| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 05A355 | A. Building<br>B. Wing | 10/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LA Paz Geropsychiatric Center | 8835 Vans Street<br>Paramount, CA 90723 |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident did not sustain unplanned severe weight loss (a weight loss greater than 5 % in one month, greater that 7.5% in three months and greater than 10 % in 6 months) of 37 pounds ([lbs. unit of measurement] 24 percent [%] in five months for one of three sampled residents (Resident 8). The facility failed to: 1. Ensure Resident 8 weigh was taken from 5/2025 through 8/2025 as ordered by the physician to identify the resident's significant weight loss in accordance with the facility's policy and procedure (P&P) titled, Notification of Physician/Prescriber, dated 10/20/2025 which indicated It is the policy of the facility to obtain height and weight upon admission and to continue to monitor the weight of persons served as required based on prescriber order or nursing clinical judgment in order to help identify metabolic complications (health problems that arise from the body's inability to properly process and regulates substances) or disorders. 2. Monitor, and report Resident 8's repeated meal refusals to the physician and Registered Dietitian (RD). 3. Notify the physician of Resident 8's refusal to eat 50 times from 6/23/2025 through 8/31/2025 and 29 times from 9/1/2025 through 9/11/2025 in accordance with the facility's P&P titled, Notification of Physician/Prescriber, dated 7/16/2025, which indicated . the licensed nurse is responsible to inform the physician or other prescriber responsible for the medical or psychiatric care of the person served of any changes in the person served emotional, behavioral, physical condition, and/or involvement in adverse events. 4. Ensure licensed nurses informed the RD of Resident 8's poor meal intake to ensure monthly monitoring and timely nutritional recommendations. These deficient practices resulted in Resident 8's 37-pounds weight loss over a five-month period (5/2025 through 9/2025) contributing to Resident 8's transfer to a General Acute Care Hospital (GACH) on 9/11/2025, and placing Resident 8 at risk for malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things), dehydration (dangerous loss of body fluid caused by illness, sweating, or inadequate intake), and skin break down. Findings:During a review of Resident 8's admission Record, the admission Record indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including 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), constipation (difficulty in emptying the bowels) and gastro-esophageal reflux disease (GERD- a chronic condition where stomach acid and other contents frequently flows back into the esophagus). During a review of Resident 8's Physician's Order Summary, dated 10/15/2024, the Physician's Order Summary indicated to weight resident's monthly. During a review of Resident 8's Weights and Vitals Summary dated 4/26/2025, the Weight and Vital Summary indicated on 4/26/2025 Resident 8 weighed 154.6 lbs. Resident 8's Weights and Vitals Summary indicated there was no weight recorded from 5/2025 through 8/2025, a total of four months During a review of Resident 8's Registered Dietician Nutrition Screening, dated 6/27/2025, the Registered Dietician Nutrition Screening indicated that Resident 8 mostly ate snacks throughout the day as well as consumed Ensure (nutritional supplement) twice a day. Registered Dietician Nutrition Screening indicated the RD documented Unclear if weight has been stable as Resident 8 has continually refused to get weighed. The Registered Dietician Nutritional Screening indicated the goal<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | for Resident 8 was to maintain stable weight of 155 lbs. with no significant changes through next assessment 9/2025. Registered Dietician Nutrition Screening form indicated the nutrition interventions included to Monitor/evaluate oral intake, monitor/evaluate monthly weight trends, and continue to provide Ensure twice a day to supplement food intake. The Registered Dietician Nutrition Screening form indicated Resident 8's daily caloric needs were 1620 kilo calorie (kcal-a unit of energy used in nutrition) per day. Registered Dietician Nutrition Screening indicated Resident 8's usual body weight ( the weight that an individual typically maintains over time) was 147 to 157 lbs. During a review of Resident 8's Meal intake record from 6/23/2025 through 8/31/2025, the Meal Intake record indicated Resident 8 refused meals including breakfast, lunch and dinner 50 times. During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool) dated 7/1/2025, the MDS indicated Resident 8's height was 64 inches (unit of measurement) and weighs 155 lbs. The MDS indicated that Resident 8 did not experience a weight loss of 5% or more in the past month, nor a weight loss of 10% or more in the past six months. During a review of Resident 8's Documentation Survey Report (Meal Intake) from 9/1/2025 to 9/11/2025, the Documentation Survey Report indicated Resident 8 refused all daily meals except on 9/2/2025. On September 2, 2025, Resident 8 consumed 100% of the dinner meal only. During a review of Resident 8's Meal Intake record for the period of 9/4/2025 through 9/11/2025, the Meal Intake record indicated Resident 8 refused all meals each day. During a review of Resident 8's Progress Notes, dated 9/7/2025, the Progress Notes indicated Resident 8 refused to go to the dining room for dinner, and did not eat when tray was brought to Resident 8's room on 9/7/2025. During a review of Resident 8's Progress Notes, dated 9/10/2025, the Progress Notes indicated Resident 8 was refusing breakfast, lunch, and dinner. During a review of Resident 8's Progress Notes, dated 9/11/2025 timed at 10:00 a.m., the Progress Notes indicated Resident 8 refused his meals for five days from 9/5/2025 to 9/10/2025. Resident 8 was noted to be disorganized (disrupted thinking, speech and behavior) , disheveled (untidy), isolated, argumentative and combative (ready or eager to fight). The Progress Notes indicated Resident 8 was sent to GACH on 9/11/2025 for further evaluation due to change in condition. Resident 8 returned to the facility on 9/17/2025. During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8 needed partial to moderate assistance from nursing staff with showering and dressing. The MDS indicated Resident 8 needed supervision or touching assistance from nursing staff with eating, oral hygiene, toileting and walking. The MDS indicated Resident 8 height was 64 inches and weighed 117 lbs. The MDS indicated Resident 8 loss 5 % or more in the last month or loss 10 % or more in last 6 months. During a review of Resident 8's Care Plan titled Risk for imbalanced nutrition less than body requirements related to diagnoses depression (mental health condition characterized by persistent feeling of sadness, loss of interest, and low energy), decreased appetite, skipping breakfast most of the time as evidenced by poor intake and weight loss dated 5/6/2025, the Care Plan goal indicated Resident 8 will be able to consume at least 75 % of meal intake and will have no significant weight loss. The Care Plan interventions included encouraging and assisting Resident 8 in going to the dining room during mealtimes, providing food substitutes when refusing to eat a full meal, weigh Resident 8 as ordered and notify Resident 8's medical doctor (MD) for any significant weight loss of 5% in a month and 10% in the last six months. During a review of Resident 8's Care Plan titled Decreased oral intake as evidenced by refusal of meals initiated on 9/10/2025, the Care Plan goals indicated Resident 8 will maintain stable weight and will consume at least 75 % of meals within one week. The Care Plan interventions indicated monitor weight weekly, consult dietician for high calorie, high protein diet or supplements, notify MD if poor intake persists for 72 hours or significant weight loss was noted. During a review of Resident 8's Weights and Vitals Summary, the Weight and Vital Summary dated 9/19/2025 indicated on 9/19/2025 Resident 8 weighed 117 pounds. During an interview on 10/21/2025 at 12:15 p.m., with the Registered Dietitian (RD), the RD stated that Resident 8 was in her room with nursing staff preparing for lunch. The RD reported that Resident 8's scheduled mealtime was 12:30 p.m. in the dining area and that Resident 8 required encouragement to attend<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | meals in the dining room. During an observation on 10/21/2025 at 12:43 p.m., in Resident 8's room, Resident 8 was observed seated at the edge of her bed with her head down. No meal tray was present at the bedside. During an interview on 10/21/2025 at 12:49 p.m., Certified Nursing Assistant (CNA) 1 stated she was assigned to Resident 8's room and that all of Resident 8's roommates had already received and eaten their lunch. During an interview on 10/21/2025 at 12:54 p.m., in the dining room Registered Nurse Supervisor (RNS) 2 stated that Resident 8 had not yet eaten. During an interview on 10/21/2025 at 1:01 p.m., CNA 3 stated that around 12:00 p.m., while covering CNA 1, CNA 3 encouraged Resident 8 to eat in the dining room. CNA 3 stated Resident 8 refused but she did not report the refusal to the charge nurse or Registered Nurse Supervisor (RNS). CNA 3 stated that refusals should be reported shortly after meal rounds and that Resident 8 could experience weight loss if meals were not provided in a timely manner. During an interview on 10/21/2025 at 1:24 p.m., RNS 2 stated she delivered a meal tray to Resident 8 at 1:15 p.m. RNS 2 stated that if a resident refuses to eat in the dining room, the tray should be brought to the resident room, and the resident should be supervised during the meal. RNS 2 stated that delayed meals could lead to hunger, refusal to eat, and weight loss. During an interview on 10/23/2025 at 9:20 a.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated that Resident 8 required encouragement to attend meals, had poor intake, and a history of weight loss. LVN 5 stated that Resident 8's weight decreased from 154 lbs. on 4/26/2025 to 117 lbs. on 9/19/2025, a loss of 37 lbs. in five months. LVN 5 stated Resident 8 was sent to GACH on 9/11/2025 after refusing meals for six days from 9/5/2025 through 9/11/2025. LVN 5 stated Resident 8's weight loss was first identified when Resident 8 agreed to be weighed on 9/19/2025 after her return to the facility from the GACH on 9/17/2025. LVN 5 stated that Resident 8 weight was not monitored prior to 9/11/2025. During a concurrent interview and record review on 10/23/2025 at 10:29 a.m., with RNS 1, Resident 8's Point of Care (POC) Response History Meal Intake Percentage dated 9/2025 was reviewed, , the POC Response History Meal Intake Percentage indicated Resident 8 refused breakfast, lunch and dinner from 9/4/2025 to 9/11/ 2025. RNS 1 confirmed that Resident 8's weight loss was not identified until 9/19/2025, on the day the resident's weight was taken. RNS 1 stated Resident 8 was hospitalized from [DATE] to 9/17/2025 for not eating for five days. RNS 1 stated the RD assessed Resident 8 on 9/26/2025 upon Resident 8's return from GACH. RNS 1 stated it was unclear whether Resident 8 was refusing food or just refusing to go to the dining room prior to hospitalization on 9/11/2025. RNS 1 reported that Resident 8 had refused 29 meals from 9/1/2025 through 9/11/2025 prior to hospitalization on 9/11/2025. RNS 1 stated it was the facility's policy to notify Resident 8's MD or RD after two to three days of meal refusal. RNS 1 stated Resident 8's MD and RD were not notified of Resident 8's meals refusal because Resident 8 was consuming snacks consisting of half cheese sandwich and sherbet per physician order dated 3/13/2025. RNS 1 stated that inadequate caloric intake (the amount of energy [calories] consumed through food and beverages) could lead to the resident's malnutrition. During an interview on 10/23/2025 at 11:24 a.m. with the RD, the RD stated she was responsible for monitoring weights and provide recommendations for interventions to prevent weight loss, and to conduct quarterly and annual residents' nutritional assessments. RD stated she does not know when Resident 8 started to lose weight. RD stated she was not aware of Resident 8's weight loss until 9/22/2025. RD stated she was not aware Resident 8 refused meals 29 times from 9/1/2025 to 9/11/2025 before being hospitalized on [DATE]. RD stated Resident 8's weight loss could have been prevented with prompt nutritional interventions to prevent a decline in condition and nutrition. RD stated Resident 8 would have benefited from being monitored monthly and stated that the facility has no system to monitor weight loss. RD stated she should have monitored Resident 8's meal intake. During an interview on 10/24/2025 at 4:04 p.m., with the Director of Nursing (DON) stated that CNAs should report residents who refuse two meals to the charge nurse and offer alternatives. The DON stated it was important to identify weight loss early. The DON stated that snacks alone were insufficient to meet Resident 8 daily caloric needs of 1620 kcal per day (based on RD assessment on 6/26/2025). The DON stated<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | that Resident 8 was not meeting nutritional requirements and was at risk for complications such as skin breakdown, weakness, and medication side effects. During a review of Resident 8's Physician's Orders Summary, dated 9/11/2025, the Physician's Order Summary indicated Resident 8 was transferred to the GACH for an evaluation of altered mental status. During a review of Resident 8's GACH records, dated 9/16/2025, the GACH records indicated, Resident 8 was assessed with failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), altered mental status, hypernatremia (the sodium concentration in the blood is abnormally high due to inadequate fluid intake), hypokalemia (the potassium level in the blood is lower than normal) and elevated creatinine kinase level (CK- an enzyme found in the muscles elevated levels indicate muscle damage). The GACH records indicated Resident 8 received potassium chloride (KCl) 20 milliequivalent (mEq- unit of measurement) one time plus a normal saline (NS- sodium chloride dissolved in one liter of water used to treat dehydration) 0.9% bolus (large dose of fluid administered over a short period to rapidly achieve a desired therapeutic concentration in the body) one liter one time. During a review of the facility's policy and procedures (P&P) titled, Resident Food Services,, revised on 1/2025, the P&P indicated The community will provide three meals daily at regular times comparable to standard mealtimes in the community or in accordance with resident needs, preferences, requests, and individualized plan of care. Meals are available so that no more than 14 hours elapses between the dinner/evening meal and the start time of the breakfast meal the following day except when a nourishing snack is served. During a review of the facility's P&P titled, Weight Variance Reporting and Committee dated 12/9/2024, the P&P indicated, It is the policy of the facility to review and monitor persons served with significant weight variance.When a Licensed Nurse identifies a significant weight change (5% or 5 lbs. or more in 30 days, 7.5% in 90 days, or 10% in 180 days) with a person's served monthly weight, he/she will notify the dietary supervisor and the interdisciplinary team (IDT). Licensed Nurse will include the individual on the list for weekly weight measurement. Licensed Nurse will check the individual to possibly determine contributory or causative factors. Physicians will be notified and consulted. Licensed Nurse will notify the responsible party of the weight change and new plan(s), if any. Licensed Nurse will initiate a or revise an existing care plan. The dietary supervisor will obtain Registered Dietitian consultation and initiate a weekly meeting with Interdisciplinary Team or Weight Variance Committee Team to follow through on the person's served weight and nutritional status. Within 7 (seven) working days after significant weight change is identified, IDT will conduct team analysis to identify causative/contributory factors (physical or psychosocial causes) and develop, update or revise the care plan. Interdisciplinary team or Weight Variance Committee Team may discontinue weekly weight monitoring until the weight is stable, or the desired outcome is achieved. During a review of the facility's P&P titled, Notification of Physician/Prescriber, dated 10/20/2025, the P&P indicated, It is the policy of the facility to obtain height and weight upon admission and to continue to monitor the weight of persons served as required based on prescriber order or nursing clinical judgment in order to help identify metabolic complications or disorders. During a review of the facility's P&P titled, Notification of Physician/Prescriber, dated 7/16/2025, the P&P indicated, .It is the policy of the facility to provide evidence-based best practices including that the licensed nurse is responsible to inform the physician or other prescriber responsible for the medical or psychiatric care of the person served of any changes in the person emotional, behavioral, physical condition, and/or involvement in adverse events. During a review of the facility's Clinical Dietician Job Description, dated 1/2029, the P&P indicated, Essential Functions and Responsibilities: Assesses the nutritional status of adult and/or geriatric patient/resident through documentation in the medical record. Uses parameters such as anthropometric (scientific study of measurements of the human body) measurements, nutrition-focused physical assessment and interpretation of laboratory values. Develops, revises and individualizes nutrition care plan based on information from the resident, medical record, family and health care team members. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure proper food handling practices were followed. The facility failed to ensure that a dietary aide washed her hands and wore a hairnet before entering the food preparation area after coming from outside. This deficient practice had the potential to result in food contamination and increase the risk of foodborne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) among residents.Findings: During a tray line (system of food preparation, used facility, in which trays move along an assembly line) observation on 10/22/2025 at 11:32 a.m., a Dietary Aide (DA) was observed standing in the kitchen food preparation area holding a cup with a straw in her hand. The DA was not wearing a hairnet at the time. When approached by the surveyor, the DA stated, I just walked in, and immediately proceeded to put on a hairnet and wash her hands.During an interview on 10/22/2025 at 3:41 p.m., DA stated that she was aware of the requirement to wear a hairnet and wash her hands before entering the kitchen. DA stated that she made a mistake by not following the protocol. DA stated that going forward, she will ensure she puts on her hairnet and washes her hands before beginning any tasks in the kitchen. During an interview on 10/22/2025 at 3:29 p.m., with the Director of Food Services (DFS), the DFS stated that all staff entering the kitchen were required to wear hairnets or hair coverings and must wash their hands before entering the food preparation area. The DFS stated that failure to follow proper hand hygiene can lead to food contamination. The DFS stated that staff have received both verbal and written in-service training on these procedures and will continue to receive ongoing education to reinforce compliance.During review of the facility's policy and procedures (P&P) titled, Uniform Dress Code revised on 01/25, the P&P indicated Wear the approved hair restraint when on duty regardless of length or presence of hair. Food service staff must wear hairnets when assembling a meal or snack. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure three of seven sampled residents (Resident 41, Resident 55 and Resident 134) were treated with respect and dignity. The facility failed to 1.Provide a privacy curtain in Resident 55's room. 2. Close Resident 40 and 134 privacy curtains to protect residents' privacy during medication administration. These failures had the potential to result in feelings of decreased self-esteem and self-worth for Resident 41, Resident 55 and Resident 134.Findings:1.During a review of Resident 55's admission Record, the admission Record indicated the Resident 55 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder(a mental illness that can affect thoughts, mood, and behavior),bipolar type(sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), antisocial personality disorder(mental health condition characterized by a persistent pattern of disregard for social norms, laws and the rights of others), and diabetes mellitus,(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 55's Minimum Data Set (MDS- a resident assessment tool) dated 7/17/2025, the MDS indicated Resident 55 had an intact cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 55 was independent (resident completes the activity by themselves without assistance from a helper) with oral hygiene, toileting hygiene, dressing, bed mobility and transfer from a bed to a chair.During a concurrent observation and interview on 10/21/2025 at 10:15 a.m. with Resident 55 in Resident 55 room, observed Resident 55 lying in bed, and no privacy curtain hanging in resident's room. Resident 55 stated he would like to have a curtain in his room so he can have privacy.During an interview on 10/23/2025, at 4:59 p.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated when she made rounds in the morning of 10/22/2025 Resident 55's privacy curtains were still present and did not know what happened to the curtains. CNA 6 stated it was important to have privacy curtains in a resident's room to ensure privacy. CNA 6 stated Resident 55 would feel bad if there was no privacy curtain because it was a resident right to have privacy.During an interview on 10/23/2025, at 10:26 a.m. with Housekeeping (HSK 1), HSK 1 stated she had to report to the Maintenance Department if a resident's room had no privacy curtains. HSK 1 stated any issues with privacy curtains and bathrooms should be reported to the Maintenance Department because the residents need to be safe and comfortable.During an interview on 10/23/2025 at 9:52 a.m. with the Housekeeping Supervisor (HS), the HS stated housekeeping staff should have informed the Maintenance Department to fix the privacy curtains. HS stated the staff could have informed HS of the missing privacy curtains in residents' rooms so they will be addressed.During an interview on 10/24/2025, at 12:21 p.m. with the Director of Nursing (DON), the DON stated privacy curtain should be present in each resident room to promote dignity and privacy. The DON stated the residents can get embarrassed and upset if privacy curtains were not provided.During a review of facility's policy and procedure (P&P) titled, Residents' Rights dated 4/30/2025, the P&P indicated The facility will treat each resident with respect and dignity and provide an environment that will maintain and enhance their quality of life.2a. During a review of Resident 41's admission Record, dated 10/23/2025, the admission Record indicated Resident 41 was admitted to the facility on [DATE] with diagnoses including insomnia (unable to sleep), major depressive disorder (a condition with persistently low or depressed mood, feelings of guilt or worthlessness) and anxiety disorder (a condition characterized by excessive and persistent fear and worry).During an observation on 10/22/2025 at 1:25 p.m., Licensed Vocational Nurse (LVN) 3 prepared one capsule of gabapentin (a medication used to treat nerve pain) 400 milligrams ([mg] a unit of measure for mass) to be administered to Resident 41. During medication administration, LVN 3 did not close Resident 41's privacy curtain while Resident 134 was also in the same room.During a<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | review of Resident 41's Order Summary Report, dated 10/23/2025, the Order Summary Report indicated the following physician order: Neurontin oral capsule 400 mg (generic name - gabapentin), give 1 capsule by mouth three times a day for mood stability manifested by (m/b) racing thoughts (rapid thought patterns) , order date 6/29/2025, start date 6/29/2025 2b. During a review of Resident 134's admission Record, dated 10/23/2025, the admission Record indicated Resident 134 was admitted to the facility on [DATE] with diagnoses that included but not limited to schizoaffective disorder, bipolar type, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and major depressive disorder.During an observation on 10/22/2025 at 1:19 p.m., LVN 3 prepared the following medications to be administered to Resident 134.1. One tablet of gabapentin 600 mg2. One tablet of metformin (a medication used to treat high blood glucose) 850 mg3. One capsule of ziprasidone (a medication used to treat mood disorders) 80 mgDuring medication administration, LVN 3 did not close Resident 134's privacy curtain while Resident 41 was also in the same room.During a review of Resident 134's order summary report, dated 10/23/2025, the document indicated but not limited to the following physician orders: Gabapentin oral tablet 600 mg, give 1 tablet by mouth three times a day for nerve pain, order date 6/5/2025, start date 6/6/2024. Metformin hydrochloride (HCl) oral tablet 850 mg, give 850 mg by mouth with meals for DM give with food, order date 10/22/2025, start date 10/22/2025 Ziprasidone HCl oral capsule 80 mg, give 1 capsule by mouth two times a day for grandiose delusions, auditory and visual hallucinations, order date 1/13/2025, start date 1/13/2025During an interview on 10/23/2025 at 9:23 a.m. with LVN 3, LVN 3 stated it was important to close the privacy curtains while administering medications to provide privacy for the residents. During an interview on 10/22/2025 at 4:08 p.m. with the DON, the DON stated the facility's nursing staff should pull the privacy curtain during medication pass, to provide privacy and protect residents' rights, so that they were not uncomfortable taking the medications in front of other residents.During a review of the facility's policy and procedure (P&P) titled Residents' Rights (SNF), dated 4/30/2025, the P&P indicated, This facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 05A355 | A. Building<br>B. Wing | 10/24/2025 |

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| LA Paz Geropsychiatric Center | 8835 Vans Street<br>Paramount, CA 90723 |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure four of six sampled residents' psychotropic medication (a drug that changes brain function and results in alterations in perception, mood, consciousness or behavior) informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), prior to starting medication. The facility failed to:1.Provide Resident 2, Resident 8, and Resident138 were provided with psychotropic medication informed consent, prior to starting medication. 2. Provide current documentation of an informed consent for Resident 90's Lexapro's ([generic name - escitalopram] a medication used to treat major depressive disorder [a mood disorder that causes a persistent feeling of sadness and loss of interest] and generalized anxiety disorder [a mental health condition characterized by excessive and uncontrollable worry about everyday things]) current dose of 10 milligrams ([mg] a unit of measurement for mass), olanzapine (a medication used to treat 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]) 10 mg, and Depakote ([generic name - divalproex] a medication used to treat mood disorder and seizure [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) extended release 750 mg, for unnecessary medications review for psychotropic medications. This failure violated the residents' right to make an informed decision regarding the use of psychotropic medications.Findings:<br><br>1.During a review of Resident 2's admission Record, (Face Sheet front page of the chart that contains a summary of basic information about the resident) dated 10/24/2025, the admission record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnosis including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), anxiety (emotion characterized by feelings of tension, worried thoughts) and insomnia (trouble falling asleep or staying asleep).<br><br>During a review of Resident 2's History & Physical (H&P) dated 9/15/2025, the H&P indicated Resident 2 was awake, alert and oriented.<br><br>During a review of Resident 2's Minimum Data Set (MDS – a federally mandated resident assessment tool), dated 9/22/2025 the MDS indicated Resident 2's cognition was severely impaired (limitations in a person's physical or mental abilities). The MDS also indicted Resident 2 needed partial/moderate assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS also indicated Resident 2 was taking an antipsychotic (a type of medication prescribed to treat mental health problem ) medication, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) medication and an anticonvulsant (mood stabilizer) medication.<br><br>During a review of Resident 2's Order Summary Report dated 10/24/2025, the order summary report indicated Resident 2 was prescribed:<br><br>1. Abilify (antipsychotic) oral tablet 10 milligrams (mg – unit of measure) at night for attention seeking behaviors/striking out, medication start date 9/15/2025.<br><br>2. Depakote (mood stabilizer) oral tablet delayed release 750 mg by mouth in the morning for mood stabilizer, medication start date 9/15/25.<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Depakote oral tablet delayed release 1000 mg by mouth in the evening for labile mood (sudden and intense changes in mood), medication start date 9/15/2025.<br><br>4. Fluoxetine (antidepressant) one capsule by mouth one time a day for depression and anxiety, medication start date 9/15/2025.<br><br>5. Haldol (antipsychotic) intermuscular, inject 200mgs at bedtime every 28 days for hyperverbal and aggressiveness, medication start date 9/15/2025.<br><br>6. Mirtazapine (antidepressant) oral tablet 7.5 mgs at bedtime for depression manifested by (m/b) decreased appetite, medication start date 9/15/2025.<br><br>During a review of Resident 8's admission Record, dated 10/24/2025, the admission record indicated Resident 8 was admitted to the facility on [DATE] with the diagnosis including schizoaffective disorder, depression and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities)<br><br>During a review of Resident 8's H&P dated 1/31/2025, the H&P indicated Resident 8 was alert and oriented.<br><br>During a review of Resident 8's MDS, dated [DATE] the MDS indicated Resident 8 had memory problems. The MDS also indicated Resident 8 was independent with ADL'S. The MDS also indicated Resident 8 was taking an antipsychotic medication, antidepressant medication and anticonvulsant medication.<br><br>During a review of Resident 8's Active order Summary Report dated 10/24/2025, the active order summary report indicated Resident 8 was prescribed:<br><br>1. Depakote oral tablet delayed release 250 mgs by mouth at bedtime for mood stabilizer, medication start date 9/26/2025.<br><br>2. Lithium (mood stabilizer) carbonate oral capsule 300 mgs 1 capsule by mouth in the morning for labile mood, medication start date 6/18/2025.<br><br>3. Lithium carbonate oral capsule 300 mgs, 2 capsules by mouth at bedtime for labile mood, medication start date 6/18/2025.<br><br>4. Mirtazapine oral tablet 15 mgs one tablet by mouth at bedtime for depression m/b poor food intake, medication start date 9/29/2025.<br><br>5. Risperdal (antipsychotic) 1.5 mgs by mouth at bedtime for paranoid delusions (having false or unrealistic beliefs) and labile mood, medication start date 9/17/2025.<br><br>6. Zyprexa (antipsychotic) 10 mg one tablet by mouth one time a day for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) m/b paranoid delusions and labile mood, medication start date 10/19/2025.<br><br>7. Zyprexa 20 mg one tablet by mouth at bedtime for psychosis m/b paranoid delusions and labile mood, medication start date 10/19/2025.<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 138's admission Record, dated 10/24/2025, the admission record indicated Resident 138 was admitted to the facility on [DATE] with the diagnosis including schizophrenia, anxiety and insomnia.<br><br>During a review of Resident 138's H&P dated 1/31/2025, the H&P indicated Resident 138 was alert and oriented.<br><br>During a review of Resident 138's MDS, dated [DATE], the MDS indicated Resident 138's cognition was intact. The MDS also indicated Resident 138 was independent with ADL'S. The MDS also indicated Resident 138 was prescribed an antipsychotic medication, anxiety medication, hypnotic (helps with sleeping) medication and anticonvulsant medication.<br><br>During a review of Resident 138's Active Order Summary Report dated 10/24/2025, the active order summary report indicated Resident 138 was prescribed:<br><br>1. Abilify inject 400 mgs intermuscular in the morning every 28 days for psychosis m/b paranoid delusions, medication start date 10/3/2025,<br><br>2. Ativan (antianxiety medication) 1 mg one tablet by mouth three times a day for anxiety m/b inability to relax, medication start date 6/17/2025.<br><br>3. Depakote delayed release 500 mgs by mouth in the morning for a mood stabilizer, medication start date 6/25/2024.4. Depakote delayed release 500 mgs two tablets by mouth at bedtime for labile mood, medication start date 11/24/2023.<br><br>5. Latuda (antipsychotic) 40 mgs 120 mgs by mouth one time a day for paranoid delusions give with food or right after a meal, medication start date 4/09/2025.<br><br>6. Zolpidem (hypnotic) 10 mgs by mouth at bedtime for difficulty sleeping, medication start date 7/7/2025.<br><br>During a concurrent interview and record review on 10/24/2025 at 8:11 a.m. with the Registered Nurse Supervisor 1(RNS) 1, Resident 2, Resident 8 and Resident 138's Informed Consents for the use of psychotropic medications were reviewed. RNS1 stated whenever a resident is started on a psychotropic medication, before the medication can be administered the resident or conservator needs to be informed of the risks and benefits of taking those medications. RNS1 stated that Resident 2, Resident 8 and Resident 138 were not notified about the risks and benefits of taking psychotropic medications or were there conservators notified prior to starting the medications. RNS1 stated Resident 2, Resident 8 and Resident 138's rights were violated.<br><br>During an interview on 10/24/2025 at 1:02 p.m. with the Director of Nursing (DON), the DON stated she was made aware that Resident 2, Resident 8 and Resident 138's psychotropic medication informed consents were not done. The DON stated informed consent on medication use and side effects needs to be discussed prior to the medications be started and then every six months with either the resident or their conservators. The DON stated that the quality of the resident's life could be affected if they are taking medications that they don't want to take.<br><br>During a review of the Policies and Procedure (P&P) titled Informed Consent for Psychoactive Medications, dated 5/6/2025, the P&P indicated, it is the policy of Telecare to ensure that persons<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | served are provided with information on psychoactive medications by the prescriber, and that the informed consent form is completed by the prescriber indicating consent was obtained from the person served and/or legal guardian for adult voluntary clients. The P&P indicated every person served receives information from the prescriber regarding psychoactive medications prescribed for them. The P&P indicated the prescriber completes signs and documents in their notes that informed consent was obtained by the adult voluntary person served and/or legal guardian. The P&P indicated the facility ensures that persons served are advised of their rights to refuse psychoactive medication except in the case of persons served found to be incompetent through a judicial hearing. This right to refuse medication does not apply to medication that is ordered in an emergency.<br><br>2.During a review of Resident 90's admission Record dated 10/23/2025, the admission Record indicated Resident 90 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, depressive type, major depressive disorder, recurrent, unspecified and unspecified dementia, unspecified severity with anxiety.<br><br>During a review of Resident 90's Minimum Data Set (MDS – a resident assessment tool) dated 7/25/2025, the MDS indicated, Resident 90's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated, Resident 90 needed supervision level of assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as personal hygiene, setup or clean-up assistance for eating and showering, and independent in performing oral hygiene, toileting hygiene, upper and lower body dressing and putting on or taking off footwear.<br><br>During a review of Resident 90's Order Summary Report dated 10/23/2025, the Order Summary Report indicated but not limited to the following physician orders:<br><br>Depakote extended release 24-hour oral tablet 250 mg (divalproex sodium), give 750 mg by mouth at bedtime for labile mood, order date 7/16/2025, start date 7/16/2025.<br><br>Lexapro oral tablet 10 mg (escitalopram oxalate), give 10 mg by mouth in the evening for depression, order date 5/28/2025, start date 5/28/2025.<br><br>Olanzapine tablet 10 mg, give 1 tablet by mouth at bedtime for disorganized thought process, paranoia, auditory hallucinations (AH- sounds a person believes to be real but are not real), and responding to internal stimuli (RTIS), order date 6/1/2024, start date 6/1/2024.<br><br>During a review of Resident 90's Medication Administration Record (MAR) dated 10/1/2025 to 10/23/2025, 9/1/2025 to 9/30/2025 and 8/1/2025 to 8/31/2025, the MAR indicated the following medications were administered daily:<br><br>a. Lexapro oral tablet 10 mg, give 10 mg by mouth in the evening for depression<br><br>b. Olanzapine tablet 10 mg, give 1 tablet by mouth at bedtime for disorganized thought process, paranoia, AH and RTIS<br><br>c. Depakote ER oral tablet 250 mg (divalproex sodium), give 750 mg by mouth at bedtime for labile mood<br><br>During an interview on 10/20/2025 and 10/23/2025 at 2:54 p.m. with Licensed Vocational Nurse<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | (LVN) 6, LVN 6 could not locate the informed consent and requested another LVN to help find the informed consents.<br><br>During a review of Resident 90's Informed Consent for Psychotropic Medications, dated 5/21/2024, the Informed Consent for Psychotropic Medications indicated an informed consent for Lexapro 5 mg by mouth at bedtime and Olanzapine 10 mg by mouth at bedtime.<br><br>During a review of Resident 90's Informed Consent for Psychotropic Medications, dated 12/2/2024, the Informed Consent for Psychotropic Medications indicated an informed consent for Namenda 5 mg by mouth two times a day.<br><br>During a concurrent interview and record review on 10/23/2025 at 4:15 p.m. with Medical Records Supervisor (MRS), Resident 90's Informed Consent for Psychotropic Medications, was reviewed. The informed consent was a printout of a scanned copy and was difficult to read. The document seemed to indicate a date of 10/1/2025 and medications listed were Lexapro 5 mg by mouth at bedtime, olanzapine 10 mg by mouth at bedtime and Depakote 750 mg with dose range of 250 mg to 1000 mg. MRS stated he would try to locate the original document.<br><br>During an interview on 10/23/2025 at 5:37 p.m. with the Director of Nursing (DON), the DON stated the informed consent for psychotropic medications should have been received every six months. The DON stated if there was a change in the dose of medications, then the facility needed to get a new informed consent. The DON stated if the last informed consent for Resident 90's psychotropic medications was in 10/1/2025 and the ones prior to this were in May 2024 and December 2024, then informed consent would be considered as lapsed. The DON stated the conservators (a person who is chosen by a law court to look after the personal affairs) and residents needed to be informed about the prescribed psychotropic medications and related side effects. The DON stated it was important to ensure patient safety by making sure that residents were on the smallest dose possible to treat their conditions and were not over-medicated to prevent oversedation and falls.<br><br>During a review of the facility's policy and procedure (P&P) titled, Informed Consent for Psychoactive Medication, dated 5/6/2025, the P&P indicated, It is the policy of the facility to ensure that persons served are provided with information on psychoactive medications by the prescriber, and that the informed consent form is completed by the prescriber indicating consent was obtained from the person served and/or legal guardian for adult voluntary clients.<br><br>During a review of the facility's P&P titled, Use of Antipsychotic Medication in Skilled Nursing Facility, dated 3/5/2025, the P&P indicated, When prescribing antipsychotic medications, the psychiatrist or provider will: 2. Obtain an informed consent for psychotropic medication.<br><br>During a review of the facility's P&P titled, Medication Administration, dated 6/2/2025, the P&P indicated, Before administration of psychotropic medication, check that the Informed Consent for the Use of Psychotropic Medication for the drug ordered is completed and signed by the Prescriber, person served, and the person served conservator (if applicable). |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Notice of Proposed Transfer and Discharge was provided to the Ombudsman (resident advocate) at the time of discharge for three of three sampled residents (Resident 2, Resident 6 and Resident 154).This deficient practice had the potential to deny Resident 2, Resident 6 and Resident 154 protection from being inappropriately discharged and violated the residents' rights. Findings:<br><br>A. During a review of Resident 2's admission Record (facesheet), dated 10/24/2025, the admission record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnosis including schizoaffective disorder (schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), anxiety ( (emotion characterized by feelings of tension, worried thoughts) and insomnia (trouble falling asleep or staying asleep).<br><br>During a review of Resident 2's History & Physical (H&P) dated 9/15/2025, the H&P indicated Resident 2 was awake, alert and oriented.<br><br>During a review of Resident 2's Minimum Data Set (MDS – a federally mandated resident assessment tool), dated 9/22/2025 the MDS indicated Resident 2's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS also indicted Resident 2 needed partial/moderate assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).<br><br>During a review of Resident 2's Post Event assessment dated [DATE], the post event assessment indicated Resident 2 was sent to GACH on 9/8/2025 at 6:05 p.m.<br><br>During a review of Resident 2's Progress Note dated 9/9/2025 at 5:30 a.m. the progress note indicated Resident 2 had been admitted to GACH for ventricular tachycardia (abnormal fast heart rate).<br><br>During a review of Resident 2's progress note dated 9/15/2025 at 5:00 p.m. the progress note indicated Resident 2 was readmitted back to the facility.<br><br>B. During a review of Resident 6's admission Record dated 10/24/2025, the admission record indicated Resident 6 was admitted on [DATE] with diagnosis including schizophrenia ((a mental illness that is characterized by disturbances in thought), insomnia, and constipation.<br><br>During a review of Resident 6's H&P dated 6/24/2025, the H&P indicated Resident 6 was alert and oriented.<br><br>During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognition was intact. The MDS also indicated Resident 6 needed set up or clean up assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).<br><br>During a review of Resident 6's Post Event assessment dated [DATE], the post event assessment indicated Resident 6 was sent to GACH on 4/24/2025 at 7:05 a.m.<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 6's progress noted dated 4/24/2025 at 10:37 a.m. the progress note indicated Resident 6 was admitted to GACH for pneumonia (infection in the lungs).<br><br>During a review of Resident 6's progress note dated 4/26/2025, the progress note indicated Resident 6 was readmitted back to the facility on 4/26/2025 at 4:20 p.m.<br><br>During an interview on 10/24/2025 at 12:43 p.m. with the Assistant Director of Nurses (ADON), the ADON stated that when residents are admitted to the GACH, the LTC Ombudsman needs to be notified. The ADON stated the LTC Ombudsman was not notified of Resident 2's admission to GACH on 9/18/2025 or Residents 6 admission to GACH on 4/24/2025. The ADON stated that even though we do are best for the residents the ombudsman is a third party who advocates for the residents and needed to be notified.<br><br>During an interview on 10/24/2025 at 1:02 p.m. with the Director of Nurses (DON), the DON stated she was made aware that the LTC Ombudsman was not notified when Resident 2 and Resident 6 were admitted to the GACH. The DON stated the LTC Ombudsman needs to be notified because they are the advocate for the residents. The DON stated this could possibly be a violation of the residents' rights.<br><br>During a review of the facility's Policy & Procedure (P&P), Admission, Transfer, and Discharge Rights and Requirements dated 10/15/2024, the P&P indicated in all cases of facility -initiated transfers and discharges, the facility personal shall notify the resident, there designated representative (if applicable), as well as the long-term care ombudsman.<br><br>C. During a review of Resident 154's admission Record, the admission Record indicated Resident 154 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought) and hypertension (HTN- high blood pressure).<br><br>During a review of Resident 154's MDS dated [DATE], the MDS indicated Resident 154's cognition was intact.<br><br>During a review of Resident 154's Order Summary dated 9/27/2025, timed at 1:26 p.m., the Order Summary indicated an order to discharge Resident 154.<br><br>During a review of Resident 154's Progress Note dated 9/30/2025, timed at 12:30 p.m., the Progress Note indicated Resident 154 was discharged , with no indication the Ombudsman was notified.<br><br>During a concurrent interview and record review on 10/23/2025 at 12:13 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when a resident is discharged , part of their process is to notify the Ombudsman and document that they were notified in a progress note. LVN 1 stated after reviewing Resident 154's progress notes, there is no indication the Ombudsman was notified. LVN 1 stated the Ombudsman should have been notified to ensure the discharge was appropriate.<br><br>During a concurrent interview and record review on 10/23/2025 at 1:39 p.m., with the Registered Nurse Supervisor (RNS) 1, the RNS 1 stated he was unsure if the Ombudsman is to be notified when a resident is discharged because he does not worry about that. RNS 1 stated the Ombudsman should be notified when a resident is discharged in case something happens to the resident, they can advocate for the resident.<br><br>During an interview on 10/24/2025 at 10:35 a.m., with the Director of Nursing (DON), the DON stated<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | when a resident is discharged , the Ombudsman should be notified because they are the ones that advocate for the residents' well-being and ensure the discharge is appropriate. The DON stated the nurses are supposed to notify the Ombudsman but are not consistent with doing so.<br><br>During a review of the facility's policy and procedure (P&P) titled, Admission, Transfer, and Discharge Rights and Requirements, undated, the P&P indicated, To the extent practicable/feasible, before the transfer or discharge occurs, the facility shall notify the resident and, if known, the family member, surrogate, or representative, as well as the Long-Term Care Ombudsman of the transfer/discharge and the reasons for the transfer/discharge and record the reasons in the clinical record. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on interview and record review, the facility failed to:1. Include signatures of two Licensed Vocational Nurses (LVNs) on the medication donation records titled Medication Destruction Record for 35 records on three out of three sampled pages in the donation log, as per facility's policy and procedure (P&P) titled, Donated Medications, dated 10/10/2024.2. Ensure the disposition or destruction records for controlled medications (medications that the use and possession of are controlled by the federal government) included signatures of a pharmacist in addition to a Registered Nurse (RN) or Director of Nursing (DON) on six of six sampled records, as per facility's P&P titled Accounting for Administered and Wasted Medications including Expired Medications, dated 6/11/2025. These deficient practices increased the risk for controlled medications diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use), misuse, and the potential for accidental exposure to harmful medications to the facility staff and residents, possibly leading to physical and psychosocial harm.Findings:1. During a concurrent interview and record review on 10/22/2025 at 9:25 a.m. with Licensed Vocational Nurse (LVN) 4, the medication donation records titled as Medication Destruction Record, dated 10/8/2025 were reviewed. LVN 4 stated she could show the medication destruction records and happened to open the donation records instead. The sampled 35 donation records indicated names of residents, medication names, medication strength, medication quantities and one licensed nurse's signature. LVN 4 stated the records were donation records for medications that were donated from facility to another location, but they were noncontrolled medications and only psychotropic medications (any drug that affects brain activities associated with mental processes and behavior). LVN 4 stated the donation record did not have a signature of Witness #2 Licensed Signature. The Medication Destruction Record for August 2025, September 2025 and October 2025 indicated one signature only. LVN 4 stated the registered nurse (RN) took care of the donation, so LVN 4 was not sure of the process. During an interview on 10/22/2025 at 4:08 p.m. with the DON, the DON stated one of the facility's charge nurses took care of the donation process. The DON stated discontinued noncontrolled psychiatric medications would be sent for donation. The DON stated the donation form needed to be corrected indicating it was a ?donation record' not destruction record. The DON stated according to the facility's donated medications policy, there should have been two licensed nurses' signatures documented. The DON stated, without a witness signature, the facility was at risk of being uncertain whether the meds were truly donated or not. During a review of the facility's P&P titled, Donated Medications, dated 10/10/2024, the P&P indicated, Medications donated will be recorded on the Donated Medications Disposition Log, complete the Donation Log with the following information: name of the drug. signature of 2 licensed staff. The P&P indicated, To provide documented accountability of medication disposal, destruction including donated medications that is consistent with State and Federal laws. Medications are disposed of as required . the donation to a voluntary drug repository and distribution program in accordance with State and Federal laws. 2. During a concurrent interview and record review on 10/22/2025 at 4:08 p.m. with the DON, there were six narcotic sheets or (controlled drug record [CDR] a document indicating perpetual inventory and administration of controlled substances) with no signatures that would indicate their disposition and no medication cards or container attached to them. The DON stated she was saving the narcotic sheets because she wanted to investigate further about the waste entries on the record. The DON stated the facility conducted controlled medication disposition on 9/23/2025 with the facility pharmacist so there were no controlled medications waiting to be destroyed. The DON stated the disposition records should have the resident's name, medication name, medication strength, quantity and one signature from the pharmacist and one signature from the DON documented on the disposition records during destruction process.During a concurrent interview and record review on 10/23/2025 at<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 5:06 p.m. with the DON, the six CDR or narcotic sheets for six different residents with controlled medications such as lorazepam (a medication used to treat anxiety), zolpidem (a medication used to treat insomnia [inability to sleep] and temazepam (a medication used to treat insomnia), were reviewed. The DON stated the narcotic sheets indicated on them the quantity remaining and copies of the medication bubble pack (a card that packages doses of medication within small, clear, or light-resistant, amber-colored plastic bubbles). The DON stated when she was informed during the survey that a pharmacy consultant would be joining the survey, the DON panicked and destroyed the six controlled medications without waiting for the facility pharmacist's presence as a witness to the process. The DON stated she did not have any witness when she wasted the controlled medications. The DON stated she signed the CDR or narcotic sheets with her signature. The DON stated she wanted to be honest instead of surveyor thinking there was medication diversion or if the nurses had been doing something they were not supposed to. During a review of the facility's P&P titled, Accounting for Administered and Wasted Medications including Expired Medications, dated 6/11/2025, the P&P indicated, The facility provides documented accountability of medications used in the facility including expired medications. The facility has in place measures to maintain. accountability of all medications delivered. administered and wasted or destroyed. The P&P indicated, Controlled Medication Disposal and Destruction Procedure. 1. Disposal of controlled medications must be completed by one RN and one pharmacist. 2c. The disposal will be inputted and recorded into the Controlled Medication Disposal Log. The pharmacist and one RN completing the disposal must both provide: 1. Patient's name.7. Signature of one pharmacist and one RN. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain and observe infection control practices by failing to:1.Ensure the laundry staff performed hand hygiene prior to handling clean linens.2.Ensure the laundry staff were keeping a log and monitoring the washing machine water temperatures and ensure the water heater was functioning prior to using the washing machines. 3. Perform proper hand hygiene procedures after checking Resident 140's blood glucose, and before and after administering insulin (medication that lowers blood sugar level), per facility's policy and procedure (P&P) titled, Hand Hygiene, dated 12/9/2024, affecting one of nine residents observed during medication administration.4.Follow facility's P&P on disinfecting blood glucose monitor after its use according to manufacturer guidelines and facility's P&P titled Cleaning of Non-critical, Reusable Equipment used by Persons Served (SNF), dated 8/11/2025, affecting one of nine residents observed during medication administration. 5.Follow facility's requirements of not using resident's blood glucose monitor for personal use and failed to disinfect blood glucose monitor after its use, per facility's P&P, titled Cleaning of Non-critical, Reusable Equipment used by Persons Served (SNF), dated 8/11/2025.6.Clean and disinfect medication cart counters before and/or after medication pass in between residents, per facility's P&P titled Cleaning of Non-critical, Reusable Equipment used by Persons Served (SNF), dated 8/11/2025, affecting three of nine residents observed during medication administration.7. Ensure that the privacy curtain in Resident 138's room was not touching the floor, maintained in a sanitary and safe condition.These failures had the potential to result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another) and place residents at risk for spread of infection. Findings:<br><br>1.During a concurrent observation and interview on 10/23/2025 at 7:40 a.m., in the laundry room, the Laundry Aide (LA) was observed unloading the washer without performing hand hygiene prior to handling the clean linens. The LA stated she should have washed her hands prior to handling the clean linens because not doing so could spread infection and germs.<br><br>During an interview on 10/23/2025 at 9:21 a.m., with the Infection Prevention Nurse (IPN), the IPN stated staff should be washing their hands prior to handling clean linens to prevent cross contamination which could lead to the residents developing a skin rash or an infection.<br><br>During an interview on 10/24/2025 at 10:42 a.m., with the Director of Nursing (DON), the DON staff should be washing their hands before handling clean linens to prevent cross contamination. The DON stated not washing their hands before handling clean linens could contaminate the linens.<br><br>During a review of the facility's Housekeeping and Laundry Supervisor Job Description, dated 11/30/2017, the Job Description indicated, Essential Functions: Inspects equipment and evaluates the need for new parts, repairs, and overhaul. Coordinates all infection control procedures. Makes daily rounds to monitor the performance of the Housekeeping and Laundry Department.<br><br>2.During a concurrent observation and interview, in the laundry room, on 10/23/2025 at 7:21 a.m., with the LA, the LA stated there was not a washer temperature log. The LA stated she does check the washer water temperatures and does not know if the water temperature was hot enough to kill bacteria. The LA stated she checks the water heater prior to washing linens but stated the water heater was not currently working. The water heater gauge reading was 78 degrees Fahrenheit (unit of measurement) and the LA stated she did not inform anyone that the water heater was not working properly but should have told the Laundry Supervisor . The LA stated she should not have been<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | washing linens being the water heater was not functioning properly.<br><br>During an interview on 10/23/2025 at 7:55 a.m., with the Housekeeper Supervisor (HS), the HS stated the LA should have informed him of the water heater not functioning properly and the LA should not have been using the washers. The HS stated washer temperatures should be monitored prior to washing anything because if the washer temperatures are incorrect, the linens and clothes may not be properly sanitized or disinfected and could lead to cross contamination and spread of infection throughout the facility.<br><br>During an interview on 10/23/2025 at 9:21 a.m., with the Infection Prevention Nurse (IPN), the IPN nurse stated there should be a washer temperature log, so the laundry staff know they were washing linens at the correct temperature to kill bacteria.<br><br>During an interview on 10/24/2025 at 10:42 a.m., with the DON, the DON stated there should be a temperature log for the washers to ensure the water was hot enough to kill germs and prevent cross contamination.<br><br>During a review of the facility's P&P titled, Soiled Linens, Collecting, and Handling, undated, the P&P indicated, It is the policy of the facility to prevent the spread of infection or cross-contamination from used/soiled linens and to provide a safe and clean environment for persons served, staff, and visitors. All soiled linens are considered to be potentially infectious, therefore careful precautionary procedures are followed by the program staff.<br><br>3. During a review of Resident 140's admission Record dated 10/23/2025, the admission Record indicated Resident 140 was admitted to the facility on [DATE] with diagnosis including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).<br><br>During a review of Resident 140's Minimum Data Set (MDS – a resident assessment tool) dated 1/24/2025, the MDS indicated, Resident 140 had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated, Resident 140 needed setup or clean-up assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, showering and personal hygiene, was independent in performing ADLs such as toileting hygiene, upper and lower body dressing and putting on or taking off footwear.<br><br>During a concurrent observation and interview on 10/22/2025 at 11:16 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 prepared to check Resident 140's blood glucose level using an blood glucose monitor in the resident's room. LVN 4 stated Resident 140's blood glucose level was 182 milligrams ([mg] a unit of measurement for mass) per deciliter ([dL] a unit of measurement for volume). LVN 4 did not wash hands after checking Resident 140's blood glucose and before administering insulin. LVN 4 stated the facility policy required the nursing staff to have a second check of insulin dose before administering to the resident. After LVN 4 received a verification for insulin dose, LVN 4 prepared and administered four units of insulin lispro (a medication used to treat high blood glucose) 100 units per mL, subcutaneously ([SubQ] - under the skin) to Resident 140.<br><br>During a review of Resident 140's Order Summary Report dated 10/23/2025, the Order Summary Report indicated but not limited to the following physician orders:<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Insulin Lispro injection solution 100 units per mL, inject as per sliding scale: if 150-250 = 4 units subcutaneous (SubQ- applied under the skin); 251-350 = 6 units SubQ; 351-450 = 8 units; over 450 call medical doctor (MD), subcutaneously before meals for DM, order date 1/20/2024, start date 1/20/2024<br><br>During an interview on 10/23/2025 at 9:23 a.m. with LVN 3, LVN 3 stated it was important to wash hands before and after checking blood glucose, to prevent spread of infection for staff and residents and to prevent cross-contamination. LVN 3 stated it was important to wash hands with soap and water before administering insulin.<br><br>During an interview on 10/22/2025 at 4:08 p.m. with the DON, the DON stated the facility's licensed nursing staff should have washed hands, gathered supplies, worn gloves, then conducted blood glucose test for the residents and disposed of everything. The DON stated the licensed nurse should have washed hands and cleaned equipment after discarding the test strip, insulin syringe and gloves. The DON stated it was important that the facility nurse washed hands after checking Resident 140's blood glucose and before administering insulin to prevent cross-contamination. The DON stated the nurse would be touching different medications and different surfaces on carts and could potentially increase the risk of spreading infection among facility residents.<br><br>4. During a concurrent observation and interview on 10/22/2025 at 11:16 a.m. with LVN 4, LVN 4 prepared to check Resident 140's blood glucose level using a blood glucose monitor in the resident's room. LVN 4 was not observed disinfecting the blood glucose monitor according to facility's P&P and manufacturer's recommendations after its use.<br><br>During an interview on 10/22/2025 at 4:08 p.m. with the DON, the DON stated the licensed nurse should have washed hands and cleaned equipment per blood glucose monitor manufacturer's recommendations after discarding the test strip.<br><br>5. During a concurrent observation and interview on 10/23/2025 at 8:46 a.m. with LVN 1, LVN 1 was observed in the facility hallway with a blood glucose monitor on top of her medication cart with the test strip attached to the monitor. LVN 1 removed the test strip off the monitor, covered it in a paper napkin and discarded it in the trash and proceeded to put the blood glucose monitor away in the medication cart drawer. LVN 1 was not observed cleaning or disinfecting the glucose monitor or medication cart. LVN 1 stated she used the blood glucose monitor in the medication cart to check her own blood glucose because she was not feeling well.<br><br>During an interview on 10/23/2025 at 9:39 a.m. with LVN 1, LVN 1 stated her blood glucose was 75 mg/dL and that's too low for me and she did not have a chance to eat breakfast in the morning. LVN 1 stated she started to feel tremors, so decided to check her blood glucose and her morning reading at home was 119 mg/dL. LVN 1 insisted that she was feeling better, so she continued to work after eating crackers and drinking coffee with sugar and creamer. LVN 1 stated facility did not know about her condition. LVN 1 stated, I do not want to be a burden to facility, and I need to take care of patients. I did not eat breakfast, so I was feeling this way today. LVN 1 became tearful and stated, It's ok it's ok. LVN 1 stated her personal blood glucose monitor was in her purse and she decided to use the blood glucose monitor stored in the medication cart. LVN 1 stated it was the facility's protocol to clean glucose monitor after each use to prevent contamination for other residents. LVN 1 stated she cleaned the glucose monitor after checking her own blood glucose and before surveyors approached her.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 10/23/2025 at 5:20 p.m. with the DON, the DON stated if the facility staff nurse was not feeling well, he/she/they should have notified the supervisor and the DON. The DON stated if the nurse was not feeling well because of a chronic condition such as high or low blood pressure, high or low blood glucose, that it could have adverse effects such as blurred vision or even stroke. The DON stated the facility nurse could cause medication errors and place residents' lives at risk if they passed medications to the residents during such circumstances. The DON stated depending on the symptoms, the facility staff might need to be tested for COVID-19 (a virus that could cause viral infection). The DON stated it would be important for the facility staff or nurse to go home if they were not feeling well to prevent residents from getting sick. The DON stated the facility staff should not have used the blood glucose monitor from the medication cart because that would increase the risk of cross-contamination and infection as they were intended for the facility residents.<br><br>6. During an observation on 10/22/2025 at 11:16 a.m., LVN 4 prepared to check Resident 140's blood glucose level and administered four units of insulin lispro100 units per mL, SubQ to Resident 140. LVN 4 did not clean or disinfect top of the medication cart counter before and after preparing medications for administration.<br><br>During an observation on 10/22/2025 at 12:35 p.m., LVN 4 prepared one tablet of divalproex sodium (a medication used to treat seizure (sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) delayed release 250 mg medication to be administered to Resident 65. LVN 4 did not clean or disinfect top of the medication cart counter before and after preparing medications for administration and between residents.<br><br>During an observation on 10/22/2025 at 1:19 p.m., LVN 3 prepared three medications to be administered to Resident 134. LVN 3 did not clean or disinfect top of the medication cart counter before and after preparing medications for administration and between residents.<br><br>During an interview on 10/22/2025 at 4:08 p.m. with the DON, the DON stated the medication cart counter tops need to be always cleaned and organized. The DON stated medication carts should be cleaned to ensure there was no risk of spread of infection between residents and rooms after medication administration.<br><br>During a review of the facility's P&P titled, Hand Hygiene, dated 12/9/2024, the P&P indicated, All employees and vendors rendering care are responsible for maintaining adequate hand hygiene by adhering to specific infection control practices. The P&P indicated, The health care worker uses soap and water only to clean their hands at these times.6. After contact with chemicals. The health care workers follow these glove guidelines: 1. Use gloves whenever contact with blood, body fluid or other potentially infectious matter is present.during cleaning activities.4. Perform hand hygiene immediately after glove removal.<br><br>During a review of the facility's P&P titled, Cleaning of Non-Critical, Reusable Equipment used by Persons Served (SNF), dated 8/11/2025, the P&P indicated, It is the policy of the facility for all programs to implement and maintain processes to ensure all non-critical, reusable equipment used by residents are routinely cleaned, disinfected, or discarded after use in accordance with existing infection prevention.and any applicable manufacturer's recommendations. The P&P indicated, Reusable Equipment and Medical Devices – are devices that health care providers can reprocess and reuse on multiple individuals served. These devices are designed for multiple uses. cleaning followed by disinfection between individuals served.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the blood glucose monitor's manufacturer recommendations titled, Guidelines for Cleaning and Disinfecting the., undated, the document indicated, The. Blood Glucose Monitoring System may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed. The meter should be cleaned and disinfected after use on each patient. The cleaning procedure is needed to clean dirt, blood and other bodily fluids. before performing the disinfecting procedure. The disinfecting procedure is needed to prevent the transmission of blood-borne pathogens.<br><br>During a review of the facility's P&P titled, Blood Glucose Monitoring, dated 6/18/2025, the P&P indicated, Procedure: 10. Dispose of lancet in the Sharps disposal container. 11. Remove gloves and wash hands.<br><br>7. During a review of Resident 138's admission Record, dated 10/24/2025, the admission record indicated Resident 138 was admitted to the facility on [DATE] with the diagnosis including schizophrenia (a mental illness that can affect thoughts, mood, and behavior), anxiety (emotion characterized by feelings of tension, worried thoughts) and insomnia (trouble falling asleep or staying asleep).<br><br>During a review of Resident 138's History & Physical (H&P) dated 1/31/2025, the H&P indicated Resident 138 was alert and oriented.<br><br>During a review of Resident 138's Minimum Data Set (MDS – a federally mandated resident assessment tool), dated 9/25/2025 the MDS indicated Resident 138's cognition was intact. The MDS also indicted Resident 138 was independent with activities of daily living (ADL's - Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).<br><br>During a concurrent observation and interview on 10/21/2025 at 12:27 p.m. with Resident 138 in Resident 138's room. Resident 138's privacy curtain was not fully attached to the curtain rack. The privacy curtain was missing five hooks and was touching the floor. Resident 138 stated his curtain had been like that for six months.<br><br>During a concurrent observation and interview on 10/21/2025 at 1:50 p.m. with Certified Nursing Assistant 7 (CNA) 7 in Resident 138's room. CNA 7 stated the privacy curtain should not be touching the floor because the bacteria that is on the floor could get on the privacy curtain and possibly get the resident sick.<br><br>During a concurrent observation and interview on 10/21/2025 at 1:55 p.m. with Licensed Vocational Nurse 7 (LVN7) in Resident 138's room. LVN 7 stated the privacy curtain should not be on the floor, and it was an infection control issue. LVN 7 stated, germs from the floor could get on the privacy curtain and possibly get Resident 138 sick.<br><br>During an interview on 10/24/2025 at 1:02 p.m. with the Director of Nurses (DON), the DON stated that the resident's privacy curtain should not be touching the floor because the floor has bacteria and germs on it.<br><br>During a review of the facilities Policy's and Procedure (P&P) titled (Safe and Comfortable Environment) the P&P indicated The facility will maintaining a safe, clean, comfortable and homelike environment includes, but is not limited to establishing and maintaining practices that ensure that the<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | physical space is routinely cleaned/sanitized in accordance with applicable infection control procedures and is free of accident hazards to the extent possible/practicable. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on observation, interview, and record review, the facility failed to notify the physician for a change in condition for one of three sampled residents (Resident 117), when Resident 117 verbalized suicidal ideations.This deficient practice had the potential for delayed physician assessment and intervention, placing Resident 117 at risk for delayed behavioral health intervention, worsening psychiatric symptoms, and possible harm.During a review of Resident 117's admission Record, the admission Record indicated the facility admitted Resident 117 on 5/16/2019, with diagnoses including schizoaffective disorder bipolar type (mental illness that can affect thoughts, mood, and behavior), dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN-high blood pressure).During a review of Resident 117's History and Physical (H&P), dated 5/8/2025, the H&P indicated, Resident 117 had impaired judgement and insight.During a review of Resident 117's Minimum Data Set (MDS-a resident assessment tool), dated 9/12/2025, the MDS indicated, Resident 117 had severely impaired cognition (ability to think and understand). The MDS indicated Resident 117 needed supervision from staff for toileting hygiene, dressing and eating.During observation and interview on 10/22/2025 at 8:44 a.m., Licensed Vocational Nurse (LVN) 2 was inside Resident 117's room, when Resident 117 stated in her primary language that she wanted to die.During a concurrent interview and record review on 10/22/2025 at 4:12 p.m., with Registered Nurse Supervisor (RNS) 3, Resident 117's Nursing Notes, dated 10/22/2025 was reviewed. The Nursing Notes indicated Licensed Vocational Nurse (LVN) 2 had no documentation of notifying physician of Resident 117's verbalization of suicidal ideation. RNS 3 stated the physician was not notified during morning shift of same day. RNS 3 stated notifying physician was important because physicians have the expertise to determine appropriate treatment, including medication review and adjustments. RNS 3 stated failure to notify physician had potential to place the resident at risk for harm.During an interview on 10/24/2025 at 12:01 p.m., with Director of Nursing (DON), the DON stated she was not aware of Resident 117's suicidal ideation. The DON stated suicidal ideations required immediate physician notification so physician can adjust medication and make a decision on resident's needs. The DON stated failure to notify the physician places the resident at risk for serious resident harm or self-injury.During a review of facility's policy and procedure (P&P), titled, Notification of physician/Prescriber, dated 7/16/2025, the P&P indicated, It is the policy of the facility to provide evidence-based best practices including that the licensed nurse is responsible to inform the physician or other prescriber responsible for the medical or psychiatric care of the person served of any changes in the person served's emotional, behavioral, physical condition, and/or involvement in adverse events.Notify the appropriate provider promptly of: Any sudden and or marked adverse change in signs, symptoms of medical condition or behavior exhibited by an individual. |

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| | 05A355 | A. Building<br>B. Wing | 10/24/2025 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a comfortable, homelike, and safe environment for one of six sampled residents (Resident 124). The facility failed to:1.Ensure adequate water flow during Resident 124's shower time.2.Maintain the physical environment by allowing the baseboard in a shared resident bathroom to peel off.This deficient practice had the potential to negatively impact Resident 124's well-being and posed a risk of accidents or injury to residents due to an unsafe and poorly maintained environment.Findings:During a review of Resident 124's admission Record, the admission Record indicated Resident 124 was admitted to the facility on [DATE] with diagnoses including schizophrenia(a mental illness that is characterized by disturbances in thought), diabetes mellitus(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), unspecified cataract( clouding of the eyes' lens but the specific cause is undetermined) and mood disorder(mental health condition where a person's emotions become severe and long-lasting and significantly interfering with their daily life).During a review of Resident 124's Minimum Data Set (MDS- resident assessment tool) dated 8/30/2025, the MDS indicated Resident 1124 had an intact cognition (ability to think, understand, learn, and remember) and was independent ( resident completes the activity by themselves with no assistance from a helper) with bathing or showering, dressing, toileting hygiene, and bed mobility.During a concurrent observation and interview on 10/21/2025 at 10:01 a.m. at Resident 124's room, Resident 124 was pointing at the shared bathroom that had peeling baseboard. Resident 124 stated in an angry tone that the shower head in one of the shower rooms was not flowing with water adequately and the pressure of water was not strong enough to have a shower. Resident 124 stated she liked a strong flow of water coming out from the shower to ensure she was clean thoroughly after a shower. Observed a peeling baseboard inside the bathroom shared by Resident 124 with other residents from the other room.During a concurrent observation and interview on 10/23/2025 at 9:18 a.m. with Maintenance Assistant (MA) at the resident shower rooms, the water in Shower room [ROOM NUMBER] was not flowing adequately. MA stated he will replace and fix the shower.2.During a concurrent observation and interview on 10/23/2025 at 9:40 a.m. at Resident 124's bathroom with MA. MA stated the baseboard had peeled off inside the bathroom shared by residents. MA stated housekeeping should notify the maintenance department with any concerns in the bathroom. MA stated the peeled baseboard will be fixed and the shower will be replaced because the residents should feel comfortable and safe in their home.During an interview on 10/23/25 at 10:26 a.m. with Housekeeping (HSK)1, HSK 1 stated they report to the maintenance department any issues in the bathroom like peeling baseboard because it can endanger the residents' safety. HSK 1 stated the residents should be provided a home-like and comfortable environment because they live in the facility.During an interview on 10/23/2025 at 9:52 a.m. with Housekeeping Supervisor (HS), the HS stated peeling baseboard in a shared bathroom can potentially lead to a hazardous situation like accidents. The HS stated the housekeeping should have notified the maintenance department to fix it.During a review of the facility's policy and procedure (P&P) titled, Safe and Comfortable Environment, dated 4/30/2025, the P&P indicated the facility will protect and promote residents right to a safe, clean, comfortable, and homelike environment by ensuring the building, grounds are kept clean, applicable equipment, supplies, and furnishing are maintained in a state of good repair. The P&P indicated efforts shall be made by the facility to provide a homelike setting which includes accommodation of residents' preferences and choices. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of three sampled residents (Residents 63) were free from sexual abuse by another resident (Resident 146). The facility failed to: 1. Supervise Resident 146 with history of inappropriate sexual comments towards staff and residents, showing his private part, standing too close to staff and not giving enough boundaries. This failure had the potential to result in Resident 63 experiencing unwanted sexual contact, placing the resident at risk for emotional trauma, psychological harm, and a compromised sense of safety within the facility. Findings:During a review of Resident 63's admission Record, the admission Record indicated Resident 63 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hyperlipidemia (abnormally high levels of cholesterol and or triglycerides in the blood), and vitamin D deficiency (it occurs when the protective cartilage that cushions the ends of the bones wears down over time).During a review of Resident 63's Minimum Data Set (MDS - a resident assessment tool) dated 10/6/2025, the MDS indicated Resident 63 had the ability to understand others with clear comprehension. The MDS indicated Resident 63 needed setup or clean-up assistance from staff with eating and showering. The MDS indicated Resident 63 was independent with oral hygiene, toileting, dressing, personal hygiene, transferring and walking. During a review of Resident 146's admission Record, the admission Record indicated Resident 146 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, drug induced subacute dyskinesia (a type of involuntary movement disorder that develops gradually over weeks to months after taking certain medications), insomnia (trouble falling asleep or staying asleep), and anxiety(emotion characterized by feelings of tension, worried thoughts).During a review of Resident 146's Psychiatric Progress Notes, dated 12/18/2024, the Psychiatric Progress Notes indicated Resident 146 continued having inappropriate behavior such as showing his private part to staff during a shower, standing too close to staff and not giving enough boundaries. During a review of Resident 146's MDS dated [DATE], the MDS indicated Resident 146 had the ability to understand others with clear comprehension. The MDS indicated Resident 146 needed supervision or touching assistance with showering and transferring. The MDS indicated Resident 146 needed setup or clean-up assistance with eating and personal hygiene. The MDS indicated Resident 146 was independent with oral hygiene, toileting, dressing, transferring and walking. During an interview on 10/21/2025 at 9:45 a.m. with Resident 63, in Resident 63's room. Resident 63 stated two days after being admitted to the facility she was in the hallway using the phone when Resident 146 touched her on the hips and buttocks. Resident 63 stated she was scared and told Certified Nursing Assistant (CNA) 8 and a male Social Worker (SW) 1. Resident 63 stated she sees Resident 63 during meals and Resident 63 approaches her for conversation. Resident 63 stated the incident happened during the night on 10/1/2025 at 8:30 p.m.During an interview on 10/22/2025 at 3:45 p.m. with Certified Nursing Assistant (CNA) 9, CNA 9 stated she was familiar with Resident 146. CNA 9 stated Resident 146 likes to talk to women and had to be watched for inappropriate behaviors last month (September 2025). CNA 9 stated she does not know what the inappropriate behaviors are. During a concurrent observation and interview on 10/23/2025 at 1:57 p.m., in the hallway with Resident 146, Resident 146 was talking to male and female residents. Resident 146 denied touching any residents without permission. During a concurrent interview and record review on 10/24/2025 at 10:03 a.m. with Licensed Vocational Nurse( LVN) 8, Resident 146's Sexual Activity Screening, dated 2/29/2024 was reviewed. The Sexual Activity Screening indicated Resident 146 exposed himself in public, kissed a female resident and touched a female resident's buttock. LVN 8 stated Resident 146 needs a lot of redirections for speaking inappropriate sexual comments towards staff and residents.<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/24/2025 at 10:55 a.m. with Registered Nurse Supervisor (RNS) 2, RNS 2 stated she had not heard of Resident 146 sexually abusing residents. RNS 2 stated the facility has made the west hallway all female to redirect male residents from going into female rooms. RNS 2 stated the facility monitors for inappropriate sexual behaviors from the beginning of admission.During an interview on 10/24/2025 at 11:20 a.m. with Social Services (SW) 2, SW 2 stated she was aware Resident 146 was sexually inappropriate to residents and staff. SW 2 stated Resident 146 exposes himself to other residents, does inappropriate touching, and tried to kiss a staff member. SW 2 stated Resident 146 was placed on monitoring on 2/29/2024 for touching a female resident. During a review of Resident 146's Care Plan titled, Living in Control, date created 8/9/2023, date initiated 8/18/2025 and date revised 10/22/2025. The Care Plan indicated Resident 146 had a history of aggression, inappropriate sexual behaviors toward residents and staff exposing his private areas. The Care Plan indicated interventions including Resident 146 will develop appropriate social interactions with peers and refrain from aggressive behavior and sexual acting (exposing, masturbating, touching buttocks and kissing). During a review of Resident 146's Order Summary, dated 10/22/2025, the Order Summary indicated Resident 146 had a physician order for observation and monitoring every 15 minutes related to allegedly touching a female resident. During a review of the facility's policy and procedure (P&P), titled Abuse Prevention and Reporting, dated 11/15/2025, the P&P indicated, Telecare is committed to protecting the physical and emotional well-being and personal possessions of every resident. Telecare Skilled Nursing Facilities have systems, procedures and a program of employee training and supervision in place to foster dignified treatment, respect, and compassion for residents. Any form of mistreatment of residents including but not limited to abuse, neglect, exploitation, involuntary seclusion, misappropriation of property or any crime are strictly prohibited. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and suspicion of a crime are reported immediately to the administrator of the facility and to other officials in accordance with State law (including to the State licensing and certification agency). All allegations mentioned shall be investigated. Reports will be made in a timely manner based on State statutes. Telecare Corporation encourages all residents, staff, families, visitors, volunteers, and resident representatives to champion resident's rights and report any suspected acts of abuse without fear of reprisal. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and record review the facility failed to ensure monitoring was done for psychotropic medications (medication used to treat mental health disorders) for two of six sampled residents (Resident 2 and Resident 8) when:1. Resident 2's target behaviors were not monitored.2. Resident 8's side effects were not monitored.These failures had the potential to cause harm to Resident 2 and Resident 8's quality of life and possible unwarranted use of psychotropic medications.Findings:A. During a review of Resident 2's admission Record (facesheet), dated 10/24/2025, the admission record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnosis including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), anxiety (emotion characterized by feelings of tension, worried thoughts) and insomnia (trouble falling asleep or staying asleep).During a review of Resident 2's History & Physical (H&P) dated 9/15/2025, the H&P indicated Resident 2 was awake, alert and oriented.During a review of Resident 2's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/22/2025 the MDS indicated Resident 2's cognition was severely impaired. The MDS also indicated Resident 2 needed partial/moderate assistance (helper does have the effort) with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS also indicated Resident 2 was taking an antipsychotic (a type of medication prescribed to treat mental health) medication.During a review of Resident 2's Order Summary Report dated 10/24/2025, the order summary report indicated Resident 2 was prescribed: 1. Abilify (antipsychotic) 10 milligrams (mg - unit of measure) at night for attention seeking behaviors/striking out, medication start date 9/15/2025.2. Haldol (antipsychotic) 200mgs at bedtime every 28 days for hyperverbal and aggressiveness, medication start date 9/15/2025. B. During a review of Resident 8's admission Record, dated 10/24/2025, the admission record indicated Resident 8 was admitted to the facility on [DATE] with the diagnosis including schizoaffective disorder, depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life) and alzheimer's disease (a disease characterized by a progressive decline in mental abilities)During a review of Resident 8's H&P dated 1/31/2025, the H&P indicated Resident 8 was alert and oriented.During a review of Resident 8's MDS, dated [DATE] the MDS indicated Resident 8 had memory problems. The MDS indicated Resident 8 was independent with ADL'S. The MDS also indicated Resident 8 was taking an antipsychotic medication.During a review of Resident 8's Active Order Summary Report dated 10/24/2025, the active order summary report indicated Resident 8 was prescribed: 1. Zyprexa (antipsychotic) 10 mg one time a day for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) manifested by (m/b) paranoid delusions (having false or unrealistic beliefs) and labile mood (sudden and intense changes in mood), medication start date 10/19/2025. 2. Zyprexa 20 mg give one tablet by mouth at bedtime for psychosis m/b paranoid delusions and labile mood, medication start date 10/19/2025.During a concurrent interview and record review on 10/24/2025 at 8:11 a.m. with the Registered Nurse Supervisor (RNS), Resident 2's behavior monitoring, and Resident 8's side effect monitoring for the use of psychotropic medications were reviewed. The RNS stated whenever residents are using psychotropic medications the resident's targeted behaviors for the use of the medications, and the side effects of the medications are monitored every shift to ensure the medications are working for the residents. The RNS stated that Resident 2's targeted behaviors for the use of Abilify and for the use of Haldol were not being monitored. The RNS stated Resident 8's side effects for the medication Zyprexa were not being monitored. The RNS stated Resident 2 and Resident 8 were at risk of being over medicated and having a poor quality of life.During an interview on 10/24/2025 at 1:02 p.m. with the Director of Nursing<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | (DON), the DON stated she was made aware that Resident 2's targeted behaviors and Resident 8's side effect monitoring for the use of psychotropic medication was not done. The DON stated behavior monitoring and side effect monitoring must be done for all psychotropic medications because psychotropic medications have a lot of negative side effects, and the residents have the potential to be come over medicated and could possibly isolate themselves in their rooms.During a review of the Policies and Procedure (P&P) titled Monitoring Possible Side-Effects from Psychotropic Medications, dated 11/13/2025 the P&P indicated, to identify side effects promptly so that necessary dose reduction, discontinuance and appropriate management can be instituted promptly. The P&P indicated the Licensed nurse will monitor, every shift, clients for possible psychotropic medication side effects and notify a physician of any positive findings. During a review of the Policies and Procedure (P&P) titled Antipsychotic Medication in Skilled Nursing Facility, dated 3/5/2025 the P&P indicated, the policy of the Skilled Nursing Facility is to maintain the right of each client to be free of any psychoactive drug administered for purposes of discipline or convenience which is not required to treat the client's symptoms and to reduce the risk of use of unnecessary drugs and minimize the risk of potential drug side effects. The P&P indicated behavioral parameters or target behaviors will be established monitored and documented in order to determine the effect of treatment for each anti-psychotic medication. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop an individualized care plan with measurable objectives, time frame, and interventions to meet the residents' needs for two of three sampled residents (Resident 112 and Resident 117) by failing to:1. Develop an individualized care plan with goals and interventions for Resident 112's hip pain and refusal of care.2. Develop an individualized care plan with goals and interventions for Resident 117's suicidal ideation. These deficient practices had the potential to negatively affect the delivery of necessary care and services.Findings:<br><br>1.During a review of Resident 112's admission Record (facesheet), the admission Record indicated Resident 112 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety (a common mental health condition characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily life), and hypertension (HTN- high blood pressure).<br><br>During a review of Resident 112's Minimum Data Set (MDS- a resident assessment tool) dated 10/16/2025, the MDS indicated Resident 112's cognition (ability to think, understand, learn, and remember) was moderately impaired.<br><br>During a review of Resident 112's Order Summary Report, the Order Summary Report indicated an order dated 10/10/2025 for a right hip Xray (images that produce pictures of the inside of the body) for right hip pain.<br><br>During a review of Resident 112's Progress Notes dated 9/25/2025, at 1:41 p.m., the Progress Notes indicated Resident 112 refused physical therapy services.<br><br>During a review of Resident 112's Social Services Progress Notes dated 10/8/2025, at 11:00 a.m., the Social Services Progress Notes indicated Resident 112 refused dentistry and optometry (eye doctor) over the last couple of months.<br><br>During a review of Resident 112's Progress Notes dated 10/11/2025, timed at 3:16 p.m., the Progress Notes indicated Resident 112 refused Xray of the right hip.<br><br>During a review of Resident 112's Progress Notes dated 10/13/2025, timed at 5:50 p.m., the Progress Notes indicated Resident 112 refused physical therapy services.<br><br>During a concurrent interview and record review on 10/23/2025 at 12:24 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated a care plan represents the treatment and goals for the residents. LVN 1 stated there was not a care plan for Resident 112's hip pain or refusal of care and treatment but there should be one for each. LVN 1 stated Resident 112 tends to refuse care and treatment.<br><br>During a concurrent interview and record review on 10/23/2025 at 1:54 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated a care plan is tailored to the residents needs and if a resident complains of pain or refuses care, a care plan should be implemented. RNS 1 stated there is no care plan for Resident 112's pain or refusal of care and treatment but should be so the staff know how to (continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | care for the resident.<br><br>During an interview on 10/24/2025 at 10:40 a.m., with the Director of Nursing (DON), the DON stated a care plan if resident centered care with specifics based on their preferences and is for the staff to be aware of the residents care. The DON stated if a resident is complaining of pain or refusing care and treatment, there should be a care plan, so they know how to care for Resident 112.<br><br>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, undated, the P&P indicated, The comprehensive care plan is an individualized written care plan based upon an initial and continuing assessment of resident needs with input, as appropriate, from the health professionals involved in the care of the resident. The care plan indicates the care to be given, the goals to be accomplished, the interventions to be used, and the professional discipline responsible for each element of care. Staff witnessing or identifying a problem or change in condition must create a care plan to address those occurrences.<br><br>2. During a review of Resident 117's admission Record, the admission Record indicated the facility admitted Resident 117 on 5/16/2019, with diagnoses including schizoaffective disorder bipolar type (mental illness that can affect thoughts, mood, and behavior), dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN-high blood pressure).<br><br>During a review of Resident 117's History and Physical (H&P), dated 5/8/2025, the H&P indicated, Resident 117 had impaired judgement and insight.<br><br>During a review of Resident 117's Minimum Data Set (MDS-a resident assessment tool), dated 9/12/2025, the MDS indicated, Resident 117 had severely impaired cognition (ability to think and understand). The MDS indicated Resident 117 needed supervision from staff for toileting hygiene, dressing and eating.<br><br>During an observation and interview on 10/22/2025 at 8:44 a.m., Licensed Vocational Nurse (LVN) 2 was inside Resident 117's room, when Resident 117 stated in her primary language that she wanted to die.<br><br>During a concurrent interview and record review on 10/22/2025 at 4:12 p.m., with Registered Nurse Supervisor (RNS) 3, Resident 117's Care Plan Report, dated 10/2025 was reviewed. The Care Plan Report indicated no comprehensive care plan was initiated to address Resident 117's verbalization of suicidal ideation. RNS 3 stated licensed nurses were responsible for updating the care plan to ensure resident's safety. RNS 3 stated care plan should be in place to monitor whether the resident condition worsened or improved.<br><br>During a concurrent interview and record review on 10/24/2025 at 12:01 p.m., with the Director of Nursing (DON), Resident 117's Care Plan Report, dated 10/2025 was reviewed. The Care Plan Report indicated no revision on Resident 117's care plan on 10/22/2025 to address Resident 117 suicidal ideation. The DON stated care plans guide patient care and failure to follow up had potential for serious outcomes, including self-harm.<br><br>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, undated, the P&P indicated, The (continued on next page) |

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| LA Paz Geropsychiatric Center | 8835 Vans Street<br>Paramount, CA 90723 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | comprehensive care plan is an individualized written care plan based upon an initial and continuing assessment of resident needs with input, as appropriate, from the health professionals involved in the care of the resident. The care plan indicates the care to be given, the goals to be accomplished, the interventions to be used, and the professional discipline responsible for each element of care. Staff witnessing or identifying a problem or change in condition must create a care plan to address those occurrences. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide one of 18 sampled residents (Resident 88) with meaningful activities or regular room visits as part of an ongoing program designed to support the resident's individual choices and preferences for activities. This deficient practice had the potential to negatively impact the resident's sense of self-worth and psychosocial well-being, contributing to feelings of isolation, decreased self-respect, and diminished self-satisfaction.Findings:During review of Resident 88's admission Records, the admission Records indicated Resident 88 was admitted to the facility on [DATE] with diagnoses including anxiety (conditions that cause excessive and persistent feelings of fear or worry that can interfere with daily life), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior ), muscle weakness (loss of muscle strength).During a review of Resident 88's Minimum Data Set (MDS a federally mandated resident assessment tool), dated 10/01/2024, the MDS indicated Resident 88's cognitive (ability to think, understand, learn, and remember) skills for daily decisions making was intact. The MDS indicated Resident 88 required setup or clean up assistance (helper set up or clean up; resident completes activity) from staff for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During an observation and interview on 10/21/2025 at 9:50 a.m., Resident 88 was observed in bed lying quietly staring at the walls of the room. During a concurrent observation and interview conducted on 10/22/2025 at 10:08 a.m., Resident 88 was observed lying quietly on his back in bed. In a soft and slow voice, Resident 88 stated in a soft and slow voice, that no one had offered him any in-room activities that he enjoys. Resident 88 stated that he does not like participating in group activities outside his room because it is sometimes too cold and noisy. Resident 88 stated that he would prefer to have activities provided in his room, stating, If they have something for me, I don't mind.During a concurrent interview and record review on 10/23/2025 at 2:04 p.m. with the Activities Director (AD), the AD stated she was responsible for overseeing resident activities. The AD stated that Resident 88 does not typically enjoy group activities but will occasionally attend special events before requesting to return to his room. The AD stated that activity staff offer options such as a radio and other items the resident may enjoy, but Resident 88 often refuses.The AD was unable to locate any recent documentation in Resident 88's medical record of what activities was offered. Reviewed Activity Note and the last documented activity note was dated 01/27/2024. The AD stated that there was no documentation reflecting what was offered or refused by Resident 88. The AD stated that staff should document all activity offerings with the date and time, conduct regular room visits, and engage the resident with personalized activities such as reading or playing music he enjoys. The AD stated that although staff were reportedly providing these services, they have failed to document them appropriately, despite having received in-service training on this issue. She further stated, It's one of our failures from the last survey, and emphasized, If it's not documented, it's not done.During an interview on 10/23/2025 at 4:39 p.m., the Director of Nursing (DON) stated that activities should be encouraged for all residents. She stated that if a resident refuses to participate in one activity, staff should offer alternatives based on the resident's preferences and ensure those preferences were asked about regularly. The DON stated if the residents continue to refuse, staff must document what was offered and the resident's response. The DON stated that it was difficult to determine whether in-service training has been effective, as staff continue to repeat the same failures. The DON stated that she will continue to provide in-service education and training for all activities staff and their supervisors to address these ongoing issues.During review of the facility's policy and procedures (P&P) titled, Program Activities, undated, the P&P indicated Facility should develop an activity schedule with person served. These activities will address current needs, skills, abilities and preference of those served. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on interview and record review, the facility failed to assess and provide treatment for constipation for one of three sampled residents (Resident 96), when Resident 96 did not have a bowel movement for four consecutive days on two separate occasions.This deficient practice resulted in delayed intervention and had the potential to cause abdominal discomfort, distention, and bowel obstruction.During a review of Resident 96's admission Record, the admission Record indicated the facility admitted Resident 96 on 6/27/2019, with diagnoses including major depressive disorder (a mood disorder that causes a persistent feelings of sadness and loss of interest), schizoaffective disorder (mental illness that can affect thoughts, mood, and behavior), and movement disorder (a neurological condition causing problems with movement either with too much, too little, or slow movement).During a review of Resident 96's Psychiatric Progress Notes, dated 10/15/2025, the Psychiatric Progress Notes indicated Resident 96 required frequent reorientation to reality.During a review of Resident 96's Minimum Data Set (MDS-a resident assessment tool), dated 10/7/2025, the MDS indicated, Resident 96 had intact cognition (ability to think and understand). The MDS indicated Resident 96 was independent for personal hygiene, dressing and toileting.During a review of Resident 96's Care Plan Report, dated 10/2025, the Care Plan Report indicated, Resident 96 at risk for hard stool formation related to use of psychotropic medications.Monitor bowel movement and follow bowel management protocol as ordered. Report any stool abnormalities.During a concurrent interview and record review on 10/24/2025 at 10:37 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 96's Bowel Movement Record, dated 10/2025 was reviewed. The Bowel Movement Record indicated, Resident 96 did not have bowel movement on 10/10/2025 to 10/13/2025 and 10/16/2025 to 10/19/2025. LVN 3 stated Resident 96 did not have bowel movement for four consecutive days on two separate occasions. LVN 3 stated the importance of monitoring residents to ensure they were not constipated and the lack of monitoring for constipation could result in abdominal discomfort, distention or obstruction.During a concurrent interview and record review on 10/24/2025 at 11:28 a.m., with Director of Nursing (DON), Resident 96's Nursing Notes, dated 10/2025 was reviewed. The Nursing Notes indicated no documented follow up by either LVN or Registered Nurse (RN) when Resident 96 had no bowel movement for more than two days. The DON stated LVN or RN should have followed up on the dates Resident 96 had no bowel movement. The DON stated bowel movement should be monitored daily, because if not checked, can result in abdominal discomfort, distention and bowel obstruction.During a review of facility's policy and procedure (P&P) titled, Job Description Licensed Vocational Nurse (LVN)/Licensed Psychiatric Technician (LPT), undated, the P&P indicated, Essential functions.Collects data relevant to care of members served.Documents the progress of members served toward their recovery plan goals. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents with or without limited range of motion (ROM-movement of joints) received appropriate treatment and services to maintain or improve mobility to ensure that one of four sampled residents (Resident 88), who had physician's orders for ROM exercises, received services as directed by the Restorative Nursing Assistant (RNA).This deficient practice had the potential to contribute to the development of contracture (conditions involving the shortening and hardening of muscles, tendons, or other tissues) and decreased functional ability in Resident 88's extremities.Findings:During review of Resident 88's admission Record, the admission Record indicated Resident 88 was admitted to the facility on [DATE] with diagnoses including anxiety (conditions that cause excessive and persistent feelings of fear or worry that can interfere with daily life), schizoaffective disorder( a mental illness that can affect thoughts, mood, and behavior ), and muscle weakness (loss of muscle strength).During a review of Resident 88's Order Summary Report indicated a physician's order dated 08/11/2025 to continue RNA exercises, daily, Monday through Friday, sit to stand, or as tolerated, Active range of motion (AROM- performance of ROM of a joint without any assistance or effort of another person) passive range of motion (PROM movement at a given joint with full assistance from another person) -, hips, knees, ankles, shoulders, elbows wrists, all plane. Supine to sit, prolonged sitting (moderate assist), as tolerated. During a review of Resident 88's Minimum Data Set (MDS -resident assessment tool), dated 10/01/2024, the MDS indicated Resident 88's cognitive (ability to think, understand, learn, and remember) skills for daily decisions making was intact. The MDS indicated Resident 88 required setup or clean up assistance (helper set up or clean up; resident completes activity) from staff for Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a concurrent interview and record review on 10/23/2025 at 11:42 a.m. with Restorative Nursing Assistant (RNA) 1, RNA flow sheet was reviewed date 10/22/2025. The RNA flow sheet indicated that ROM (range of motion) exercises were not performed for Resident 88 on 10/22/2025. The RNA flow sheet for 10/22/2025 was not signed, and no documentation was present. RNA 1 stated, Yes, I misread the order. I thought it was discontinued. RNA 1 stated she was looking at the discontinued order and missed the active order for 10/22/2025 to perform ROM exercises. RNA 1 further stated that it was important to perform ROM exercises as ordered, especially for residents who are unable to perform these movements independently. RNA 1 stated that without consistent ROM exercises, staff cannot accurately assess whether a resident was improving or declining in mobility. RNA 1 stated Moving forward, I will make sure I don't miss any RNA exercise orders. I will read the orders carefully, sign, and document once I complete my duties. During an interview on 10/23/2025 at 4:39 p.m., the Director of Nursing (DON) stated that Restorative Nursing Assistants (RNAs) were expected to read and follow physician orders accurately and document their tasks immediately after completion. The DON stated that if staff were unclear about any aspect of a physician order, they should seek clarification and ask for assistance, as support was always available. The DON stated the need for improvement and stated that additional training and in-service education will be provided to RNA staff to reinforce proper documentation practices and ensure compliance with physician orders.During review of the facility's policy and procedures (P&P) titled, Rehabilitative Nursing Care, undated. The policy indicated that, Facility rehabilitation nursing Care program is designed to assist each resident to achieve and maintained that optimal a level of care self-care and independence.4.Rehabilitation nursing care program is performed daily by RNA, at least five times a week for those who require such service. Such program includes but is not limited to maintaining good alignment and proper positioning includes. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the privacy curtain was secured to its curtain rack for one of one resident (Resident 138).This failure had the potential for Resident 138 to sustain an injury.Findings:During a review of Resident 138's admission Record, dated 10/24/2025, the admission record indicated Resident 138 was admitted to the facility on [DATE] with the diagnosis including schizophrenia (a mental illness that can affect thoughts, mood, and behavior), anxiety (emotion characterized by feelings of tension, worried thoughts) and insomnia (trouble falling asleep or staying asleep).During a review of Resident 138's History & Physical (H&P) dated 1/31/2025, the H&P indicated Resident 138 was alert and oriented.During a review of Resident 138's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/25/2025 the MDS indicated Resident 138's cognition was intact. The MDS also indicated Resident 138 was independent with activities of daily living ([ADL's] - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a concurrent observation and interview on 10/21/2025 at 12:27 p.m. with Resident 138 in Resident 138's room. Resident 138's privacy curtain was not fully attached to the curtain rack. The privacy curtain was missing five hooks and was hanging on the floor. Resident 138 stated his curtain had been like that in his room for six months. During a concurrent observation and interview on 10/21/2025 at 1:50 p.m. with Certified Nursing Assistant 7 (CNA7) in Resident 138's room, CNA 7 stated the privacy curtain should not be touching the floor. CNA 7 stated there was a safety concern and Resident 138 could possibly fall and get injured.During a concurrent observation and interview on 10/21/2025 at 1:55 p.m. with Licensed Vocational Nurse 7 (LVN7) in Resident 138's room. LVN 7 stated the privacy curtain should not be on the floor because Resident 138 could fall and get injured. During an interview on 10/24/2025 at 1:02 p.m. with the Director of Nurses (DON), the DON stated the resident's privacy curtain should not be touching the floor. The DON stated the residents could become anxious and fall trying to get through the privacy curtain.During a review of the facilities Policy's and Procedure (P&P) titled (Safe and Comfortable Environment) the P&P indicated The facility will maintaining a safe, clean, comfortable and homelike environment includes, but is not limited to establishing and maintaining practices that ensure that the physical space is routinely cleaned/sanitized in accordance with applicable infection control procedures and is free of accident hazards to the extent possible/practicable. F-689 cross reference F880 |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of two sampled residents (Resident 56) received effective pain management. The facility failed to:1.Ensure that Licensed Vocational Nurses (LVNs) administered appropriate pain medication based on Resident 56's assessed pain level.This deficient practice had the potential to result in inadequate and ineffective pain management for Resident 56, placing the resident at risk for unnecessary discomfort, and potential decline in physical and psychosocial well-being.Findings:During a review of Resident 56's admission Record, the admission Record indicated Resident 56 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety disorder( mental health condition characterized by excessive and persistent worry, fear or nervousness), bilateral (both) osteoarthritis of knee(progressive disorder of the joints, caused by a gradual loss of cartilage ) and extrapyramidal movement disorder( problem with muscle tone and control that causes involuntary movements like shaking and stiffness). During a review of Resident 56's Minimum Data Set (MDS- resident assessment tool) dated 7/9/2025, the MDS indicated Resident 56 had an intact cognition (ability to think, understand, learn, and remember) and was independent with bed mobility, toileting hygiene, and dressing.During a review of Resident 56's Care Plan titled Resident had an alteration in comfort related to pain due to osteoarthritis of both knees initiated on 1/23/2024 and revised 5/30/2025, the Care Plan goal indicated Resident 56 pain will be controlled with a target date of 10/27/2025. The Care Plan interventions included administering medicine and evaluating effectiveness in controlling or relieving pain.During a review of Resident 56's Medication Administration Record (MAR) , the MAR indicated a physician order dated 1/2/ 2024 of Tylenol ( medicine to relieve pain) 325 milligrams (mg- unit of measurement) two tablets by mouth every eight hours as needed for mild pain ( pain scale [ assessment tool used to measure the intensity of patient's pain by using numerical value of 1 to 10] of 1 to 3).During a concurrent observation and interview on 10/21/2025 at 9:46 a.m. with Resident 56 at her room, Resident 56 was sitting in her bed complaining of bilateral knee pain. Resident 56 stated the staff would only give her Tylenol and it does not relieve her pain.During a concurrent interview and record review on10/23/2025 at 11:57 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 56's Order Summary Report, dated 1/2/2024 and MAR, dated October 2025, were reviewed. The Order Summary Report indicated a Physician Order dated 1/2/2024 of Tylenol 325 mgs. two tablets every eight hours as needed for mild pain (pain level 1-3). The MAR indicated Resident 56 received Tylenol 325 mgs. two tablets for pain level were assessed as 4 on 10/22/2025. LVN 2 stated Resident 56 sometimes complained of pain in her knees and the staff provided her with Tylenol and diclofenac (medicine used for pain) cream. LVN 2 stated Tylenol 325 mgs. two tablets will not be effective in managing Resident 56's pain because it was ordered for pain level of 1 to 3 and the resident's pain level was at 4 at that time on 10/22/2025.During a concurrent interview and record review on 10/24/2025 at 10:27 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 56's MAR, dated October 2025 was reviewed. The MAR indicated, on 10/22/2025, Resident 56 pain level was 4 and on 10/24/2025 resident pain level was 5. The MAR indicated Resident 56 received Tylenol 325 mgs. two tablets by mouth for mild pain (pain level of 1 to 3) on 10/22/2025 and 10/24/2025. LVN 3 stated she should have contacted the physician to obtain additional medicine for pain because Tylenol 325 mgs. two tablets were only for mild pain (pain level 1 to 3) and the resident was assessed for pain level of 5. LVN 3 stated Resident 56 could be at risk for unresolved pain by not providing effective pain management.During an interview on 10/24/2025 at 12:14 p.m. with the Director of Nursing (DON), the DON stated the licensed nurse should have notified the physician to obtain treatment or medicines that can relieve Resident 56's pain to ensure resident's pain was managed and controlled.During a review of facility's Job Description of a Licensed Vocational Nurse undated, the facility's Job Description of LVN<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | indicated the LVN will provide recovery focused services related to the safe and appropriate administration of medical treatment, including medications prescribed by the physician. The Job Description of LVN indicated the LVN will notify the prescriber and nursing supervisor of any changes in condition of a resident. |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN 4) received in-service training on physician notification, weight loss, nutrition, and hydration.This failure had the potential to result in residents not receiving appropriate nursing care and posed a risk of harm due to unmet healthcare needs.Findings:During an interview on 12/2/2025 at11:23 a.m. with LVN 4, LVN 4 stated she works on a per diem basis and had not received in-service training related to weight loss, nutrition, or hydration. LVN 4 stated she could not recall whether she had received training on physician notification procedures. During a concurrent interview and record review on 12/2/2025 at 3:35 p.m. with the Director of Staff Development (DSD), the In-Service Sign-In Sheets titled Notification of the Physician, dated 10/28/2025 and 10/29/2025, were reviewed. The documentation indicated that LVN 4 did not complete the required fields for employee name, signature, title, and department. Additionally, In-Service Sign-In Sheets titled Weight Loss, Nutrition, and Hydration, dated 10/27/2025, 10/28/2025,11/1/2025,11/2/2025,11/3/2025 and 11/10/2025 were reviewed. The In-Service Sign-In Sheets indicated LVN 4 had not documented attendance or provided the required identifying information. The DSD stated that all staff were expected to participate in in-service training to ensure nursing care, particularly related to meals and weight loss, was delivered appropriately. During an interview on 12/2/2025 at 4:18 p.m. with the Director of Nursing (DON), the DON stated staff that were not present for the in-services were sent emails to attend the in-service when they returned to work. The DON stated LVN 4 would not know how to proceed with implementing care for residents without attending the in-services. During a review of the facility's policy and procedure (P&P), titled Staffing (SNF), dated 11/15/2024, the P&P indicated, The facility must have sufficient nursing staff with appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. |

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| F 0732<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Post nurse staffing information every day.<br><br>Based on observation, interview, and record review, the facility failed to ensure actual hours worked was posted in an area visible to residents and the public. This failure had the potential to mislead residents and families about nursing staff and potentially affecting residents' care and safety.During an observation on 10/22/2025 at 10:28 a.m. the nurse staffing document titled Daily Schedule was posted by the entrance in between the staff restroom and living room near the nursing station. The Daily Schedule was updated with staff call offs and add on but did not indicate actual hours worked.During an observation on 10/23/2025 at 7:40 a.m. the nurse staffing titled Daily Schedule was posted by the entrance in between the staff restroom and living room near the nursing station. The Daily Schedule was updated with staff call offs and add on but did not indicate actual hours worked.During a concurrent interview and record review on 10/24/2025 at 10:06 a.m. with the Director of Nursing (DON), The DON stated the total nursing staff of 24 included the infection prevention nurse and minimum data set (MDS- assessment tool) nurse. The DON stated the Daily Schedule did not include actual nursing hours worked, and the nursing hours were not updated throughout the day. The DON stated the requirement for posting nursing hours was somewhere visible to the residents and the public and the form should be updated throughout the day. The DON stated the reason for actual hours worked to be posted and updated was to ensure patient safety and identify if there were enough staff scheduled and worked to care for the residents. During a review of the facility's policy and procedure titled, Daily Nursing Staffing Sheet or Equivalent dated, 05/03/2025, the policy does not specify anything about actual hours worked. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's Quality Assurance and Performance Improvement (QAPI data-driven plan of action to correct identified and potential problems) failed to maintain and develop action to correct identified and potential problems. The facility failed to:1.Provide effective oversight and ensure implementation of the plan of correction related to the deficient practice identified during the previous recertification survey regarding the prevention, identification, and reporting of abuse.2.Identify and monitor residents at risk for weight loss to ensure timely interventions and prevent further decline.These failures had the potential to negatively impact residents' quality of care and safety, and could result in abuse going unrecognized and uninvestigated, as well as unaddressed nutritional decline among vulnerable residents.Findings: 1.During a review of facility's Center of Medicare and Medicaid 2567 (CMS- survey report that documents and justifies a nursing home's compliance with federal health requirements) Recertification Survey dated 10/18/2024, the CMS 2567 indicated the facility failed to ensure a resident was free from abuse. The CMS 2567's plan of corrections (POC- actions or interventions of the facility to correct deficient practice) indicated resident behavior monitoring logs would be added to the Registered Nurse (RN) shift report to ensure the charge nurse communicated with physician of any resident exhibiting aggressive behavior, what orders and interventions were carried out and findings will be incorporated into the monthly QAPI meetings. The CMS 2567's POC included quality audits would be reviewed by the Administrator.During an interview on 10/24/2025 at 9:45 a.m. with Resident 63, Resident 63 stated Resident 146 touched her hip and behind while on the phone two days after being admitted to the facility on [DATE]. Resident 63 stated the incident made her feel scared and she informed a nurse (unknown), the Administrator and a male social worker about the incident. The allegation of abuse was reported to CDPH (California Department of Public Health) after the CDPH surveyor spoke to the Administrator on 10/21/2025 at 11:14 a.m. about what happened to Resident 63.2. During the Recertification Survey conducted from 10/21/2025 to 10/24/2025, the survey team identified significant weight loss on Resident 8.During an interview on 10/24/2025 at 3:47 p.m. with the Clinical Director (CD), the CD stated the residents were identified for weight loss by doing weekly meetings, weighing resident's weekly who are at risk for weight loss.During an interview on 10/24/2025 at 3:47 p.m. with the Director of Nursing (DON), the DON stated Resident 8 was not identified for weight loss and unfortunately the staff was not able to let them know due to a problem with staff competency.During an interview on 10/24/2025 at 3:47 p.m. with the Administrator (ADM), the ADM stated it was important to have QAPI in the facility to identify problems and improve quality of care.During a review of facility's policy and procedure (P&P) titled SNF Quality Assurance Performance Improvement Program approved on 3/12/2025, the P&P indicated The facility must develop, implement, and maintain an effective, comprehensive, data driven QAPI Program that will focus on the indicators of care and quality of life. The P&P indicated QAPI Program will be ongoing, comprehensive, and capable of addressing the full range of care and services the facility provided. The P&P indicated The facility must address all systems of care including clinical care, quality of care, quality of life and resident's choice. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 05A355 | A. Building<br>B. Wing | 10/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LA Paz Geropsychiatric Center | 8835 Vans Street<br>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 0911<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that resident bedrooms did not accommodate more than four residents, as required. The facility failed to ensure:1.Rooms 12, 13, 20, and 21 did not exceed the maximum occupancy by having six residents each and rooms [ROOM NUMBER] did not exceed the limit by having five residents each.This failure had the potential to compromise residents' privacy, reduce their quality of care, and negatively impact their overall quality of life.Findings:During a record review of the Client Accommodations Analysis Form, completed by the facility on 10/21/2025, the Client Accommodations Analysis Form indicated four (4) rooms, Rooms 12, 13, 20, and 21 accommodated six residents and room [ROOM NUMBER], 47, and 48 accommodated a total of 5 residents in each room.The observation made to the requested rooms during the annual recertification survey at the facility from 10/21/2023-10/24/2023, revealed there were no noted concerns with space, privacy, care, and safety issues to the residents.During an interview on 10/24/2025 at 12:12 p.m. with the Director of Nursing (DON), the DON stated there were no complaints about care, privacy and safety issues from residents in the rooms where more than four residents were accommodated.During a review of the facility's policy and procedure (P&P) titled, Safe and Comfortable Environment, dated 4/30/2025, the P&P indicated no more than four residents shall be accommodated in one room within the facility |