/30/2025, the P&P indicated residents rights include the resident's right to be free from abuse, neglect, misappropriation of property and exploitation.During a review of the facility's P&P titled, Abuse Prevention and Reporting, dated 12/22/2025, the P&P indicated the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility is committed to protecting the physical and emotional well-being and personal possessions of every resident, the facility has systems, procedures and a program of employee training and supervision in place to foster dignified treatment, respect and compassion for residents.