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	05/22/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure an informed consent (a document ensuring the resident was educated of the risks and benefits of the treatment and agreed or disagreed to continue with the treatment) was obtained for one of one resident's (Resident 3) Zyprexa (olanzapine - a medication used to treat mental health conditions such as schizophrenia [a mental illness that is characterized by disturbances in thought] and bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs]) prior to administration on 5/18/2026.This deficient practice resulted in Resident 3 receiving Zyprexa without being informed of the medications purpose, risks, benefits, and potential side effects.Findings:During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 6/20/2022 with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), extrapyramidal and movement disorder (movement disorders that regulate unconscious, reflective, posture-related motor control), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 3's psychiatric (medical specialty in treating mental illness) progress notes dated 4/6/2026, the psychiatric progress notes indicated Resident 3 was alert and oriented to person, place, and situation with mild confusion. The psychiatric progress notes indicated Resident 3's insight and judgement were impaired due to ongoing psychotic (a mental condition where a person has trouble telling what is real from what is not) symptoms.During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 3/26/2026, the MDS indicated Resident 3 had moderate impairment of the ability to think or make decisions. The MDS indicated Resident 3 needed staff supervision with personal hygiene, setup assistance with showering, and was independent with eating, oral and toileting hygiene, upper and lower body dressing, and putting on or taking off footwear.During a review of Resident 3's Post Event Assessment Form Part 1 (COC - change of condition) dated 5/18/2026, the COC indicated Resident 3 was observed banging and punching the entrance double door and displaying physical aggression attempting to hit staff during redirection. The COC indicated olanzapine 10 mg (milligrams - metric unit of measurement, used for medication dosage and/or amount) with Benadryl (diphenhydramine hydrochloride) 50 mg intramuscular was administered.During a review of Resident 3's Order Review Report dated 5/21/2026, the Order Review Report indicated a physician's order for Olanzapine (Zyprexa) Intramuscular Solution Reconstituted 10 mg Inject 10 mg intramuscularly (in the muscle) every 8 hours as needed for banging on doors and severe agitation for 14 days give with Benadryl, give if refuse PO (oral) as needed, not to exceed three doses in 24 hours and diphenhydramine hydrochloride (Benadryl) injection solution 50 mg /ml (milliliters - a metric unit of volume used to measure small amounts of liquid) inject 1 ml intramuscularly every eight hours as needed for banging on doors and severe agitation for 14 days give with Zyprexa, give if refuse oral as needed, not to exceed three doses in 24 hours started on 5/5/2026.During a review of Resident 3's Medication Administration Record (MAR) for 5/2026, the MAR indicated Resident received a dose of Zyprexa and Benadryl on 5/18/2026.During an interview on 5/19/2026 at 10:30 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated during the incident on 5/18/2026, she observed Resident 3 banging on the double doors (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	located near the entrance of the facility. LVN 1 stated Resident 3 had an order for Zyprexa and Benadryl and administered the medications as prescribed for the indication of banging on doors. LVN 1 stated prior to the administration of Zyprexa on 5/18/2026 she did not get a chance to verify if Resident 3 had an informed consent for Zyprexa. LVN 1 stated informed consents for psychotropic medications (medications affecting the central nervous system to treat psychiatric disorders or illnesses) should be obtained upon receiving the physicians order or prior to administration of the first dose.During a concurrent interview and record review on 5/19/2026 at 4:53 p.m., with the Assistant Director of Nursing (ADON), Resident 3's informed consents were reviewed. The ADON stated there was no evidence facility staff obtained an informed consent document for the Zyprexa that was ordered on 5/5/2026. The ADON stated informed consents should be obtained upon receiving the physician's order or prior to administration of the first dose. The ADON stated prior to administration of psychotropic medications, staff should verify if informed consent was obtained. The ADON stated the importance of an informed consent was to ensure the resident or the conservator (a court-appointed individual or organization legally authorized to manage the financial or personal affairs of a person deemed incapacitated) was informed about the medication's purpose, risks, benefits, and potential side effects. The ADON stated if an informed consent was not presented to the resident or the conservator, there would be a potential for Resident 3 to receive medications without knowledge of the purpose, effect, potential side effects, risks or benefits.During a review of the facility's policy and procedures (P&P) titled Informed Consent for Psychoactive Medication dated 4/21/2026, the P&P indicated .Every person served received information from the prescriber regarding psychoactive medications prescribed for them. The prescriber completes, signs and documents in their notes that informed consent was obtained by the adult voluntary person served and/or legal guardian. Adult involuntary and all persons served.must provide a signature on the form.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one resident's (Resident 3) administration of Zyprexa (olanzapine - a medication used to treat mental health conditions such as schizophrenia [a mental illness that is characterized by disturbances in thought] and bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs]) and Benadryl (diphenhydramine - a medicine given to treat or prevent side effects caused by antipsychotics medications) was documented upon administration on 5/5/2026.This failure had the potential to result in inaccurate medication records, uncertainty regarding whether Resident 3 received Zyprexa and Benadryl as ordered by the physician, unmonitored medication effectiveness and adverse effects, and medication errors.Findings:During a review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 6/20/2022 with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought) , extrapyramidal and movement disorder (movement disorders that regulate unconscious, reflective, posture-related motor control), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 3's psychiatric (medical specialty in treating mental illness) progress notes dated 4/6/2026, the psychiatric progress notes indicated Resident 3 was alert and oriented to person, place, and situation with mild confusion. The psychiatric progress notes indicated Resident 3's insight and judgement were impaired due to ongoing psychotic (a mental condition where a person has trouble telling what is real from what is not) symptoms.During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 3/26/2026, the MDS indicated Resident 3 had moderate impairment of ability to think or make decisions. The MDS indicated Resident 3 needed staff supervision with personal hygiene, setup assistance with showering, and was independent with eating, oral and toileting hygiene, upper and lower body dressing, and putting on or taking off footwear.During a review of Resident 3's progress notes dated 5/5/2026, the progress note indicated Resident 3 was observed banging and kicking on the door near room [ROOM NUMBER]. The progress notes indicated staff attempted verbal redirection, but Resident 3 became physically aggressive and attempted to strike and push staff members. The progress notes indicated the physician was notified of Resident 3's physical aggression and lack of response to redirection. The progress notes indicated as needed orders for Zyprexa and Benadryl were received, noted, and administered. During a review of Resident 3's Order Review Report dated 5/21/2026, the Order Review Report indicated a physician's order for Olanzapine (Zyprexa) Intramuscular Solution Reconstituted 10 mg Inject 10 mg intramuscularly (in the muscle) every 8 hours as needed for banging on doors and severe agitation for 14 days give with Benadryl, give if refuse PO (oral) as needed, not to exceed three doses in 24 hours and diphenhydramine hydrochloride (Benadryl) injection solution 50 mg /ml (milliliters - a metric unit of volume used to measure small amounts of liquid) inject 1 ml intramuscularly every eight hours as needed for banging on doors and severe agitation for 14 days give with Zyprexa, give if refuse oral as needed, not to exceed three doses in 24 hours started on 5/5/2026.During a review of Resident 3's Medication Administration Record (MAR) for 5/2026, the MAR did not indicate Resident 3 received a dose of Zyprexa and Benadryl on 5/5/2026.During an interview on 5/20/2026 at 7:32 a.m., with Registered Nurse Supervisor (RNS) 3, RNS 3 stated, on 5/5/2026 between 1:00 a.m. and 2:00 a.m. Resident 3 displayed episodes of banging on a door near room [ROOM NUMBER] and Resident 3 was not redirectable. RNS 3 stated she informed the physician and received orders for Zyprexa and Benadryl and administered intramuscular dose to Resident 3. RNS 3 stated she did not obtain the medications from the emergency kit because Resident 3 had previous medications in the medication cart. RNS 3 stated she documented Resident 3's received the Zyprexa and Benadryl in her progress (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notes on 5/5/2026.During a concurrent interview and record review on 5/20/2026 at 4:18 p.m., with the Assistant Director of Nursing (ADON), Resident 3's progress notes and MAR dated 5/5/2026 and station 1 facility emergency box log (e-kit logbook) were reviewed. The ADON stated Resident 3's progress notes dated 5/5/2026 indicated Resident 3 was prescribed and received Zyprexa and Benadryl on 5/5/2026 at 1:28 a.m. The ADON stated staff did not document on Resident 3's MAR dated 5/5/2026 Resident 3 received Zyprexa and Benadryl on 5/5/2026. The ADON stated the staff did not document on the e-kit logbook a dose of Zyprexa and Benadryl was taken from the emergency kit on 5/5/2026. The ADON stated the importance of documenting a medication administration was to ensure there was a record of medication given to Resident 3 to avoid medication errors. The ADON stated there would be potential for Resident 3 to receive another dose shortly after the undocumented dose was given and potentially would be over medicated.During a review of the facility's policy and procedure (P&P) titled As Needed Medication PRN - Administration dated 8/8/2025, indicated Procedure: .3. PRN medications are initialed electronically or in the appropriate place on the paper MAR immediately following administration.