STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A355	A. BUILDING _____ B. WING _____	**05/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to adequately supervise one of two sampled residents (Resident 2) after he was placed on continuous 1:1 monitoring (One staff to constantly monitor one resident) due to almost getting into a physical altercation with Resident 1. Resident 2 threatened to beat up Resident 1 and would not comply with staying away from Resident 1. The facility failure to adequately supervise Resident 2 resulted in Resident 2 hitting Resident 1, who sustained swelling to the forehead and left side of his face. Findings: A review of Resident 1's Admission Record indicated Resident 1 was admitted on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS-a care assessment and screening tool) dated 1/1/20, indicated Resident 1 was cognitively intact (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 1 was independent with bed mobility and transfers. required extensive assistance with dressing, toilet use, and personal hygiene with one-person physical assist. A review of Resident 1's Progress Notes dated 2/29/20, at 2:07 p.m., indicated Resident 1 had multiple episodes of delusions (beliefs that are not true) and responding to internal stimuli. Attempted to fight peers and staff related to delusions of people hitting his wife. A review of Resident 1's Progress Notes dated 3/1/20, at 10:57 a.m., indicated staff was doing 1:1 monitoring with Resident 2, when Resident 2 suddenly push Resident 1, who then fell to the floor. Resident 1 stated Resident 2 hit me in the face and that is why I fell . Resident 1 had swelling on the forehead and left side of his face and complained of pain of 6/10 (on a pain scale of 0-10 with 0-no pain to 10-extreme pain). A review of Resident 2's Admission Record indicated the resident was admitted on [DATE], with [DIAGNOSES REDACTED]. Resident 2 was independent in bed mobility, transfers, and toilet use. Resident 2 required supervision with dressing, eating, and personal hygiene. A review of Resident 2's Social Service Progress Note, dated 2/29/20, at 1:10 p.m., indicated Resident 2, almost getting into a physical altercation with male peer (Resident 1). The note indicated the male peer accused him of trying to steal his girlfriend. Resident 2 was agitated with male peer throughout the day. Resident 2 stated, I am going to beat his a because he keeps f . . with me. The Clinical Director discussed with Resident 2 that the male peer would be kept away from him (Resident 1). Resident 2 stated, I don't care, I am going to get him. Resident 2 would not comply with staying away from male peer (Resident 1). Resident 2 was placed on 1:1, close observation. A review of Resident 2's Social Service Progress Note, dated 3/1/20, at 9 a.m., indicated after smoke break, staff asked Resident 2 if he wanted to go to his room. Resident 2 stated he wanted to walk. Resident 2 walked toward the front lobby. Resident 1 was standing by there. Resident 2 suddenly pushed Resident 1. Resident 2 stated, I hit him in the face. Tell him not to mess with me. During an interview, on 3/11/20, at 1 p.m., Resident 2 stated he hit Resident 1 in the eye, causing Resident 1 to fall. Resident 2 stated, I got him back. During an interview on 3/11/20, at 2:11 p.m., the Director of Nurses (DON) stated, that Resident 1 and Resident 2 had a prior altercation, which led Resident 2 to be a 1:1 observation. The DON stated, because of the history of Resident 1 and 2, and Resident 2 being on 1:1 at the time of the incident, the expectations of the staff should have been to keep Resident 1 and 2 away from one another, or step in between them, if they did happen to cross paths within the facility. The DON further stated that the incident between Resident 1 and 2 could have been prevented. A review of the facility's policy and procedures, titled, Precautions (Close Observation), revised on 6/13/18, indicated residents who are demonstrating increased amount of harm and risk may be place on close observation or precaution for a set amount of time to better monitor their behaviors and ensure safety. Residents on CO (close observation)/Precautions will have documentation of their whereabouts/activity every 15 or 30 minutes on the individual Close Observation/Precautions Record in the Medical Record. It may be necessary to place a resident on constant observation, 1:1 observation.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.