STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A355	A. Building B. Wing	10/18/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview and record review, the facility failed to ensure two of four sampled residents (Resident 65 and Resident 89) was free from physical abuse by failing to: 1. To protect Resident 65 from Resident 37 who hit a staff member on the way to their room, and then hit Resident 65 with a table who was her roommate. This failure resulted Resident 65 getting hit by the table sustaining a small cut to right forehead. Findings: During a review of Resident 65's Admission Record, the Admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses that included paranoid schizophrenia (mental illness characterized by a pattern of behavior where a person feels distrustful and suspicious of other people and surroundings) and unspecified dementia (a progressive stated of decline in mental abilities) without behavioral disturbance. During a review of Resident 65's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 8/30/2024, the MDS indicated the resident had an intact cognition (thought process) and was independent with bed mobility, walking and transfer to and from a bed to a chair. During a review of Resident 65's Post Event Assessment Form dated 10/11/2024, the Post Event Assessment Form indicated on 10/11/2024, at 3:00 p.m., Resident 65 came to the nursing station seeking help and staff observed the resident was bleeding on her right forehead. During a review of Resident 65's Progress Notes dated 10/11/2024, at 3:00 p.m., the Progress Notes indicated the resident came to the nursing station seeking help and was bleeding from the right side of the forehead, The Progress Notes indicated Resident 65 Resident 37 had thrown a table while she was passing by which caused the table to hit her. During a review of Resident 65's Care Plan, the Care Plan initiated on 10/11/2024 indicated the resident is at risk for psychosocial distress related to unintended occurrence (small cut to right forehead). The Care Plan's interventions included notification of the physician for any changes and the staff will check the resident and allow the resident to express feelings. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 37's Admission Record, the Admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and schizophrenia ((a mental illness that is characterized by disturbances in thought). During a review of Resident 37's MDS dated [DATE], the MDS indicated the resident was able to make herself understood and able to understand others. The MDS indicated the resident had moderately impaired cognitive skill (difficulty in thinking, learning, remembering, and using judgements) and was independent with bed mobility, walking and transferring to and from a bed to a chair. During a review of Resident 37's Post Assessment Event Form dated 10/11/2024, at 6:11 p.m. , the Post Assessment Event Form indicated on 10/11/2024, at 3:00 p.m. the resident was exhibiting delusional (having false or unrealistic beliefs) thinking and stated Love, I was asleep and the two ladies came up to me and one of them put her thumb up my butt and with her other hand took out my fetus, it's still there outside you can see it, then the other one came with razor blades and cut my face, see all this blood and look at my back they did a number on me. Ms. [NAME] expressed remorse for inadvertently harming Resident 65, stating, I am so sorry hunny, you should not be getting in people's way when they are upset, I did not mean to hit you. During a review of Resident 37's Psychiatric Notes dated 10/11/2024, at 3:48 p.m., the Psychiatric Notes indicated resident was seen in her room with paranoid delusional (a type of delusion that involve intense fear and anxiety and the belief that others are persecuting or threatening) content and accusing roommate to have caused her to have miscarriage. The Psychiatric Notes indicated the resident was involved in two physical incidents on 10/11/2024, first one was a staff who was hit on the right arm and the second incident was resident's roommate whom the resident hit on the right side of the forehead. During a review of Resident 37's Care Plan initiated 10/11/2024, the Care Plan indicated the resident is at risk for further escalating behavior related to bizarre delusions. The Care plan goals included the resident will have no episodes of escalating (worsening) aggressive behavior. The Care Plan interventions included the staff will anticipate escalating behavior, monitor for increased agitation and to notify the psychiatrist if observed. During a concurrent observation and interview on 10/15/2024, at 10:43 a.m. on Resident 65's room, Resident 65 was counting with her fingers and had a band aid on the right side of her forehead. During an interview on 10/16/2024, at 9:31 a.m. with Resident 37, Resident 37 stated she got in a fight with her roommate and hit her with a table. Resident 37 stated Resident 65 had a little bruise and cut on her head. During an interview on 10/16/2024, 1:14 p.m. with Certified Nursing Assistant (CNA 8), CNA 8 stated Resident 37 had behavioral issue like slamming door, talking loudly, stating to get out of the room because her sister is on the way and throwing things on the floor. CNA 8 stated on Resident 37 liked to strip the bed then toss the beddings or clothes on the floor. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/16/2024, at 3:24 p.m. with RN Supervisor (RNS 1), RNS 1 stated Restorative Nursing Assistant (RNA1) told him that Resident 37 hit her while Resident 37 was walking back to her room. RNS 1 stated Resident 37 slammed the door after entering and shortly after that Resident 65 came out of the room and asking for help. RNS 1 stated Resident 65 was holding her head and was bleeding on the right side of the forehead. RNS 1 stated Resident 65 was not manifesting any behavioral problem that day and Resident 37 was seen talking to herself but was in good mood. RNS 1 stated someone should have gone to check Resident 37 after hitting RNA 1 and slamming the door to ensure Resident 37 is not a threat to anyone and ideally someone should have observed that her behavior is escalating. During an interview on 10/18/2024, at 10:44 a.m. with Assistant Director of Nursing (ADON), ADON stated the incident between Resident 65 and Resident 37 was preventable if someone had come to the room when Resident 37 hit a staff on her way to her room and slammed the door to deescalate the situation. ADON stated someone should have talked to Resident 37 when she was manifesting this kind of behavior. During an interview on 10/18/2024, at 12:22 p.m. with Social Service (SS1), SS 1 stated Resident 37 was upset and threw a table to Resident 65 who was passing by. SS 1 stated Resident 37's behavioral symptoms are physical aggression, verbal aggression, auditory hallucinations, paranoid delusions, and disorganized thoughts. SS 1 stated paranoia triggered the aggression of Resident 37. SW 1 stated the nursing staff should have come to Resident 37's room to address the issue to prevent escalation of behavior and harm to herself others or others. During an interview on 10/18/2024, at 12:54 p.m. with SS 2, SS 2 stated Resident 65 had no history of aggression towards other residents. SS 2 stated Resident 65 used to go out in the patio but lately she's just staying in her room. During an interview on 10/18/2024, at 5:07 p.m. with Director of Nursing (DON), DON stated Resident 37's behavior was unpredictable, and a staff member should have immediately entered the room to see what was going on and defuse Resident 37's delusions. DON stated the staff should have assessed Resident 37, calmed her down and redirected her behavior to prevent Resident 65 from getting hurt. During a review of facility's policy and procedure (P/P) titled Abuse Prevention and Reporting approved on 1/30/2024, the P/P indicated the facility is committed in protecting the physical and emotional well-being of every resident. The P/P indicated the staff is required to intervene, identify, and correct situations where any type of abuse or suspected crimes may occur. 49889