

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/24/2026
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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the physician of an elevated laboratory result for one of five sampled residents (Resident 5's). The facility failed to:1.Ensure Resident 5's physician was notified of elevated prostate-specific antigen level (PSA- a simple blood test to help look for [prostate- a walnut-sized gland in the male reproductive system that makes fluid for semen] problems) laboratory result of 18.2 nanograms (ng-unit of measurement)/milliliters (mL- unit of measurement) greater than 10 ng/mL: Probability of prostate cancer - 50%) dated 1/28/2026.2.Document physician notification or obtain timely follow-up after the abnormal laboratory result was identified.This deficient practice had the potential to delay physician evaluation, diagnostic workup, and implementation of appropriate medical treatment for Resident 5.Findings:During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), and depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).During a review of Resident 5's Minimum Data Set (MDS ?a resident assessment tool) dated 5/14/2026, the MDS indicated Resident 5 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for toileting hygiene and oral hygiene.During a review of Resident 5's Progress Notes dated 1/30/2026, the Progress Notes indicated, Resident has been scheduled for Gastroenterology (specialist diagnose and treat conditions affecting the digestive system) /Colonoscopy (medical test that uses a tiny camera on a soft, bendable tube to look inside the large intestine (colon)for 5/6/2026 with time to follow. Registered Nurse Supervisor (RNS) was aware.During a review of Resident 5's Progress Notes dated 2/6/2026, the Progress Notes indicated, Assessment Prostate specific antigen outside reference range referral to urology (medical and surgical specialist that deals with diseases if the male and female urinary tract).During a review of Resident 5's Medical Progress Notes dated 2/16/2026, the Medical Progress Notes indicated, elevated Prostate-Specific Antigen level (PSA- a simple blood test to help look for [prostate- a walnut-sized gland in the male reproductive system that makes fluid for semen] problems) PSA at 18.2.Plan: PSA outside reference range, referral to urology.During a review of Resident 5's Physician Progress Notes dated 3/4/2026, the Physician Progress Notes indicated PSA outside reference range, referral to urology.During a review of Resident 5's Care Plan titled Resident PSA level of level of 18.2 ng/mL and considered to be elevated at risk for urinary changes as in incontinence (loss of bladder and/or bowel control), frequency and urgency, painful urination, blood in the urine dated 3/2026 the Care plan intervention interventions including urology consult for evaluation and (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 05A355
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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment. During a review of Resident 5's Medical Progress Notes dated 3/16/2026, the Medical Progress Notes indicated, plan: PSA outside reference range, referral to Urology. During a review of Resident 5's Physician Progress Notes dated 4/3/2026, the Physician Progress Notes indicated, PSA outside reference range, referral to Urology. During a review of Resident 5's Annual History & Physical (H&P) dated 4/13/2026, the Annual H&P indicated, PSA outside reference range, referral to Urology. During a review of Resident 5's Order Summary dated 5/15/2026, the Order Summary indicated, urology consult related to elevated PSA and urinary incontinence. During a review of Resident 5's Appointment Progress Notes dated 5/21/2026, the Appointment Progress Notes indicated, resident has a new patient Urology appointment scheduled on 7/1/2026 at 2:00 pm. RN Supervisor was aware. During a review of Resident 5's Appointment Progress Notes dated 6/16/2026, the Appointment Progress Notes indicated, resident had a scheduled colonoscopy appointment on 6/3/2026 but the doctor's office rescheduled it. The appointment was rescheduled for 7/31/2026 7:00 a.m., with all pre-procedure information to follow including the location of the procedure. RN Supervisor was aware. During the review of Resident 5's Appointment Progress Notes dated 6/29/2026, the Appointment Progress Notes indicated the resident had a new patient urology appointment scheduled for 7/1/2026. The doctor's office called to cancel the appointment because the resident was unable to sign the consent forms. The office suggested a higher level of care since the resident was under conservatorship (a legal arrangement where a judge names a helper (a conservator) to take care of an adult who cannot safely make their own choices). The RN Supervisor was aware. During a review of Resident 5's Medical Progress Notes dated 7/3/2026, the Medical Progress Notes indicated, elevated prostate PSA, referral to Urology pending. Patient was unable to get into last urology in June. Discussed with staff importance of getting into a new urology for testing. During a review of Resident 5's Appointment Progress Notes dated 7/13/2026, the Appointment Progress Notes indicated the resident had a new patient urology appointment scheduled for 8/19/2026 at 10:15 a.m. The notes indicated instructed staff to bring the appropriate labs and paperwork to the appointment. The RN Supervisor was aware. During a concurrent interview and record review with License Vocational Nurse (LVN) 1 on 7/23/2026 at 2:11 p.m., Resident 5's laboratory results were reviewed. The PSA laboratory result was dated 01/28/2026, with a reported PSA level of 18.2. LVN 1 stated Resident 5's PSA level was elevated and stated the physician should have been notified of the abnormal laboratory result and notification should have been documented in Resident 5's progress notes. Resident 5's progress notes was conducted with the LVN 1. The record review revealed no documentation Resident 5's physician had been notified of the elevated PSA level of 18.2. LVN 1 was unable to accurately state her understanding of the PSA level. LVN 1 stated failure to report an elevated PSA result to the physician could result in a delay in care. LVN 1 stated potential outcomes could include delayed evaluation and diagnosis of an underlying condition, delayed treatment, worsening of the resident's condition, or progression of an underlying condition due to lack of timely medical evaluation and intervention. During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 7/24/2026 at 10:00 a.m., Resident 5's electronic medical record was reviewed. The ADON stated she first became aware of Resident 5's elevated PSA in February 2026 but was unsure how she was informed. She stated nursing staff were responsible for reviewing lab results, notifying the physician, and documenting the notification in the progress notes. She stated communication among nursing staff occurred during change of shift reports and daily stand up meetings. The ADON stated that she could not identify who notified the physician or when, because there was no documentation in Resident 5's electronic medical record. She stated there was no documentation showing the physician had been notified of the elevated PSA and that the facility (continued on next page)		

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